Ministry of Public Health
and Sanitation

Standards for Peer-Education and Outreach Programs for Sex Workers

September 2010

Standards for Peer-Education and Outreach Programs for Sex Workers

September 2010

Ministry of Public Health
and Sanitation

Standards for Peer-Education and Outreach Programs for Sex Workers

Compiled for the National AIDS/STD Control Programme of the Kenya Ministry of Public Health and Sanitation by FHI

Project sponsor:

- National AIDS/STD Control Programme (Kenya)

Additional support from:

- FHI
- PATH

This report was made possible by the generous support of the United States Centers for Disease Control and Prevention (CDC). The contents are the responsibility of the National AIDS/STD Control Programme of the Kenya Ministry of Public Health and Sanitation and do not necessarily reflect the views of CDC or the United States Government.

National AIDS/STD Control Programme
Ministry of Public Health and Sanitation
P.O. Box 30016 GPO
Nairobi 00100, Kenya

Telephone: 254 (20) 2729502
Fax: 254 (20) 2710518
Email: info@aidskenya.org
www.aidskenya.org

September 2010

Table of Contents

Acknowledgments

The National AIDS and STI Control Programme (NASCOP) would like to acknowledge the invaluable efforts by individuals and implementing organizations and stakeholders in the development of standards for peer-outreach programs for sex workers. These efforts have resulted in a closer working relationship between organizations and have created a potential for sharing resources and program synergy that we hope will lead to a bigger impact on HIV prevention programs that target most-at-risk populations.

NASCOP would therefore like to thank all the organizations that participated in this process. These include the United States Centers for Disease Control and Prevention (CDC)/Kenya, FHI/Kenya, PATH, Pathfinder International, the National Organizations of Peer Educators (NOPE), Family Health Options Kenya (FHOK), and the Sex Worker Prevention Program (SWOP). We would also like to thank the nongovernmental organizations that were involved in the process activities, including a situational analysis of organizations that implement HIV prevention programs with a peer-outreach component for sex workers, the pretesting of the standards, and the final consensus meeting.

Special thanks go to members of the technical working group: Mercy Muthui (CDC/Nairobi, Kenya), Helgar Musyoki, Patrick Mutua (NASCOP), John Waimiri (PATH), Margaret Lubale (Pathfinder International), Esther Muketo (FHOK), Job Akuno (NOPE), Gloria Gakii (SWOP), John Ndiritu, Lorina Kagosha, and Hellen Nyongesa, APHIA II Coast and Rift, and Stephen Mucheke and Rachael Manyeki (FHI/Kenya), who coordinated the activities of this project. In addition, we also recognize the contribution by Ken Odera and Jennifer Atieno (APHIA Nyanza) and June Omollo (APHIA Western) for facilitating field activities.

We would also like to acknowledge the contribution of Joanne Ashton of Joint Commission International for ably facilitating the drafting workshops and national consensus meeting for these standards. In addition, we appreciate the invaluable leadership of Bruno Bouchet (Health Systems Strengthening, FHI); Naomi Bock (Global AIDS Program, CDC, Atlanta), Shama Patel (Global AIDS Program, CDC, Atlanta), and Nicole de Gier and Nilu Rimal (FHI) for their contributions to this process; and Debbie McGill (FHI) for managing editorial production, Janet Wheaton (FHI) for editing, and Dick Hill (FHI) for design and layout of this publication.

NASCOP would like to acknowledge the financial support from CDC and PATH for making this pilot project possible. We would also like to express our gratitude to Peter Mwarogo, director of FHI/Kenya, for overall managerial support in the implementation of this project.

Thank you for your tireless efforts in this invaluable process.

Dr. Nicholas Muraguri, Head, National AIDS/STD Control Programme (NASCOP)
Ministry of Public Health and Sanitation, Nairobi

Foreword

Kenya's national HIV prevalence rate of 7.1 percent is driven by subgroups within the general population that engage in high-risk sexual and drug-related HIV risk behaviour. These include sex workers and their clients, men who have sex with men, prisoners, and injecting drug users.

This underscores the need to improve the quality of the peer-education and outreach component of programs targeting female and male sex workers, with the goals of increasing the coverage of the target population and making these programs more effective in reducing the rate of new infections.

Peer education and outreach is a process by which trained individuals conduct sessions with their peers to improve knowledge, skills, and attitudes that reduce the risk of acquiring or transmitting HIV and STIs. In this regard, peer education and outreach are recognized as key components of a comprehensive HIV prevention program, and in recent years, it has become a popular methodology for HIV prevention programming for most-at-risk populations in Kenya. But because of a lack of capacity and evidence-based approaches, the effect and impact of peer education on the overall program outcomes have been compromised. It is on this realization that Kenyan organizations, with funding support from the Centers for Disease Control and Prevention (CDC), and under the leadership of the National AIDS and STI Control Programme (NASCOP), initiated the development standards for peer-education and outreach programs for sex workers.

In this process, NASCOP collaborated with FHI, PATH, and CDC to lead key prevention partners that are involved in peer-outreach programs in a participatory process to develop standards. These standards were tested within selected organizations to gauge their relevance and acceptability. Key stakeholders led by NASCOP reviewed the standards and reached a consensus in Nairobi in April 2010.

These standards are therefore the outcome of an effort at the national level to respond to prevention-program needs for sex workers. It is our hope that this document will provide much-needed guidance as Kenya rolls out the Kenyan National AIDS Strategic Plan (KNASP) III, and will be a valuable resource to program managers, coordinators, and supervisors who are involved in the implementation of HIV prevention programs for sex workers.

It is our expectation that these standards will be applied widely and that the lessons learned will be documented and shared in order to inform new program designs targeting the most-at-risk populations. Application of these standards will create synergy, maximize program impact, and open the way for program scale-up in Kenya.

Dr. S. K. Sharif , Director
Ministry of Public Health and Sanitation

Dr. F. M. Kimani, Director
Ministry of Medical Services

Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
APHIA	AIDS Population and Health Integrated Assistance
ART	Antiretroviral therapy
CDC	United States Centers for Disease Control and Prevention
FBO	Faith-based organization
HIV	Human immune deficiency virus
IDU	Intravenous drug user
M&E	Monitoring and evaluation
MARPS	Most-at-risk populations
MOPHS	Ministry of Public Health and Sanitation
MSM	Men who have sex with men
NASCOP	National AIDS and STI Control Programme
NGO	Nongovernmental organization
PE	Peer educator
PEP	Post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PWP	Prevention with Positives
STI	Sexually transmitted infection
SW	Sex worker
SWOP	Sex Workers Prevention Program
USAID	United States Agency for International Development

Introduction

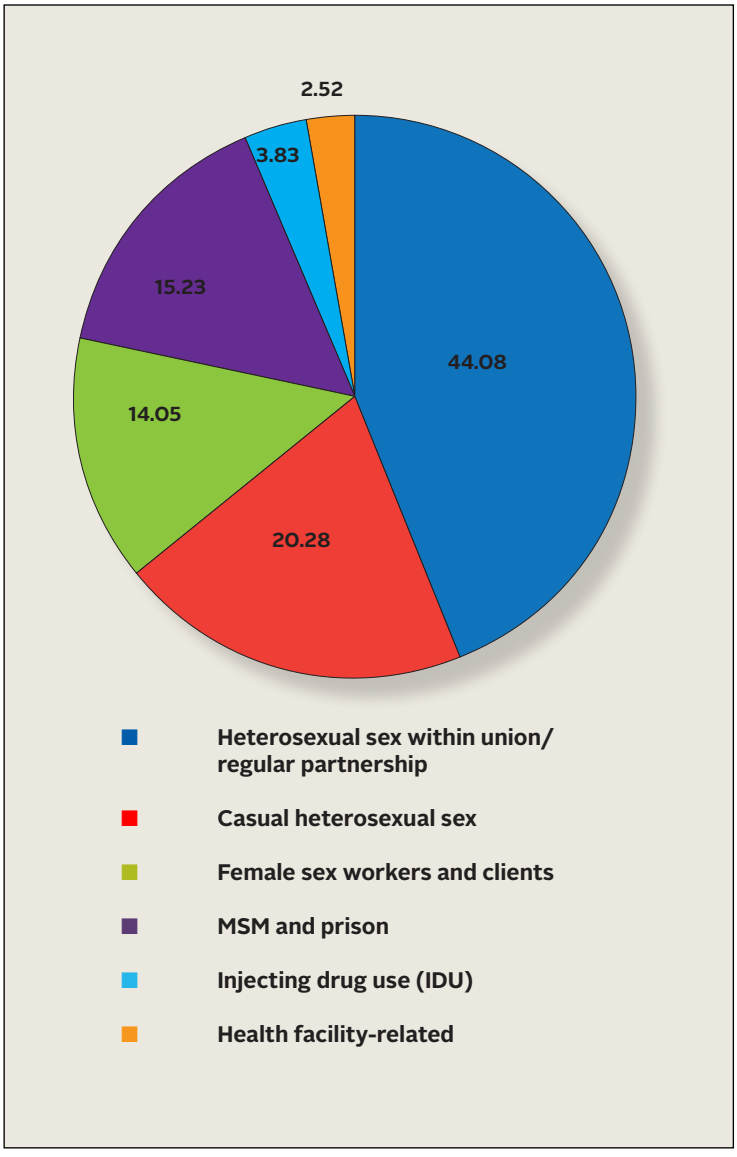
Purpose

The purpose of this document is to describe the process that was used to develop standards for peer-education and outreach programs for sex workers (SWs) in Kenya, and to list the standards that will serve as a basis for improving the quality and effectiveness of these programs. Peer-education and outreach programs are an important component of the services described in the *National Guidelines for HIV/STI Programs for Sex Workers.*[1]

Background

Kenya experiences a mixed epidemic (both generalized and concentrated). As of 2007, 1.3 million people between the ages of 15 and 64 were living with HIV and the national HIV prevalence rate was 7.1 percent.[2] The generalized epidemic is driven by serodiscordance, unprotected sex, multiple or concurrent partnerships, low male circumcision (MC) rates among some cultural groups, and unawareness of HIV status.[3] The concentrated epidemic is driven by subgroups that engage in high-risk sexual behaviour, such as unprotected anal or vaginal sex, and drug-related HIV-risk behaviour, such as unsafe injection practices. These subgroups include SWs and their clients, men who have sex with men (MSM), prisoners, and injecting drug users (IDUs).[4] These at-risk populations account for one-third of the new infections in Kenya, as shown in Figure 1.

Figure 1. Distribution of new HIV infections in Kenya[5]



Among most-at-risk populations (MARPs), female SWs and their clients account for 14 percent of new HIV infections in Kenya. Female SWs' high incidence of HIV[6, 7] and STIs[8] is a result of their high-risk sexual behaviour (unprotected sex, frequency and number of sexual clients, anal intercourse, dry sex, and substance use). Sex workers in general not only have a higher risk of transmitting and acquiring HIV and STIs than the general population, but also are hard-to-reach members of society. Factors that increase SWs' vulnerability to HIV and STIs and that make it difficult for SWs to access services include the following:

- Stigmatization and marginalization by health and program staff create barriers for SWs to access health and social services.

- Punitive and restrictive legislation and policies hinder the ability of SWs to access voluntary and confidential health information and services.
- SWs often lack resources and economic opportunities.
- Gender, economic, and power inequalities limit the ability of SWs to negotiate safer sexual practices (such as condom use) and encourage SWs to engage in unsafe sexual behaviours (such as unprotected vaginal sex).
- High geographic mobility interrupts SWs' access to health care and increases the number of sexual networks per SW, which might also increase the rate of HIV transmission within the country.
- Health care services are generally not addressed, acceptable, accessible, or affordable to male and female SWs.[9, 10, 11]

Programs for the prevention, care, and treatment of HIV and STIs need to be developed (and existing programs need to be tailored) to reach and address the particular needs of these MARPs effectively. As members of society, SWs must have access to the same health care services as other members of society, in accordance with their rights as human beings. For these programs to be effective, program management, planning, and implementation must be a participatory process—that is, SWs must be involved. A participatory process builds consensus and ownership of the programs and empowers SWs to seek services and to advocate for their health care and human rights. Their involvement also helps sustain the programs, because it gives SWs a vested interest in the success of the programs.

Peer-Education and Outreach Programs

Strategic interventions such as peer-education and outreach programs can reduce SWs' HIV risk and vulnerability as well as reduce the number of new HIV infections among the general population.[12] Accordingly, peer-education and outreach programs are included as basic components of the HIV/STI Package of Services in the Kenyan *National Guidelines for HIV/STI Programs for Sex Workers.*[13] Through these programs, trained individuals conduct sessions with their peers with the goal of improving knowledge, skills, and attitudes to reduce the risk of transmitting and acquiring HIV and STIs.

Peer education and outreach are key components of a comprehensive HIV-prevention package for persons engaged in high-risk behaviours; and peer-education and outreach programs are central to prevention efforts for MARPs, including SWs, injecting and noninjecting drug users, and MSM. The objectives of peer education and outreach for MARPs are (1) to reduce participation in high-risk sexual and drug-using behaviours and increase participation in risk-reduction behaviours, such as the correct and consistent use of condoms, safe injecting practices, and proper disposal of injection devices; and (2) to increase the number of individuals in MARPs who receive necessary services, including HIV counselling and testing, STI screening and treatment, and antiretroviral therapy (ART) and other drug treatments.

The coverage and effectiveness of service delivery is dependent on the quality of the peer-education and outreach programs. Peer-education and outreach programs need to be community-based and acceptable to the target population. The development and implementation of a standards-based approach to these programs is imperative to ensuring the delivery of high-quality peer education and outreach within prevention programming.

Standards Development and Quality Assurance Approach

Standards are the foundation of the quality assurance and improvement processes. Figure 2 depicts the Quality Assurance Triangle, which has three primary elements: defining quality, measuring quality, and improving quality.

- Defining quality refers to (1) setting the administrative and clinical standards for processes and services—that is, the expectations for quality; and (2) communicating and implementing the standards. When standards are defined, measurements can determine if the standards have been met.
- Measuring quality refers to collecting data to determine whether standards are being met, processes are being carried out as planned, and services are being delivered as defined—that is, identifying any gaps between the standards and their implementation. Gaps become opportunities for improvement.
- Improving quality refers to staff members and their supervisors working together (1) to understand the identified gaps; and (2) to develop and implement strategies and methodologies to close the gaps and meet the standards—that is, to improve the quality of processes and services.

Figure 2. Quality Assurance Triangle[14]

Creating an effective process to develop meaningful standards is a challenge for international health development organizations. A critical component of nearly all current efforts to set standards is a serious commitment to forging a consensus between the community (the beneficiaries of the standards), political bodies, and professional organizations. On the one hand, the standards must reflect the shared values and commitments of the community if they are going to be accepted. On the other hand, these standards need to do more than reflect current practice if they are going to bring about change. A systematic process for developing and implementing standards based on sound change-management strategies will increase the acceptance of the standards and the likelihood of their implementation. FHI has outlined seven steps for developing standards to assist organizations with this process.[15] These steps, listed on the next page, are:

1. Define the topic.
2. Identify the participants.
3. Gather information.
4. Draft the standards.
5. Test the standards.
6. Communicate the standards.
7. Implement the standards.

This document describes the process that was used to develop and test standards for peer-education and outreach programs for SWs in Kenya—that is, the first five steps that led to finalizing the standards.

Step 1. Define the Topic

FHI led a group of stakeholders to participate in a situational analysis of organizations implementing HIV prevention programs with a peer-outreach component for sex workers. As part of this analysis, the group reviewed 14 programs and identified varying approaches and outcomes of peer-education and outreach programs. Each program endeavored to reduce infection rates, decrease the number of sexual clients, increase the use of condoms, and encourage individuals to seek treatment. But none of these programs measured results or used common standards to support their activities.[16]

Step 2. Identify the Participants

Various stakeholders were identified that were important in the development of standards for peer-education and outreach programs for SWs in Kenya: the Ministry of Public Health and Sanitation (MOPHS) and its National AIDS and STI Control Programme (NASCOP); the civil society and many local nongovernmental organizations (NGOs); international NGOs and their technical assistance programs (PATH; FHI); international sponsors and partners of the Government of Kenya through the United States President's Emergency Plan for AIDS Relief (PEPFAR) funding; the United States Centers for Disease Control and Prevention (CDC) and United States Agency for International Development (USAID); and the male and female sex workers who are the beneficiaries of the peer-education and outreach programs.

With leadership from NASCOP, 17 local and international stakeholders attended a three-day workshop in Naivasha, Kenya, March 2–4, 2010, to draft standards for peer-education and outreach programs for SWs. The standards working group set the following goal: to establish standards for quality peer-education and outreach programs for SWs and their clients in order to reduce the risk of acquiring or transmitting HIV and STIs through behaviour change. The group identified the results that they expected from implementing the standards. They are listed below:

- Increased frequency of protected sex through the use of condoms with clients
- Increased practice of protected sex with the regular clients

- Increased proportion of SWs having correct knowledge of their HIV status
- Increased effectiveness of referrals to facilities
- Increased quarterly HIV testing for people who are seronegative
- Increased recognition of STI symptoms
- Increased uptake of the HIV/STI Package of Services for SWs, as set forth in the *National Guidelines for HIV/STI Programs for Sex Workers*

Step 3. Gather Information

The ultimate value of the standards that were developed depends on the availability of scientific evidence generated by research studies and best practices developed by programs. Gathering information entailed reviewing current research and experiential reports of peer education and outreach and conducting a situational analysis of organizations that implement HIV prevention programs with a peer-outreach component for sex workers. The core group who participated in the Naivasha workshop reviewed the results of the literature review and analyzed the current programs through flow-charting, cause-and-effect analyses, and affinity diagrams. This helped identify and clarify the components of peer-education and outreach programs, from which the group identified 12 components that should be standardized (see Box 1). These activities led to the publication by FHI of two reports that document and synthesize the core group's findings.[17, 18]

Box 1. Standards

Standard 1: Management
Standard 2: Selection Process
Standard 3: Training
Standard 4: Retention
Standard 5: Access to Health Services
Standard 6: Peer-Education and Outreach Services
Standard 7: Supplies, Materials, and Tools
Standard 8: Enabling Environment
Standard 9: Referral System
Standard 10: Supportive Supervision
Standard 11: Ongoing Support
Standard 12: Monitoring and Evaluation

Step 4. Draft the Standards

During the Naivasha workshop, the working group developed a set of standards using a consistent format for each standard: a statement of the standard, the intent of the standard, and criteria describing the elements required to meet the standard. Box 2 provides an example of this format.

Box 2. Example of a Standard: Statement, Intent, and Criteria

Standard 3. All peer-education training is curriculum-based.

Intent: To ensure that training is conducted using evidence-based and approved curricula that include correct and complete information and relevant skills and that will create favorable attitudes among peers. Training lays the foundation for the successful implementation of peer-education and outreach programs. Principles of client-provider interaction and counselling provide the basis for developing key counselling skills, attitudes, and knowledge. The training process includes initial, refresher, and continuing levels of learning that reflect current behavioural theory and principles of participatory and adult learning.

Criteria:

3.1 An assessment of training needs is conducted using a standardized tool.

3.2 A relevant and evidence-based curriculum is used.

3.3 Interactive, participatory, and skill-development educational approaches are used, such as role-playing and sharing safe-sex, role-model stories.

3.4 The environmental setting and group size are designed to maximize learning.

3.5 Qualified trainers who have been certified through a nationally recognized authority are engaged.

Following the Naivasha workshop, a consensus-building workshop was held in Nairobi, April 28 and 29, 2010. Approximately 50 individuals representing a broad range of stakeholders participated in this activity. The participants were provided with the background information, including presentations of Kenya's situational analysis and literature review. FHI and its consultant made presentations regarding the conceptual framework for developing standards (the Quality Assurance Triangle). In addition, exemplary peer-education and outreach programs in India and the Ivory Coast were described to stimulate ideas within the group.

Participants were then organized into groups of five to seven individuals with cross-representation of the stakeholders in each group. The groups were tasked to review one or two of the standards and respective criteria based on the attributes of a good standard (see Box 3), although it is not realistic to expect that all standards meet all attributes perfectly. The groups' recommendations were then discussed in plenary until a consensus was reached.

Box 3. Attributes of a Good Standard

- Validity: The standard is based on scientific evidence or other acceptable experience (expert consensus at a minimum).
- Clarity: The standard is understood the same way by everyone and not subject to misinterpretation.
- Measurability: Elements are quantifiable and can be assessed through use of valid instruments.
- Relevancy: Elements are significant, appropriate, important, and of consequence.
- Reliability: The standard yields the same results in different settings.

Step 5. Test the Standards

A technical working group representing all stakeholders tested the standards for clarity, measurability, feasibility, and reliability through interviews with eight peer-education and outreach program managers and staff members. A specific instrument was designed for that purpose. As a result of the test, the technical working group recommended a few slight changes in the wording of the standards and their criteria. The final version was then produced and approved.

Standards and Criteria

Standard 1. Management

A management system is in place.

Intent: To provide direction and oversight to the peer-education and outreach programs for sex workers according to the national guidelines. An effective management team, with defined roles and responsibilities, is required to plan and implement successful peer-education and outreach programs for SWs. The involvement of peer educators (PEs) and SWs in the management of the peer-education and outreach programs is imperative to the success of the initiative. The *National Guidelines for the Implementation of the HIV/STI Package for Sex Worker Programs* is the basis for the development and implementation of the programs. All programs are planned to reach SWs in the defined catchment area. For optimal results, the needs of SWs will be assessed and a plan developed to meet those needs with available resources, such as time, skilled personnel, and finances. Planning involves SWs and other stakeholders and clarifies the roles, responsibilities, and objectives of the programs. A defined management team that includes SWs is responsible for establishing processes to implement and oversee the quality of the programs.

Criteria (Assessing/Planning):

1.1 Mapping is conducted to identify existing hotspots, services, and resources.

- 1.1.1 SWs and their clients are defined.
- 1.1.2 Risky behaviours in the locality (hotspot neighbourhoods) are identified.[19]
- 1.1.3 Population size is estimated annually or seasonally to determine the required number of PEs.
- 1.1.4 A baseline capacity assessment is conducted.
- 1.1.5 Hotspot mapping is disaggregated by the type of sex work.
- 1.1.6 Stakeholders—such as gatekeepers, night guards, disk jockeys, law enforcement agencies, establishment owners and managers, and service providers—are identified.

1.2 An annual plan is developed for peer-education and outreach sessions and supervision, including objectives and time frames.

1.3 A sustainability plan for the peer-education and outreach programs is established and reviewed annually:

- 1.3.1 The continuity of services is established.
- 1.3.2 The plan is owned and managed by SWs.
- 1.3.3 The continuity of funding is planned.

1.4 Program decisions are based on current information, research, or data.

1.5 An annual budget is allocated to support implementation at all levels.

1.6 A communication strategy is developed.

Criteria (Organizing/Directing):

1.7 Program managers have the skills and experience to carry out their defined roles and responsibilities.

1.8 Managers coordinate and link peer-education activities with other program services and stakeholders.

1.9 Resources are mobilized to support program activities in line with the sustainability plan.

1.10 Managers ensure compliance with program standards using approved tools.

1.11 Managers facilitate annual meetings with stakeholders (government, donors, etc.) for formal review and feedback.

1.12 Managers establish a process of engaging stakeholders through formal and informal mechanisms.

1.13 Managers are actively involved in, and contribute to, the project's monitoring and evaluation function.

Standard 2. Selection Process for Peer Educators

An effective peer-educator selection process is established.

Intent: To select peer educators in a manner that will promote acceptance by sex workers and reach the target population effectively. The success of peer-education programs depends on the individuals who are chosen as PEs. Consequently, the process for selecting PEs is critical to the success of the programs. The methods for recruiting PEs affect how the target population perceives them.[20] Core elements of this process include (1) identifying and selecting popular opinion leaders (POLs) who represent different segments of a target population, and (2) reaching a critical mass of POLs that is large enough to establish new norms and behaviours within a community population.[21, 22] The selection of PEs requires the development of a consultative mechanism to ensure equitable representation of PEs through vetting.

Criteria:

2.1 Effective selection criteria are used:

- 2.1.1 Equitable representation for the catchment area and targeted hotspots is achieved.
  - 2.1.1.1 Subtypes of SWs are represented.
  - 2.1.1.2 The number of PEs is proportional to the SW population, according to each educator's capacity.
- 2.1.2 PEs have strong interpersonal skills, including social skills and the ability to uphold confidentiality.
- 2.1.3 PEs are acceptable to their peers (POLs).
- 2.1.4 Both genders are represented.[23]
- 2.1.5 PEs are available and willing to serve.

2.2 The process promotes participatory engagement of SWs, gatekeepers, and stakeholders.

2.3 A standard process (such as a checklist) is used to guide the selection.

2.4 The effectiveness of the selection process is monitored.

Standard 3. Training of Peer Educators

All peer-education training is curriculum-based.

Intent: To ensure that training is conducted using evidence-based and approved curricula that include correct and complete information and relevant skills and that create favorable attitudes among peers. Training lays the foundation for the successful implementation of peer-education and outreach programs. Principles of client-provider interaction and counselling provide the basis for developing key counselling skills, attitudes, and knowledge. The training process includes initial, refresher, and continuing levels of learning that reflect current behavioural theory and principles of participatory and adult learning.

Criteria:

3.1 An assessment of training needs is conducted using a standardized tool.

3.2 Relevant curricula from the Government of Kenya and other evidence-based peer-education curricula are used.

3.2.1 Curricula are based on behavioural and adult-learning theory.

3.2.2 Topics and training in the curricula include, but are not limited to, stigmatization, discrimination, HIV/STIs, ART adherence, reproductive health and family planning, substance abuse, the use and demonstration of male and female condoms, the use of lubricants, risk assessment and reduction, skills to negotiate condom use, ethics (human rights and responsibilities), interpersonal skills, social skills, assertiveness training, improvement in self-efficacy, referrals, and training in confidentiality and awareness and sensitivity to individuals' values.[24]

3.2.3 Curricula are routinely (for example, semi-annually) reviewed and revised as necessary to address the needs of the target population, emerging evidence, best practices, and changing contexts.

3.2.4 Training curricula include practicum sessions through which the trainer provides supportive supervision.

3.3 Educational approaches are interactive, participatory, and skill developing; and they embed positive and culturally acceptable norms and practices—for example, role-playing and sharing safe-sex role-model stories.[25]

3.4 The environmental setting and group size are designed to maximize learning.

3.5 Qualified trainers who are certified through a nationally recognized authority are engaged.

3.6 Refresher and continuing-education training opportunities are provided.

3.7 Appropriate and effective educational tools and materials are developed, used, reviewed, and revised as appropriate.

3.7.1 Learning aids such as penile and vaginal models, exemplar conversational messages, and monitoring and evaluation and referral tools are used.

3.7.2 Tools and materials are developed in the language of the target population, and they are culturally appropriate, age appropriate, and gender sensitive.

3.7.3 Appropriate materials are provided to participants to reinforce learning.

3.8 The effectiveness of the training program is evaluated.

3.9 Participants are evaluated for their competency in carrying out their responsibilities as PEs.

Standard 4. Retention of Peer Educators

Establish a system for retention of peer educators.

Intent: To sustain an effective program by limiting attrition. Retention of PEs is essential to the effectiveness and sustainability of the program. Low retention of PEs is a recognized problem.[26] Strategies need to be developed based on factors that are known to affect attrition. Motivators of the targeted population need to be identified and included in the planning process. Incentives are not necessarily monetary, as two of the greatest incentives can be recognition and appreciation. When PEs relinquish their posts, transitioning to new PEs is important to provide continuity of services.

Criteria:

4.1 A needs assessment is conducted to guide retention planning.

4.2 Effective strategies are established for retention of PEs according to the findings of the needs assessment.

4.2.1 Certification by a national body is provided for training programs.

4.2.2 Recognition for service is provided.

4.2.3 Expectations of the PEs are clarified.

4.2.4 PEs are involved in decision making for peer-education and outreach activities.

4.2.5 Linkages are made with microfinance institutions and vocational training opportunities.

4.3 Responsibilities are distributed equitably among PEs based on their individual capacities.

4.4 Strategies are developed and implemented to prevent burn-out or drop-out.

4.5 Succession and replacement mechanisms are in place.

Standard 5: Access to Health Services by Sex Workers and Their Clients

Health care services are accessible by sex workers and their clients.

Intent: To expand SWs' options for HIV and STI prevention and treatment services and to promote their use of these services. Barriers to SWs seeking services include inconvenient hours and locations, unwelcoming or judgmental attitudes on the part of

staff and other clients, and the cost of services. Service providers need to consider these potential barriers and plan service delivery to minimize them.

Criteria:

5.1 Health care services are responsive to the needs of SWs and their sexual clients.

5.2 Health care services are offered at times that are convenient for SWs and their sexual clients.

5.3 Health care services including outreach services are offered in locations that are convenient for SWs and their clients.

5.4 Health care services and medications are affordable.

5.5 Health care service providers are friendly to SWs and nonjudgmental.

5.6 Health care service providers are available and competent to provide all elements of the basic package of services and make references as appropriate.

5.7 The following health care services are periodically integrated with peer-outreach activities:

- 5.7.1 STI and cervical-cancer screening and management
- 5.7.2 Reproductive health and family planning
- 5.7.3 Post-exposure prophylaxis (PEP)
- 5.7.4 HIV testing and counselling, prevention of mother to child transmission (PMTCT), ART, and adherence support

Standard 6. Peer-Education and Outreach Services for Sex Workers

Comprehensive peer-education and outreach services are provided.

Intent: To respond to the health information needs of sex workers with competent providers who offer an integrated HIV/STI package at the convenience of the SWs. Successful HIV/AIDS prevention and care programs for those involved in sex work are based on several strategies. The *National Guidelines* outline the services to be provided in peer-education and outreach programs. These services include information on HIV/STI, emergency contraception, PEP, cervical cancer, sexual reproductive health, and substance abuse; demonstrations and distribution of condoms and lubricants; skills building; encouragement to determine one's HIV status; and referral to clinical and nonclinical services. Peer-education and outreach programs should be designed to meet the broad health-information needs of SWs and their clients. Partnering health care workers with PEs to provide outreach services is recommended.

Criteria:

6.1 Formal enrollment is documented for each beneficiary.

6.2 Accurate, relevant, up-to-date, and complete information on STIs, HIV, and other health issues is provided.

6.3 Individualized risk assessments are conducted.

6.4 Individualized risk-reduction plans are developed.

6.5 Male and female condoms and lubricants and instructions and demonstrations regarding their correct and consistent use are provided to each SW and to his or her clients.

6.6 PEs converse with SWs personally and endorse the benefits of risk-avoidance behaviours.[27]

6.7 PEs provide problem-solving support and critical thinking about stigmatization of SWs.

6.8 SWs are supported in building skills to negotiate condom use.

6.9 SWs are assisted in building life skills, including orientation on sexual gender-based violence.

6.10 SWs are encouraged to:

6.10.1 Check their HIV status (quarterly for HIV-negative persons).

6.10.2 Access the Prevention with Positives (PWP) services in accord with the *National Guidelines.*

6.10.3 Access STI and cervical cancer services when necessary, including quarterly screening for STIs and cervical cancer and referral for treatment when necessary.

6.11 PEs collaborate with health care service providers to ensure that information on HIV, STIs, and family planning is integrated into peer-education and outreach programs when feasible.

6.12 PEs guide peers to explore their attitudes toward health services, risky behaviour, and treatment.

6.13 A basic HIV/STI package of services is provided during peer education and outreach in accord with the *National Guidelines*. The package includes the following:

6.13.1 Information on risk reduction

6.13.2 Education on preventing and detecting cervical cancer

6.13.3 Distribution of condoms, lubricants, and contraceptives

6.13.4 Referrals for health care services and community support

Standard 7: Supplies, Materials, and Tools for Peer Educators and Sex Workers

The program provides the necessary supplies, materials, and tools.

Intent: To provide appropriate supplies, materials, and tools to peer educators in sufficient quantities, when and where they are needed. Peer-education and outreach programs work best when supplies such as condoms, models, and learning materials are tailored to meet the needs of the male and female SWs and provided in adequate quantities to PEs in a timely manner. Information, education, and communication materials are needed to meet adult learning goals and they are used most effectively when provided at points of service delivery.

Criteria:

7.1 Information, education, and communication materials that are tailored to the SWs' needs are readily available and acceptable.

7.1.1 Materials are developed in a format suitable to the needs of the target populations (SWs and their clients)—for example, audio for truck drivers and migratory SWs and picture-coded materials for illiterate SWs.

7.1.2 The materials are tested with the target populations for cultural and language acceptability and effectiveness.

7.1.3 Clinically and behaviourally relevant information is presented in an interactive and engaging manner to primary and secondary clients (secondary clients include clients of SWs, brothel owners, etc.).

7.1.4 The materials are based on needs of both male[29] and female sex workers and focus on specific types of sex work.

7.2 Facilitation tools for peer-education and outreach sessions (discussion guides, peer-education diaries, and attendance records) are developed, tested, and made available.

7.3 PEs collaborate with service providers to ensure that supplies for integrated outreach programs are available. These supplies should include the following:

7.3.1 Medications to treat STIs

7.3.2 HIV test kits

7.3.3 Male and female condoms

7.3.4 Lubricants

7.4 A system to manage stock is in place to ensure that adequate supplies are available.

Standard 8: Enabling Environment

An enabling environment is established for peer education of sex workers and outreach to sex workers and their clients.

Intent: To promote and enhance the health, rights, and well-being of sex workers. An enabling environment is key to increasing the uptake of quality services by SWs and their clients. Sex workers often have a wide range of concerns that directly and indirectly affect their health, well-being, and capacity for action. These concerns may include worries about children, police harassment, exploitative working conditions, housing problems, domestic violence, migration status, and HIV-related stigmatization. Increasing SWs' involvement and control over their working and social conditions is important toward improving their situation. Reducing stigmatization and discrimination can be achieved through support groups and working with police, managers and owners of establishments, and others. Creating easy access to health care, increasing empowerment through developing alternative life skills, and capacity building are other ways to create an enabling environment. Adherence to a code of ethics by PEs and health care providers and collaborative interventions with stakeholders are also important.

Criteria:

8.1 A code of ethics for PEs is developed and used to guide recruitment, training, service delivery, retention, and disciplinary and dismissal processes.

8.2 PEs educate SWs on their human rights and responsibilities in accord with the *National Guidelines*, including referrals and linkages to sustainable alternatives for economic empowerment.

8.3 Peer education and outreach are culturally appropriate and gender sensitive.

8.4 Physical facilities ensure that services can be provided to SWs confidentially.

8.5 Confidentiality is maintained by all service providers (PEs and health care workers).

8.6 Measures to reduce stigmatization (of self, among peers, at referral sites, and within the community) and discrimination among PEs and SWs are in place.

8.7 Health care facilities, such as drop-in centres, are friendly and conveniently located in appealing, accessible, and secure places, and they provide services at convenient hours.

8.8 Partnerships are created with community gatekeepers (opinion leaders, ecumenical or faith-based organization [FBO] leaders, local administration, law enforcement agencies, and owners of recreational facilities and hotspots) to protect the health and safety of SWs.

Standard 9: Referral System for Sex Workers and Their Clients

An effective referral system is established.

Intent: To address the economic, social, legal, emotional, psychological, and physical needs of sex workers. Providing a networking infrastructure that is capable of supporting the specific needs of SWs and their clients is key to quality peer-education and outreach programs. PEs are in a position to learn about these needs, but they are not empowered to intervene in all areas. It is therefore important that they be fully aware of the resources within the community to which they can refer the SWs and their clients for assistance.

Criteria:

9.1 A referral directory is developed and updated annually or as needed with the following information:

- 9.1.1 Location of referral sites within the community
- 9.1.2 Services available and cost of the services
- 9.1.3 Contacts of key service providers at referral sites

9.2 Service providers are oriented to the referral processes, tools, facilities, and sites.

9.3 PEs are aware of the referral systems and sites.

9.4 PEs routinely share the information in the referral directory among themselves and with SWs.

9.5 Linkages for clinical management of HIV and STIs for SWs and their clients are defined in accord with the *National Guidelines*.

9.6 Linkages for nonclinical HIV and STI services for SWs and their clients are established in accord with the *National Guidelines*.

9.7 A clear mechanism exists to provide feedback between the health facility and the SW community:

9.7.1 Peer to peer

9.7.2 Peer to referral site

9.7.3 Referral site to peer

9.8 Children of SWs are linked to existing support systems for relevant services, such as child protection and vaccinations.

9.9 A standard tool is developed and in use for tracking effective referrals.

9.10 Periodic (no less than quarterly) meetings of PEs and service providers are held to review performance.

9.11 PEs, when feasible, document referrals and services provided to each SW.

Standard 10. Supportive Supervision of Peer Educators

Supportive supervision is provided on an ongoing basis to all peer educators.

Intent: To establish a mechanism for monitoring peer-educator staff during routine activities and identifying factors that affect work output. Supportive supervision is a process of guiding, helping, teaching, and learning from PEs at their places of work in order to help them perform their work better. In supportive supervision, equal emphasis is placed on identifying and solving problems and two-way communication between the supervisors and those being supervised. It is also a powerful tool for monitoring and measuring the quality of services provided. The supervisor provides a link between the various levels of service and assists in integrating the services to meet the SWs' needs. Frequent support visits have been identified as a key factor in motivating PEs.[30]

Criteria:

10.1 Training sessions are conducted to build capacity and certify peer-education and outreach supervisors.

10.2 Supervisors certified in peer education and outreach conduct supervision of PEs.

10.3 A feedback mechanism is in place for staff at all levels.

10.4 Supportive supervision is provided at the program level at least quarterly.

10.5 The results of supportive supervision are used for making decisions.

10.6 Supervision of peer-education and outreach activities is provided regularly.

10.7 Standard supervision tools are used to document observations, plans, and activities.

10.8 Quality improvement processes are in place for the following:

10.8.1 Identifying performance gaps

10.8.2 Analyzing the causes of problems

10.8.3 Designing and implementing solutions

10.8.4 Monitoring the results of the interventions

10.9 Periodic review meetings are held to improve the technical knowledge and skills of PEs and respond to emerging needs.

10.10 A mechanism is in place to discuss and respond to grievances of SWs and PEs regarding service provision.

Standard 11. Ongoing Support for Sex Workers

Continuous and sustained contact with sex workers is undertaken.

Intent: To provide an opportunity for updating and furthering education, increasing skill competency, and motivating for change. Evidence has shown that beneficial behaviour change occurs when repeated and sustained contact with peers takes place. Peer contacts offer a mechanism for responding to other socio-economic factors and service utilization. The program documents follow-up of SWs to ensure that programs are implemented effectively.

Criteria:

11.1 A plan of ongoing contact with SWs is developed.

11.2 Ongoing contact is implemented as planned and can be facilitated by forming support groups.

11.3 Individualized risk assessments are updated regularly for each SW (for example, quarterly).

11.4 Risk-reduction plans are revised regularly to reflect changes in risk behaviour.

11.5 Options for alternative modes of income generation for interested SWs are identified.

Standard 12. Monitoring and Evaluation

Participatory monitoring and evaluation (M&E) is carried out for peer-education and outreach programs.

Intent: To continually improve and adjust programs in order to better suit the needs of sex workers. Participatory M&E is an important component of quality programming. Effective programs require data that managers can use to make decisions about how to design their programs and adjust them if data show the need for improvement. Knowing which data are needed for decision making ensures that the right data are collected. Standardization of M&E systems helps to clarify expectations on what the program will achieve. Standardization also enables comparisons across sites and over time.[31] Identifying an M&E focal person can be helpful in providing oversight to ensure that correct and complete information is obtained.

Criteria:

12.1 An M&E training plan is established.

12.2 Staff members have the capacity to plan and implement M&E at the program and peer-educator level.

12.3 An M&E plan is established that includes the following:

12.3.1 Relevant and clear objectives

12.3.2 Defined measurable quality outcomes of program activities

12.3.3 Appropriate input, process, and outcome indicators

12.3.4 Definition of the data flow process across the program

12.3.5 Standardized definitions and M&E formats across sites

12.3.6 A timeline for periodic evaluation

12.4 An M&E plan is implemented, including data-quality audits on a quarterly basis. Progress and any relevant information regarding the peer-education and outreach programs are shared with SWs, their partners, PEs, and stakeholders.

12.5 The collected data are analyzed and used to make decisions to improve the program.

12.6 Clear guidelines are outlined on how data will flow from the community to the national level.

12.7 Feedback is collected and provided to clients and service providers on the use of referral services.

12.8 Appropriate documentation tools are developed for the target audience.

12.9 Documentation of SWs' attendance at peer-education and outreach sessions is accurate and complete.

12.10 Feedback is collected and provided to clients and service providers on the use of referral services.

Appendix A. Glossary

Catchment area: The geographic coverage area of a program.

Controllers: Power-holding intermediaries between the sex worker and the client and often between the sex worker or client and local authorities (pimps, madams, etc.).

Gatekeepers: Individuals who facilitate or hinder access to sex workers (law enforcement, controllers, taxi drivers, etc.).

HIV/STI Package of Services: Evidence-based package of HIV/STI and reproductive health care services for SWs that includes interventions and services designed specifically for SWs, to decrease the transmission of disease and improve the quality of their health and lives. (See Appendix B.)

Hotspots: Places where high-risk behaviour occurs—e.g., where individuals exchange sex for money.

Men who have sex with men (MSM): Males who have sex with other males, regardless of whether or not they have sex with women or have a personal or social identity associated with that behaviour (being homosexual, bisexual, or transgender).[32]

Participatory process: Active participation of the target population (sex workers) in program planning, management, and implementation.

Peer-education and outreach: Programs that involve selecting and training peers (individuals who share demographic characteristics or risk behaviours, such as sex work, with the target population) to modify the knowledge, attitudes, beliefs, or behaviours of their peers through small groups or one-on-one interpersonal interactions in the community where SWs congregate, work, or live (includes referrals to HIV/STI and other services). [33, 34, 35]

Peers: Sex workers who are reached by PEs.

Persons who engage in sex work (sex workers): Individuals (male, female, and transgender) who exchange sexual acts for something of value (cash, material items, etc.) that would otherwise not be extended to them by their sexual partners.[36]

Referral: The process through which the HIV/STI-related needs of the sex worker are assessed and she or he is helped to access the identified services.

Risk assessment: A process to gather information about sex workers' behaviours that could increase their risks of acquiring or transmitting HIV or STIs. The goal of an individualized risk assessment is to provide the SW with insight into his or her high-risk behaviours and to help him or her minimize the likelihood of acquiring or transmitting HIV or STIs. Information from risk assessments helps service providers to individualize prevention messages and health services.

Risk-reduction counselling: A tailored, client-centered behavioural intervention designed to change a person's knowledge, attitudes, behaviours, or practices in order to reduce HIV/STI-risk behaviours that are identified in a risk assessment.

Service providers: Individuals (PEs, health care workers, nurses, doctors, clinical officers, and program staff) who offer information and services on HIV, STIs, and reproductive health to SWs.

Sex work: The exchange of money for sexual services.

Sexual clients of SWs: Paying or nonpaying individuals who have anal, vaginal, or oral sex with sex workers and may include clients, regular sexual clients, and primary sexual clients.

> **Clients of sex workers:** Men and women who exchange money with sex workers. They have a range of professions and levels of education and come from various socio-economic strata.
>
> **Regular sexual clients:** Individuals who have anal, oral, or vaginal sex with SWs on a regular basis (more than five times) and may or may not exchange material items for sex with SWs.
>
> **Primary sexual partner:** Individuals who have defined long-term relationships with sex workers, such as boyfriends, girlfriends, cohabiting clients, or spouses.

Appendix B. HIV/STI Package of Services

The HIV/STI Package of Services is an evidence-based package of HIV/STI and reproductive health services for sex workers that includes the following:

Basic components. A core set of interventions that must be offered to each SW routinely:

- Outreach and education (especially peer education and outreach)
- Risk assessment, risk-reduction counselling, and skills building
- Promotion, demonstration, and distribution of male and female condoms and water-based lubricants

Clinical components. HIV/STI and reproductive health services tailored to SWs:

- HIV testing and counselling
- STI screening and treatment
- TB screening and referral to treatment
- HIV care and treatment
- Reproductive health services
  - Family planning
  - Post-abortion care services
  - Cervical cancer screening
- Emergency contraception
- Post-exposure prophylaxis (PEP)
- Substance-abuse assessment and treatment

Nonclinical components. Services that increase the overall health status and protect the human and health rights of SWs:

- Psycho-social support
- Services to mitigate sexual violence
- Family and social services
- Support to expand choices beyond sex work

Structural intervention. Approaches to alter the social, economic, political, and environmental factors that determine HIV risk and vulnerability:

- 100-percent condom use program

Interventions for clients of SWs. HIV/STI services to reduce acquisition and transmission of disease:

- Peer-education and outreach
- Promotion, demonstration, and distribution of condoms and lubricants
- Access to STI and HIV services including clients' treatment for STIs

Notes

1. Government of Kenya. National guidelines for HIV/STI programs for sex workers (Draft). Nairobi, Kenya: Government of Kenya; 2010.
2. Ministry of Public Health and Sanitation, National AIDS and STI Control Programme (NASCOP). Kenya AIDS indicator survey 2007; final report September 2009. Nairobi, Kenya: Government of Kenya; 2009.
3. Kenya National AIDS Control Council, Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Bank HIV/AIDS Program. Kenya HIV prevention response and modes of transmission analysis. Nairobi, Kenya: UNAIDS; 2009.
4. NASCOP, 2007.
5. Kenya National AIDS Control Council, Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Bank HIV/AIDS Program. Kenya HIV prevention response and modes of transmission analysis. Nairobi, Kenya: UNAIDS; 2009.
6. Simonsen JN, Plummer FA, Ngugi EN, Black C, Kreiss JK, Gakinya MN, et al. HIV infection among lower socioeconomic strata prostitutes in Nairobi. AIDS. February 1990; 4(2):139-44.
7. Martin HL, Jackson DJ, Mandaliya K, Bwayo J, Rakwar JP, Nyange P, et al. Preparation for AIDS vaccine evaluation in Mombasa, Kenya: establishment of seronegative cohorts of sex workers and trucking company employees. AIDS Res Hum Retroviruses. 1994; 10 Suppl 2:S235-37.
8. Simonsen, et al., 1990.
9. Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS Guidance Note on HIV and Sex Work. New York, USA: UNAIDS; 2009.
10. Pathfinder International. HIV prevention among vulnerable populations: the Pathfinder International approach. Watertown, MA: Pathfinder International; 2008.
11. National AIDS Control Council. Kenya National AIDS strategic plan 2009/10–2012/13: delivering on universal access to services. Nairobi: National AIDS Control Council; 2009.
12. Morris C, Ferguson A. Estimation of the sexual transmission of HIV in Kenya and Uganda on the trans-Africa highway: the continuing role for prevention in high risk groups. Sexually Transmitted Infections. 2006;82(5):368-71.
13. Government of Kenya. National guidelines for HIV/STI programs for sex workers (Draft). Nairobi, Kenya: Government of Kenya; April 2010.
14. Franco LM, Silimperi D, Veldhuyzen van Zanten T, MacAulay C, Askov K, Bouchet B, Marquez L. Sustaining quality of healthcare: institutionalization of quality assurance. QA Monograph Series 2(1). Bethesda, Maryland: Published for the United States Agency for International Development by the Quality Assurance Project; 2002.
15. Family Health International (FHI). Standards development: a guide to developing, communicating, and monitoring standards. Research Triangle Park, NC: FHI; 2009.
16. Family Health International (FHI). Situational analysis of organizations implementing HIV prevention programs with a peer-outreach component for sex workers in Kenya. Nairobi, Kenya: FHI; 2010a.
17. Family Health International (FHI). Literature review of evidence for effective peer education and outreach programs to protect sex workers from HIV. Nairobi, Kenya: FHI; 2010b.
18. FHI, 2010a.
19. Coleman LM, Ford NJ. An extensive literature review of the evaluation of HIV prevention programs. Health Education Research Theory and Practice. 1996; 11(3): 327-38.

20. Medley A, Kennedy C, O'Reilly K, Sweat M. Effectiveness of peer education interventions for HIV prevention in developing countries: A systematic review and meta-analysis. AIDS Education and Prevention. 2009; 21(3):181-206.

21. Kelly JA. Popular opinion leaders and HIV prevention peer education: resolving discrepant findings, and implications for the development of effective community programmes. AIDS Care. 2004; 16(2):139-150.

22. Amirkhanian YA, Kelly JA, Kabakchieva E, Kirsanova AV, Vassileva S, Takaks J, et al. A randomized social network HIV prevention trial with young men who have sex with men in Russia and Bulgaria. AIDS. 2005; 19:1897-1905.

23. Okal J, Luchters S, Geibel S, Chersich MF, Lango D, Temmerman M. Social context, sexual risk perceptions and stigma: HIV vulnerability among male sex workers in Mombasa, Kenya. Culture, Health & Sexuality. 2009; 11(8):811-26.

24. Coleman, et al., 1996.

25. Shuguang W, Van deVan P. Peer HIV/AIDS education with volunteer trishaw drivers in Yaan, People's Republic of China: process evaluation. AIDS Education and Prevention. 2003; 115(4):334-45.

26. Medley, et al., 2009.

27. Kelly, 2004.

28. Cornish F, Campbell C. The social conditions for successful peer education: a comparison of two HIV prevention programs run by sex workers in India and South Africa. Am J Community Psychol. 2009; 44:123-35.

29. Geibel S, Luchters S, King'ola N, Esu-Williams E, Rinyiru A, Tun, W. Factors associated with self-reported unprotected anal sex among male sex workers in Mombasa, Kenya. Sexually Transmitted Diseases. 2008; 35(8):746-52.

30. Laukamm-Josten U, Mwizarubi BK, Outwater A, Mwaijonga CL, Valadez JJ, Nyamwaya D, et al. Preventing HIV infection through peer education and condom promotion among truck drivers and their sexual partners in Tanzania, 1990-1993. AIDS Care. 2000; 12(1):27-40.

31. WHO/SEARO. Toolkit for monitoring and evaluation of interventions for sex workers. 2009. Available from: http://www.searo.who.int/LinkFiles/Publications_ToolKitMandE.pdf World Health Organization, Regional Office for South-East Asia, India.

32. Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS action framework: universal accesses for men who have sex with men and transgender people. Geneva, Switzerland: UNAIDS, 2009.

33. Medley, et al., 2009.

34. Medlin C, Balkus J, Padian N. Report to the UNAIDS HIV Prevention Reference Group on developing minimum quality standards for HIV prevention interventions. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS, 2008.

35. Joint United Nations Programme on HIV/AIDS (UNAIDS). Peer education and HIV/AIDS: concepts, uses, and challenges. Geneva, Switzerland: UNAIDS, 1999.

36. Harcourt C, Donovan B. The many faces of sex work. Sexually Transmitted Infections. 2005; 81:201-06.

Ministry of Public Health
and Sanitation