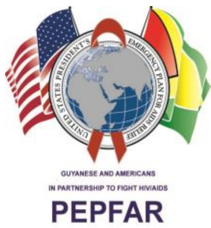

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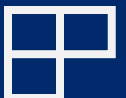
Ministry of Health/National AIDS Program Secretariat (MOH/NAPS)/USAID Guyana HIV AIDS Reduction and Prevention (GHARP) Project Phase II

A Joint Government of Guyana – U S Government Project

Most-At-Risk Populations (MARPs) Guidelines and Standards for Non Governmental Organizations

With support from The President's Emergency Plan for AIDS Relief (PEPFAR), The United States Agency for International Development (USAID), and the Guyana HIV/AIDS Reduction and Prevention Project (USAID/GHARP II)



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FOREWORD

Guyana has a low-level, generalized epidemic with pockets of higher prevalence within certain at-risk groups. In 2010, UNAIDS reported an HIV prevalence rate of 1.2%, making Guyana the seventh-highest country in the Caribbean in terms of adult HIV prevalence. The 2008/9 BBSS found an HIV prevalence rate for female sex workers (FSW) of 16.6%, with a rate of 19.4% amongst men who have sex with men (MSM). Other vulnerable populations found to be at increased risk for HIV in Guyana are miners (4.0% prevalence), prisoners (5.24% prevalence), and security guards (2.7% prevalence). Though there is no prevalence data on loggers, they are assumed to be at increased risk of infection due to the isolated and mobile nature of their work, and the fact that they are often clients of sex workers. To address the higher levels of HIV prevalence among these most at risk populations, MOH/NAPS and USAID-GHARP II developed prevention programs, resources, and materials that promote behavior change and risk reduction. Technical support and funding is provided to local organizations who implement HIV prevention outreach programs for members of these groups.

The Government of Guyana is determined to provide quality prevention, care and treatment services to PLHIV, to reduce morbidity and mortality associated with the disease, to reduce the number of new HIV infections, and to increase the number of persons who know their HIV status. Although we have made progress in our prevention response and can report some successes, such as the reduction of HIV prevalence amongst sex workers and MSM (from 26.6% to 16.6% and from 21.5% to 19.4% respectively), and the increase in demand for condoms and lubricants and access to HIV counseling and testing, there are still gaps. One challenge has been the inconsistent quality of prevention program implementation by different groups in the various administrative Regions of Guyana.

These guidelines are intended to address this challenge. They provide standards for HIV prevention program implementation for non-governmental organizations and civil society organizations, against which services provided to the target populations can be monitored and evaluated to ensure quality and client satisfaction. The elements of a comprehensive prevention program for MARPS, including behavioral, biomedical, and structural activities, are described, and standard operating procedures and relevant screening and data collection tools are included.

This document is another good example of the collaborative efforts that exist in our program and among our partners. The MOH/NAPS developed this document in collaboration with USAID/GHARP II, the U.S. Peace Corps, and the USAID-funded non-governmental organizations working in HIV prevention. It is guided by UNAIDS' Prevention Principles and Standards, Guyana's National Strategic Plan for Prevention, and relevant technical and programmatic guidance from the Office of the Global AIDS Coordinator for funds expended under the President's Emergency Plan for AIDS Relief (PEPFAR). The guidelines drew for its structure and content from the Kenyan National Sex Workers Guidelines, Guyana's National VCT Guidelines, and Guyana's Community Home and Palliative Care Guidelines. We are grateful to the United States Agency for International Development (USAID), the Guyana HIV/AIDS Reduction and Prevention Project (GHARP II), Artiste In Direct Support, United Bricklayers, Hope For All, Hope Foundation, Linden Care Foundation, FACT and Guyana Sex Workers Coalition for their support in the development of these guidelines.

Dr. Shanti Singh-Anthony
Programme Manager
National AIDS Programme Secretariat
Ministry of Health

ACRONYMS

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral drug
BBSS	Biological and Behavioural Surveillance Survey
BCC	Behavior change communication
CBO	Community-based organization
CDC	US Centre for Disease Control
CHPC	Community Home and Palliative Care
CSW	Commercial sex workers
FSW	Female sex workers
GBV	Gender-based violence
GHARP II	Guyana HIV/AIDS Reduction and Prevention Project Phase II
HIV	Human immunodeficiency virus
IPED	Institute for Private Enterprise Development
MARPs	Most-at-risk populations
MOH	Ministry of Health
MSM	Men who have sex with men
NAPS	National AIDS Programme Secretariat
NGO	Non-governmental organisation
OI	Opportunistic infection
PEPFAR	The President's Emergency Plan for AIDS Relief
PEP	Post-exposure prophylaxis
PITC	Provider initiated testing and counseling
PLHIV	Person(s) living with HIV
PMTCT	Prevention of mother to child transmission of HIV
PHD&P	Positive Health, Dignity and Prevention
SNS	Social networking strategy
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organisation

SECTION 1: INTRODUCTION

DEFINITION OF MOST AT RISK POPULATIONS (MARPS)

For the purpose of this document, *most-at-risk-populations* (MARPs) are defined as those populations at highest risk for sexual acquisition/transmission of HIV due to either the number of partners that they have, or the higher risk sex that they engage in, and include FSW and their clients (miners, loggers) and MSM.

MARPS RISK BEHAVIORS

According to the 2008/2009 Guyana BBSS, a relatively high proportion of sex workers and MSM were found to engage in sex with multiple partners, alcohol and drug mis-use or abuse, and relatively low condom use with regular and non-regular partners. Many respondents did not see themselves as being at risk of HIV infection, and therefore were not taking precautionary measures to avoid or reduce risk.

GUIDING PRINCIPLES

The implementation of all prevention programs targeting MARPs should conform to the Guyana National HIV Prevention Principles, Standards and Guidelines 2010:

Principle 1:
In Guyana, HIV prevention is multi-sectoral, multi-dimensional, aligned with the 'one national program', of a *scope* and *mix* that is effective, an *intensity* that is sustained, and of a *scale* to reach and impact everyone. .

Principle 2:
In Guyana, HIV prevention is based on and driven by the promotion, protection and respect of human rights, diversity, gender equality, and addresses the most vulnerable and the drivers of the epidemic, with priority and special consideration.

Principle 3:
In Guyana, "Combination prevention" of HIV is devoid of dogma, and based on science; HIV prevention programmes are targeted, focused, evidence-informed, and developed, delivered and maintained at a high level of excellence.

Principle 4:
In Guyana, HIV prevention is locally-adapted and prioritized, according to the epidemiological scenario and socio-cultural contexts, in partnership with those for whom HIV prevention programs are developed and implemented.

Principle 5:
In Guyana, the delivery of HIV prevention interventions is informed by continuous research and development of innovative prevention technologies.

PROGRAM OBJECTIVES

The MARPs prevention program goals are:

- To reduce the vulnerability of the most-at-risk people to HIV infection through increased risk awareness, risk reduction or avoidance, health promotion and the creation of an enabling environment.
- The provision of high quality, user friendly health services that encourage increased access by target populations and encourage increased community involvement (Principle 2)
- To strengthen the effectiveness of the referral system for members of the most-at-risk populations

The MOH, USAID/GHARP II and USAID-funded NGOs (Principle 1) all promote a comprehensive approach to prevention. The recommended components for a comprehensive approach to prevention (Principle 3) are:

- Biomedical interventions
- Behavioral interventions
- Structural interventions

The program's commitment to reaching MARPs is in line with international guidance, as summarized in the following 3 pillars proposed by UNAIDS:

- Pillar 1: Assure universal access to comprehensive HIV prevention, treatment, care and support
- Pillar 2: Build supportive environments, strengthen partnerships and expand choices
- Pillar 3: Reduce vulnerability and address structural issues

The guidelines presented in this document address these proposed UNAIDS pillars, the relevant PEPFAR guidelines, the national standards, and the USAID/GHARP II prevention objectives in supporting the reduction of HIV/STIs among MARPs.

GOAL OF THE GUIDELINES

- To ensure provision of high-quality prevention services for MARPs

OBJECTIVES OF THE GUIDELINES

1. To provide guidance on developing, implementing, monitoring and evaluating HIV programs for MARPs
2. To describe the rationale for and the components of a comprehensive package of services for MARPs
3. To set the minimum standards for the program.

DEVELOPING HIV PREVENTION PROGRAMS FOR MARPS

(Principle 5) Effective HIV programs for MARPs are based on a clear understanding of the people most-at-risk, in terms of where, when and how they operate and the factors that affect their use of HIV/STI and other services. Qualitative and quantitative data may need to be collected periodically by program providers to identify new populations at-risk, to monitor emerging trends, and to assess HIV prevalence. Existing HIV services in a given area may need to be tailored so that they are acceptable, accessible, affordable and appropriate for MARPs.

Key steps in developing HIV programs for MARPs include the following:

1.1 Review of existing data
1.2 Conduct Knowledge Attitude Practices study of MARPs
1.3 Determine availability and appropriateness of HIV services
1.4 Tailor services as needed
1.5 Create an enabling environment

(Principle 4) When designing programs, members of MARPs as well as other key stakeholders (gatekeepers, “controllers”, law enforcement, government, community-based organizations, etc.) must be involved. A participatory process builds consensus and ownership of the program, empowers individuals to seek services and to advocate for their health and human rights, and helps sustain the program, as more individuals and groups have a vested interest in ensuring services and activities continue.

SECTION 2: DELIVERY OF A COMPREHENSIVE PACKAGE OF SERVICES FOR MARPS

The HIV package of services is described below, but prior to going into the details, it is important to understand the principles underlying effective delivery of services to MARPs.

PRINCIPLES UNDERLYING SERVICE DELIVERY TO MARPS

Service providers should take into consideration the following, which contribute to effectiveness and sustainability of HIV interventions with MARPs:

- Ensure activities are conducted in ways that do not expose or harm people
- Respect individual human rights and accord all basic dignity (e.g. services are voluntary)
- Recognize that people at risk are part of the solution, and can usually be highly motivated to improve their own health and well-being
- Build capacity and leadership among MARPs in order to facilitate participation and community ownership
- Include leaders of MARPs in program planning and implementation
- Ensure the implementation of the program is adapted to suit the diversity of the MARPs

To ensure increased uptake of the HIV package of services, components need to be "MARPs-friendly"; "friendly" services need to be appropriate, accessible, acceptable, affordable, and the target population needs to be aware of where they are offered.

Appropriateness of Services

Interventions must be culturally appropriate and based on the needs of the individuals (e.g. language - Portuguese for the Brazilian sex workers, native languages for Amerindians, etc.). Therefore, members of the population should be involved in all stages of program planning and implementation to ensure activities are timely, appropriate and respond to the current needs of the population.

Awareness of Services

Individuals must be made aware of what services are being offered and the benefits to be derived from accessing those services. This will help empower the beneficiary to make informed choices, and will create demand for the services being offered.

Accessibility/availability of Services

Accessible health services are conveniently located (e.g. near the identified locations where MARPs frequent ("hotspots") and transport routes) and open at hours that are acceptable to those who will use the services. Accessible activities have limited logistical barriers to participation, thereby increasing the number of individuals who can easily obtain the services. Whenever possible, services should be integrated and/or co-located to expand the coverage for a broader range of health services accessed in a single visit.

Acceptability of Services

HIV/AIDS health services should not only be accessible, but also friendly to members of the most-at-risk populations. Service providers must adopt a non-judgmental, non-stigmatizing attitude and be

trained in dealing with the special needs of this population. Health services must be confidential and voluntary to ensure the health and human rights of MARPs are protected.

Affordability of Services

Services should be free or affordable. A large barrier to accessing services by individuals is the cost of services and of transportation to and from service delivery sites. Since many individuals engage in high-risk acts due to economic and social needs, programs are advised to offer subsidized or free services and commodities (i.e. male and female latex condoms and water-based lubricants) as a way to ensure that individuals have access to the complete package of HIV services.

NOTE: Whenever possible, services and products should be taken to "hot spots" where MARPs can be found, e.g. during outreach, thereby helping to offset cost. Service providers must never force individuals to access services. Individuals must be provided with relevant information regarding the available services in order to make an informed decision about whether they will access or not.

COMPREHENSIVE PACKAGE OF SERVICES

To effectively reduce the risk of HIV to MARPs, a comprehensive package of services is recommended. This comprehensive package of services is made up of elements of a combination prevention approach that consists of behavioral and structural strategies to reduce vulnerabilities from risky behavior and biomedical strategies to reduce the probability of transmission

The recommended minimum package for MARPs includes a variety of services, clinical and non-clinical, as well as facility-based and non facility-based that fall under the categories of behavioral, biomedical and structural. Non-governmental and civil society organizations must provide peer education and outreach, risk reduction counseling, HIV counseling and testing, condoms and lubricants, support group to the target population as part of the minimum package of services. In addition to the minimum packages, organizations should provide referrals for other services that are listed in sections that follow (3, 4 and 5). Services should be developed and modified to suit members of a specific risk group, depending on their risk behavior and/or health care needs.

Biomedical strategies include medical approaches to prevent infection, decrease infectiousness, or reduce infection risk. Some components of the Guyana MARPs package of services will be clinical/facility-based (such as HIV care and treatment) while others, such as HIV testing and counseling, can be delivered within the community. The following evidence-based biomedical strategies are included in the package of services

- Voluntary counseling and testing (VCT)
- STI screening and treatment
- HIV care and treatment
- Reproductive health services- family planning
- TB screening and treatment

Behavioral strategies are basic components of the HIV package of services and can be implemented with individuals, couples, families, peer groups or networks, institutions, and entire communities. The goal of behavioral interventions is to reduce behaviors that put people at risk of contracting HIV. To reach this goal, programs should attempt to decrease the number of an individual's sexual partners, increase the number of sexual acts where condoms are used, encourage adherence to biomedical strategies preventing HIV transmission, and decrease substance use.

The following evidence-based behavioral strategies are included in the package of services:

- Peer education and outreach
- Risk reduction counseling and skills building
- Promotion, demonstration and distribution of male and female latex condoms and water-based lubricants
- Screening and treatment for drug and alcohol abuse

Structural strategies acknowledge that an individual's behaviors are, in part, governed by social, cultural, political and economic norms. Strategies under this component aim to change the wider societal, political and economic contexts which can contribute to vulnerability and risk. The following structural strategies are included in the package of services:

- Creating an enabling environment through community mobilization, service provider sensitization, stigma and discrimination reduction, and behavior change communications
- Economic strengthening activities

DEVELOPING A REFERRAL NETWORK

Since programs may not be designed to include all components of the HIV package, NGOs need to establish an effective referral network to ensure that every at-risk individual has access to each component of the HIV package of services based on their needs. This will require government, NGOs, CBOs, and international agencies working together to provide the package of HIV services**.**

A referral network includes providers of different kinds of services, including a referral directory, and the referral system includes a process for making and tracking referrals and monitoring the referral process. Referral networks are usually developed for a defined geographic area, and not for the entire country or region. The referral process should ensure the health and psychosocial needs of the individual are assessed, and the person is helped to access the identified relevant services. The referrals system is strengthened when a structured understanding of the relationship and roles and responsibilities among organizations/service providers is developed. This facilitates the organizations/providers working together and avoids duplication of services, thus improving the efficiency of program delivery.

Note: The Ministry of Health-approved referral forms must be used between service providers to complete the referral process. (Referral register/log, referral service directory and referral forms – See Appendices 16, 17 and 18)

STANDARD OPERATING PROCEDURES FOR A REFERRAL NETWORK

To create a referral network, NGOs will:

- Identify the needs to be met through referrals (i.e. components of the HIV package not provided by the individual NGOs)
- Map the catchment area making note of location and availability of services (note if staff "MARPs-friendly", operating hours, etc.); possible barriers to services (cost, location, etc.) and stakeholders that need to be contacted (gatekeepers, law enforcement, etc.), and the services provided by facilities
- Define the target population (type of population, structure, etc.) and geographic coverage area
- Identify an individual within the organization who will manage and monitor the referral network (who was referred, when and to what services) in the geographic coverage area
- Identify and sensitize referral organizations/institutions about how to provide "MARPs-friendly" services
- Develop Memorandum of Understanding between organizations within the referral network
- Identify contact person within the referral organizations to whom personalized referrals can be made
- Produce a referral directory listing the name of the location, hours of operation, services provided, cost and point person of each organization within the referral network
- Use standard referral forms and create registers to be used by all organizations within the referral network to track referrals (see MOH/NAPS-approved form)
  Create a feedback process for getting client input and program follow-up on the referral service and process
- Monitor the referral system, documenting the number of successful referrals (those people linked to the service they were referred to and who received the service) and following up with those who didn't access their referral

ESSENTIAL RESOURCES FOR PROGRAM IMPLEMENTATION

Technical Staffing Requirements for Prevention/MARPs programs

- Prevention Coordinator
- Social Worker
- Peer Supervisors/Prevention Officer
- Peer Educators/Navigators

The above mentioned staff must meet the minimum requirements as stated in the attached job descriptions (JDs)

Staff Training:

All Prevention staff/volunteers must complete the following trainings

- Peer Education(initial)- Five (5) days
- Outreach Facilitation - Three (3) days
- Case Navigation Two (2) days

Facility:

Each NGO providing onsite prevention services must ensure that

- A qualified social worker is employed
- Have trained peer educators (recommended to be from the gay and other MSM or sex worker communities. For USAID-funded programs, this is a requirement)
- Provide VCT services for the populations
- Adequate supply of latex condoms (both male and female) and lubricant

SECTION 3: BEHAVIORAL COMPONENTS FOR HIV PREVENTION

3.1: PEER EDUCATION AND OUTREACH

Peer education programs involve the selection and training of peer educators. Peer educators are trained to modify the knowledge, attitudes, beliefs, or behaviors of their peers through small group or one-on-one interpersonal interactions. They are also trained to provide referrals for needed services.

Outreach is a delivery technique in which peer educators offer peer education within the target community where people congregate and/or live.

The goals of peer education and outreach are to:

1) Reduce HIV risk behaviors (i.e. unprotected sex, substance abuse, etc.)

2) Promote risk reduction behaviors (e.g. decrease number of partners, increase correct and consistent condom use), and

3) Increase the number of individuals accessing HIV and other services.

An added benefit of peer education and outreach programs is the empowerment of both the peer educator and the client to advocate for their own health needs.

Description of Peer Education and Outreach:

- Peer education and outreach programs provide correct health information; demonstrate, promote and distribute condoms and water-based lubricants; encourage HIV risk reduction behaviors; and refer peers to additional components of the HIV package of services, such as STI screening and treatment and HIV testing and counseling. Well-trained peer educators may also be able to conduct risk assessments, help their peers develop a personal risk reduction plan, and navigate their peers into needed services.

- These programs rely heavily on peer educators, who are accepted and trusted by their community and who are motivated and committed to assisting their peers to reduce their HIV risk. They serve as role models, and communicate information on HIV prevention, care, and treatment, and reproductive and sexual health. Peer educators should be provided with initial and refresher training on HIV 101, on the signs and symptoms of STIs, family planning, condom demonstration and negotiation skills, and counseling and interpersonal skills. For peer educators to be effective, on-going supervision by program staff is required, along with targeted and regular capacity building.

- Peer education is most effective when an on-going relationship is established and maintained with peers over a period of time. This includes having multiple peer education and outreach sessions with the same individual or group to provide information, build trust, and to encourage and reinforce behavior change. This allows the peer educator to monitor the risk reduction progress of each peer and assist, encourage and motivate him/her to continue reducing his/her risk and to access needed services.

STANDARD OPERATING PROCEDURES OF PEER OUTREACH

a. Outreach contacts should occur in areas that have been specifically identified previously by the organization. Outreach should be conducted at least twice weekly
b. When an individual is encountered/reached for the first time, an assessment of the individual's knowledge should be done. Interventions will be based on the assessment. Peer educators should ask their peers if anyone from the Keep the Light On or Path for Life programs spoke with them in the past. If it is the first encounter, **discuss basic HIV, STI information, risk reduction behavior, provide information (including demonstration) on condom and lubricant usage, distribute condoms and lubricant,** and if necessary make relevant referrals. If the individual was reached before, ask them to share what they learnt at the last encounter, provide clarity if necessary, offer additional information and follow-up.
c. Each peer educator is required to be trained and certified by NAPS/GHARP II. Copies of the certificates must be kept in the staff/volunteer file at the NGO.
d. In conducting outreach, peer educators should always be equipped with their outreach tool kit (see complete list of peer educators tools listed below).
e. Referrals for STI, HIV, substance abuse screening and treatment, reproductive health, risk reduction counseling, and/or other services should be provided to peers, when applicable, using the NAPS forms.
f. It is recommended that mobile counseling and testing be offered in the same areas where an NGO conducts outreach activities, if fixed-site VCT services are not available, mobile testing should be done.
g. Every person that is met during an outreach should be referred to the social worker for risk reduction assessment
h. All outreach activities should be planned a month in advance. The details of the proposed activities must be forwarded to NAPS and USAID GHARP II fifteen (15) days prior to the start of the month. The schedule must contain the following; venue, date and time. The peer educator must use a code to record interactions. For every person with whom they conduct peer education, the peer educator creates a code with the persons' initials, followed by day, month and year of birth and the sex of the individual e.g. name is Jane Doe, born December 31st, and hence the code will be JD 31121976 F This should be documented in the peer educator's diary

TYPES OF ENCOUNTERS:

A **contact** is defined as an episode in which a peer educator provides minimal HIV risk information and condoms to a client. (Less than 10 minutes)

An **encounter/reach** is defined as an episode in which a peer educator has a dialogue with the peer including an individual assessment and specific service delivery e.g VCT, risk reduction, in response to the identified need(s) of the peer(s). An encounter includes, but is not limited to, providing basic information of HIV modes of transmission, condom demonstration, distribution of water based lubricants and condoms, a risk-reduction discussion and referral information. It is the encounter that provides a

more significant opportunity for helping a peer initiate and sustain behavior change. These persons will be considered ‘reached’ by the peer educator.

Tools of the peer educator: Outreach tool kit

- BCC materials (brochures, referral cards, palm cards)
- Peer Educator Diary
- Condoms- male and female
- Water based lubricants
- Penis/Vagina models
- Referral slips
- Cell phone
- Identification badge
- Flashlight
- Writing utensils
- Emergency contact information
- Referral directory
- Risk assessment screening tools (alcohol, drug, GBV, mental health)
- Hand sanitizer
- Tissues

3.2: SOCIAL NETWORKING

Social Networking is a recruitment strategy whereby public health services (e.g. VCT) are expanded through the community. The strategy is based on the concept that individuals are linked together to form large social networks, and that infectious diseases often spread through these networks. The strategy is a programmatic, peer driven, recruitment strategy to reach the high-risk persons who may be infected but are unaware of their status. This is accomplished by enlisting peer (MSM and FSW) recruiters on an ongoing basis and navigating persons in their networks to access services.

NGOs will use this approach to expand coverage of the MARPs programs to reach closeted MSM, ship- and home-based sex workers, gay men on the down low etc., with HIV prevention messages and services. Appropriate materials should be developed.

Incentives

The NGOs may provide incentives (e.g. certificates of appreciation or certificates of participation in the program, phone cards, etc. --depending on the availability of funds and donor policy on incentives, etc.) to encourage recruiters to refer their network associates. **Cash incentives are not recommended**. Use of incentive must always be carefully considered because of the possibility that they may be, viewed as coercive. Incentives could be provided on a one-time basis to encourage potential recruiters to participate in the program. (Refer to CDC Interim Guide for HIV counseling, testing and referral Programs – Social Networks Testing)

3.3: RISK ASSESSMENT, RISK REDUCTION COUNSELING AND SKILLS BUILDING

Individual risk assessment, risk reduction counseling and skills building are strategies intended to enable people to identify and reduce their personal HIV risk behaviors by providing them with information and by developing a risk reduction plan. Risk reduction counseling is a tailored, client-

centered behavioral activity designed to change a person's knowledge, attitudes, behaviors, or practices in order to reduce HIV risk behaviors.

Elements of Risk assessment, Risk Reduction Counseling and Skills Building:

The goal of an individualized risk assessment is to provide individuals with insight into their HIV risk behaviors. When conducting a risk assessment, questions should focus on frequency of oral, anal, and vaginal sex, number of clients and of regular partners, condom use with clients and with regular sex partners, lubricant use, douching, frequency of 'dry' sex, and substance use. In asking questions about HIV risk behaviors, it is important that service providers are able to:

- Be non-judgmental
- Convey a caring and respectful attitude
- Use non-confrontational language to request more information
- Reassure the client that all information will be treated confidentially and not be used to further stigmatize the individual
- Review responses to confirm understanding and to allow correction of information provided

Information from the risk assessment will assist social workers in delivering risk reduction counseling. It is recommended that the MARPS Risk Assessment Tool should be used to gather personalized risk information of the individual. Social workers should encourage individuals to find their own ways to reduce their HIV risk behaviors, thereby ensuring ownership of both the process and the outcome of the desired behavior change. Risk reduction plans should have behavioral goals that are:

- Concrete, specific and clear to the individual
- Incremental, whereby each behavioral goal builds on a previous one
- Individualized and realistic and based on the individual's circumstances and his/her readiness to change his/her behavior
- Challenging, yet achievable, to help move the client along the continuum of decreasing risky behaviors.

Once a risk reduction plan is developed, the service provider will provide risk reduction supplies (condoms, lubricants, etc.) to the client, and help them develop skills to implement the goals in his/her risk reduction plan (for example correct and consistent condom use, condom negotiation skills).

Standard Operating Procedures of Risk Reduction and Skills Building for MARPs

- Conduct an initial and on-going individual HIV risk assessment
- Develop a personalized risk reduction plan in collaboration with the individual
- Assess needs regarding other services
- Monitor progress of risk reduction routinely and modify/adjust the plan as necessary
- Provide risk reduction supplies (i.e. male/female condoms and lubrication, encourage MARPs to use free or purchased condoms)
- Build skills to implement the personalized risk reduction plan
- Routinely reinforce risk reduction skills
- Encourage and motivate peers to know their HIV status

3.4; PROMOTION, DEMONSTRATION AND DISTRIBUTION OF LATEX CONDOMS (MALE AND FEMALE) AND WATER-BASED LUBRICANTS

The goal of this intervention is to provide individuals with the information, skills and supplies needed to correctly and consistently use male or female condoms with water-based lubricants. A male or female condom is a device that is designed to be used during sexual intercourse (vaginal, anal or oral) to reduce HIV/STI transmission, and unintended pregnancies. Water-based lubricants are one of the safest methods to reduce friction between the condom and the skin during sex. Tears in the skin during sex lead to greater chances of HIV transmission.

Elements of Latex Condom and Lubricant, Demonstration and Promotion

Condoms and lubricants must be readily available to clients either free or at low cost, and must conform to global quality standards. Peer educators should be able to demonstrate correct male and female condom use on penile and vaginal models, and then to request that peers use the models to demonstrate correct condom use. It is also advised that peer educators should be able to demonstrate correct use of water-based lubricants. The demonstrations will help clients internalize the mechanics of correct condom and lubricant use. Peer educators should use the demonstration as an opportunity to help clients build skills in negotiating condom use with all partners.

Programs can use peer educators and targeted BCC materials to actively promote the use of and to create demand for condoms and lubricants. Peer educators should promote amongst peers and gatekeepers (pimps, kaimoo owners, etc.) the benefits of correct condom and lubricant use and this should be done in a non-judgment manner to help create an enabling environment for MARPs.

Standard Operating Procedures of Condom and Lubricant Promotion, Demonstration and Distribution

- Provide information on, and promotion of use of, male/female condoms and water-based lubricants to peers, clients, gatekeepers and “pimps”
- Demonstrate male/female correct condoms application using a penile or vaginal model, respectively
- Build client skills in negotiating condom use with all partners, and in correct condom and water-based lubricant use
- Provide or create easy access to an uninterrupted supply of free or subsidized male/female condoms and water-based lubricants
- Provide targeted BCC materials to promote use of male/female condoms and water-based lubricants
- Reinforce correct condom and water-based lubricant use and condom negotiation skills at outreach, support group, counseling and testing, risk reduction services

3.5: SUPPORT GROUPS

Support groups are a gathering of individuals with like needs who offer support to one another through sharing, discussion and empathy. Support groups are convened over multiple sessions consisting of groups of varying sizes (recommended to be no more than 20 participants maximum) with a focus on providing social support for participants, including support for the adoption and maintenance of HIV-related risk reducing behaviors, as well as psychosocial support related to HIV or associated issues.

A support group differs from group-level small group sessions in that group-level small group sessions are guided by a pre-established curriculum, are associated with specific behavioral objectives, have membership "closed" after the first session, and have a pre-determined number of sessions over a relatively short period of time.
All support group meetings must be planned a month in advance. The details of the proposed meeting should be forwarded to the respective MARPs technical officer of NAPS two days after the scheduled has been finalized. The schedule must contain the following; venue, date and time. **(Please refer to Support Group Guide in appendix 2)**

Standard operating procedures of support group sessions

- Sessions should focus on reinforcing risk reduction practices
- Sessions should be held monthly
- No more than 20 persons should attend a session
- Separate sessions should be held for MSM who are opened about their sexuality and for those who are closeted
- Peer educators should facilitate their support group session with support from the social worker
- Promote, demonstrate and distribute male and female latex condoms and water based lubricants

3.6: BEHAVIOR CHANGE COMMUNICATIONS (BCC)

Behavior change communication is a process of any intervention with individuals, communities and/or societies to develop communication strategies to promote positive behaviors which are appropriate to their settings. This in turn provides a supportive environment which will enable people to initiate and sustain positive and desirable behavior outcomes. BCC is a key component of any comprehensive prevention program. It aims to increase knowledge, risk perception, stimulate community dialogue, promote attitude change, reduce stigma and discrimination and promote access to prevention products and services. BCC can be used in different forums, such as:

Outreach**:** Approaches are geared to reaching individuals from specific target groups on a one-on-one level through interpersonal communication.

- Peer education and outreach (street, venue-based)
- Basic information on HIV/STI transmission
- Risk reduction counseling
- Condom and lubricant promotion and distribution
- Distribution of BCC materials – brochures, etc.

- Referrals to health, psychosocial, and other services

<u>Community Mobilization</u>: Approaches are geared to motivate positive behavioural change in peer groups, families, networks or communities. Community forums can be used to table discussions on health risks and appropriate community responses to HIV and other health issues.

3.7: SCREENING FOR DRUG AND ALCOHOL USE

Screening for drug and alcohol use includes the identification of misuse, abuse and dependence, and referral to appropriate treatment. The use of alcohol and drugs can increase HIV-related risk behaviors. According to the BBSS 2008/9 over 50% of MSMs who participated in the research were reported as possible problem drinkers and about 32% of sex workers reported daily use of alcohol. Over 30% of both populations reported using marijuana.

Elements of Drug and Alcohol Mis-use

Social workers and peer educators are advised to screen for drug and alcohol use during interactions with individuals. Screening can be conducted using standard tools. Based on the screening results, individuals should be referred for individualized risk assessment at the organization, and if necessary refer to a drug or alcohol treatment facility for appropriate services. However, peer educators may be able to offer brief motivational interventions which are 5-10 minutes discussion used to provide prevention messages and skills to reduce alcohol and drug related risk behaviors.

Standard operating procedures of drug and alcohol abuse

- Provision of information on alcohol and drug mis-use, drug dependency and related HIV risk
- Screen for drug and alcohol mis-use, abuse and dependence
- Conduct HIV risk assessment
- Provide brief behaviors intervention and skills building to reduce alcohol/drug
- Refer to appropriate treatment for alcohol and drug abuse
- Promote, demonstrate and distribute male and female condoms and water based lubricants

SECTION 4: BIOMEDICAL COMPONENTS OF HIV PREVENTION

4.1: VOLUNTARY HIV COUNSELING AND TESTING (VCT)

HIV counseling and testing enables individuals to know their HIV status and receive counseling and support in coping with a positive or negative result. The goal of VCT is to increase the number of persons who know their status. The goal for those found to be HIV-positive is to increase their uptake into HIV care and treatment services, and for those found to be HIV-negative, to develop risk reduction skills to remain HIV-negative.

Elements of Voluntary Counseling and Testing:

During the provision of VCT, the three C's must be maintained – consent, counseling and confidentiality. VCT service providers will share pre-test information to enable individuals to make an informed decision about testing. Post-test counseling is provided to help clients cope with a positive or negative result and to provide appropriate referrals (i.e. HIV care and treatment) for those who test HIV positive, interventions to remain negative for those who test negative).

Types of Voluntary Counseling and Testing (VCT)

Client-initiated HIV testing and counseling refers to a situation whereby an individual, couple, or group actively seek out HIV testing and counseling at a site where these services are provided. Client-initiated VCT puts emphasis on individualized risk assessment and counseling.

Provider initiated HIV testing and counseling (PITC) is a model of HIV testing and counseling in which the healthcare provider offers and recommends HIV testing to patients as a standard component of medical care. Since post-test counseling is limited during PITC, service providers may choose to refer people to VCT sites for further counseling services, depending on the individual's need.

Special Considerations for VCT for members of the MARPs

Semi-annual HIV re-testing for HIV negative at-risk people: It is recommended that at-risk individuals who tested negative to be re-tested semi-annually.

Risk reduction counseling and skills building**:** Since members of the MARPs often do not seek services as frequently as the general population, it is important that VCT service providers take the opportunity to conduct risk reduction counseling and skills building based on their risk assessment.Although in-depth risk reduction counseling is rarely offered during PITC, service providers should consider individualized counseling given the high-risk nature of anal sex and sex work; or at a minimum, referral to counseling services should be done.

HIV testing for partners of MARPs**:** FSWs and MSM are encouraged to promote VCT with their regular partners. Couples counseling is an important intervention and may be appropriate for the individuals and their regular partners, but should be based on the sex worker's or MSM's comfort to disclose their status to their partner.

Standard Operating Procedures of VCT

- Conduct targeted marketing of VCT to increase demand for services by those most at risk
- Provide individual or group pre-test information session and individual provision of rapid HIV test
- Conduct risk-reduction counseling and skills building tailored to the individual's HIV status
- Promote, demonstrate and distribute male/female latex condoms and water-based lubricants
- Refer HIV-positive people to HIV care and treatment
- Refer HIV-positive pregnant women to PMTCT services
- Refer HIV-negative people to on-going support/interventions to remain negative
- Suggest semi-annual HIV testing and counseling for HIV-negative people engaged in high-risk behavior
- Provide VCT for partners and children of sex workers and MSM
- Assess needs and provide referrals to additional services as needed

4.2: STI SCREENING AND TREATMENT

Sexually transmitted infections are viruses, bacteria or fungi transmitted through oral, vaginal or anal sex. People are placed at a higher risk for STIs through sex with multiple partners, increased frequency of partner change, and unprotected sex. The goal of STI screening and treatment is to identify, treat and prevent future STI acquisition and transmission.

Note: NGOs targeting MARPs who do not provide STI services should link to STI treatment facilities through a referral system.

Elements of STIs Screening and Treatment

STI screening begins when the service provider obtains a sexual history from the individual. This includes gathering information on present illnesses, reproductive and medical history, and a behavioral risk assessment similar to the one described in the previous sections. Appendix 13 outlines the types of questions that should be asked of high-risk individuals. STI screening consists of either lab tests to identify the specific STI and/or questions to diagnose the presence of STI symptoms. Screening for anal, oral and genital STIs is recommended for all people engaging in high-risk sexual behavior. After identification, STI treatment is provided based on laboratory results or syndromic diagnosis. The presence of untreated STI may increase the risk of transmission of HIV during exposure.

During STI screening and treatment, service providers are expected to ensure that the 4Cs – **compliance (i.e. adherence), condoms, counseling, and contact tracing** (i.e. partner services) are provided. Service providers should ensure compliance to STI treatment; promote, demonstrate and distribute latex condoms and water-based lubricants, as well as provide skills to negotiate condom use; provide counseling to prevent future STIs; and, if possible, identify sex partners that may need

treatment. Since Guyana has a low-level, generalized HIV epidemic, it is recommended by WHO that all patients receiving STI screening and treatment also receive PITC.

To reduce the spread of STIs, it is important to treat the sex partners of those who are infected. Clients should be encouraged to bring their sex partners into the service delivery site for screening and treatment if necessary. Partner treatment must respect the confidentiality and privacy of the individuals. In most cases, it may only be possible to provide STI services to regular sex partner(s), as these individuals can be easily identified and contacted by the client.

Standard Operating Procedures of STI Screening

- Provide correct STI information, including male and female STI symptoms
- Conduct sexual history and behavioral risk assessment
- Refer for screening for anal, oral, and genital STIs
- Provide PITC and refer to appropriate services based on HIV rapid test results
- Ensure the 4 C's

  Compliance (i.e. adherence) to prescribed therapy
  Condoms (male/female) and lubricants promotion, demonstration and distribution
  Counseling and skills building for risk reduction
  Contact tracing and partner STI treatment when feasible
- Assess the needs of and refer clients to additional services

4.3: HIV CARE AND TREATMENT

HIV care and treatment includes interventions to maintain the health and well-being of HIV positive individuals. The goal of HIV care and treatment is to restore the immune system, reduce HIV- and AIDS-related morbidity (sickness) and mortality (death), improve quality of life, decrease viral load, and reduce HIV transmission to others. HIV-positive individuals must have access to HIV care and treatment in line with national guidelines.

Elements of HIV Care and Treatment

HIV positive individuals should have access to a core package of HIV care and treatment services (as stated according the CHPC guidelines)

Special Considerations for HIV Care and Treatment with members of MARPs

Ensure accessible services**:** To increase HIV care and treatment access by members of the most-at-risk populations, it may be beneficial to modify the operating hours of the comprehensive care centers, train service providers on delivering "MARPs-friendly" services, and create demand for the services through targeted outreach and education.

Individualized "Positive Health Dignity and Prevention" interventions**:** These are designed to reduce HIV transmission and increase the well-being of the person living with HIV. Positive prevention interventions may need to be modified, given the primary source of income for FSWs and some MSM is the exchange of sex for money. For example, they may not be able or willing to leave sex work;

therefore tailored risk reduction counseling for HIV-positive individuals is a crucial component of positive prevention. This should focus on reducing risk of HIV transmission through:

1) Uninterrupted supply of latex condoms and lubricants,
2) Skills building for correct and consistent male and female condom and water-based lubricant use
3) Promotion of consistent condom use with all sex partners
4) Risk assessment and risk reduction counseling to reduce the number of sex partners (MSM and clients of sex workers).
5) Disclosure counseling
6) Counseling to encourage adherence to medications
7) What of counseling on avoiding alcohol use?

In addition, HIV positive members of the MARPs can suffer the dual stigma of being HIV positive and being sex workers and/or MSM. Tailored psychosocial individual or group support may be warranted to address these issues.

Screening and treatment for alcohol and drug abuse**:** Many people engaging in high-risk behavior abuse drugs and alcohol, therefore service providers need to screen and refer MARPs for alcohol and drug abuse treatment. Alcohol and drug use interferes with adherence to ARVs, and some illicit drugs are known to result in adverse reactions when combined with ARVs. Please refer to screening tool in Appendix 11

Referral for quarterly STI Screening: HIV-positive individuals should be screened for STIs at least quarterly, and provided with treatment. Quarterly screening provides an opportunity to detect and treat anal, oral, and genital STIs early, to deliver risk reduction counseling, and to increase access to condoms and lubrication.

Standard Operating Procedures of HIV Care and Treatment

- Provide HIV care and treatment information (benefits and limitations of ART, recognition and benefits of early OI treatment, importance of treatment adherence, etc.)
- Refer for baseline and on-going biomedical and laboratory assessment
- Refer for screening, and treatment of opportunistic infections (TB, Hepatitis B and C, etc.)
- Provide tailored positive dignity health and prevention interventions
- Provide adherence counseling including alcohol/drug abuse screening, referral and treatment, if warranted
- Refer to PMTCT services for pregnant HIV-positive FSW
- Provide counseling and testing for sex partners and family members
- Assess the needs of the individuals, and refer for additional components of the HIV/STI package, as needed

4.5: REPRODUCTIVE HEALTH (RH) SERVICES AND FAMILY PLANNING (FP)

Reproductive health services ensure men and women have access to prevention, care, and treatment for diseases, infections, and other health-related conditions that affect the reproductive system.

Family planning helps women and men make informed choices about their sexual and reproductive lives, including the timing and spacing of births, which can improve their own health and substantially increase their child's chances of survival and good health. For members of the MARPs, the objective is to provide easy, free, or affordable access to family planning services.

Note: Since NGO programs targeting MARPs do not provide these RH services on-site, they should link to "MARPs-friendly" RH services through a strong referral system.

Elements of Family Planning:

Family planning includes various methods and must be prescribed based on medical eligibility. These include barrier methods such as condoms and diaphragms, contraceptive pills (combined or progestin-only therapy), injectable contraceptives, and intrauterine devices (IUDs) (IUDs are not recommended for persons with multiple partners). It is important that service providers emphasize the need for dual protection (using both condoms and another method), since condoms are the only family planning method that can prevent HIV/STIs. Family planning service providers should also offer PITC quarterly to HIV-negative sex workers or sex workers with an unknown status. Targeted outreach and education should be provided to sex workers to increase correct knowledge of, and demand for, family planning. Provision of family planning must be in line with national reproductive health guidelines.

Standard Operating Procedures of Family Planning for Sex workers

- Provide family planning information and the need for dual protection Refer pregnant sex workers to ANC and/or PMTCT (if HIV positive)
- Refer to family planning counseling to determine sex worker's pregnancy intentions and discuss available family planning methods
- Promote, demonstrate, and distribute male/female condoms and water-based lubricants
- Offer PITC and referrals to appropriate services based on HIV rapid test results
- Assess the needs of female sex workers, and refer them to additional components of the HIV/STI package as needed

SECTION 5: STRUCTURAL COMPONENTS OF HIV PREVENTION

To address the underlying factors that determine HIV risk and vulnerability, structural approaches are needed. These aim to mitigate the impact of HIV/STI by altering 'structural' factors, which include physical, social, cultural, organizational, community, economic, legal or policy aspects of the environment that determine HIV risk and vulnerability. For those most-at-risk of HIV infection, structural interventions aim to alter the physical and social environments in which risky behaviors take place. Structural interventions involve more than the service providers and beneficiaries; they include working with various government agencies and addressing the factors that impede or facilitate efforts to prevent HIV infection.

5.1: CREATING AN ENABLING ENVIRONMENT

MSM and sex workers are often hard to reach and stigmatized, which may create barriers to accessing the HIV package of services. Programs need to work with other stakeholders at the national and community levels to create an enabling environment that reduces HIV risk and vulnerability and increases access to services, and offers a safe and protective environment.

5.2: COMMUNITY MOBILIZATION

Engaging members of the most-at-risk communities will ensure "ownership" of the program and can help improve efforts for program sustainability. NGOs are advised to engage MSM and sex workers during the program planning cycle, and encourage these individuals to organize themselves and advocate for their health and human rights. Programs are encouraged to promote community mobilization initiatives, as these empower individuals to advocate for local structural changes to reduce stigma and to increase access to HIV services. Community mobilization initiatives bring together people with similar backgrounds and encourage and motivate them to advocate for their own rights. This process allows members of the MARPs to advocate for protection of their human and health rights, as well as to take an active role in program planning, implementation, monitoring, and evaluation.

5.3: STIGMA AND DISCRIMINATION SENSITIZATION AND TRAINING

Individuals engaging in high-risk behavior often suffer stigma and discrimination from health care providers, society, and law enforcement agencies. These create barriers to accessing services and result in increased vulnerability of MARPs to HIV. To reduce the stigma associated with high-risk behavior, training should be provided to sensitize health workers, program staff members, law enforcement agencies, and other relevant parties on providing "MARPs-friendly" services that protect the health and human rights of all. Behavior change communication (BCC) activities may also be used to educate the public to reduce stigma and discrimination towards this population. It was recommended that stigma reduction training is needed for all health professionals across Guyana and for *all* categories of staff (including guards, clerks and cleaners) at health facilities where members of the most-at-risk populations and PLHIV access services.

Activities should also build the capacity of members of the MARPs to cope with stigma and discrimination. Mullens et al. 2010 found that within the MSM population there is self-stigma, which causes persons to be overly sensitive to everyday issues and situations and can be a barrier to their accessing health services. All levels of stigma within the community need to be addressed by NGOs, through support groups and one-on-one counseling sessions with trained social workers or counselors.

Service providers should be sensititized and mentored to strengthen their skills in interacting, counseling, and treating people who engaged in high-risk behaviors. Service providers should also be trained on other related issues, including sexual violence, legal matters, stigma, and discrimination.

All service providers must be sensitized to ensure their attitudes and personal views and beliefs do not influence their ability to meet the health needs of their clients. Privacy and confidentiality of individuals must be maintained, unless they give verbal or written consent for information to be shared. In training service providers the goal is to provide acceptable services that address the needs of the population while respecting health and human rights.

5.3.1: Sensitization of owners of locations frequented by MARPs

Owners and operators of 'hotspots' should be sensitized by NGOs on the purpose of the HIV prevention outreach activities in an effort to gain their support.

The NGOs should also sensitize operators of pharmacies on the need to provide services in a non-stigmatizing, non discriminatory way.

5.3.2: Sensitization on the MOH Stigma and Discrimination Policy

Members of the at-risk populations should be made aware of the Ministry of Health's stigma and discrimination policy statement. Further, it's important that they know what recourse is available if they encounter stigmatization or discrimination while trying to access services. NGO staff will regularly sensitize individuals about the policy and what it means for them.

SECTION 6: CROSS CUTTING SERVICES OF HIV PREVENTION

6.1: SERVICES TO MITIGATE SEXUAL AND GENDER-BASED VIOLENCE

In the HIV/AIDS epidemic, gender plays an integral role in determining an individual's vulnerability to infection, his or her ability to access care, support or treatment, and his or her ability to cope when infected or affected. Gender norms, for example, often dictate that women and girls should be ignorant about and passive towards sex, which greatly constrains their ability to negotiate safer sex or access needed services. Similarly, gender norms cast women as being primarily responsible for reproductive and productive activities within the home, in sharp contrast to men who are cast as primary economic actors and producers outside the home. Such gender stereotypes account for women having much less access than men to key productive resources such as education, land, income, credit, and employment, which significantly reduces the leverage they have in negotiating protection with their partners and greatly affects their ability to cope with the impact of infection. For men and boys, gender norms create social pressure to take risks, be self-reliant, and prove their manhood by having sex with multiple partners. Such norms expose men and boys to the risk of infection and create barriers to their use of HIV/AIDS prevention, care, or support services.

Elements to Mitigate Sexual Violence

NGOs should assist at-risk individuals to develop skills to deal with violent clients and partners. Programs to mitigate sexual violence should also engage and sensitize clients, gatekeepers, and regular partners to stop sexual violence. NGOs are advised to refer people who experience sexual violence and rape to a "MARPS-friendly" health facility to obtain Post Exposure Prophylaxis (PEP), emergency contraceptive and a general examination. The collection of specimens during the examination will also assist in the legal prosecution of the perpetrator. After the examination, individuals should be provided with psychosocial support to begin to cope with the distress that is likely to occur because of rape. Victims of violence should also be referred to other biomedical and non-biomedical services as required.

Standard Operating Procedures to Mitigate Sexual/Gender-based Violence

- Provide "MARPs-friendly" services
- Provide skills to assist individuals in dealing with violent clients and partners (emotional intelligence and conflict resolution etc)
- Sensitize clients, partners, gatekeepers and "controllers" to stop sexual violence against MARPs
- Provide or refer to a health facility for post-rape examination, PEP and emergency contraceptives.
- Provide or refer for psycho-social support
- Distribute male/female condoms and water-based lubricants
- Assess the needs of, and refer individuals to additional services

6.2: ECONOMIC STRENGTHENING FOR SEX WORK

Some sex workers may want to exit sex work or develop other income-generating skills. By obtaining income from other activities, they may be able to reduce their number of partners and negotiate safer sex practices, thus reducing their HIV/STI risk and vulnerability.

Sex workers who want to expand their choices beyond sex work should have access to a meaningful and comprehensive set of services that respond to their individual circumstances. Programs must also address substance dependency, family rejection, psychosocial distress, children, and legal issues. A comprehensive package of services to facilitate expanding choices beyond sex work includes the following:

- Alternative employment and livelihood opportunities, including income generating activities, financing (microcredit and microfinance, repayment of debts) and alternative livelihood skills training
- Training in career guidance and small business management
- Assistance in obtaining family and social services (e.g. house lots, children's school uniforms, public assistance, birth certificates, etc.)
- Education and life skills including literacy classes, vocational, and business skills training

Standard Operating Procedures of Expanding Choices Beyond Sex Work

- Provide information on choices beyond sex work
- Build skills or refer for services that will expand sex workers' choices
- Assess the needs of sex workers and refer them to additional components of the HIV/STI package
- Create linkages with the Ministry of Labour Human Service & Social Security, IPED, microfinance organizations, etc.
- Provide training in career guidance and small business management

6.3: PSYCHOSOCIAL SUPPORT

Psychosocial stress among individuals is caused by various factors; the nature of sex work itself, coerced to commit unwanted sexual acts, sexual violence, depression, family crisis, concern for their children, anxiety, lack of money, lack of acceptance by society, harassment by law enforcement agencies, stigma and discrimination.

NGOs staff should be trained on the specific psychosocial stresses experienced by MARPs, and are advised to educate and counsel individuals on ways to manage and cope with psychological and social stressors. Trained social workers will provide risk assessment, risk reduction counseling and skills building, as well as provide condoms and water-based lubricants as part of psychosocial support services.

Standard Operating Procedures of Psychosocial Support for members of MARPs

- Provide information on available psychosocial support
- Provide skills in identifying signs and symptoms of psychosocial distress
- Counsel and provide support to clients to help them manage and cope with psychosocial distress
- Conduct risk assessments, provide risk reduction counseling and skills building to reduce HIV/STI risk
- Distribute male/female latex condoms and water-based lubricants
- Assess the needs of and refer individuals for additional components of the HIV/STI package

APPENDICES

APPENDIX 1

Monitoring and Evaluation

Monitoring of MARPs services should be on going in order to ensure that there is optimal service quality, the objectives of the program are reached, and the desired outcome and impact are achieved. The goal of monitoring in the context of prevention services is to ensure that activities are being implemented as planned; show how services are delivered and the nature of networking among partners.

Organizations should be familiar with and have access to all the frontline tools for collecting data including:-

- Peer educator's diary
- Prevention outreach frontline tool for outreach activities with groups and one on one
- MARPs Prevention Log
- Referral Forms
- Screening Tools

Recommended indicators for internal monitoring of programs for sex workers, miners, loggers, adjacent communities and men who have sex with men

Proposed Indicator	Proposed indicator definition	Original Source of Data	Data Collection Method
Number of MARPS who were referred for STI services	*Definition:* This is a count of the number of unique MARPs who were referred for STI Services	Source: Outreach register/referral register / referral slips	Quarterly Assessment using supervisory tool
Number of MARPS who were referred that accessed STI services	*Definition:* This is a count of the number of unique MARPs who were referred for STI Services and who **actually accessed** the services	Peer Educator's diary / Referral slips /referral register	Quarterly Assessment using supervisory tool
Number of MARPS who were referred for VCT services	*Definition:* This is a count of the number of unique MARPs who were referred for VCT Services	Source: VCT referral register / Referral slips	Quarterly Assessment using supervisory tool
Number of MARPS who accessed risk reduction counseling	*Definition:* This is a count of the number of unique MARPS who were provided with risk reduction counseling	Source: Social worker's risk reduction register	Quarterly Assessment using supervisory tool

Proposed Indicator	Proposed indicator definition	Original Source of Data	Data Collection Method
Number of persons screened for any of the following:	*Definition:* This is a count of the number of persons evaluated for the need for intervention in any of the four areas. This screening is done by the peer educators or social workers using the appropriate screening tool.	Peer Educator's diary / Referral Register / case file / social worker log	Quarterly Assessment using supervisory tool
Number of CSW who completed the economic strengthening program	*Definition:* This is a count of the number of unique CSWs who were enrolled in an economic strengthening program and completed the program (i.e. the initiative in which they were engaged)	Economic strengthening register	Quarterly Assessment using supervisory tool
Number of CSW whose economic strengthening program yielded income for the last three months	*Definition:* A count of all persons who, after completing training in economic strengthen program become gainfully employed (with an agency or self employed) and who receive income of no less than $50,000.00 per month for three consecutive months during the reporting period	Economic strengthening register	Quarterly Assessment using supervisory tool

Please refer to the Monitoring and Reporting Guidelines for guidance on monitoring and evaluation systems and tools.

APPENDIX 2

Support Group Guide

The objectives of Support Groups are to provide an opportunity for MARPs:-

- To receive educational and skills building information in order to increase their perception of their risk and increase risk reduction behaviors, and/or

- To meet and offer emotional, moral and psychosocial support to each other as well as to exchange information.

Both types of support groups provide a means to promote access to prevention, care and treatment services, especially VCT referrals.

Support groups are generally not guided by a pre-established curriculum and do not have specific behavioral outcomes associated with them. Support groups generally have "open" membership and do not usually have a specified end date. Each individual is encouraged to participate to whatever extent they feel comfortable.

Types of Support Groups:

Educational Support Group – Facilitated by peer educator with the intent of providing education on HIV and discuss ways and reasons for risk reduction behaviors. This type of group is not meant to be long-term but rather for a specific number of sessions; however it may vary depending on the needs of the group.

Psychosocial Support Group – Facilitated by peer educator with the assistance of the social worker with the intention of providing a forum for emotional, moral, and psychosocial support for high-risk negative and/or HIV positive individuals. In this group the peer educator leads the group discussion while the social worker is present to facilitate the group through crisis issues that may arise. This type of group can be a long-term group with unlimited number sessions based on the needs of the members. These groups are guided by the rules below:

Group rules

- These group rules are to facilitate the development of trust in the group and enable members to share their thoughts and feelings with each other. As the group develops, additional rules may be added.
- Because confidentiality is essential, we expect that each person will respect and maintain the confidentiality of the group. What is said in the group is not to be repeated or discussed at any other time or place.
- Individuals are there to share their own feelings and experiences; they should try not to give advice.
- Each individual should share the responsibility for making the group work.
- They should try to accept people, just as they are, and avoid making judgments.
- Everyone should be given an opportunity to share.
- Everyone has the right to speak and the right to remain silent.
- Give supportive attention to the person who is speaking and avoid side conversations
- Avoid interrupting. If they do break in, return the conversation to the person who was speaking.
- Each person has the right to ask questions and the right to refuse to answer.
- Everyone should try to be aware of their own feelings and talk about the issues that are current, rather than what life was like in the past.
- Do not discuss group members who are not present.
- Begin and end meetings on time.
- Differences of opinion are O.K – all are entitled to their own point of view.

- Everyone is equal – accept cultural, social and racial differences and promote their acceptance.
- Use “I” language – Everyone is a unique individual, and only they know what is best for them. Example: “In my experience, I have found …”
- It's everyone’s responsibility to make the discussion-groups a safe place to share – We respect confidentiality, treat each other with respect and kindness, and show compassion.

<u>DON’T’s</u>

- It’s okay not to share – People do not have to share if they do not wish to.
- No physical violence or threats of physical violence will be tolerated.
- The group is not used as a place to find sexual or dating partners – sexual or emotional exploitation is not accepted as part of the norm.

<u>Guide to Mobilize Membership</u>

- Make a plan to recruit support group members – How will you let people know about the support group? Members can recruit peers; other NGO can refer, etc.
- Decide on the location of the support group meetings: The location must offer some privacy as well as convenience for members. Consideration must be given to the availability of HIV services before and after the meetings.
- Select convenient days and times for the support group and decide how often the group will meet. Consideration for work schedules, personal chores or whether children/spouse/partner can accompany members.
- Give support group members a clearly defined role.
- Psychosocial support groups: A minimum of twice-monthly meetings is recommended with a maximum of ten (10) persons at a meeting. If the membership is larger than 10, it will be expected that two (2) meetings be held. Individuals can choose to attend one of the two (2).
- Education support groups: A minimum of once per week is recommended with a maximum of twenty (20) persons at a meeting.
- Decide who will lead the support group meetings, the topic of discussion, curriculum to be used, and/or who will be invited to speak, i.e. technical officer, peers and or guest speakers. The leadership of the support group should be rotated amongst the peer educators
- Plan the logistics of the meeting
- Allow for privacy at the meeting space
- Adequate seating. (room arrangement for participants is in a semi circle)
- Arrangement for snacks for the meeting
- Record of attendance and other records of the support group

APPENDIX 3

Training Guide

All peer educators must be trained in Peer Education, Case/Peer Navigation, Social Networking Strategy and Outreach Facilitation.

Peer Education
Persons selected for peer education training should be members of the target population and participate in group activities that focus on and engage their particular peer group (e.g. SW, MSM, logger, miner). Peer educators should be trained for a minimum of 5 days or 40 hours using the respective national peer education manuals - "Keep the Light On" or "Path for Life". The recommendation is that the trainer will gauge the amount of time needed for each exercise and will make the necessary adjustments.

Certification of peer educators

- All peer educators should have at least forty hours (40) of training using the respective manual (Keep the Light On, or Path for Life).
- All peer educators should complete the recommended training (in-house or GHARP II) and receive certification before conducting outreach activities.
- All peer educators should be observed by the peer education supervisor and peers alike and demonstrate the quality of communication skills required. See Peer Outreach Practical Evaluation, Appendix 5.
- Participation in seventy-five percent (75%) of scheduled group meetings and activities.
- A period of evaluation (for at least 3 months after the training) of their abilities as peer educators before they are officially certified.

After this initial evaluation phase, the supervisor should accompany and observe the peer educators bi-monthly (6 times/year) when they go out to perform outreach activities. The supervisor should then provide feedback to the peer educator on their progress and abilities.

Selection criteria for peer educators

- Representative of the targeted population
- Ability to read and write proficiently and communicate effectively with his or her peers
- Ability to accurately complete required reporting formats
- CXC English would be considered a bonus
- Commited to the time requirements of outreach activities
- Be genuinely interested in working with the target population
- Demonstrate appropriate "helping" characteristics and skills
- Have evidence of emotional security
- Understand the type of services to be provided
- Understand HIV and have the ability to educate and support peers in risk reduction behaviors

Recruitment of peer educators

Peer educators can be recruited from among the target population with recommendations from gatekeepers and workshop facilitators.

Qualities to look for in persons you hope to train as peer educators

- Strongly motivated to work towards HIV risk reduction
- Demonstrate respect, care, compassion, tolerance and sensitivity towards persons living with HIV and AIDS
- Self-confident and show potential for leadership
- Demonstrate they have the time and energy to devote to do the work
- Ability to communicate clearly or at least demonstrate the potential to do so
- Good interpersonal skills, including active listening skills

- Respected and accepted by their peers
- Have a non-judgmental attitude
- Able to maintain confidentiality
- Have potential to be a 'safer sex' role model for their peers

Outreach Facilitation

In addition to 40 hours training in peer education, peer educators should undergo a 3-day training in Outreach Facilitation using the Outreach Facilitation Manual modified and adapted by GHARP II. This includes elements of outreach, behavior change, responsibilities of peer educators and supervisors, steps of the outreach process, mapping, outreach standards, protocol and documentation. The methodology for this training should be group work and role plays.

Social Networking\Case Navigation

All peer educators must be trained in Peer/Case Navigation and the Social Networking Strategy (SNS). The CDC Social Networks Testing Manual is recommended for SNS training and should be conducted for 3 days. At the end of the training, peer educators must submit an implementation plan to the NGOs

All initial trainings should be done by MOH/NAPS and technical partners. All refresher trainings and updating of peer educators skills should be done by the respective NGOs

NOTE:
After completing trainings in peer education and outreach facilitation, peer educators must complete twenty (20) hours of practice sessions and observation before certification as a peer educator.

APPENDIX 4

Peer Educator's Code of Conduct

Each peer educator is an integral part of the prevention program of NAME OF NGO and its mission. As a result, the NGO expects all staff to respect the rights and feelings of persons participating in the NGOs' programs and to exhibit a high degree of personal integrity and professionalism.

The following lists set forth the code of conduct for peer educator:

- I maintain the confidentiality of the individuals served.
- I work for the agreed upon hours per day for the program.
- I do not entertain customers while working for the program.
- I do not develop sexual relationships with individuals served by the program.
- I am not intoxicated or under the influence of drugs while working for the program, and I do not carry any alcohol or drugs with me while working for the program.
- I do not get involved with fights because of drunkenness or drugs or any other reason at any time, whether working for the program or not.
- I respect the opinions of others and abide by program decisions.
- I try hard to understand others and be friendly with them.
- I do not engage in any type of relationship with individuals served that would conflict with my role as educator and advocate.
- I am open to learning new things and sharing what I have learned with others.
- I do not accept gifts of cash or in-kind from individuals served.
- I complete and sign timesheets according to established procedures.
- I do not falsify any agency records, including, but not limited t, client records, logbooks, referral forms, reports, and time sheets.
- I come to work in a timely manner.
- I present a clean, neat, and well-groomed appearance.
- I follow the directive of my supervisor and comply with program procedures.
- I do not make false, slanderous, abusive, or malicious statements about the individuals served, other staff, or the agency.

I, NAME OF PEER EDUCATOR, have read, understand, and agree to abide by the Peer Educator Code of Conduct while representing NAME OF NGO.

_______________________ ___________________________
Signature of Peer Educator Date

_____________________________ _____________________________
Signature of Supervisor Date

APPENDIX 5

Peer Outreach Training Practical

Name of Training Participant: __________________________ Date: ___________

Names of Peer Outreach Team: ____

DIRECT OBSERVATION	**Excellent 5**	**Good 4 4**	**Average 3**	**Below Average 2**	**Poor 1**	**N/A 0**
Trainee took part in or conducted briefing session.						
Trainee approached and engaged high-risk clients in discussion on HIV and related topics.						
Trainee provided appropriate and correct HIV/AIDS information.						
Trainee provided appropriate referrals when requested.						
Clients were provided with appropriate educational materials, condoms, etc.						
Trainee adhered to confidentiality, safety, and other policies.						
Trainee accurately logged outreach activity.						
Trainee took part in or conducted debriefing session.						

When trainee is assessed as being Below Average or Poor, the observer should provide specific examples which led to that impression.

Overall Comments
Strengths: Areas which need improvement: Comments:

Recommendation:

This trainee, ____________________ is/is not ready to become part of a peer outreach team at this time. If the training participant is not recommended for joining an outreach team, please use the back of this form to describe a plan for continued supervised practice.

APPENDIX 6

Peer Outreach Practical Protocol

In addition to classroom training and role plays, it is important for peer educators to have some supervised practice in real outreach *situations*. In order to maximize the impact of this aspect of training, the supervised practice will take place in or nearby the participant's region with an established peer outreach team from the same or nearby region. The practical will take place in three steps that gradually introduce the trainee into peer outreach with decreasing levels of supervision.

Step 1: Matching Participants
Trainee will contact MOH/NAPSI technical officer to identify a team within their region. With the help of the technical officer, the trainee will be matched with an established peer outreach team. Matching will be based on similarity of target populations whenever possible.

Step 2: Observation
After participants have been matched with their peer outreach teams, they will have the opportunity to observe their peers. Trainee will observe and be involved in all steps of outreach: mapping, briefing, contacts and encounters and debriefing. Participants will use this time to observe typical outreach encounters and the application of the safety protocol. This observation step should take place for at least one outreach session (2-4 hours).

Step 3: Supervised Practice
Practice: Once the participants have observed "field veterans" conducting outreach, they will be ready to move on to the next step – practice. In this step, participants will again go out with the peer educator team, but the trainee will do most of the outreach work. Peer outreach teams and MOH/NAPS technical officers will observe the trainees.

Feedback: During a special debriefing, the peer outreach team or MOH/NAPS technical officer will provide the trainee with suggestions and feedback on the outreach session. However, if there is need for immediate feedback during the session, in order to ensure the safety of the team, or the accuracy of information, the peer outreach team should provide it as needed. Peer outreach teams and MOH/NAPS technical officers will use the Peer Outreach Training Practical evaluation form for providing feedback to trainees.

At this time, the peer outreach team may feel that the trainee is ready to join a peer outreach team. If so, no further supervised practice is necessary, and the peer outreach team will send a copy of the evaluation form indicating this recommendation to the MOH/NAPS technical officers. The peer outreach team may wish to recommend that the participant continue with supervised practice to refine his/her outreach skills.

APPENDIX 7

Prevention Outreach Frontline Tool
(For Community Outreach Activities with Groups of Persons)

DATE OF OUTREACH: _____/____/_____
dd/ mm/ yyyy

LOCATION: ____________________________

TARGET GROUP: ________________________

Of Condoms distributed: *Male*_______ *Female* ________

Of BCC materials distributed: _______

PRIMARY MESSAGE SHARED/TOPIC DISCUSSED:

Abstinence only (A) ☐ Faithfulness only (B) ☐

Abstinence & Faithfulness (A&B) ☐ Stigma and Discrimination ☐

Beyond A&/B (Other) ☐

CURRENT SESSION

# of males _______ # of females _______ TOTAL # of persons reached _______

For persons participating in the current session please state how many have previously participated in similar sessions

# of males _______ # of females _______

TOTAL # of participants __________
(previously reached (*this is the sum of male & female reported to have participated in a previous session)*

Notes:
____

____

Signature:________________ Date: __________ Outreach Code:_________

Prevention Outreach Frontline Tool
(For Community Outreach Activities Involving One-On-One Peer Ed)

Date of Outreach: _____/____/_____ Location: ___________________________

Target Group: ____________________

Of Condoms distributed: Male ______ Fem______ # Of BCC materials distributed: _________

CURRENT SESSIONS

	Abstinence Only (A)	Faithfulness Only (B)	Beyond A&B (Other) {E.g. condoms }	Stigma & Discrimination	TOTAL
MALES					
FEMALES					
TOTAL					

For persons participating in current sessions, please record in the table below those who have been previously reached in a similar session.

	Abstinence Only (A)	Faithfulness Only (B)	Beyond A&B (Other) {for e.g. Condoms etc }	Stigma & Discrimination	TOTAL
MALES					
FEMALES					
TOTAL					

Signature: ______________ Date: _______________ Outreach Code: ___________

APPENDIX 8

MARPS Peer Educator's Diary

Date:

Place:

Total number persons reached

Client Code(s):

Number of persons (old): MSM ☐ FSW ☐

Number of persons (New): MSM ☐ FSW ☐

Number of condoms distributed:

Male: MSM ☐ FSW ☐ Other ☐

Female: MSM ☐ FSW ☐ Other ☐

Number of referrals made: MSM ☐ FSW ☐

Number of BCC Materials Distributed: ☐

Topics Discussed:

APPENDIX 9

Prevention Log for interventions targeted to MARPS

NAME OF PLACE VISITED	DATE dd/mm/yy	Number of MARPS Reached																		Number of BCC materials Distributed		Number of Condoms Distributed		Number of persons Referred		Number of persons Referred/reached
		Miners			Loggers			Adjacent Population			MSM			FSWs			Total									
		N	O	T	N	O	T	N	O	T	N	O	T	N	O	T	N	O	T	FSWs	MSM	FSWs	MSM	MSM	FSWs	Partners
Totals																										

APPENDIX 10

Gender Based Violence/Intimate Partner Violence Screening Tools

"HITS" tool for violence screening

Instruction: Circle the most appropriate option.

How often does your partner:-

Physically **hurt** you?	Never,	Rarely,	Sometimes,	Fairly often,	Frequently
Insult or talk down to you	Never,	Rarely,	Sometimes,	Fairly often,	Frequently
Threaten you with harm	Never,	Rarely,	Sometimes,	Fairly often,	Frequently
Scream or curse at you	Never,	Rarely,	Sometimes,	Fairly often,	Frequently

Interpretation: Each item is scored from 1-5. Thus scores for this inventory ranges from 4 to 20. A score of greater than 10 is considered positive. Refer to social worker at NGO

IPPF's screening tool for gender-based violence

1. Have you ever felt hurt emotionally or psychologically by your partner or another person important to you?
2. Has your partner or another person important to you ever caused you physical harm?
3. Were you ever forced to have sexual contact or intercourse?
4. When you were a child, were you ever touched in a way that made you feel uncomfortable?
5. Do you feel safe returning to your home tonight?

Three brief questions to screen for gender based violence.

1. Have you ever been hit, kicked, punched or otherwise hurt by someone within the last year? If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

Screening questions that can be asked indirectly

1. Your symptoms may be related to stress. Do you and your partner tend to fight a lot? Have you ever gotten hurt?
2. Does your husband or partner have any problems with alcohol, drugs or gambling? How does it affect his behaviours with you and the children?
3. When considering which method of contraception if best for you, important factor is whether you can or cannot anticipate when you will have sex. Do you generally feel you can control when you have sex. Are there times when your partner may force you unexpectedly?
4. Does your partner ever want sex when you do not? What happens in such situations?

APPENDIX 11

Substance Abuse Screening Tools

Alcohol Abuse Screening Tool (CAGE)

Instructions: Check either Yes or No for each question:

Have you ever felt you should **cut down** on your drinking? Yes No

Have people **annoyed** you by criticizing your drinking? Yes No

Have you ever felt bad or **guilty** about your drinking? Yes No

Have you ever had an **eye opener** first thing in the morning to steady your nerves or to get rid of a hangover? Yes No

Interpretation: Two "yes" answers to CAGE test indicate problems with alcohol. A score of 1-3 should create a high index of suspicion and warrants further evaluation

Score of 1 – 80% are alcohol dependent

Score of 2 – 98% alcohol dependent

Score of 3 – 99% alcohol dependent

Score of 4 – 100% alcohol dependent

DAST (Drug Abuse Screening Test)

1.	Have you used drugs other than those required for medical reasons?	**Yes**	No
2.	Have you abused prescription drugs?	**Yes**	No
3.	Do you abuse more than one drug at a time?	**Yes**	No
4.	Can you get through the week without using drugs (other than those required for Medical reason?	Yes	**No**
5.	Are you always able to stop using drugs when you want to?	Yes	**No**
6.	Do you abuse drugs on a continuous basis?	**Yes**	No
7.	Do you try to limit your drug use to certain situations?	**Yes**	No
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	**Yes**	No
9.	Do you ever feel bad about your drug abuse?	**Yes**	No
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	**Yes**	No
11.	Do your friends or relatives know or suspect you abuse drugs?	**Yes**	No
12.	Has drug abuse ever created problems between you and your spouse?	**Yes**	No
13.	Has any family member ever sought help for problems related to your drug use?	**Yes**	No
14.	Have you ever lost friends because of your use of drugs?	**Yes**	No
15.	Have you ever neglected your family or missed work because of your use of drugs?	**Yes**	No
16.	Have you ever been in trouble at work because of drug abuse?	**Yes**	No
17.	Have you ever lost a job because of drug abuse?	**Yes**	No
18.	Have you gotten into fights when under the influence of drugs?	**Yes**	No
19.	Have you ever been arrested because of unusual behavior while under the influence of Drug?	**Yes**	No
20.	Have you ever been arrested for driving while under the influence of drugs?	**Yes**	No
21.	Have you engaged in illegal activities to obtain drugs?	**Yes**	No
22.	Have you ever been arrested for possession of illegal drugs?	**Yes**	No
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		

		Yes	No
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?	**Yes**	No
25.	Have you ever gone to anyone for help for a drug problem?	**Yes**	No
26.	Have you ever been in hospital for medical problems related to your drug use?	**Yes**	No
27.	Have you ever been involved in a treatment program specifically related to drug use?	**Yes**	No
28.	Have you been treated as an outpatient for problems related to drug abuse?	**Yes**	No

Scoring: Each item in bold = 1 point

6 or more = substance use problem (abuse or dependence)

APPENDIX 12

Mental Health Issues Screening Tools

Screening questions for Anxiety

Instruction: Check either Yes or NO for each question

Are you **worrying** more than usual? Yes No

Have you been **anxious** (nervous) lately? Yes No

Have you had trouble **sleeping**? Yes No

Are you **tense** or irritable? Yes No

Screener for possible Depression

If the answer is yes to either question, further evaluation is indicated:

During the last month, have you been feeling down, depressed or hopeless?

During the past month, have you been having little interest in things you used to like, find little pleasure in things you used to enjoy?

Other useful screening questions:

Are you eating a lot more or have no appetite?
Have you been jumpy or restless, or do you feel slowed down?
Have you had a drop in your sexual interest or energy>

(adapted from presentation by Dr. M. Teitelman)

APPENDIX 13

STI Screening Questions

Simple screening questions for STIs:

1) Ask if they have noticed any sores, boils or ulcers on your private parts?

   If yes, ask if they have seen a doctor about them. If yes, ask about the treatment and any challenges they maybe having

   If no, refer

2) Ask if they have noticed any discharge or smell from their parts. If yes, refer to a STI clinic or doctor for diagnosis and treatment.

(3) Ask if they have notice any growth or persistent itching in the genital area or anus. If yes, refer to a doctor for diagnosis and treatment.

Always remember to follow up after treatment to ensure entire course of treatment was taken.

APPENDIX 14

Risk Reduction

Name:____

I plan to decrease my risk by (check all that apply) :

Partner Choice strategies

- Avoiding places/people that cause me to take risks
- Choosing partners based on their HIV status
- Finding people I can talk to
- Eliminating casual partners

Condom/Barriers Use

- always carrying condom/barriers
- increasing the use of condom/barriers

Reduce sexual Episodes

- reducing episode of anal intercourse
- reducing episode of vaginal intercourse
- using mutual masturbation only (not exchanging fluids)
- choosing not have sex
- not sharing sex toys

Disclosure/Communication strategies

- Telling my partners that I have HIV
- Asking my partners if they have HIV
- Taking to my partner about safer sex

Drug-related Strategies

- using a needle exchange program to get **clean works**
- using only clean drugs works
- not sharing needles/works
- not having sex while using alcohol/drugs

Other

- continuing my current risk reduction plan

Date:____________ **Provider:**____________________

APPENDIX 15

Risk Reduction Grid

Sexual Relations	Sex I know I don't know	HIV Status	# of sexual Partners	Vaginal sex	Oral Sex	Anal Sex	STI	Condom use
Me								
My Main Partner								
My other Partner								
My Main Partner's , Partners								
My other Partners' Partners								

Instructions on how to complete this grid:

The first column on the left hand side refers to the individual's direct and indirect sexual relations. The first row across after the first column refers to important sexual risk.

For example, for my main partner, the 2nd row across: Who is my main partner having sex with a man, a woman etc. Do I know the HIV status of my main partner?, Do I know the # of sexual partners my partner has? Do I know if my partner is engaged in vaginal sex? Do I know if my partner is engage in oral sex? Do I know if my partner is engage in anal sex? Do I know if my main partner has an STI? Do I know if my main partner always uses a condom correctly and consistently? Your response can either be "**I know**" or "**I do not know**". A tick can indicate "**I know**" and X can indicate "**I do not know**". This will follow through with the various sexual relations on the extreme left.

APPENDIX 16

MINISTRY OF HEALTH REFERRAL FORM

Name of Health Facility/Organisation: ___________________________________

Facility Phone number and Address:____________________________________

Date: ______________________________

Client code **(Initials, date of birth & Gender):** ____/____/ ___/___/___/ _______
Initials: First/Last D.O.B (day/month/year)
Gender (M/F)

This person is being referred from:____

This person is being referred to (name of organization/person):______________________
Dear colleague, Kindly attend to this client who has received service in our health facility/organisation. We are referring him/her for the following reason:

1. ART ☐	7. Social and peer support ☐
2. Home Based and Palliative Care ☐	8. Legal Support ☐
Family members are aware of client's status YES ☐ NO ☐	9. Welfare Assistance ☐
3. Medical management ☐	10. Psychological Support ☐
4. HIV testing ☐	11. Orphan Support ☐
5. Reproductive/Family Planning Service ☐	
6. Prevention of Mother to Child Transmission Service ☐	
Other (please specify service required) --	

____ _________________________
Name & signature of person referring client **Designation**

Please cut off this section and store it carefully until it is collected by the health facility/organization that referred this client. This is extremely important as it will allow the referring organization to know whether persons utilize the services for which they were referred.

Date:___________________________ Name of organization: _____________________

Client code (Initials, date of birth & Gender)**:** ________/________/ _____/____/______/ ______
Initials: First Last D.O.B (dd/mm/yyyy) Gender (M/F)

Service/s client referred for:____

Service/s client received:____

Follow-up required: ____
____
____

______________________________________ ______________________
Name & signature of person who delivered service **Designation**

APPENDIX 17

Referral Register/Log

Date Referral Made	Client Code	Referred by: (organization name)	Name of Referring Officer	Services referred for: (use codes below)	Referred to: (organization name)	Contact Person	Services provided: (use codes below)	Date referral accessed	Services completed (yes/no)	Comments/Follow-up action

For services use the following codes:				
1. Adherence counseling 2. Antiretroviral therapy 3. Education/ schooling 4. Family planning 5. Financial support	6. HIV counseling and testing 7. Home-based care 8. Legal support 9. Mental health services 10. Microfinance	11. Nutrition counseling 12. OB/GYN services 13. Peer counseling 14. PEP services 15. PLHA support	16. PMTCT services 17. Psychosocial support 18. Social services 19. Spiritual support 20. STI services	21. Substance abuse management 22. Support for gender based violence 23. Treatment support 24. TB services 25. Other________

APPENDIX 18

Referral Service Delivery Directory

S/N	Name of Organization	Services Provided	Description	Operating Days/Hours	Telephone/ Location/ email	Contact Persons	Type of Referrals

APPENDIX 19:

Workshop Sign In Sheet

Name of workshop:____________________________________Type of training: ________________________________
Date: __________________________ Venue: ____________________
Facilitators: _____________________________

No.	**Name of Participant**	**Facility**	**Designation**	**Telephone #**	**Email Address**	**ATTENDANCE**						**SIGNATURE**
						Day 1	Day 2	Day 3	Day 4	Day 5	Total	
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

N.B Please use additional sheets if necessary

Total # of Participants: ________

APPENDIX 20:

MARPs Risk Assessment Tool

Client Name or ID: ________________________ Date: _______________

Gender of Client: ( ) Female ( ) Male ( ) Other Age:____

ETHNICITY: ( )Negro ( )East Indians ( )Amerindian ( )Mixed

Target population: ( ) Female sex worker ( ) Male sex worker ( ) MSM ( ) Children of sex workers ( ) Client of sex worker

Introduction to client: I am going to ask you a series of questions to assess your risk for HIV and other sexually transmitted infections. These are very personal and intimate questions. In order to give you an accurate assessment of your behavioral risks factors, I need to ask these questions and it's important that you answer as honestly and accurately as possible

PART ONE: STI INFORMATION		
Question 1: To the best of your knowledge, do you now have or have you ever had any of the following?		
Gonorrhea Syphilis Herpes Anal/Genital Warts or HPV	( )Yes ( )No ( )Don't know ( )Yes ( )No ( )Don't know ( )Yes ( )No ( )Don't know ( )Yes ( )No ( )Don't know	If no or don't know to all, skip to question 2
1b: if yes, are you currently being treated or were you previously treated for?		
Gonorrhea Syphilis Herpes Anal/Genital Warts or HPV	( )Yes ( )No ( )Don't know ( )Yes ( )No ( )Don't know ( )Yes ( )No ( )Don't know ( )Yes ( )No ( )Don't know	If no or don't know Provider/refer to care for appropriate STI treatment
1c: Have you notice any		
• sores, boils or ulcers on your private parts? • discharge or smell from your parts? • growth or persistent itching in the genital area or anus?	( )Yes ( )No ( )Don't know ( )Yes ( )No ( )Don't know ( )Yes ( )No ( )Don't know	If yes, refer to STI clinic or doctor for diagnosis and treatment
Question 2: When did you have your most recent HIV test?	Never been tested Date of most recent test	If never been tested, skip to Question 3
2b: What was the result of your most recent test?	( )Positive ( )Negative ( ) Don't know	If negative or don't know, skip to question 3. This question should be asked by the social worker only.
2c: If positive, have you seen a doctor for HIV care and treatment in the last 6 months?	( )Yes ( )No	If no; refer to HIV care and treatment

<table>
<tr><td colspan="2">PART TWO: SEXUAL RISK</td></tr>
<tr><td colspan="2">Question 3: have you had unprotected oral sex with more than one partner in the last three months</td></tr>
<tr><td>Yes No Don’t know</td><td>If yes or don’t know:
Provide risk reduction counseling and
Refer to testing for STIs</td></tr>
<tr><td colspan="2">Question 4: have you had unprotected vaginal sex with more than one partner in the 3 months?</td></tr>
<tr><td>Yes No Don’t know</td><td>If yes or don’t know:
Provide risk reduction counseling and
Refer to testing for STIs</td></tr>
<tr><td colspan="2">Question 5: have you had unprotected anal sex with more than one partner in the last three months?</td></tr>
<tr><td>Yes No Don’t know</td><td>If yes or don’t know:
Provide risk reduction counseling and
Refer to testing for STIs</td></tr>
<tr><td colspan="2">PART THREE: SUBSTANCE ABUSE</td></tr>
<tr><td colspan="2">The following risk factors may be indicators of existing or developing problems. These should be considered by the service provider. Referrals for further evaluation by clinician or substance abuse specialist may be needed to diagnose a specific condition or otherwise address client’s risk.</td></tr>
<tr><td colspan="2">Question 9:</td></tr>
<tr><td>(a) Are you frequently high or intoxicated?
(b) Do your social activities focus on drinking?
(c) Do your social activities focus on drug use, including obtaining, using and recovering from use?
(d) Do you ever feel the need to cut down on the use of drugs or alcohol?
(e) Do you rely on drugs or alcohol as a means of coping with stress or problems?
(f) Do you have any medical conditions which increase the risk of substance abuse use?</td><td>( )Yes ( )No
( )Yes ( )No
( )Yes ( )No
( )Yes ( )No
( )Yes ( )No
( )Yes ( )No</td></tr>
<tr><td colspan="2">PART FOUR: CONDOM USE (please document everything the client says)</td></tr>
<tr><td colspan="2">Question 10:</td></tr>
<tr><td>(a) Can you show me how to use condoms? if yes, allow the client to demonstrate and note if done correctly
(b) Can you encourage your partner(s) to use a condom?
(c) Can you explain how it is done? If no, what makes it difficult for you?
(d) Did you use a condom at your last sexual encounter?
(e) Do you use alcohol and drug before sexual encounters?</td><td>( )Yes ( )No

( )Yes ( )No

( )Yes ( )No
( )Yes ( )No
( )Yes ( )No</td></tr>
<tr><td colspan="2">PART FIVE: RISK PERCEPTION (please document everything the client says)</td></tr>
<tr><td colspan="2">Question 11:</td></tr>
<tr><td colspan="2">(a) Does too much use of drugs make someone less aware of becoming infected with HIV? ( ) Yes ( ) No
(b) Does having more than one partner increase your risk for STI?
(c) Do you see yourself needing to reduce your risk? ( ) yes ( ) No
(d) What have you been doing to reduce your risk?</td></tr>
</table>

PART SIX: MENTAL HEALTH
Question 12:
(a) How do you deal with things that bother you? (b) Do you feel the need to get help for dealing with stress? ( )Yes ( ) No (c) Who do you turn to for support? (d) Do you feel depressed? ( ) Yes ( ) No
PART SEVEN: GENDER-BASED VIOLENCE
Question 13:
(a) Are you made to feel bad or ashamed of yourself? ( )Yes ( ) No (b) Do you feel afraid to speak or are you forced to do things you don't like? ( )Yes ( )No (c) If yes, tell me more about it
PART EIGHT: OTHER QUESTIONS
Question 14: These questions have focused on the highest risk behaviors. What questions or concerns do you have about these or other risk behaviors?

SUMMARY OF RECOMMENDATIONS

Testing:
Risk Reduction Counseling:
Client Referrals:
Partner Referrals:
Other:

Assessment conducted by:

Job title:

FOLLOW UP INTERVENTION PROVIDED

Service(s) provided:
Reflection:
Follow up action:
Next appointment due:
Other:
Signature of Social Worker:

Instructions for using this form:

Purpose

This Risk Assessment Tool exists for the purpose of collecting information for client-level data collection for risk reduction interventions.

The tool offers several benefits for organizations implementing HIV prevention programs. First, it helps improve NGOs' capacity to assess the sexual behaviors of their clients. This information can be utilized to help counsel clients about their individual risks and to assess changes in clients' behaviors during and after their participation in HIV prevention activities. Second, it helps NGOs gauge the effectiveness of their targeted recruitment for prevention services, to see if programs are reaching persons who are at highest risk for HIV infection. This can help NGOs maximize their limited HIV prevention resources to prioritize those clients who are most in need of services.

The tool collects information regarding:

- Client demographic characteristics (race/ethnicity, age, gender)
- Sexual practices including condom use
- Substance abuse
- HIV-related risk factors
- HIV/STI testing history
- Mental Health
- Gender based violence

When Required

NGOs must utilize this form for the following interventions.

- The tool must be completed with all clients in individual-level and group-level interventions.
- The tool may also be completed 6 months after the client is discharged from risk reduction interventions.

How to administer the tool

The tool must be administered by the Social Worker. He/she can interview a client on a one-on-one basis and record the client's answers as the interview is being conducted. After the data collection process, the social worker provides follow up services as required.