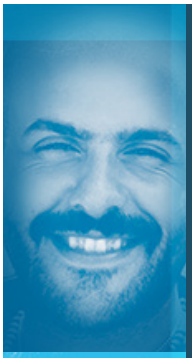

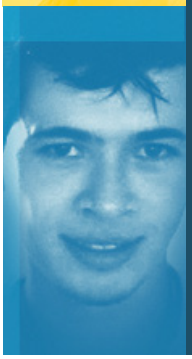

MARCH 2016

KEY POPULATION PROGRAM IMPLEMENTATION GUIDE

USAID
FROM THE AMERICAN PEOPLE

PEPFAR

LINKAGES
Across the Continuum of HIV Services for Key Populations

fhi360
THE SCIENCE OF IMPROVING LIVES

This program implementation guide is made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The contents are the responsibility of the LINKAGES project and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government.

The program implementation guide was created by the LINKAGES technical team. We thank the World Health Organization for its input into the Clinical Services program area. We also thank the University of Manitoba and LINKAGES consultants, who provided essential input. We gratefully acknowledge members of LINKAGES country teams who offered valuable feedback on a draft at a workshop in Kenya in February, 2016. We thank the Bill & Melinda Gates Foundation for its technical and financial support, and James Baer for his assistance in drafting the implementation guide.

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Contents

Introduction

Key populations — sex workers (SWs), gay men and other men who have sex with men (MSM), transgender people (TG), and people who inject drugs (PWID) — are disproportionately affected by HIV. At the same time, the stigma, discrimination, and threat of criminal prosecution faced by key populations around the world pose serious barriers to their ability to access quality, rights-based health care. The LINKAGES project (*Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV*), supported by the US President's Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID), aims to accelerate the ability of partner governments, key population-led civil-society organizations, and private-sector providers to plan, deliver, and optimize comprehensive HIV prevention, care, and treatment services at scale that reduce HIV transmission among key populations and extend life for those who are HIV positive. LINKAGES is partnering with more than 20 countries in Africa, Asia, and the Caribbean.

The LINKAGES approach is summarized in the cascade of services for HIV prevention, diagnosis, care, and treatment (see Figure 1). The Cascade is aligned with the United Nations 90–90–90 objective—by 2020, 90% of all people living with HIV will know their HIV status, 90% of people diagnosed with HIV infection will receive sustained antiretroviral therapy (ART), and 90% of people receiving ART will have viral suppression (Figure 2).

Figure 1. LINKAGES Cascade Framework

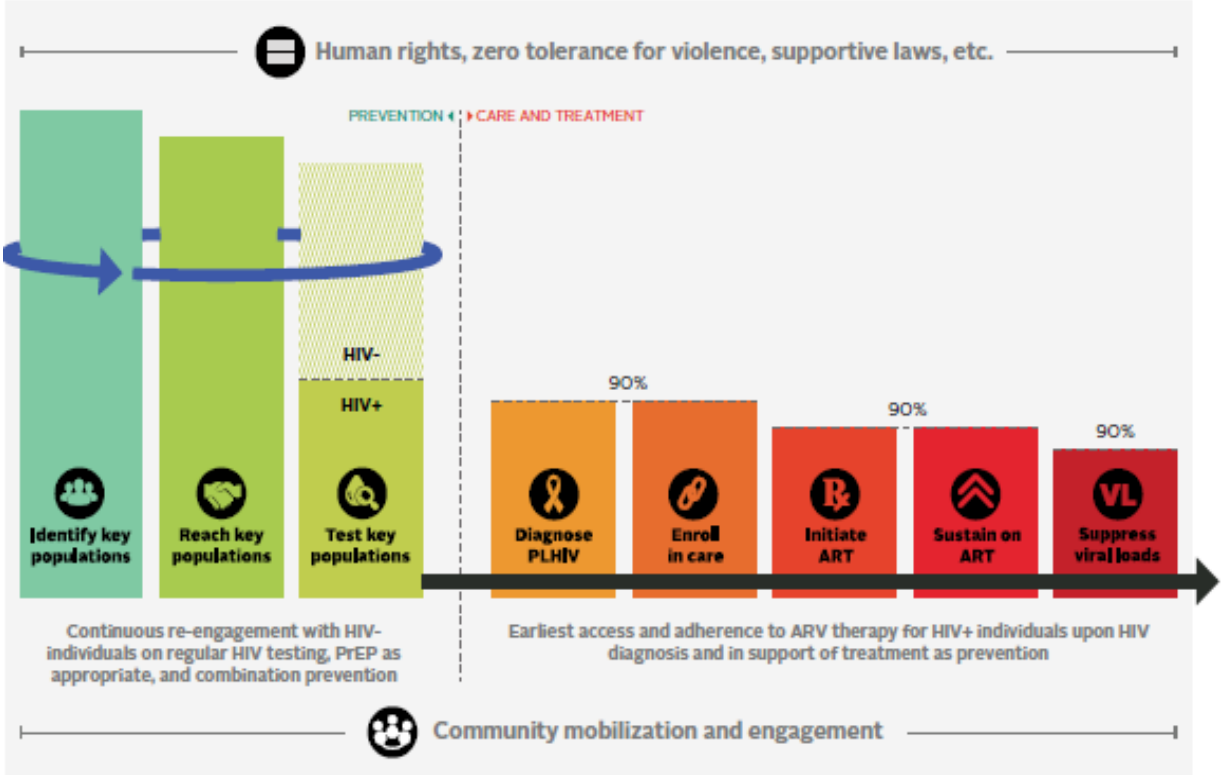
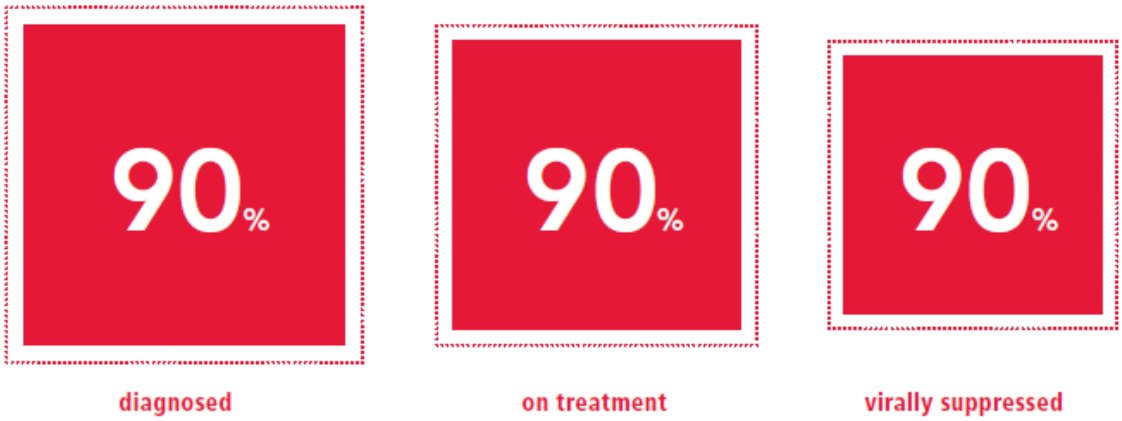


Figure 2. UNAIDS 90–90–90 goals for 2020



LINKAGES has established a global Program Acceleration Initiative that will use its existing partnerships to accelerate and strengthen the delivery of the comprehensive package of services at scale. This implementation guide is part of the initiative. It sets out the steps that programs can take to deliver services to key populations effectively and quickly.

Who Should Use this Guide?

This implementation guide will be useful for LINKAGES staff members wherever the program is operating, and for organizations that implement the LINKAGES program at the local level ("on the ground"). Although the guide may help partners that work with LINKAGES at the country level, such as Ministries of Health, the guide is designed for LINKAGES country programs.

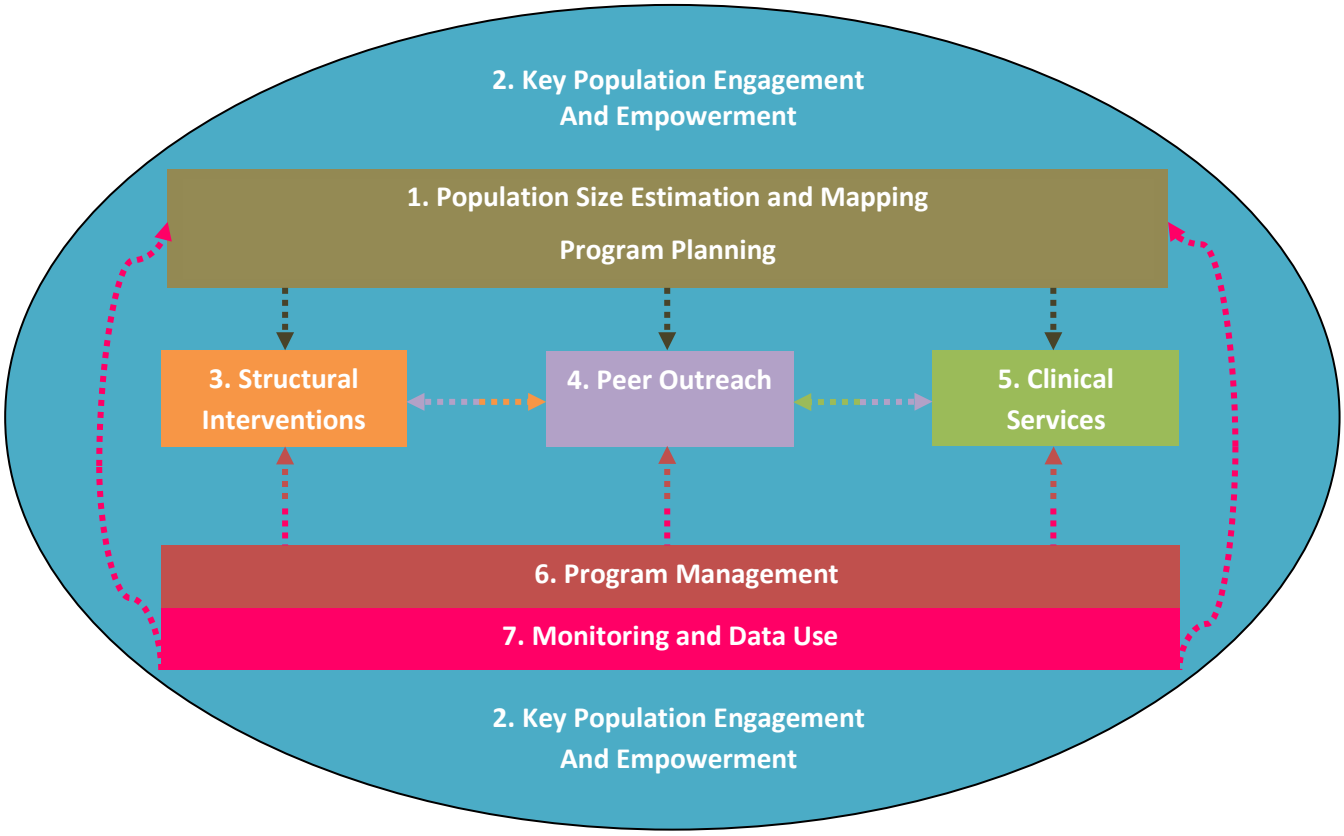
The guide is not exhaustive. It does not cover every intervention that could be useful, and it does not go into great detail about every aspect of an intervention. Instead, it aims to give information on the essential elements of the LINKAGES program, and to help standardize country programs based on proven, high-quality interventions from other countries.

In many LINKAGES countries, some of these elements may already be in place and may be functioning well. Annex 5 provides a simple checklist based on the implementation guide to assess existing programs and to identify gaps or ideas for developing and improving programs. It is important to note that the detailed implementation of these interventions may be subject to national guidelines and standards.

How to Use This Implementation Guide

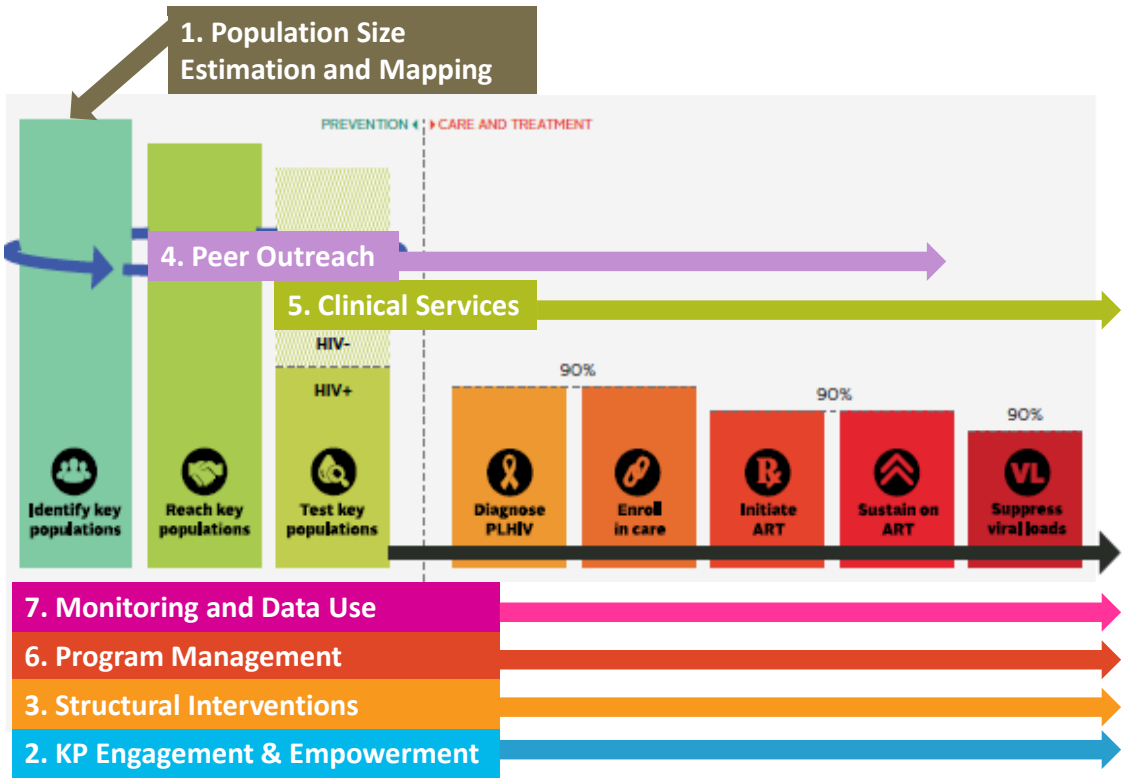
This guide is divided into seven sections, each covering a specific program area. These are numbered 1 to 7 in Figure 3, which shows the program cycle. **Population size estimation and mapping** (1) is the first stage of program planning. This is done in conjunction with the **engagement and empowerment of key populations** (2), which is the context for the whole program cycle. The program is implemented through **structural interventions** (3), **peer outreach** (4), and **clinical services** (5), which are interrelated. **Program management** (6) ensures high coverage of key populations with high-quality interventions and services. **Monitoring and data use** (7) also help to strengthen the reach and quality of services, and to revalidate population size estimates so that programming can be refined.

Figure 3. Program cycle



Each program area is relevant to at least one part of the LINKAGES Cascade, and several areas are relevant across the whole Cascade (Figure 4).

Figure 4. Program acceleration areas and the LINKAGES Cascade Framework



In this guide, each program area is divided into multiple "elements." These are listed on the following page, which serves as a table of contents. Pressing "Ctrl" on your keyboard and clicking on any element will take you to that element in the main part of the guide.

Index of Program Areas and Program Elements

1. In this Implementation Guide, each Program Area is laid out as a table.

2. Within each Program Area there are one or more Elements – the essential components of that Program Area.

Program Area 3. Structural Interventions

The structural interventions listed in this program area are essential for effective HIV prevention programs, since they address factors that prevent many KP members from prioritizing or addressing health concerns, including HIV. At the same time, programs or mechanisms that already exist in some countries, such as human rights commissions or systems for reporting and addressing violence, may provide a basis on which to develop the interventions described below.

Note that Elements 3.1 and 3.2 may be most effective if implemented at the same time, since responding to, and preventing, violence are activities that involve many of the same stakeholders, i.e. KP members, police, etc.

ELEMENT 3.1 ESTABLISH SYSTEM TO RESPOND TO INCIDENTS OF VIOLENCE, ABUSE, HARASSMENT, AND DISCRIMINATION AGAINST KP MEMBERS

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Assess the frequency, types, and perpetrators of violence through discussions with KP members.	•		Crisis Response Handbook, Step 1	Wherever possible, crisis response should build on processes (informal or formal) already existing in the community. Peer outreach workers are often members of crisis response teams. NGO staff (e.g. a designated outreach supervisor or others known to and trusted by the KP community) can provide technical assistance and support, but the response should be KP-community-led to the fullest extent possible.
2. Discuss with KP members the forms crisis response can take, and assess whether there are informal crisis response mechanisms within the				
is for				
hem				
c			SWIT 2.2.2	
			MIT 2.1 & Box 2.1	

3. For each Element, there is a series of numbered Implementation Activities. These are the steps that will help put that Element into action. Most Elements have fewer than 10 steps. In most cases, these activities should be followed in sequence, but occasionally they may overlap or be done simultaneously.

4. The dot indicates approximately when the activity should be done during the life cycle of the program. The "Start-up" phase is roughly the first four months, when this Program Area is being established. The "Roll-out" phase covers activities after about four months.

5. This column includes references to other resource materials, include the LINKAGES Monitoring Toolkit, other publications on programming with key populations, and items in the annexes at the end of this Guidebook. See Annex 4 for a list of these resources.

6. The Notes column gives brief additional explanations of general approaches to implementing each Element, or more specific guidance on content of the Implementation Activities.

Glossary

Hotspot: A specific location or area where members of key populations gather to meet. For example, a hotspot might be a bar where sex workers meet clients, or where men meet other men to arrange sexual encounters; it might be a park or public toilet where sexual encounters take place; a brothel where sex workers work; or an isolated area or private home where people gather to inject drugs together. Given that some members of key populations increasingly use the Internet to connect with one another, websites and social media can also be seen as "virtual" hotspots where programming for key populations can take place, such as through targeted information, education and communication.

Key populations: These are groups that are categorized by a behavior or gender identity, who are at high risk of contracting HIV. In the context of HIV and of LINKAGES, key populations are sex workers, gay men and other men who have sex with men, transgender people, and people who inject drugs. Their HIV risk is related to their behaviors but also to structural factors such as discrimination, stigma, violence, poverty, criminalization, and lack of access to health services. For closer definitions of these key populations, please see the Monitoring Toolkit, Section 1.2. "Key population members" are individuals in a key population; so sex workers are a key population, and an individual sex worker is a key population member.

Participation: In this implementation guide, participation is the active involvement of key population members in the planning, design, and implementation of programs. Meaningful participation of key populations is essential to building trust and establishing relationships that will make programs effective in the long term. Participation is meaningful when key populations choose how they are represented in the process of planning and designing programs, and who will represent them. It also means that their opinions, ideas, and contributions are given equal weight alongside those of people who are not key population members.

Power-holders and stakeholders: Power-holders are individuals, groups or organizations who hold and use power in a way that affects key populations. They could be law-enforcement officials, criminal gangs, brothel owners or pimps, religious organizations, and military or paramilitary groups. Stakeholders are individuals or organizations that have a relationship with key populations and an interest in what happens to them. Stakeholders could be providers of medical, psychosocial or legal services; the family, friends, or wider community of key population members; the police; or religious leaders. As will be clear, stakeholders may also be power-holders.

Prevention commodity: A prevention commodity is an item that can be used to help protect an individual from contracting HIV or another blood-borne disease. Prevention commodities include condoms and lubricants, needles and syringes for those who inject drugs, other drug-injecting equipment (e.g., sterilizing equipment and filters), and drugs to implement PrEP and PEP.

Sensitization: Sensitization is the process of helping an individual or institution learn about key populations and to better understand the identities and lives of key population members, and the particular difficulties that many of them face. Sensitization might include talking about sexual or drug-injecting behaviors, sexual orientation (in the case of men who have sex with men) or gender identity (in the case of trans people). Sensitization also includes explaining the stigma, discrimination and violence faced by many key population members, and helping individuals or institutions ensure that they do not stigmatize or discriminate against key population members. Sensitization is often most effective when carried out by key population members themselves.

Abbreviations

ART	Antiretroviral therapy
DIC	Drop-in center (drop-in service center)
HTS	HIV testing services
LINKAGES	Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV
OI	Opportunistic infection
OST	Opioid substitution therapy (methadone-assisted treatment)
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PPT	Periodic presumptive treatment
PrEP	Pre-exposure prophylaxis
SOP	Standard operating procedures
STI	Sexually transmitted infection
TB	Tuberculosis
TOR	Terms of reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Program Areas and Program Elements

Program Area 1. Population Size Estimation, Mapping, and Using Data for Program Planning				
ELEMENT 1.1 NATIONAL-LEVEL POPULATION SIZE ESTIMATION AND MAPPING				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Collect and review data from any previous national-level mapping or size-estimation exercises and HIV-prevalence studies, and determine the need for further mapping. 2. Map key populations in a high proportion (e.g., 70%) of urban centers with a general population greater than 5,000. 3. Compile, compare, and analyze data to finalize estimates for each type of key population. 4. Prioritize programs to saturate coverage in geographic areas with the largest key populations (Element 1.4).	• • • •		Monitoring Toolkit 4.1, 4.2 Monitoring Toolkit, Tool 1	The absence of national-level mapping or population-size estimates should not prevent programs from making plans at the local and hotspot level. Mapping of key population members at the local and hotspot level (Element 1.2 and Element 1.3) may be sufficient to begin programs; population-size estimates gathered at these levels can validate national figures. Useful sources of HIV-prevalence data include national studies, PMTCT (prevention of mother-to-child transmission) data, and HIV-testing data. The size of the urban centers to be mapped will depend on population density in the country. In some contexts it may be advisable to map 80% of urban centers to ensure accurate size estimates. In countries where there is evidence that sex work takes place primarily in rural areas, mapping should also focus on a selection of rural areas. Wherever possible, mapping should take place in collaboration with key-population representatives. Strict ethical standards must be maintained to ensure that mapping is not intrusive and does not endanger any key population members. See Monitoring Toolkit, p.35 (Ethical issues with mapping) and Element 6.2.

ELEMENT 1.2 LOCAL-LEVEL POPULATION SIZE ESTIMATION AND MAPPING *The local level is the level at which the implementing partner is working. This may be a county or district, or a defined area within a county or district.*				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Conduct mapping and size estimates within the county or district to increase the accuracy of the numbers, locations, and types of key populations within the area. 2. Compare and analyze data. 3. Prioritize programming to saturate coverage in specific areas with the largest numbers of key population members and those key population members who are most at risk and hardest to reach.	• • •		Monitoring Toolkit 4.1.2	
ELEMENT 1.3 HOTSPOT-LEVEL POPULATION SIZE ESTIMATION AND MAPPING				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Train and support key population members to conduct hotspot-level mapping and size estimates to precisely locate key population members, including "sub-types," and identify existing services, and the potential locations for other services (e.g., drop-in centers and clinics). 2. Conduct site validation on a regular basis (every six months) to keep mapping and site data up to date.	•	•	Monitoring Toolkit 4.1.2 Monitoring Toolkit, Tools 1, 1A, 1B Monitoring Toolkit, Tool 2	A key population may consist of "sub-types." For example, sex workers may be street-based, brothel-based or home-based; and some MSM may be sex workers, whereas others are not. Key population members who conduct such micro-level planning may go on to work as peer outreach workers. Peer outreach workers should develop micro-plans to identify and locate the individuals they are responsible for reaching each month. For further details, see Element 4.1.

ELEMENT 1.4 PLAN THE PROGRAM USING MAPPING AND SIZE ESTIMATION DATA				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Use mapping and size-estimation data to set program denominators.	•			
2. Calculate the number of service sites needed in a program area.	•		Monitoring Toolkit 4.2 and 4.3 Element 2.2	The number of key population members per site may need to be adjusted if they are widely dispersed in a geographic area (e.g., in rural areas) or if the geography makes travel very difficult (e.g., mountainous areas).
3. Assess existing infrastructure (e.g., clinics) and what is needed at the site level (project office, drop-in centers, or clinical services).	•		Monitoring Toolkit 4.3.1 and Tool 2	
4. Use data to identify the locations of drop-in centers and clinics as needed. See Element 2.2 and Program Area 5.	•			
5. Use mapping data to identify locations for condom and lubricant supply and distribution, e.g., hotels, bars, or health clinics.	•		Monitoring Toolkit 4.4.3 Monitoring Toolkit Tool 8A	
6. Where possible, analyze data to identify hotspots with high levels of violence.	•			
7. Complete an organizational chart for the program at the site level, showing the number of staff members (including peer outreach workers) required.	•		Monitoring Toolkit 4.3.2 Monitoring Toolkit Tools 3, 4 Annex 3	See also Element 4.1 for ratios of peer outreach workers to key population members.
8. Assign peer outreach workers to hotspots at the site level.	•		Monitoring Toolkit 4.2.2	

Program Area 2. Key Population Engagement and Empowerment

*Members of key populations should be integral to the planning, implementation, and monitoring of programs. This includes **all** the program areas listed in this implementation guide.*

ELEMENT 2.1 DEVELOP STAFFING OF PROGRAMS AND TEAMS BY KEY POPULATION MEMBERS

There are many positions within a program that are suitable for key population members. Engaging, supporting, and remunerating peer outreach workers and peer navigators is addressed in Program Area 4.

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Working with key population members, identify and prioritize program components where key population staffing is needed or will be beneficial.	•		SWIT 1.2.3 MSMIT 1.2.2	Positions may include outreach supervisors, drop-in center staff (see Element 2.2), and clinic staff. (See also Program Area 5.)
2. Write a "scope of work" for each position, including criteria and compensation.	•			These steps describe an ideal process. In the initial stages of a program, it may be more effective to use an informal process to identify and recruit key population members as program staff. Key population members should participate, and the process should be as open as possible. A more formal procedure should be adopted as soon as possible.
3. Develop a recruitment process for open positions and encourage key population members to apply.	•			
4. Sensitize the existing staff on working with key population members on the staff.	•			
5. Hire and train initial positions.	•		Monitoring Toolkit, Tool 5	
6. Establish regular supportive supervision (see also Element 6.3).	•			Consider the importance of hiring staff members who reflect the diversity of the target population, e.g., male, female, and transgender sex workers for a sex-work program, including the sub-types.
7. Gather regular feedback from service recipients and staff members (including the key population staff) on program effectiveness, including ways to maximize the contributions of the key population staff. Consider suggestion boxes, focus-group discussions, and anonymous surveys.	•			In all situations where program staff members who are not key population members are working with key population members, be aware of the dynamics of power, and work to ensure that key population voices are heard and respected. Non-key population staff members should be oriented to key population issues by key population
8. Develop a plan for professional development of key population staff (see also Element 4.6), including opportunities for key population staff to	•			

mentor new staff, and expanding the range and openings for key population staff. 9. Develop a plan to recruit new key population staff, including the management of turnover.		•		members.

ELEMENT 2.2 ESTABLISH DROP-IN CENTERS

- *A drop-in center (or "safe space") is a room rented by the program for community members to:*
  - *Relax in a safe environment, e.g., for sex workers who wish to shower, rest or make themselves up before or after work; or for key population members who wish to dress according to their gender expression*
  - *Meet one another and hold social activities and informal discussions, which are important components of building solidarity and of community mobilization*
  - *Take part in structured activities and training for community empowerment and mobilization*
  - *Meet the program staff and receive some program services, including clinical services for HIV (see Element 5.2).*
- *The drop-in center should be managed by the key population community as far as possible to suit their needs.*

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Work with key population communities to identify safe and accessible locations for drop-in centers, based on a review of mapping data, where available (see Element 1.4, Step 4).	•		SWIT 3.3 MSMIT 4.4.4	Community participation and input is essential in deciding the location, opening hours, choice of activities, and management of the drop-in center. The drop-in center should be located close to the greatest number of key population members to make access easier, but the safety of key population members who use the center is an essential consideration. The community should determine how the center should be identified: What kind of sign will not draw unwanted attention? Program services that may be provided at the drop-in center include: • Community empowerment and mobilization
2. Establish a drop-in center committee of key population members to plan and oversee the center and its activities (see Element 2.4).	•			
3. Consider whether advocacy or sensitization is needed with residents or business owners in the vicinity to allow for key population members to enter and leave freely.	•			
4. Determine the hours of operation and the facilities or services to be provided according to community needs.	•			

5. Budget for and procure necessary staffing and equipment. In budgeting, determine whether staff will need to have a background in certain areas such as counseling for survivors of violence. 6. Negotiate the lease with the landlord, clearly stating duration, rent, and notice period for either party to cancel lease. 7. Set up room(s) to be welcoming and safe. 8. Establish a schedule of key population members or staff members to be present at the drop-in center during open hours to welcome people and provide oversight. (The receptionist can be a key population member.) 9. Write rules of conduct for inside and outside the drop-in center (to avoid conflict between key population community members and local residents). 10. Establish an initial schedule of activities. 11. Publicize the drop-in center and its activities within the key population community, through other program outreach services and informal social networks. 12. Identify community priorities for further activities, including community capacity building (see Element 2.3). 13. Develop ways for communities to manage training and other drop-in center activities.	•	•	SWIT 3.3 MSMIT 4.4.4	activities, e.g., support groups, training on human and legal rights, advocacy training • Information, education and communication materials on HIV prevention, violence prevention, etc. • Condoms and lubricants, and needle and syringe exchange • Basic clinical services, e.g., HIV testing, ART, STI testing/screening, diagnosis and treatment • Contact with program staff, e.g., outreach supervisors For more details, see SWIT 3.3.2, MSMIT 4.4.4 If the drop-in center provides program services, these should follow national policies, just like services delivered at clinics or other facilities. There should be a dedicated space *separate* from the service delivery area for key population members to relax and hold social activities. A small room for private meetings is useful. If possible, provide separate areas for socializing/relaxing and for group meetings/training. A bathroom is an important feature; it should be gender-neutral to help transgender individuals feel comfortable. Community members may wish to decorate the room(s) themselves. Drop-in centers may be located near clusters of hotspots; if so, they may need to be relocated periodically if the locations of hotspots change.

14. Develop policies and procedures for handling issues that arise in managing the drop-in center, including a drop-in center oversight committee that can also address adverse events. 15. Periodically evaluate mapping data to determine whether the center is still located in an appropriate place (particularly if the lease is up for renewal). Relocate the center if this will make it more accessible and acceptable to key population members (and if it is logistically and financially possible).		•		The lease agreement should include a written understanding of the activities, likely numbers of visitors, and hours of activity, to avoid misunderstandings or giving any pretext for eviction. Consider security needs (secure locks on doors and on any cabinets containing confidential information) and safety needs (fire extinguisher, clearly marked exits). Scheduled activities may be purely social or provide training on livelihood skills. Activities may provide opportunities for key population members to connect with one another in a structured setting, such as support groups for individuals who have experienced violence. During the roll-out phase, activities may include training and structured forms of community mobilization and empowerment. The center can be used to celebrate key population members' birthdays, the births of their children, or other celebrations. Such events will encourage feelings of safety and ownership of a space where they are respected and valued.
		•		

ELEMENT 2.3 SUPPORT KEY POPULATION GROUPS THROUGH CAPACITY DEVELOPMENT AND ORGANIZATIONAL STRENGTHENING				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Support activities that help key population members identify common issues that they wish to address, and that increase their ability to develop their own initiatives.	•		Monitoring Toolkit 4.6.4	Activities can include informal discussions and organized meetings (power analysis, stakeholder analysis, or problem-solving). The drop-in center is a natural location for such activities. In all situations where the program staff is working with key population members, be aware of the dynamics of power, and work to ensure that key population voices are heard and respected.
2. Support the formation and development of community groups at the local level (venue, mentoring, institutional support where needed).	•		Monitoring Toolkit, Tool 15	
3. Foster leadership and governance skills through mentoring and training.		•	SWIT 6.7.1–6.7.3 MSMIT 6.5.2–6.5.6 South-to-South Mentoring Toolkit	Community groups may require support to establish democratic norms and leadership, and to work as a group to address community priorities.
4. Help key population members to become involved in other relevant program groups and committees (e.g., planning, funding, or implementation) so that they can gain knowledge, skills, and contacts.		•	SWIT 1.2.5, 1.2.6 MSMIT 1.2.5, 1.2.6	The process of legal registration can sometimes be assisted by national or regional networks of key populations or nongovernmental organizations. Specific training may be useful in resource mobilization, project management, and networking.
5. Help key population members to become involved in relevant events, committees and organizations at regional and national levels to advocate for key population concerns, including HIV prevention.		•		It is important to consider the local environment and whether attempts to legally register a key population organization might increase hostility or violence towards key population members.
6. Help new key population groups to network with established groups that work in HIV-related fields or key population rights.		•	SWIT 6.7.4 MSMIT 6.5.7 South-to-South Mentoring Toolkit	Although establishing key population groups is an essential feature of engagement and empowerment, programs must also recognize that some key population members may not wish to be involved in a group, and their choice should be respected. It is also important to understand that key populations are groups of diverse individuals,
7. Help form national or international networks of key population groups to learn from each other, including South-to-South mentoring.		•	SWIT 1.2.8 MSMIT 1.2.8 South-to-South Mentoring Toolkit	

8. Support organizational development of groups that wish to become legally registered so that they can apply for and receive funds, function independently of the program, and conduct democratic elections.		•	SWIT 6.6 MSMIT 6.5.1	and a key population member may not always identify with other key population members. Where one or more key population groups already exist in the program's geographic area, it is important to work with them to determine whether and how to develop any new groups. It is equally important to understand and be aware of any power dynamics between existing groups.
9. Help groups develop a plan for their sustainability.		•		Consider these elements of sustainability: • Setting clear goals for the group, and a process to review and adjust them periodically • Welcoming new members and involving them in the group's activities • Developing the leadership's accountability to its members • Developing new leaders to enable transitions of leadership over time • Developing financial solvency

ELEMENT 2.4 FOSTER OVERSIGHT OF CLINICAL SERVICES AND OTHER SERVICES BY THE KEY POPULATION COMMUNITY *Committees can be established to oversee clinical services, drop-in centers, peer outreach, clinical services, crisis response, and advocacy work. The role of the committee is to help ensure the effectiveness of the program and increase its coverage by consulting regularly with key population members who receive services and discussing any problems, recommendations and new ideas with service providers. This is done through regular meetings between key population committee members and the program staff.*				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Form key population community committees at the local level to meet monthly with the program staff.	•			
2. Develop TOR for the key population committees and build their capacity.	•		Kenya National Key Population Guidelines, pp.67–68	
3. Establish procedures for record keeping so that meetings are properly documented and decisions are followed up.	•			
4. Facilitate regular meetings of the key population community committee and the staff with the wider key population community to provide updates on project activities, and to share progress and challenges.	•			Project progress can be shared through easy-to-understand communication materials such as graphs, maps, or other visual aids. However, the confidentiality and safety of key population members must always be protected when information about the program is displayed.
5. Provide a strategic planning forum that allows committee members to recommend ways to increase the community's involvement in the program.		•		

Program Area 3. Structural Interventions

The structural interventions listed in this program area are essential for effective HIV-prevention programs because they address factors that prevent many key population members from prioritizing or addressing health concerns, including HIV. At the same time, programs or mechanisms that already exist in some countries, such as human rights commissions or systems for reporting and addressing violence, may provide a basis on which to develop the interventions described below.

Note that Elements 3.1 and 3.2 may be most effective if implemented at the same time, since responding to, and preventing, violence are activities that involve many of the same stakeholders, i.e., key population members, police, etc.

ELEMENT 3.1 ESTABLISH A SYSTEM TO RESPOND TO INCIDENTS OF VIOLENCE, ABUSE, HARASSMENT, AND DISCRIMINATION AGAINST KEY POPULATION MEMBERS

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Assess the frequency, types, and perpetrators of violence in talks with key population members.	•		Crisis Response Handbook, Step 1	Wherever possible, crisis response should build on processes (informal or formal) already existing in the community. Peer outreach workers are often members of crisis-response teams. Staff members of NGOs (e.g., a designated outreach supervisor or others trusted by the key population community) can provide technical assistance and support, but the response should be led by the key population community where possible. In all situations where program staff members who are not key population members are working with key population members, be aware of the dynamics of power, and work to ensure that key population voices are heard and respected. Initially the NGO may need to be involved in education to build relationships with stakeholders. Sub-activities include regular meetings, training, recognition for positive support, and endorsements from officials. Police training on
2. Discuss the different forms of crisis response with key population members, and assess whether existing mechanisms in the community might serve as a basis for organizing more formal responses to crises.	•			
3. Help the key population community understand that violence is not an acceptable norm, and that they deserve protection from violence as a matter of human and civil rights.	•		SWIT 2.2.2 MSMIT 2.1 & Box 2.1 Crisis Response Handbook, Step 6	
4. Contact the local police chief to explain the program and solicit support for violence prevention and response (see also Element 3.2).	•		SWIT 2.2.4 MSMIT 2.2.3 Crisis Response Handbook, Step 6	
5. Identify the infrastructure and supplies needed for crisis response: • Phones • Private space at drop-in center for interviews	•			

	or counseling for those who have experienced violence • IEC materials (posters, pamphlets, etc.) about services related to violence • Training of response team members, counselors, and documenters • Travel costs • Legal costs (if lawyers are retained rather than *pro bono* service)				violence and legal rights should be conducted by lawyers and key population members. In practice, the implementation of some steps will overlap. In particular, educating the key population community and building wider public support for a crisis response are ongoing tasks that will happen simultaneously.
6.	Write selection criteria and a scope of work for a crisis-response team, including defining an area of operation.	•		Crisis Response Handbook, Step 2 & Section 2	The crisis response protocol must include: • Continuous staffing of the system by crisis response team members • How to manage the hotline and phones • How to communicate with the crisis-response team when an incident is reported • Responsibilities of team members in responding to an incident • Procedures for immediate medical/legal/psychosocial care of the person who has experienced violence, including a dedicated team member to accompany the individual to services from external organizations. Medical care should include the provision of PEP (see Element 5.7). • Documenting the incident • Follow-up activities Community members can strengthen the system through their own initiatives, e.g., by setting up a Whatsapp group to share information and tips. Where centers already exist to provide support to people who have experienced gender-based violence, staff members should be given training to
7.	Write a protocol for crisis response, including communications and reporting system.	•		Monitoring Toolkit 4.6.1 Crisis Response Handbook, Sections 2.9, 2.10	
8.	Establish links with legal aid (e.g., lawyers willing to work *pro bono* or to offer legal-rights training to the staff and to key population members).	•			
9.	Establish links with trained psychosocial support providers.	•			
10.	Recruit and train crisis-response teams, and organize institutional support (from the implementing organization). This includes training response-team members, peer outreach workers and the drop-in center staff on how to respond to incidents of violence, and how to identify signs of violence among key population members.	•		Crisis Response Handbook, Step 3	
11.	Implement crisis response, and publicize the response system.	•		Crisis Response Handbook, Step 4	

12. Provide supportive supervision to crisis-response team members and others who are repeatedly exposed to stories of violence, to mitigate secondary trauma.	•			sensitize them to the particular needs of key population members, including MSM and transgender individuals.
13. Report and analyze data on violence and response, at local and higher levels (regional, state, and national). Ensure data is also fed back to the key population community.	•		Monitoring Toolkit, Tool 12 Crisis Response Handbook, Step 5	
14. Develop links with social service and health providers to screen clients for violence and to offer support to key population members who have experienced violence.	•		SWIT 2.2.7 MSMIT 2.2.6	
15. Continue to build public acceptance and support for crisis-response management by working with the media, networking with other groups, venue owners, police sensitization, and ongoing advocacy with the government.		•	Crisis Response Handbook, Step 7	
16. Integrate crisis-response activities with advocacy and community-mobilization activities.		•	Crisis Response Handbook, Step 8	
17. Integrate the crisis-response system with National Human Rights Commission to help ensure sustainability and ownership.		•		

ELEMENT 3.2 IDENTIFY, DESIGN, AND IMPLEMENT STRATEGIES FOR VIOLENCE PREVENTION WITH THE KEY POPULATION COMMUNITY AND WITH POWER-HOLDERS

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Ask key population members whether they have found ways to prevent violence, and determine whether these strategies can be systematically extended to protect and empower more of the key population community through:	•		For examples of strategies, see SWIT 2.2.5, MSMIT 2.2.4	Strategies may vary with the key population and the country context; it is essential to involve key population members in violence prevention. Make sure that strategies for violence prevention

• Contacts between peer outreach workers and key population members • Informal or formal group meetings at the drop-in center • Organized workshops and trainings • Training of the program staff and other service providers (see Element 3.3).				do not blame the survivors. For example, it would not be appropriate to tell someone their behavior made him or her a target after they share an experience of violence. When working with the police (and other power-holders or government bodies) use data to highlight the link between violence and HIV, and the resulting need to address violence.
2. Use existing structures at the county or district level (like technical working groups for key population members) in advocacy efforts to address violence against key populations.	•			Power-holders may include: • Police • Owners of bars or sex-work venues • Religious groups or religious leaders • Criminal gangs • Military or paramilitary groups • Health-care workers (see Element 3.3) • Schoolteachers (e.g., teachers of children of sex workers, or teachers of young MSM)
3. Program staff members and key population representatives should identify local power-holders and any concerns with police activities.	•			
4. Map police stations near the intervention area and target them for sensitization.	•			
5. The program director should make initial contacts with the police chief to introduce the program, explain its approach and its benefits to the wider community, and offer sensitization training as an HIV-prevention benefit for police officers.	•		Monitoring Toolkit 4.6.2 Crisis Response Handbook, Step 6	
6. Adapt the existing curriculum on violence prevention to address local circumstances if a suitable curriculum does not already exist.	•			Educate the police and others involved in the law-enforcement and judicial system on (a) the rights of key populations and people living with HIV, (b) the nature of the violence against key populations (provide local examples, and include physical, sexual, psychological, and economic violence), and (c) how to respond appropriately.
7. Train trainers in violence prevention, including key population members and police officers.	•		SWIT 2.2.4	
8. Pilot police training and gather feedback.	•		Monitoring Toolkit, Tool 13	
9. Monitor key population members' reports of violence, discrimination, or harassment by the police; follow up with the police as appropriate.	•	•		Training police officers to train other officers helps to ensure that knowledge and best practices are communicated to incoming officers. The

(See also Element 3.1, Step 15.) 10. Schedule regular violence-prevention trainings to reach the entire local police force and to cover new intakes of officers. 11. Repeat Steps 1 to 7 with other local power-holders, e.g., psychosocial service-providers, religious authorities, brothel owners, lodge owners, etc. 12. Offer recognition and appreciation to police officers and other power-holders who make a positive contribution to the well-being of the key population community. 13. Work with National Human Rights Commission to document, track, and respond to cases of violence.	•	•		involvement of key population members as trainers or co-facilitators helps to ensure that issues are communicated accurately and that key population members are seen as actively involved in addressing violence. Other power-holders should be encouraged to report incidents of violence to the crisis response team.

ELEMENT 3.3 DEVELOP STRATEGIES FOR REDUCING STIGMA IN HEALTH-CARE SETTINGS

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Ask the Ministry of Health for permission and support to sensitize the staff members of public health-care facilities that serve key population members.	•			Where clinical services are provided by referral to private providers, advocacy may be conducted at the level of the private-provider network (if this exists) or with the directors of individual clinics.
2. Arrange with directors of clinical facilities to conduct a rapid assessment of the facilities using the Key Population Stigma Assessment Tool, and discuss the results with key-population representatives and with lead staff members of the clinical facilities.	•		Key Population Stigma Assessment Tool	LINKAGES offers two components to help reduce stigma and discrimination in health-care settings: • A rapid assessment of stigma and discrimination experienced by key population members, using a tool developed for LINKAGES • A training curriculum on reducing stigma and improving clinical competency related to key populations, and on addressing other structural and programmatic barriers to
3. Consult with the directors and the lead staff members of the clinical facilities and with key population representatives to agree on a process	•		HCW Training	

for training health-care workers, and identify the number of staff members working with key population members who need training. 4. Develop written policies and procedures on stigma reduction to incorporate into the trainings of health-care workers as appropriate. 5. Develop regular training schedules, taking into account the need for an initial (and follow-up) training of the entire staff and for training new staff members. 6. Identify and train the trainers, including key population members. 7. Schedule the initial training, prepare materials, copies of the curriculum, and arrange a venue. 8. Collect feedback from the initial training as a basis for revising future trainings. 9. Monitor outcomes by tracking reports of stigma or discrimination by health-care workers at facilities where training has taken place. Key population members and oversight committees of key-population clinics can provide such reports.	• • • • • •			improve retention among key population members. The curriculum will show health-care workers how to provide the recommended package of health services in a nonjudgmental, supportive, responsive, and respectful manner. In countries where assessment using the Key Population Stigma Assessment Tool is not practicable, the training on stigma reduction can still take place (begin at Step 2). In this case, try to gather evidence or examples of stigma and demonstrate how it prevents access to services, and the need to address the issue. Key population members should be trainers or co-facilitators so that the health-care staff can understand the issues and learn to see key population members as skilled and informed advocates rather than as passive recipients of services. In some instances, a panel of key population members could also share their experiences. Other sources of stigma may also need to be considered, including: • Health-care staff members who stigmatize their colleagues who are key population members or who are HIV positive. • Key population members who are uncomfortable receiving health-care services from other key population members (often because of concerns about confidentiality).

Program Area 4. Peer Outreach

Peer outreach workers are trained key population members who link other key population members to program services. They are each assigned a number of key population members whom they meet with individually on a monthly basis. The peer outreach worker discusses the factors that put the key population member at risk of HIV, provides information and needed prevention commodities (condoms and lubricant, needles and syringes, and other harm-reduction items for people who inject drugs), and supports and encourages the key population member to manage his or her health through regular medical check-ups and behavior change, as appropriate.

Peer outreach workers do not usually work full-time, but they should receive an agreed monthly stipend to compensate them for their time, skill, and expenses related to their work (see Element 4.3 below). Where resources are too limited to provide compensation proportionate to that of other program staff members (e.g., full-time staff outreach workers), programs should still find ways to compensate peer outreach workers and show that their work is valued and respected.

Program staff members who are not key population members must be aware of the dynamics of power when they work with key population members. They should work to ensure that key-population voices are heard and respected. Ultimately, community-based programs must strive to institutionalize the role of peer outreach workers so they are recognized as integral to any HIV program for key populations.

ELEMENT 4.1 MAP OR VALIDATE KEY POPULATIONS AND SET TARGETS FOR OUTREACH

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Recruit local key population members to participate in mapping key populations (or, if mapping has been done, in validating) and identifying priority hotspots for interventions.	•		SWIT p.47 MSMIT p.144 Monitoring Toolkit, Tools 1, 1A	Mapping should take into account key population members — such as home-based sex workers, MSM who meet through Internet sites or apps — who do not frequent conventional hotspots. (MSMIT 5.3)
2. Working with key population members, develop policies and procedures on mapping, especially the safety of key population members and confidentiality and security of data.	•		Monitoring toolkit Section 4.1 MSMIT p.214	Targets: peer outreach workers should meet 80% of the individuals they cover at least once a month; key population members should visit a clinic once each quarter; condom distribution targets based on estimated need should be met during outreach.
3. Conduct programmatic mapping to determine where the greatest concentrations of key population members are located and the available services.	•		Monitoring Toolkit Section 4.1	Ratio of peer outreach workers to key population members:

4. Determine the services, the infrastructure, and the number of peer outreach workers needed to reach at least 80% of key population members. 5. Conduct site validation by re-mapping the sites on a regular basis to track any changes in location or numbers of key population members.	•	•	Monitoring Toolkit 4.3 Monitoring Toolkit, Tools 1 and 1A	• Sex workers: between 1:30 and 1:50 • Men who have sex with men/transgender people: between 1:25 and 1:40 • People who inject drugs: between 1:20 and 1:35 The ratio will vary with the local situation (e.g., rural versus urban needs, concentrations of key population members, ease of transportation). See Monitoring Toolkit 4.2.1.

ELEMENT 4.2 DEVELOP OR ADAPT MICRO-PLANNING TOOLS				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Adapt or develop micro-planning tools for peer outreach workers to record, plan, and monitor their outreach. 2. Train peer outreach workers to use tools. 3. Support and supervise use of the tools for planning and monitoring. 4. Provide refresher trainings during monthly meetings to improve use of the tools. 5. Use the tools to monitor project indicators and the performance of peer outreach workers at the hotspots. 6. Adapt ICT platforms (mobile phone systems or computer systems) so that peer outreach workers can use them to record contacts directly without paper records.	• • • • • •	• •	Monitoring Toolkit, Tools 7A, 7B Micro-planning Handbook, Section 2	Micro-planning tools help the peer outreach worker to plan and monitor outreach to key populations who are at highest risk. The tools help the worker provide information, services and commodities based on individual needs, while considering factors such as age, typology, risk profile, and the best time to reach the key population member. The scope of the peer outreach workers' responsibilities will increase as their skills develop. Similarly, the micro-planning tools should be enhanced with more indicators as peer outreach workers increase their understanding of key population members' risk and vulnerability.

ELEMENT 4.3 RECRUIT PEER OUTREACH WORKERS				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Write a scope of work for peer outreach workers. Include policies on compensation or remuneration. 2. Develop guidelines for recruiting, training, retaining, assessing, and promoting peer outreach workers. 3. Design a supportive supervision system, including mentoring and activities to help the retention of peer outreach workers, and procedures to support them if external circumstances make it hard for them to fulfill their work role.	• • •		SWIT 3.2.1 MSMIT pp.142, 147 Monitoring Toolkit, Tool 4 SWIT p.50 MSMIT p.146	Remuneration should be a fair stipend to account for lost income opportunities. It should be consistent across the country if possible. Additional allowances or reimbursement may also be given for necessary work-related travel costs, mobile phone use, etc. Providing mobile phone credit, travel and meals, and additional professional development opportunities can be an incentive to peer outreach workers and show them that their work is valued and respected. Recruitment may initially be done informally, e.g., by inviting key population members who have been involved in community-level mapping. But an organized process should be developed to deepen the pool of potential peer outreach workers and ensure that enough trained workers are available. Ratio of supervisors to peer outreach workers should be 1:4 or 1:5. Supervisors may be non-key population staff members, or peer supervisors (key population members trained for this role). When peer outreach workers are part of violence prevention or response, supportive supervision should include opportunities to discuss experiences and self-care. Secondary trauma can occur when someone is repeatedly exposed to stories of violence.

ELEMENT 4.4 TRAIN PEER OUTREACH WORKERS				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Decide topics to be covered in basic training.	•		SWIT p.53 MSMIT p.149 Kenya Peer Education Standards, Standard 3	Ideally, training content should be standardized across the country. The training should evolve to reflect outreach experience from the field and the enhanced skills of staff and key population trainers.
2. Check whether an existing curriculum is suitable for the local context or whether it can be adapted.	•			For a sample code of conduct for peer outreach workers, see Monitoring Toolkit Section 2.5.
3. Identify and train trainers on violence prevention, detection, and response messages and protocols. Ensure that trainers are key population members wherever possible.	•			
4. Conduct an initial training.	•		Monitoring Toolkit, Tool 5	
5. Use feedback on training to modify the curriculum for the next round or for advanced training of peer outreach workers.	•			Refresher training is important. Plan at least 10 to 12 days of training per year. Monthly meetings can be also used as forums to train peer outreach workers.

ELEMENT 4.5 IMPLEMENT AND MANAGE PEER OUTREACH				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Conduct validation mapping of sites with peer outreach workers to confirm the number of key population members to be reached and to assign outreach workers to these individuals.	•		Monitoring Toolkit 4.1 and Tools 1, 1A	Supervisors of peer outreach workers should try to develop a coaching or mentoring relationship with the people they are supervising — acknowledging and developing their capacities rather than seeing them as subordinates in need of monitoring and training.
2. Ensure that peer outreach workers are delivering a minimum package of services: • Information on protection from STIs and HIV, and related health services • Provision of condoms and lubricants; condom demonstrations (see Element 5.4); provision of needles and syringes and other harm reduction commodities • Community mobilization and empowerment • Information on the drop-in center and its services • Referrals to testing, care and treatment services for HIV and STIs • Follow-up appointments • Information on violence and services that respond to violence	•		Monitoring Toolkit, Tools 7A, 7B SWIT p.54	
3. Ensure that peer outreach workers receive regular (weekly) supportive supervision and mentoring to manage their work effectively and solve problems. See also Element 6.3.	•		SWIT p.58	
4. Ensure that data from outreach is being recorded by peer outreach workers on micro-planning calendars and forms (Element 4.2).	•		SWIT p.56 MSMIT p.150 Monitoring Toolkit, Tool 7A	

ELEMENT 4.6 PROVIDE ADVANCED TRAINING AND SUPPORT FOR PROFESSIONAL DEVELOPMENT				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Determine the curriculum for training based on input from peer outreach workers and other program staff members.		•		
2. Conduct the training.		•		
3. Use feedback on training to modify the curriculum for the next round.		•		
4. Develop a policy and a plan for peer outreach workers to move into other areas of programming, including supervising peer outreach workers, and program management. Ensure that the policy is enacted so that key population members understand the opportunities available to them.		•	SWIT p.61 MSMIT p.152	Professional development is sometimes known as "peer progression," — the peer outreach worker may progress to other positions within the implementing organization as their experience and skills develop. Mentoring of new peer outreach workers by more experienced ones is one way to help peer progression.
5. Develop a mentoring plan so that experienced peer outreach workers can support and help new workers.		•		
6. Consider opportunities for peer outreach workers to learn through visits to other programs in the country, or through South-to-South learning from programs in other countries.		•		

ELEMENT 4.7 SUPPORT RETENTION IN CARE OF HIV-POSITIVE KEY POPULATION MEMBERS

Key population members who test positive for HIV require dedicated attention and support to ensure that they receive the treatment and care they need, especially antiretroviral therapy, on a sustained basis. Adherence to treatment and care can be challenging for many reasons. Programs need procedures to keep track of HIV-positive key population members and support their adherence. This support can best be provided by knowledgeable and sympathetic individuals trained to do this work. They may themselves be HIV positive and have experience navigating health-care and other systems.

Programs to support HIV-positive key population members must be designed according to what will work best in the local context. Systems may already exist, they may be adaptable, or they may have to be created from scratch. Programs must also be sensitive to issues of confidentiality and the stigma that may exist against HIV-positive individuals, outside and within the key population community.

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Evaluate any current supportive systems for individuals (or specifically for key population members) who are HIV positive.	•			Systems may exist through NGOs or CBOs, or through the public health-care system.
2. Analyze the need for additional or new support for HIV-positive key population members.	•			Support includes these components: • Accompanying a key population member to medical appointments, upon request • Explaining the importance of adhering to treatment • Checking regularly with the key population member to ensure that she or he is adhering to treatment • Addressing related health needs such as nutrition and the treatment of opportunistic infections (OIs) • Problem-solving with the key population member • Offering support and information on issues related to the disclosure of HIV status • Organizing and facilitating support groups for key population members living with HIV

3. Determine the best way to deliver support to HIV-positive key population members. Ensure that HIV-positive key population members understand that they have the right to request support and follow-up — or to decline it when it is offered. 4. Establish partnerships with clinical facilities to allow others to accompany HIV-positive key population members to appointments. Develop policies and procedures to ensure that the clinic staff are aware of and understand the program. 5. If dedicated peer navigators are used, write a scope of work and policies on the stipend or compensation. Recruit and train peer navigators. 6. Ensure that those who provide support to HIV-positive key population members (and who are working directly with the NGO/CBO) receive regular (weekly) supportive supervision and mentoring to manage their work effectively and solve problems. See also Element 6.3. 7. Collect data on support contacts with HIV-positive key population members (at facilities or by follow-up phone calls or meetings) to: • Monitor performance • Monitor coverage of clients at the local program level • Report to higher program levels. A robust tracking mechanism is needed if care is provided in partnership with another service provider. Data can also be discussed regularly with the oversight committee of the key-population clinic, and with the clinic staff to show program impact.	•	•	MSMIT p.153	One or more models may be adopted. Depending on the local context, support may be provided by: • Peer outreach workers • "Peer navigators" (key population members, who may be peer outreach workers who have moved into this role) • Community health workers Training is required, especially if the individual is not a key population member (e.g., a health worker who is trained to work with HIV-positive people in the general population, but not specifically with key population members). Support may be provided in different venues, again according to local context but especially with regard to the wishes of HIV-positive key population members: • At the drop-in center • At the clinic (accompanied by a staff member or by having a dedicated peer navigator at the clinic) • Outreach to the key population member (in person or by phone) if he or she does not regularly visit the drop-in center or clinic • By attending or facilitating support groups for HIV-positive key population members It may be necessary to work with key population members who are not HIV positive to sensitize them to the needs of key population members living with HIV. This will ensure that the latter are not stigmatized by other key population members at the drop-in center or elsewhere.

Program Area 5. Clinical Services				
GENERAL CONSIDERATIONS FOR ESTABLISHING AND PROVIDING CLINICAL SERVICES TO KEY POPULATIONS				
ELEMENT 5.1 ASSESS CURRENT SERVICES AND THE SERVICE NEEDS OF KEY POPULATIONS				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Determine availability, accessibility, and acceptability of clinical services for key populations through: • Mapping (see Element 1.3) • Discussions with key population representatives.	•			The key population members' perceptions of whether existing clinical services are accessible and acceptable must be taken seriously.
2. Define an essential clinical-service package and the ways to deliver services to specific key populations.	•			Each country will have its own minimum package of clinical services. However, the WHO standard minimum package includes: • Condom promotion and basic prevention education • STI services • HIV testing services • ART • PrEP • PEP • Harm reduction for PWID • Sexual and reproductive health, including family planning • Psychosocial support
3. Assess policies related to service delivery, infrastructure and human resources.	•			

ELEMENT 5.2 ORGANIZE EFFECTIVE, HIGH-QUALITY, AVAILABLE, AND ACCESSIBLE SERVICES				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Develop a plan to improve existing services or establish new services based on the local context.	•			Sustainability of services should be an important consideration. The plan should aim to ensure that government facilities are also key-population centered and acceptable to key populations.
2. Designate service packages to be provided through different delivery models (i.e., which services will be delivered at which facilities): • Stand-alone clinic • Clinic within the DIC • Outreach/mobile services (see Element 4.5) • Government facilities • NGO and private practitioners	•		SWIT Chapter 5 MSMIT Chapter 4 COGS	Decisions on the type of services should consider the context, resources available, accessibility and acceptability of services. • Location and timing of services are critical to their accessibility. • Provide integrated services where possible.
3. Designate a clinical hub as a center for the provision of services, referrals, and commodities.	•			The clinical hub is the center for the provision of clinical services for key population members. It can be a program-run clinic or a government clinic that has the clinical expertise to provide a wide range of services to key population members. The hub manages clinical services for key population members, including provision of basic clinical services; identifies referral services; and ensures commodities and supplies are available. The clinical hub can serve as the central distribution point for clinical commodities. It may also be a center for training clinical staff, peer outreach workers, and peer navigators on the provision of clinical services, and it can be actively involved in supportive supervision. The drop-in center can be the hub for the continuum of prevention to care

				services (see Element 2.2). Necessary elements include: • Functional commodities management system • Forecasting of drugs and laboratory needs • Maintaining a checklist of needed resources • Stock in and stock out listing • Efficient procurement system • Regular inventory check
4. Ensure adequate resources and commodities to provide free or affordable STI diagnosis and treatment, HIV testing, ART, basic OI medications, condoms and lubricants, and family planning, in accordance with national guidelines.	•			
5. Identify a laboratory network to provide decentralized or integrated laboratory and diagnostic services.	•			Criteria include: • Available testing algorithms (HIV, syphilis) • Available laboratory standard operating procedures • Use high-quality, evaluated and reliable diagnostic tests • Adequate equipment, regularly maintained • Support for a dedicated specimen referral system (reliable specimen collection, handling, storage, and transport) • Internal and external quality assurance system • Adequate waste management • Laboratory data management system
6. Determine the availability of treatment protocols, testing manuals, guidelines, standard operating procedures, training manuals, and other job aids in line with national guidelines and policies.	•		COGS National guidelines and manuals, WHO guidelines (See Annex 4)	Guidelines are needed for ART, PEP, PrEP, management of opportunistic infections, STI treatment, algorithms for HIV testing, and SOPs for laboratory testing.
7. Specify roles and responsibilities at the different facilities, including the level of supervision and technical support (see also Element 6.3).	•			
8. Identify communication and coordination mechanisms for the different service-delivery	•			

points. 9. Ensure an adequate number of trained staff members (including key population members) to deliver high-quality clinical services.	•			Provide training to the staff for specific clinical services. Training should also include a curriculum to reduce stigma and discrimination toward key populations and PLHIV (see Element 3.3). Key populations involved in clinic operations should be compensated accordingly (see Element 2.1 and Element 2.4).
10. Provide high-quality clinical services.	•		SWIT Chapter 5 MSMIT Chapter 4 COGS	Aspects to consider: • Address stigma and discrimination in the delivery of clinical services (Element 3.3). • Ensure confidentiality (Element 6.2). • Provide integrated services when feasible. • Design an efficient flow in the clinic — history-taking, examination, consultation, counseling, and laboratory services. • Establish adequate health education and counseling services (treatment adherence, prevention, schedule for follow-up) (see also Element 4.7). • Ensure infection control services.
11. Maintain individual client records and ensure regular reporting (see Element 7.1 and Element 7.2).	•	•	Monitoring Toolkit, Tools 9A, 9B, 10	Coordinate with M&E to ensure the quality of clinical reporting and the generation of clinic data to improve services. Ensure confidentiality of client records
12. Ensure regular training, mentoring, and supportive supervision of clinical services staff members at LINKAGES-supported clinics and outreach facilities (e.g., drop-in centers).	•			Quarterly supportive supervision should take place at all LINKAGES-supported facilities. Referral sites should be visited at least semi-annually and mentoring or training offered, as appropriate.

13. Conduct regular coordination meetings between the clinic staff and outreach workers, peer outreach workers, and other community-based service providers.	•	•		Where possible, the clinic staff should join peer outreach workers in their outreach activities.
14. Monitor the quality of clinical services.	•	•		Systems include: • Tools for monitoring the quality of care • A regular system of monitoring and supportive supervision (Element 6.3) • Monthly clinic reports to determine coverage and accessibility of services (Element 6.3) • Ensure key population members are involved in monitoring the quality of care (Element 2.4)

ELEMENT 5.3 ORGANIZE REFERRAL SYSTEMS AND TRACK REFERRALS				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Identify referral mechanisms that are needed for services that are not offered in the clinic, but are essential for key population members. For example, program partner X refers clients to a: • Government or other non-program clinic • Clinic run by program partner Y • Clinic run by program partner X	•		Monitoring Toolkit 4.3.1 Tools 9C, 10A, 14, 17	Referrals can be made for multiple services as needed, e.g., STIs, HIV testing, or ART. In all cases, program partners are responsible for actively referring and tracking individuals through the systems for diagnosis, treatment, and care. Investigate external referral sites before making referral arrangements, with particular attention to the cost, quality, and timeliness of their services and their acceptance of key populations. Referral sites should provide services to key populations without discrimination against identity or HIV status, and they should be assessed by key population representatives to ensure their acceptability. • For external referrals, consider developing a formal agreement signed by the referral site representative and the program. • If one program sub-partner is referring to another program sub-partner, consider developing a formal or informal agreement between them. • If a formal agreement is not possible, a TOR could be developed. It is important to define (a) the services that will be provided by each referral facility, (b) how referrals will be handled (including payments) and (c) the communication mechanisms.
2. Compile a simple list of referral sites with basic contact information (phone, address) for each site.	•			

3. Record and follow up on referrals, and invite patient feedback.			Monitoring Toolkit Tool 9C and 10A	Establish a tracking system for referrals to allow managers to monitor the effectiveness and efficiency of the system, from initiation of the referral to receiving the referral report form. Where referrals are unsuccessful, programs should analyze the reasons (e.g., poor service quality, long wait times, or discrimination by the staff) and address these with the service providers.
4. Maintain a monthly report of referrals and actions.	•	•		

Considerations for specific clinical services

ELEMENT 5.4 CONDOM AND LUBRICANT PROMOTION

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Identify the national sources (e.g., the national government) of condom and lubricant supplies and determine how the program can acquire supplies.	•		Monitoring Toolkit, Tool 8B	Promote male condoms and supply female condoms with education on usage. Female condoms are particularly important for female sex workers, who can control their use when they are with a client. Although female condoms are not approved by WHO or UNFPA for use in anal intercourse, some key population members (e.g., men who have sex with men and transgender people) may also use them for this purpose.
2. Forecast commodity needs on a quarterly or bi-annual basis to maintain adequate supplies at key distribution points (peer outreach workers, drop-in centers or hotspots).	•			
3. Establish all LINKAGES sites — including clinics and drop-in centers, and outreach staff — as distribution points for condoms and lubricant.	•		Condom Programming Guide	
4. Ensure that all clinical services and peer outreach	•			

workers promote condoms, lubricant, and safer sexual practices. 5. Ensure a link between condom promotion and supply at the clinic and by community-based interventions (drop-in centers and peer outreach workers — see Element 2.2 and Element 4.5). 6. Routinely track the program's inventory of condoms and lubricant (and needles and syringes for people who inject drugs), including quantities received, and quantities distributed to individual hotspots or other locations. 7. Track the distribution of commodities to individual key population members.	• • •		Monitoring Toolkit, Tool 8A, 8C Monitoring Toolkit 4.4.3 & 4.4.4 Monitoring Toolkit, Tools 8B, 8C	Avoid stock-outs by carefully forecasting needs, which may fluctuate seasonally (e.g., sex workers in some areas may have more clients at certain times of the year because of seasonal migrant workers or festivals). Micro-planning tools can be used by peer outreach workers to estimate the number of condoms required for outreach (see Element 4.2 and Element 4.5).
ELEMENT 5.5 STI SERVICES				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Establish systems to provide essential STI services delivered through appropriate delivery points: • Syndromic management of symptomatic STIs • Regular monthly or quarterly check-ups to screen for STIs • Semi-annual syphilis screening (in conjunction with regular HIV screening) • Treatment of asymptomatic STIs — periodic presumptive treatment (PPT); quarterly or semi-annual, as appropriate • STI treatment based on national guidelines (monitor treatment failure) • Treatment or referral for anal warts • Clinic-based health education and condom promotion.	•		WHO Key Population Consolidated Guidelines, Section 4.6.2.1 SWIT Section 5.6 MSMIT Section 4.2.9 WHO PPT Recommendations WHO STI/RH Guide	STI services provide an opportunity to address the varying needs of key population members, including other services such as HTS and PrEP, and to promote condom use. Based on the available resources, STI check-ups should take place at least quarterly. STI service provision should be linked to peer-led outreach to help ensure regular STI check-ups (see Element 4.5). Community-based STI services (outreach, mobile, drop-in services or venue- based) may be more accessible and acceptable to key population members. • Define the services that can be provided by

				peer outreach workers or peer navigators, e.g., promote STI services, probe for STI symptoms, administer PPT, and refer to other services. New patients who are sex workers or men who have sex with men should be treated presumptively for gonorrhea and chlamydial infection. Frequency of asymptomatic treatment is based on condom use, prevalence of STIs, and the availability and accessibility of STI services.
2. Refer for syphilis screening and ensure treatment of syphilis-positive key population members.	•			Link to HIV testing if feasible. See WHO PPT Recommendations.
ELEMENT 5.6 PRE-EXPOSURE PROPHYLAXIS (PrEP)				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Ensure accurate knowledge and information about PrEP among health-care providers, peer outreach workers and key population members.	•		WHO PrEP Guidelines	PrEP is not available in all countries, and programs will have to follow national guidelines. Where available, PrEP should be offered as an additional prevention choice to people at substantial risk of HIV.
2. Determine suitable distribution points for PrEP (in line with the approach for delivery of other clinical services): • Drop-in centers • Community outreach services • STI services • Services for people who inject drugs	•			Designate a trained health-care provider trusted by key population members to provide PrEP as part of other services.
3. Develop the basic components of PrEP provision, based on national guidelines: • Identify the need for PrEP (e.g., key population member has a substantial risk of HIV).	•		SWIT Section 5.3.3 MSMIT Section 4.2.7	Refer to WHO guidelines (September 2015)

• Explain PrEP to the key population member and offer it as a choice. • Conduct the initial laboratory work up (creatinine services). • Administer the drug and provide supplies for 3 months. • Promote the use of condoms, lubricants, and regular HIV testing. • Provide quarterly follow-up in conjunction with other services such as STI check-ups. • Offer brief client-based counseling on adherence and enhancing safer sex behavior. • Monitor for side effects. • Monitor for drug adherence. • Determine when to discontinue PrEP with the client. 4. Establish a mechanism and a reporting routine to monitor the implementation of PrEP.	•			It is important to monitor the clients' HIV status, condom use and STI rates in addition to their adherence to PrEP.

ELEMENT 5.7 POST-EXPOSURE PROPHYLAXIS (PEP)				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Ensure availability of guidelines and SOPs on PEP: • When to provide PEP • What to provide • HIV testing and follow-up 2. Ensure that a PEP kit is available at clinical service facilities and monitor expiry dates. 3. Determine whether to move key population member from PEP to PrEP.	• • •		WHO PEP Guidelines SWIT Section 5.7.2	Refer to WHO guidelines or national guidelines on when to offer PEP. Ensure there is clear evidence of exposure of an HIV-negative key population member: • Condom use with HIV positive partner or client • Condom breakage • Sexual assault or sexual abuse

ELEMENT 5.8 HIV TESTING SERVICES (HTS) *In some countries, HIV testing services may also be known as voluntary HIV testing and counseling (HTC) or voluntary HIV counseling and testing (HCT).*				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Assess the delivery of, and gaps in, HIV testing services.	•		WHO HTS Guidelines	The assessment is part of hotspot-level mapping (See Element 1.3). In addition to assessing coverage, it is important to assess barriers, linkages to services, HIV testing policies and standards, and the quality of HIV testing.
2. Establish or designate HTS to increase access and address gaps, ensuring appropriate location and timing of services.	•			HIV testing services should be community-based if this is possible under national guidelines, as this will increase coverage and improve referral to other services.
3. Identify and train providers and community outreach workers who provide counseling and laboratory testing.	•			It is more acceptable if counseling is provided by trained peer outreach workers.
4. Promote HTS.	•			Promote HTS through peer outreach and campaigns.
5. Deliver HTS: • Provide counseling before the test — HIV information, process of testing, its voluntary nature, and risk assessment. • Obtain consent. • Ensure confidentiality. • Conduct HIV testing. • Provide results confidentially. • Provide post-test counseling (see Notes column).	•		WHO HTS Guidelines SWIT Section 5.2 MSMIT Section 4.2.6	Essential components are the *Five Cs:* consent, confidentiality, counseling, correct results, and connection. Encourage quarterly testing for key population members. Provide HIV testing with other services, such as STI check-ups. Repeat the HIV test if an STI is diagnosed. If HIV negative: • Discuss risk reduction. • Discuss PrEP. • Schedule for repeat testing. If HIV positive:

				• Actively link and track to ART services and HIV care facility (see Element 5.9). • Link to support for retention in care; e.g., peer navigator or other systems established for HIV-positive key population members (see Element 4.7). • Actively refer and track members to a community-led support group. • Schedule follow-up visits with a reminder system (SMS, phone calls, or personal visits). • Offer psychosocial support.

ELEMENT 5.9 ANTIRETROVIRAL THERAPY (ART)				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Define the service delivery model for ART and identify specific facilities for initiation, maintenance, and dispensing of ART. • Establish an ART hub for the provision of ART and other support services, including laboratory testing.	•		WHO Key Population Consolidated Guidelines 4.4.1 WHO ART Guidelines Monitoring Toolkit, Tool 11 & 11A SWIT Section 5.3 MSMIT Section 4.3	Consider models that will ensure maximum ART adherence and retention to care (see also Element 4.7). Ongoing care requires broad support from key population communities and the health-care team, in order for key population members living with HIV to stay in care, adhere to ART, and cope with stigma. Services can be integrated with other services or decentralized. Decentralized services may include: • ART initiation at a hospital or primary health-care level • ART maintenance at primary health-care level or (if feasible) community-based • ART dispensing at a community-based service point, provided that peer outreach workers/peer navigators are trained to do this.

2. Ensure systems are in place to provide ART services based on national guidelines: • Availability of guidelines and SOPs on ART delivery, laboratory testing, HIV care, patient monitoring, treatment adherence • Training manuals and job aids • Staffing and human resources • Supply management • Adequate infrastructure • Referral mechanisms	•			An information system should track key population members who receive care to ensure continuity of services. Identify the potential need for task-shifting — involving peer navigators or peer outreach workers in the provision of HIV care and follow-up. Services must be integrated or linked to ensure comprehensive and consistent patient management.
3. Provide ART access based on national ART guidelines: • Refer HIV-positive key population members immediately to ART service points.	•			Offer accompanied referrals (see Element 4.7).
4. Ensure adherence to ART and follow-up services: • Adherence counseling and adherence support (text messages, community health worker or peer outreach worker/peer navigator). • Establish frequency of clinic visit and medication pick-up. • Establish tracking of medication pick-up (individual patient record) including peer-outreach support. • Ensure access to ART services — location, waiting time, travel time. • Integrate ART services in community-based clinics if feasible. • Check for side effects of drugs. • Monitor adherence (pill count, self-reporting, pharmacy refill records).	•			
5. Monitor ART response (viral load testing).	•			Monitoring to be based on national guidelines.
6. Ensure links to appropriate related services:	•			See also Element 4.7.

• Support group for HIV-positive key population members • Nutritional support • Psychological support and mental health • Broader medical services (including the transgender population) 7. Establish a support mechanism for palliative care and end-of-life care.	•			This can include hospital care and hospice care.

ELEMENT 5.10 PREVENTION, SCREENING, AND MANAGEMENT OF COMMON INFECTIONS AND CO-INFECTIONS

Tuberculosis (TB) and viral hepatitis B and C are common co-infections in people living with HIV. Also screen for opportunistic infections. Some HIV-negative key population members also have a high risk of infection with TB and hepatitis and should be screened during regular medical check-ups.

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Screen patients to assess the need for OI prophylaxis: • CD4 cell count (as a basis for co-trimoxazole prophylaxis, cryptococcal prophylaxis and overall clinical management of late presenters) • TB screening • Hepatitis B and C screening	•		WHO PEP/OI Guidelines WHO ART Guidelines WHO TB Guidelines WHO HBV Guidelines WHO HCV Guidelines	Based on national guidelines
2. Support adherence to prophylaxis and treatment of co-morbidities: • Isoniazid preventive therapy • Co-trimoxazole prophylaxis • Cryptococcal prophylaxis • TB treatment • HCV treatment	•			Based on national guidelines Coordinate with ART designated services or TB center. Link to DOTS services for TB treatment. Link to malaria prevention programs (in high-burden malaria countries).
3. Viral hepatitis: • Offer catch-up hepatitis B vaccination to key population members in settings where infant immunization has not reached full coverage.	•			Based on national guidelines Presence of HIV increases the rapid progression of HCV infection.

• Screen for HCV infection in high-prevalence settings. • Screen for alcohol use. • Assess degree of liver fibrosis and cirrhosis. • Refer for management.				Link to harm-reduction and blood-safety programs.

ELEMENT 5.11 HARM REDUCTION FOR PEOPLE WHO INJECT DRUGS				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Establish needle and syringe programs (NSP) in line with national guidelines: • Establish policies and procedures. • Ensure adequate logistic support. • Identify service delivery points. • Ensure infection control and waste disposal for needles and syringes.	•		WHO, UNAIDS, UNODC NSP Guidelines	Establish relationships with local authorities and police. Policies for needle and syringe distribution: unlimited, capped, one-on-one exchange. Ensure adequate supplies of needles and syringes, condoms, filters, sterile water, alcohol, swabs, spoons, puncture-proof containers, acidifiers, tourniquets, bleach, and disinfectant.
2. Offer information and services on the prevention of HIV, safe injection techniques, overdose recognition and treatment, and wound care.	•			Offer first-aid training on overdose and availability of Naloxone.
3. Establish the provision of opioid substitution therapy (OST) in line with national guidelines.	•		Monitoring Toolkit, Tools 8B & 8C	Provide OST with methadone or buprenorphine at appropriate dosages for long-term maintenance in conjunction with other components. Treatment should be supervised during the initial phase.
4. Offer counseling on harm-reduction strategies and psychological support in association with opioid dependence.	•			
5. Provide or refer to services for hepatitis B and C prevention and management.	•			
6. Refer to self-help groups when appropriate.	•			

ELEMENT 5.12 OTHER DRUG AND ALCOHOL DEPENDENCE				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Screen for excess drug (amphetamine) or alcohol use. 2. Provide health information related to drug use and alcohol use. 3. Encourage key population members to articulate their personal goals and explore how these relate to their drug or alcohol dependence. 4. Refer clients to appropriate counselors and organizations for evaluation and treatment.	•		WHO mhGAP IG	Refer to drug use and drug-use disorder flowchart mhGAP Implementation Guide master chart (pp.67–68)
ELEMENT 5.13 SEXUAL AND REPRODUCTIVE HEALTH SERVICES, INCLUDING FAMILY PLANNING				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Provide family planning services: • Provide information on contraception. • Determine pregnancy intention of female key population members. • Discuss available contraceptive methods and the need for dual protection. • Provide (or refer to) contraceptive services. 2. Provide safe pregnancy care (for pregnant key population members): • Refer for regular antenatal care. • Provide HIV and syphilis screening. • Provide appropriate vaccination, nutrition, and advice on healthy lifestyle. 3. Provide anal health care.	• •		SWIT Section 5.7 MSMIT Section 4.2.10	Emphasize the need for dual protection to prevent HIV/STI and pregnancy. Emergency contraception may be provided (within 72 hours) to women who have unprotected vaginal sex or have been sexually abused and are not currently using contraception. Educate on anal health (condom and lubricant use, dangers of rectal douching and enemas, insertion

				of foreign objects). Encourage anal examination to identify injuries, lesions and other STIs and manage accordingly.
4. Provide advice on cancer screening.	•			Breast cancer, cervical cancer, anogenital and prostatic cancer screening should be provided as appropriate.
5. Make post-abortion referrals for care.	•			
6. Provide support and referrals to other sexual-health services.	•			
7. Provide advice on douching and the use of drying agents.	•			
8. Provide education on hormonal therapy for transgender patients.	•			

ELEMENT 5.14 MANAGEMENT OF SEXUAL VIOLENCE

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. The topic of violence must be approached with sensitivity if a key population member presents with injuries or conditions that suggest physical abuse. (This is not part of universal screening).	•		WHO UN Women UNFPA IPV Handbook	The following may be indications of violence: ongoing emotional health issues, self-harming behavior, injuries that are repeated or not well explained, repeat STIs, unwanted pregnancy, unexplained chronic pain, repeated health consultation. Suspect violence when a partner is intrusive or when children have emotional and behavioral problems. Health-care workers should be trained to make compassionate responses to key population members who disclose experiences of violence.
2. Provide first-line support for sexual assault and intimate partner violence. • Link to a crisis response team (see Element 3.1).	•			Provide practical care and respond to the individual's emotional, physical, safety, and support needs, without intruding on privacy. Listen, inquire about needs and concerns, validate

				feelings, and enhance safety and support (through services and social services). Offer accompanied referral to services by a crisis response team member or peer navigator.
3. Provide physical health care after a sexual assault.	•			Take the client's history; conduct a physical examination; treat physical injuries; provide emergency contraception, presumptive treatments for STIs, PEP, and a plan for self-care.
4. Provide psychosocial support by professionally trained care providers after a sexual assault.	•			
5. Schedule follow-up visits at 2 weeks, 1 month, 3 months and 6 months.	•			Care for injuries; during follow-up, check for STIs, pregnancy and provide psychosocial support.
ELEMENT 5.15 MENTAL-HEALTH CARE				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Provide screening for mental-health disorders.	•		WHO mGAP Intervention Guide	Screening should be based on mhGAP-IG master chart (page 7 to 8)
2. Document identified mental-health issues.	•			
3. Screen for drug use and drug-use disorder.	•			Use mhGAP IF master chart (page 66 to 67)
4. Refer for management.	•			

Program Area 6. Program Management

ELEMENT 6.1 CONTRACT, HIRE, AND TRAIN STAFF

- Healthcare providers (doctors, nurses, other clinic staff)
- Program and technical staff (managers and coordinators)
- Outreach supervisors
- Peer outreach workers (See Program Area 4)

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Decide hiring needs based on the number of sites and the number of key population members to be served.	•		Annex 3	Hiring should be based on the work plan, program monitoring plan, and the sub-agreement with an implementing partner.
2. Write a scope of work for each position.	•		SWIT 6.4	Training may involve onsite mentoring, learning site visits, classroom training, etc.
3. Advertise positions and hire staff members.	•			Training for the staff should also include sensitization to working with key populations (see Element 3.3).
4. Provide initial training.	•			See also Monitoring Toolkit, Section 4.3.3.
5. Develop a training plan to build staff skills.		•		

ELEMENT 6.2 ESTABLISH AND IMPLEMENT POLICIES AND PROCEDURES ON DATA SAFETY, CONFIDENTIALITY, AND ETHICS

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. Identify all staff members, peer outreach workers, and others (e.g., oversight committee members) who may have contact with other key population members or with data on individual key population members in the course of providing services.	•			Key population members must take a leading role in drafting a code of ethics and providing input to policies and procedures on data safety and confidentiality. This helps ensure that the program will be trusted by the key population community.
2. With representatives from the staff, key population community and other service providers, discuss areas that are to be covered in a code of ethics, and in policies and procedures	•		Monitoring Toolkit 2.4	Consider involving representatives of referral providers wherever possible because stigmatization and discrimination can be a problem in government or private hospitals and clinics.

for confidentiality. 3. Discuss and define confidentiality for different components of services (e.g., at drop-in centers, in clinics, etc.). 4. Write a code of ethics and a related client "bill of rights." 5. Train staff members, peer outreach workers and key population oversight committee members on the code of ethics. 6. Write policies and procedures on data security and confidentiality. If stories of violence will be documented (and particularly if they will be shared — even anonymously — to provide evidence of human-rights violations), develop a specific consent process for collecting those experiences. 7. Train the staff and others who handle data on the policies and procedures; ensure that all new staff members are also trained. 8. Review all policies and procedures and conduct follow-up and review trainings on a regular basis.	• • • • •	• •		A code of ethics should include: • An explicit understanding of human rights and legal protections for all citizens (and non-citizens), including health as a human right • The duty not to discriminate, stigmatize or be judgmental in any aspect of service provision • Confidentiality and non-disclosure of personal and medical information • Protection of all client data

ELEMENT 6.3 ESTABLISH SYSTEMS FOR SUPPORTIVE SUPERVISION AND TECHNICAL SUPPORT

Supportive supervision takes place in two contexts:

- *Implementing partners provide supportive supervision to their staff members and their peer outreach workers, focused on problem solving and on using data to manage and improve their work.*
- *The country-level staff provides supportive supervision to the program managers of the implementing partners, focused on problem solving and on improving program outcomes.*

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
IMPLEMENTING PARTNER AND REGIONAL OR NATIONAL LEVEL:				
1. Develop tools and establish teams for supportive supervision.	•			
2. Develop organizational chart showing lines of reporting.	•			
3. Schedule regular supervision sessions.	•		SWIT 6.2.7 MSMIT 6.2.8	
4. Write guidelines on topics to be covered in supervision, including reports or forms that are to be reviewed.	•			
IMPLEMENTING PARTNER LEVEL:				
5. Write policy and procedures on how supervision content and outcomes are to be recorded.	•			
6. Develop procedures for mentoring and retaining staff.	•			
7. Establish a monthly meeting of managers and program staff members to review monitoring data at the site level and to provide program input.	•			
8. Establish weekly or monthly meetings of outreach supervisors and peer outreach workers for each implementing partner to review monitoring data	•		Monitoring Toolkit 6.1 & 6.2 Monitoring Toolkit,	

at the peer outreach worker level, to provide input into outreach work, and for peer outreach workers to plan their future outreach.			Tool 16	
9. Ensure that service data are discussed regularly with the oversight committees for the key-population program. See Element 2.4.	•			
10. Establish a schedule of regular field visits by program officers or directors to observe outreach, clinics, etc.	•			A good practice is for the program director to visit the field quarterly, and for program officers to do so monthly.
REGIONAL OR NATIONAL LEVEL:				
11. Establish regular technical assistance meetings for different groups of staff members across the implementing partners (e.g., HTS counselors, clinicians, data-entry staff, and outreach supervisors) to discuss common issues and problems across the program and the best practices for addressing them.	•			The lead implementing partner in a region, or the country office, can convene these meetings and use them to identify best practices among implementing partners and provide technical input.
12. Establish a schedule of regular field visits to implementing partners by regional or national staff members.	•			
13. Establish monthly meetings of implementing partners to discuss program-wide issues.	•			

Program Area 7. Monitoring and Data Use

Monitoring is an aspect of each program area in this implementation guide. Collecting, reporting and analyzing data are key parts of effective monitoring, and important steps in many program elements. Programs should foster a culture of data use, so that staff members have the responsibility and authority to use data to improve programming, and develop a strong connection between data analysis and action.

- *Program Area 1 describes the use of data to plan programs.*
- *The LINKAGES Monitoring Toolkit shows how to track the progress of specific interventions.*
- *Program Area 7 describes how to adapt or supplement existing forms to collect all necessary data on interventions, how to ensure that data are recorded efficiently and accurately, and how to use data to monitor progress and drive improvements.*

Each program should develop a data-monitoring plan that covers all these elements.

ELEMENT 7.1 DEVELOP OR ADAPT DATA-COLLECTION TOOLS

Implementation Activities	Timeframe		References/ Resources	Notes
	Start-up	Roll-out		
1. National program managers and LINKAGES staff members should collectively review the data-collection forms that exist in the national program, and compare these with the data-collection requirements for reporting LINKAGES indicators.	•		Monitoring Toolkit, 6.2 PEPFAR MER Guidelines	Countries often have standard forms for monitoring, especially of clinical services. It may not be possible to change these, but other forms can be used to capture additional monitoring data.
2. Where needed, use LINKAGES forms in the Monitoring Toolkit as a model and adapt these to complement national program forms.	•		In-country key population M&E plans	It is important to clearly indicate the frequency of data collection, and who is responsible for collecting and reporting the data.
3. Write protocols for data collection.	•			Check definitions against national (i.e., government) program definitions and address any inconsistencies.
4. Train relevant staff members on data collection, processing and reporting.	•			
5. Repeat Steps 1 to 4 for regional and local reporting forms.	•			

ELEMENT 7.2 ENSURE THE QUALITY OF DATA COLLECTION, ANALYSIS, AND REPORTING				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Design and implement electronic management systems or mechanisms for data collection, analysis, and reporting.	•			A data-entry officer or designated staff member should input data.
2. Establish a schedule for compiling data reports on a monthly basis, including deadlines for receiving forms from peer outreach workers, clinics, etc.	•			
3. Establish a protocol for data entry and train relevant staff members.	•			
4. Establish protocols for data security and confidentiality.	•			
5. Conduct regular checks of data quality.	•			
ELEMENT 7.3 REGULARLY REVIEW AND ANALYZE DATA AND USE FOR PROGRAMMING				
Implementation Activities	**Timeframe**		**References/ Resources**	**Notes**
	Start-up	**Roll-out**		
1. Peer outreach worker reviews and analyzes data after each day of outreach work to plan further outreach needs.	•			As peer outreach workers become more experienced, they will be able to identify and fill gaps in coverage without much assistance from a supervisor.
2. Supervisor reviews, analyzes and discusses outreach data weekly with individual peer outreach workers.	•			
3. Supervisor meets every two weeks with all peer outreach workers to analyze gaps in coverage and prioritize outreach.	•			
4. Field officer meets monthly with all supervisors to review outreach data.	•			

5. Program managers meet monthly to review and analyze dashboard indicators to monitor the program's progress. 6. Program managers support the analysis of site-level data with staff members to support their work and improve outcomes. 7. Conduct routine training on data use and analysis at all levels of the program. 8. At the program level, conduct quarterly performance review meetings for all partners.	• • •	 • •	Monitoring Toolkit 6.2 Annex 2 (sample indicator dashboard)	The dashboard is a set of key indicators that is automatically generated from the data entered into the computer. It shows the performance in various program areas and can be used to gauge progress against targets for outreach and other services, and to identify areas where there are difficulties.

Annex 1. Table of responsibilities for implementing Program Elements

N = LINKAGES national country team IP = Local implementing partner

1. Population Size Estimation and Mapping	
1. National-level population size estimation and mapping	N
2. Local-level population size estimation and mapping	N
3. Hotspot-level population size estimation and mapping	IP
4. Plan the program using mapping and size estimation data	N/IP
2. Key Population Engagement and Empowerment	
1. Develop staffing of programs and teams by key population members	IP
2. Establish drop-in centers	IP
3. Support key population groups through capacity development and organizational strengthening	IP
4. Foster oversight of clinical services and other services by the key population community	IP
3. Structural Interventions	
1. Establish a system to respond to incidents of violence, abuse, harassment, and discrimination against key population members	N/IP
2. Identify, design, and implement strategies for violence prevention with the key population community and with power-holders	N/IP
3. Develop strategies for reducing stigma in health-care settings	N/IP
4. Peer Outreach	
1. Map or validate key populations and set targets for outreach	IP
2. Develop or adapt micro-planning tools	IP
3. Recruit peer outreach workers	IP
4. Train peer outreach workers	N/IP
5. Implement and manage peer outreach	IP
6. Provide advanced training and support for professional development	N/IP
7. Support retention in care of HIV-positive key population members	IP

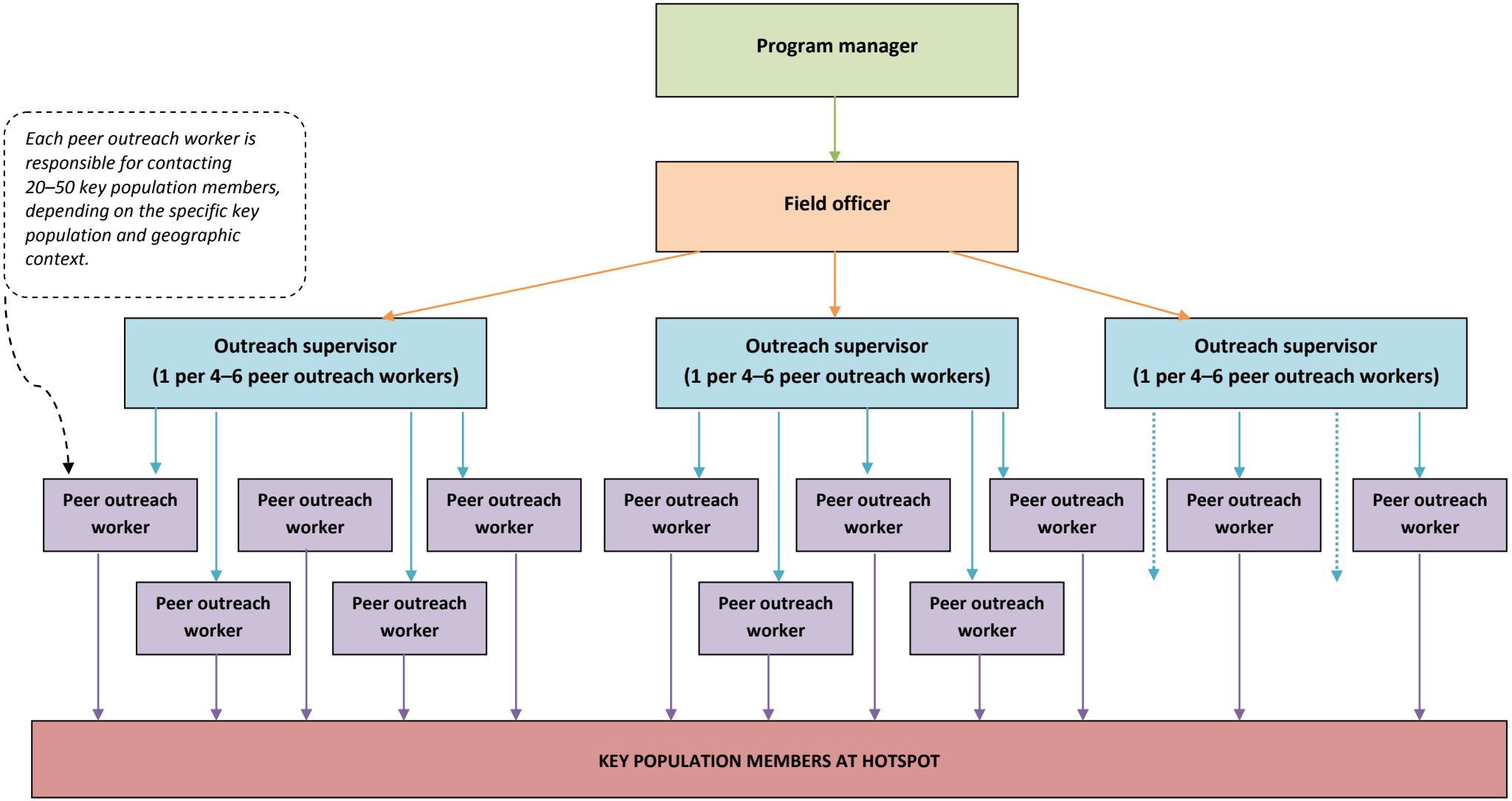
5. Clinical Services	
1. Assess current services and the service needs of key populations	IP
2. Organize effective, high-quality, available, and accessible services	N/IP
3. Organize referral systems and track referrals	N/IP
4. Condom and lubricant promotion	N/IP
5. STI services	IP
6. Pre-exposure prophylaxis (PrEP)	IP
7. Post-exposure prophylaxis (PEP)	IP
8. HIV testing services (HTS)	IP
9. Antiretroviral therapy (ART)	IP
10. Prevention, screening, and management of common infections and co-infections	IP
11. Harm reduction for people who inject drugs	IP
12. Other drug and alcohol dependence	IP
13. Sexual and reproductive health services, including family planning	IP
14. Management of sexual violence	IP
15. Mental-health care	IP
6. Program Management	
1. Contract, hire, and train staff	IP
2. Establish and implement policies and procedures on data safety, confidentiality, and ethics	N/IP
3. Establish systems for supervision and technical support	N/IP
7. Monitoring and Data Use	
1. Develop or adapt data-collection tools	N/IP
2. Ensure the quality of data collection, analysis, and reporting	N/IP
3. Regularly review and analyze data and use for programming	N/IP

Annex 2. Sample monitoring indicators

See Element 7.3

Indicators	Level of Analysis
Program Coverage	
Proportion of key population individuals registered (cumulative) in the intervention through outreach compared to estimated key population	*Hotspot level, Partner Level & Program Level*
Proportion of key population individuals receiving outreach regularly for HIV services	*Hotspot level, Partner Level & Program Level*
HIV Testing by key population members	
Proportion of key population members who were tested and received results for HIV in last three months	*Hotspot level, Partner Level & Program Level*
HIV CARE for key population members	
Proportion of key population members who are HIV positive and registered for care	*Hotspot level, Partner Level & Program Level*
Proportion of key population members who are on ART among those registered for care	*Hotspot level, Partner Level & Program Level*
Number of key population members who faced violence last month	*Hotspot level, Partner Level & Program Level*
Proportion of violence cases that were addressed within 24 hours	*Hotspot level, Partner Level & Program Level*
Mean number of participants per advocacy workshop and meetings with key stakeholders	*Hotspot level & Program Level*

Annex 3. Sample organizational chart for peer outreach



Annex 4. List of reference documents

The list below identifies the documents referred to in the References/Resources column of the program area tables. Since these tables use abbreviated titles, the item numbers in the list will guide you to the full title of each resource in the list of reference documents that follows.

Name used in the implementation guide	Item	Name used in the implementation guide	Item
COGS	23	WHO ART Guidelines	28
Condom Programming Guide	22	WHO HBV Guidelines	30
Crisis Response Handbook	14	WHO HCV Guidelines	31
IDUIT	5	WHO HTS Guidelines	27
Kenya National Key Population Guidelines	39	WHO Key Population Consolidated Guidelines	1
Kenya Peer Education Standards	18	WHO mhGAP	34
Micro-planning Handbook	15	WHO mhGAP Intervention Guide	35
Monitoring Toolkit	46	WHO PEP/OI Guidelines	26
MSMIT	3	WHO PPT Recommendations	22
PEPFAR MER Guidelines	49	WHO PrEP Guidelines	25
South-to-South Mentoring Toolkit	9	WHO STI/RH Guide	23
SWIT	2	WHO TB Guidelines	29
TRANSIT	4	WHO, UNAIDS, UNODC NSP Guidelines	32
		WHO UN Women UNFPA IPV Handbook	33

General

1. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2014.

2. Implementing comprehensive HIV and STI programmes with sex workers: practical guidance for collaborative interventions. Geneva: World Health Organization; 2013. *French translation available here.*

3. Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions. New York: United Nations Population Fund; 2015.

4. Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions. New York: United Nations Development Programme; 2016 (forthcoming).

5. Implementing comprehensive HIV and STI programmes with people who inject drugs: practical guidance from collaborative interventions. Vienna: United Nations Office on Drugs and Crime; 2016 (forthcoming).

6. LINKAGES Cascade Framework.

Community empowerment

7. Collective courage: sex workers tell stories of change. Nairobi: Ministry of Health, National AIDS and STI Control Programme.

8. From isolation to solidarity: how community mobilization underpins HIV prevention in the Avahan AIDS India Initiative. Washington (DC): Futures Group; 2013.

9. South to South Mentoring Toolkit for Key Populations. LINKAGES; 2016.

Structural interventions

10. Police and HIV/AIDS: a training resource. Essential Advocacy Project. Constella Group; 2009.

11. Community led crisis response systems—a handbook. New Delhi: Bill & Melinda Gates Foundation; 2013.

12. Learning site: violence prevention and response. Nairobi: Ministry of Health, National AIDS and STI Control Programme.

Peer outreach (including supporting retention in care of HIV-positive key population members)

13. Micro-planning in peer led outreach programs—a handbook. New Delhi: Bill & Melinda Gates Foundation; 2013.

14. Learning site: micro-planning tools. Nairobi: Ministry of Health, National AIDS and STI Control Programme.

15. Learning site: outreach and micro-planning. Nairobi: Ministry of Health, National AIDS and STI Control Programme.

16. Standards for Peer-Education and Outreach Programs for Sex Workers. Nairobi: Ministry of Public Health and Sanitation; 2010.

17. National standards for peer education and outreach for HIV prevention and care among key population: Mozambique. Republic of Mozambique: Conselho Nacional de Combate ao HIV/SIDA.

18. Peer educators' advanced training manual. New Delhi: FHI 360; 2010.

19. Best practices for integrating peer navigators into HIV models of care. Washington (DC): AIDS United; 2015.

20. Optimizing entry into and retention in HIV care and ART adherence for PLWHA: a train-the-trainer manual for extending peer navigators' role to patient navigation. Washington (DC): International Association of Physicians in AIDS Care; 2012.

Clinical services

21. Contraceptive forecasting handbook for family planning and HIV/AIDS prevention programs. Arlington (VA): Family Planning Logistics Management (FPLM)/John Snow, Inc., US Agency for International Development; 2000.

22. Comprehensive condom programming: a guide for resource mobilization and country programming. New York (NY): United Nations Population Fund; 2011.

23. Clinic operational guidelines and standards (COGS). Comprehensive STI services for sex workers in Avahan-supported clinics in India**.** New Delhi: Bill & Melinda Gates Foundation and FHI.

24. Periodic presumptive treatment for sexually transmitted infections: experience from the field and recommendations for research. Geneva: World Health Organization; 2008.

25. Sexually transmitted and other reproductive tract infections: a guide to essential practice. Geneva: World Health Organization; 2005.

26. Rapid advice on syndromic STI Management in Kenya. Nairobi: Ministry of Health, National AIDS and STI Control Programme; 2015.

27. Technical update on pre-exposure prophylaxis (PrEP). Geneva: World Health Organization; 2015.

28. Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV related infections among adults, adolescents and children: recommendations for a public health approach. Geneva: World Health Organization; 2014.

29. Consolidated guidelines on HIV testing services. Geneva; World Health Organization; 2015.

30. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV**.** Geneva: World Health Organization; 2015.

31. Guidelines on the management of latent tuberculosis infection. Geneva: World Health Organization; 2015.

32. Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. Geneva: World Health Organization; 2015.

33. Guidelines for the screening, care and treatment of persons with hepatitis C infection. Geneva: World Health Organization; 2014.

34. Guide to starting and managing needle and syringe programmes. Geneva: World Health Organization; 2007.

35. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva; World Health Organization; 2014.

36. WHO mental health gap action programme. Geneva: World Health Organization.

37. mhGAP intervention guide for mental, neurologic and substance use disorders in non-specialized health settings. Geneva; World Health Organization; 2010.

Program planning and management

38. Avahan Common Minimum Program for HIV prevention in India. New Delhi: Bill & Melinda Gates Foundation; 2010.

39. National guidelines for HIV/STI programming with key populations. Nairobi: Ministry of Health, National AIDS and STI Control Programme; 2014.

40. Standard Operating Procedures for Implementing HIV Programmes among key populations. Republic of Ghana: Ghana AIDS Commission.

41. National guidelines for implementation of HIV prevention programmes for female sex workers in Nigeria. Abuja: National Agency for the Control of AIDS; 2014.

42. Standard Operating Procedures for HIV/STI prevention program with sex workers in Zambia. Republic of Zambia: National AIDS Council.

43. Consolidated strategic information guidelines for HIV in the health sector. Geneva: World Health Organization; 2015.

44. Guidelines on estimating the size of populations most at risk to HIV. Geneva: UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance; 2010.

45. Practical guidance for scaling up health service innovations. Geneva: World Health Organization and ExpandNet; 2009.

Monitoring, evaluation, and data use

46. Program monitoring toolkit for programs providing peer outreach and support to key populations. (LINKAGES; 2016).

47. SIMS Community Master Tool, version 2.0. Washington (DC): United States Agency for International Development; 2015.

48. SIMS Facility Master Tool, version 2.0. Washington (DC): United States Agency for International Development; 2015.

49. PEPFAR Monitoring, Evaluation and Reporting Indicator Reference Guide. Washington (DC): PEPFAR; 2015. *At this hyperlink, look under the sub-heading* "PEPFAR Fiscal Year 2015 Country/Regional Operational Plan (COP/ROP) Guidance (February 2015)".

50. Tool to set and monitor targets for prevention, treatment and care for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015.

51. Toolkit for monitoring and evaluation of interventions for sex workers. New Delhi: World Health Organization; 2009.

52. Use it or lose it: how Avahan used data to shape its HIV prevention efforts in India. New Delhi: Bill & Melinda Gates Foundation; 2008.

Annex 5. Self-assessment checklist

Use this checklist to conduct a rapid assessment of a program's elements for the prevention, diagnosis, treatment, and care of HIV and other STIs among key populations. The checklist will provide an overview of an existing program and identify the elements of the program that are already in place. This exercise will help to ensure that technical assistance and other resources are focused where there is the greatest need. This checklist should take no more than 90 minutes to complete.

Consider following these steps to conduct the self-assessment:

1. Designate a LINKAGES team member to lead the self-assessment.
2. Engage a small group of staff and key population members (3 to 8 people) to participate in the process.
3. Conduct the self-assessment. Discuss each element as a group and agree on a single score.
4. Analyze the scores.
5. Develop action points to improve the program.

Assessing your program

- The elements in the checklist are based on those in this program implementation guide.
- The LINKAGES national country team ("N" in the column marked "Who?") and/or the local implementing partner ("IP") should consider each of the elements in the table, and write a score in the relevant box to indicate whether that element has "not been done" (score 0), has been "partially done" (score 1,) or has been "completed" (score 3).
- If you feel that the program needs help with a particular element (whatever score you have given it), place an X in the final column.
- Below each section of the table there is a space for comments. Use this to note the reason(s) for the scores.
- Use the table on the final page to note any further key findings about each program area and key action points. For example, suggest specific actions to improve the program or identify specific needs for assistance.

Depending on the results of the baseline self-assessment, conduct follow-up assessments at these intervals:

Score	Follow-up interval
0–30	After 3 months
31–50	After 6 months
51–78	After 1 year

1. POPULATION SIZE ESTIMATION AND MAPPING	WHO?	SCORE Not done = 0 Partially done = 1 Completed = 2	NEED HELP *(no score, mark X)*
1.1 National-level population size estimation and mapping	N		
1.2 Local-level population size estimation and mapping	N		
1.3 Hotspot-level population size estimation and mapping	IP		
1.4 Program planned using mapping and size estimation data	N/IP		
TOTAL SCORE FOR THIS PROGRAM AREA *(maximum 8)*			
COMMENTS:			

2. KEY POPULATION ENGAGEMENT AND EMPOWERMENT	WHO?	SCORE Not done = 0 Partially done = 1 Completed = 2	NEED HELP *(no score, mark X)*
2.1 Staffing of programs and teams by key population members (positions other than peer outreach workers)	IP		
2.2 Drop-in centers established	IP		
2.3 Capacity development and organizational strengthening of key population groups	IP		
2.4 Key population community committees for oversight of clinical services and other services	IP		
TOTAL SCORE FOR THIS PROGRAM AREA *(maximum 8)*			
COMMENTS:			

3. STRUCTURAL INTERVENTIONS	WHO?	SCORE Not done = 0 Partially done = 1 Completed = 2	NEED HELP *(no score, mark X)*
3.1 System to respond to incidents of violence, abuse, harassment, and discrimination against key population members	N/IP		
3.2 Violence prevention with key population community and with power-holders	N/IP		
3.3 Stigma reduction in health-care settings	N/IP		
TOTAL SCORE FOR THIS PROGRAM AREA *(maximum 6)*			
COMMENTS:			

4. PEER OUTREACH	WHO?	SCORE Not done = 0 Partially done = 1 Completed = 2	NEED HELP *(no score, mark X)*
4.1 Key populations mapped or numbers validated, and outreach targets set	IP		
4.2 Micro-planning tools developed or adapted	IP		
4.3 Peer outreach workers recruited	IP		
4.4 Peer outreach workers trained	N/IP		
4.5 Peer outreach implemented	IP		
4.6 Advanced training and support for professional development of peer outreach workers	N/IP		
4.7 Retention in care of HIV positive key population members supported (through peer navigation, accompanied referrals, etc.)	IP		
TOTAL SCORE FOR THIS PROGRAM AREA *(maximum 14)*			
COMMENTS:			

5. CLINICAL SERVICES	WHO?	SCORE Not done = 0 Partially done = 1 Completed = 2	NEED HELP *(no score, mark X)*
5.1 Current clinical services for key populations and their clinical needs assessed	IP		
5.2 Effective, high-quality, available, and accessible services organized	N/IP		
5.3 Referral systems organized	N/IP		
5.4 Condom and lubricant promotion	N/IP		
5.5 STI services	IP		
5.6 Pre-exposure prophylaxis (PrEP)	IP		
5.7 Post-exposure prophylaxis (PEP)	IP		
5.8 HIV testing services (HTS)	IP		
5.9 Antiretroviral therapy (ART)	IP		
5.10 Prevention, screening, and management of common infections and co-infections (TB, hepatitis, etc.)	IP		
5.11 Harm reduction for people who inject drugs	IP		
5.12 Other drug and alcohol dependence	IP		
5.13 Sexual and reproductive health services, including family planning	IP		
5.14 Management of sexual violence	IP		
5.15 Mental-health care	IP		
TOTAL SCORE FOR THIS PROGRAM AREA *(maximum 30)*			
COMMENTS:			

6. PROGRAM MANAGEMENT	WHO?	SCORE Not done = 0 Partially done = 1 Completed = 2	NEED HELP *(no score, mark X)*
6.1 Staff contracted, hired, and trained	IP		
6.2 Policies and procedures on data safety, confidentiality, and ethics	N/IP		
6.3 Systems for supervision and technical support	N/IP		
TOTAL SCORE FOR THIS PROGRAM AREA *(maximum 6)*			
COMMENTS:			

7. MONITORING AND DATA USE	WHO?	SCORE: Not done = 0 Partially done = 1 Completed = 2	NEED HELP *(no score, mark X)*
7.1 Data collection tools developed or adapted	N/IP		
7.2 Data collection, analysis, and reporting	N/IP		
7.3 Data regularly reviewed, analyzed, and used in programming	N/IP		
TOTAL SCORE FOR THIS PROGRAM AREA *(maximum 6)*			
COMMENTS:			

TOTAL SCORE FOR ALL PROGRAM AREAS ***(Add scores from all 7 program areas; maximum 78)***	

Key Findings	Key Action Points
1. POPULATION SIZE ESTIMATION AND MAPPING	
2. KEY POPULATION ENGAGEMENT AND EMPOWERMENT	
3. STRUCTURAL INTERVENTIONS	
4. PEER OUTREACH	
5. CLINICAL SERVICES	
6. PROGRAM MANAGEMENT	
7. MONITORING AND DATA USE	