Preventing HIV among Guyana's Key Populations

Guidelines

July 2019

USAID
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The Global Fund

MEASURE Evaluation

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CONTENTS

FIGURES

ABBREVIATIONS

ART	antiretroviral therapy
FSW	female sex worker
HPV	human papilloma virus
HTC	HIV testing and counselling
IEC	information, education, and communication
KP	key population
M&E	monitoring and evaluation
MOPH	Ministry of Public Health
MSM	men who have sex with men
NAPS	National AIDS Programme Secretariat
NGO	nongovernmental organization
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
STI	sexually transmitted infection
TB	tuberculosis
TG	transgender
TWG	technical working group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VMMC	voluntary medical male circumcision
WHO	World Health Organization

BACKGROUND

The National AIDS Programme Secretariat (NAPS) in Guyana has focused on key populations (KPs) in the country's HIV program because they face a higher burden of disease than the rest of the population. The most recent national survey of HIV prevalence (Guyana Biobehavioral Surveillance Survey of 2013/14) found that men who have sex with men (MSM) had similar rates as the general population (1.1%) and female sex workers (FSWs) had slightly elevated rates (2.0%) (NAPS & MEASURE Evaluation, 2014). These rates represent a limited sample and may not be fully representative of those populations, which have displayed much higher prevalence rates in previous studies (NAPS and MEASURE Evaluation, 2014). Nevertheless, KPs continue to report elevated risk in their behaviours and sexual partnerships. They show elevated prevalence of sexually transmitted infections (STIs), engage in sex work and unprotected sex, and report larger numbers of sexual partners (NAPS & MEASURE Evaluation, 2014).

Recognizing that KPs are an essential component of the HIV prevention puzzle in Guyana, the National HIV Strategic Plan (2013–2020), known as HIVision 2020, states that "an intensified focus would be placed on addressing the epidemic at its core; among key populations at higher risk. These will include MSM, sex workers, […] and communities linked to these populations" (Ministry of Public Health [MOPH], 2013). One of the strategic objectives of the HIVision 2020 is to "reduce sexual transmission among key populations at higher risk" through behaviour change, condom and lubricant distribution, and universal access to HIV testing services (MOPH, 2013).

To meet the Joint United Nations Programme on HIV/AIDS (UNAIDS) targets of 90 percent of people knowing their status, 90 percent of HIV-positive people on treatment, and 90 percent of people on treatment being virally suppressed by 2020, a focus on KPs in a limited resource setting is a wise investment. "Projections suggest that the impacts of improved service coverage of key populations could range from averting a considerable number of infections in countries with generalized epidemics," such as Guyana (World Health Organization [WHO], 2016a). KPs are a broad category of people with diverse risk levels and needs. The NAPS strives to meet those needs through diverse programming involving both national and donor support.

Guiding Principles

These Guidelines for Preventing HIV among Guyana's Key Populations follow the same guiding principles outlined in the HIVision 2020 document, namely:

1. **Coordination:** HIV programming involves collaboration and strengthening of linkages with local, regional, and international partners, and community-based organizations, the private sector, and KPs at higher risk for HIV.
2. **Rights-based approach or respect for human rights and dignity:** HIV programming is based on the "Positive Health, Dignity and Prevention" approach of people living with HIV. HIV programming is respectful of people's rights to privacy and confidentiality, considers human rights, gender, and diversity, and encourages environments free of stigma and discrimination.
3. **HIV programming** will adhere to the principle of the Greater Involvement of People Living with and Affected by HIV: "Nothing about us, without us."

4. **Equity**: HIV programming is developed and delivered to ensure equitable access to all services regardless of age, gender, ethnicity, sexual orientation, or any other demographic characteristics, and with additional consideration given to special populations at higher risk for HIV infection.
5. **Cultural context**: HIV programming respects social and cultural issues, and takes them into consideration.
6. **Integration:** HIV programming will, as much as possible and where appropriate, be integrated in primary healthcare and other relevant programmes to create synergies between services, to maximize efficiency, and to leverage the best possible health outcomes.
7. **Monitoring and evaluation and the use of strategic information:** HIV programming is guided by ongoing monitoring, evaluation, and research, and adjustments are made, where necessary, to ensure evidence-informed planning.
8. **Strategic investment:** HIV programming is based on prioritisation, through a strategic investment framework that is intended to result in effective and efficient management of the Guyana national HIV response (MOPH, 2013).

Goals of the Guidelines

The goal of these guidelines is to support the national vision of reducing "the social and economic impact of HIV and AIDS on individuals and communities and ultimately the development of the country, and the overall strategic objectives of reducing the spread of HIV and improving the quality of life of people living with HIV" (MOPH, 2013). These guidelines seek to achieve this vision by guiding the provision of high quality, user-friendly health services for KPs to realize a healthy life, prevent HIV infection, and live with dignity.

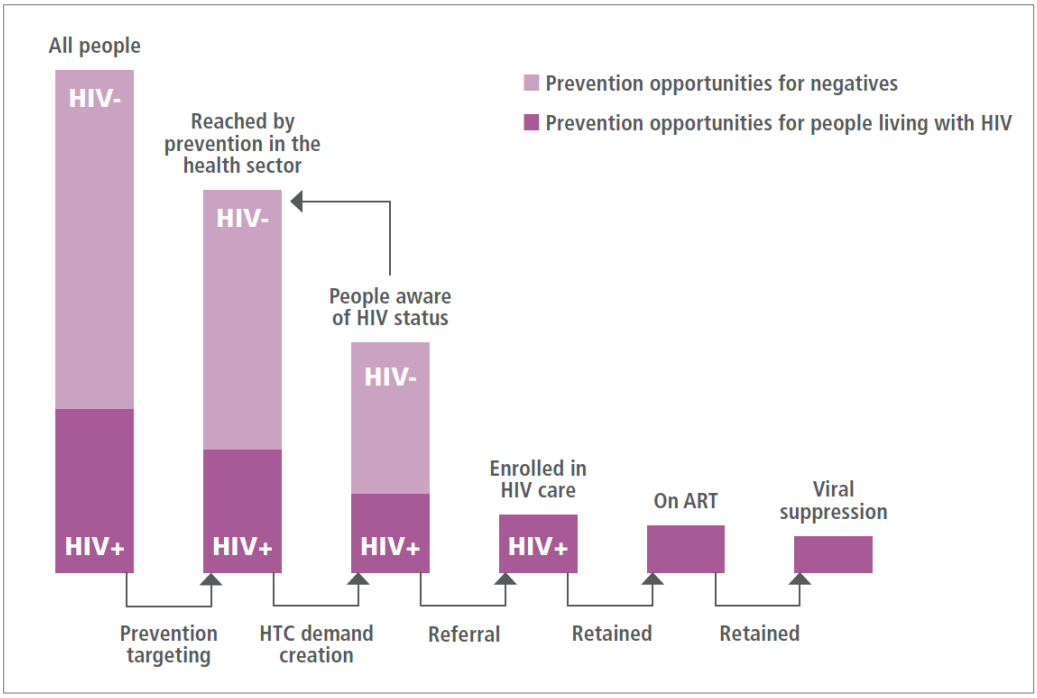
Purpose of the Guidelines

These guidelines are designed to outline the public health response to HIV among KPs in Guyana. The specific objectives are to:

- Define the populations of interest
- Define the combination prevention package for KPs
- Update guidance on the operationalization of interventions
- Define programme monitoring and evaluation (M&E) for KP prevention activities

The focus of these guidelines is on HIV prevention for KPs and priority populations. To meet the HIVision 2020 goal of eliminating HIV in Guyana, a multi-pronged approach that goes beyond prevention will be required. These guidelines highlight the approaches needed before care and treatment are given and linking with treatment for people who have HIV. The focus is on the first three pillars of the prevention and treatment cascade shown in Figure 1.

Figure 1. Cascade of HIV prevention, diagnosis, care, and treatment



Source: WHO, 2016a

Intended Audience

These guidelines are addressed to national HIV programme managers and community-based organizations that work with KPs in the provision of HIV prevention and referral to care.

Development of the Guidelines

These guidelines were developed through a collaborative process that began with a review of the existing guidelines: *Most-At-Risk Populations (MARPs) Guidelines and Standards for Non Governmental Organizations* (Ministry of Health/NAPS/USAID Guyana HIV AIDS Reduction and Prevention Project Phase II, 2012). These guidelines have been used by national stakeholders for KP programming since their development, but there was recognition by the NAPS, the MOPH, KP stakeholders, and donors that they should be updated to better reflect current best practices in comprehensive services for KPs.

The process was led by the USAID-funded MEASURE Evaluation project in close collaboration with NAPS. These guidelines align with USAID's goal of controlling the HIV/AIDS epidemic.

Definitions of Key Populations

Key populations: KPs are groups of people who are categorized by certain behaviours and vulnerabilities that can put them at higher risk for HIV. It is important that their HIV prevention needs (and health needs, more broadly) are met, and that stigma and discrimination are addressed to positively impact the dynamics of HIV transmission. In Guyana, where the epidemic is both general and concentrated among KPs (NAPS and MEASURE Evaluation, 2014), KPs are important partners in HIV prevention. For the purposes of these guidelines, KPs refer specifically to sex workers, MSM, and transgender (TG) persons. Other priority populations that also display elevated prevalence of HIV are miners and loggers.

It should be noted that these groups of people are not inherently at greater risk than other population groups, but evidence suggests that many people in these categories engage in higher risk activities compared with non-KP groups. They also face increased vulnerabilities, both social and structural, that can make them more vulnerable to infection and the impact of HIV.

Sex workers: "Sex workers include 'female, male, and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally.' Sex work may vary in the degree to which it is 'formal' or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities" (WHO, 2013).

Operational definition: A person who has exchanged cash, goods, or services for sex in the past six months.

Types of sex workers:

Female sex workers (FSWs) are women who exchange cash or goods for sex. Woman are particularly affected by gender-based and intimate-partner violence, especially in the context of their work, although violence affects all types of sex workers.

Male sex workers are men who exchange cash or goods for sex. Male sex workers are less likely to identify as a sex worker, but nevertheless engage in the practice. Male sex workers may have women and/or men as clients.

Transgender sex workers are people who identify as a gender different than their sex assigned at birth who exchange cash or goods for sex. They can be both people who currently identify as men and those who currently identify as women.

Adolescents engaged in transactional sex are people below the age of 18 who exchange cash or goods for sex. They are not defined as sex workers due to their age of minority. They should not be defined by a profession, but by their behaviour.

Street-based sex workers are sex workers who meet potential clients on the street. They are often at highest risk compared with venue-based sex workers.

Venue-based sex workers are sex workers who are associated with a particular venue, such as a brothel or those who more regularly meet potential clients at venues or "hot spots." They may not have any formal relationship with the venue or be employed by or referred by the venue.

Internet-based sex workers are sex workers who find clients through Internet-based apps and/or social media sites. They may not meet their clients in public spaces once the connection is made online.

Multiple Identities

Some KPs may identify as more than one KP group (i.e., an MSM sex worker). For reporting purposes, individual clients should only be reported under one KP group. If a KP falls in more than one of these categories, s/he should be reported under the highest risk group based on reported HIV prevalence.

Men who have sex with men: "Men who have sex with men and the corresponding acronym 'MSM' refer to all men who engage in sexual and/or romantic relations with other men or who experience sexual attraction towards the same sex." MSM "can include men who identify as gay or bisexual, transgender men who have sex with men, and men who identify as heterosexual. Some men who have sex with men also form relationships with, or are married to, women. Some men sell sex to other

men, regardless of their sexual identity. Some men who have sex with men do not associate themselves with any particular identity, community, or terminology" (United Nations Population Fund [UNFPA], 2015). "Men" can refer to males of any age, but special attention should be given to adolescents, as addressed separately. Men may also refer to imprisoned populations who face even greater barriers to accessing services and may be exposed to HIV in coercive situations.

Operational definition: A man who has had anal sex with a man in the past six months.

Transgender people: "Persons whose gender identity (their internal sense of their gender) is different from the sex they were assigned at birth. Transgender is an umbrella term that describes a wide variety of cross-gender behaviours and identities. It is not a diagnostic term and does not imply a medical or psychological condition… 'Trans' represents an all-inclusive perspective of cross-gender identity and expression" (United Nations Development Programme, 2016).

Operational definition: A person who identifies as a gender different from the sex they were assigned at birth.

Adolescents

There are no age exclusions in KP definitions, because people of all ages fit in these categories. Adolescents who are MSM, TG persons, sex workers, or miners and loggers may be at increased risk for HIV because of lower levels of education, empowerment, and difficulty accessing health services. Access to prevention should not be denied to KPs based on their age.

Definitions of Priority Populations

Miners: People directly employed by formal or informal mining operations and those in adjacent industries who work with miners or provide services to miners, especially in landings.

Loggers: People directly employed by logging and forestry operations and those in adjacent industries who work with loggers or provide services to loggers, especially in landings.

COMBINATION PREVENTION SERVICES

The public health response to HIV among KPs is a multifaceted approach to address the proximate and distal factors affecting HIV transmission. Ultimately, biologic exposure needs to be reduced to prevent transmission and to curb the epidemic. The standard combination prevention package (Figure 2) helps reduce exposure to HIV and susceptibility among KPs (UNFPA, 2013). This includes increasing protection during sex and injecting drugs, reducing biologic susceptibility through reproductive health and viral suppression, and creating an environment in which KPs can seek appropriate care. The standard combination prevention services for KPs according to human rights standards, global best practices, and scientific evidence in Guyana are the following:

Figure 2. Standard combination prevention services for KPs in Guyana

Behavioural	• Counselling on risk reduction • Comprehensive sex education • Peer education programs • Psychosocial support and mental health
Biomedical	• HIV testing and counselling • HIV treatment and care • Antiretroviral therapy • Pre-exposure prophylaxis and post-exposure prophylaxis • STI screening and testing • Coinfection prevention and management • Voluntary male medical circumcision
Structural	• Decriminalization of transmission and of KPs • Laws to protect rights • Interventions to reduce stigma and discrimination • Gender and gender violence approach • Community empowerment

The combination package of services is divided into two different types of interventions:(1) health sector interventions; and (2) enabling environment or structural interventions. Health sector interventions can be further broken down into (1) behavioural interventions and (2) biomedical interventions (Figure 2). The enabling environment can be further broken down into (1) social enablers and (2) programme enablers (WHO, 2016a). Although the focus of these guidelines is on behavioural interventions, all types of interventions are described in the sections that follow. After the description of the interventions, information on the "how" of the interventions—how they can be achieved in the context of Guyana—is provided.

Behavioural Interventions

Behavioural interventions strive to reduce individual risk for acquiring HIV or exposing others to HIV if they are already infected. This includes reducing the number of sexual partners, protection during intercourse, safely injecting drugs, and avoiding other harmful substance abuse that affects decision making. The interventions are evidence-based and are recommended by the WHO in the *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (WHO, 2016a).

Peer Education

Peer education is the sharing of knowledge and information between trained KPs and their fellow KPs in the same community. It can take different forms, from one-on-one education to group meetings. During these educational opportunities, programmes can implement information and skills building activities associated with HIV prevention, testing, and related services. It is also an opportunity to provide prevention commodities and linkages to other services.

The goals of peer education and outreach are to:

1. Reduce HIV risk behaviours
2. Promote risk reduction behaviours
3. Increase the number of people accessing HIV testing and other services
4. Increase access to mental health services

Educational engagement. Peer educators should be trained to provide essential components of HIV prevention education, which should include:

- Information on how to reduce the risk for getting HIV and other STIs
- How to access health services
- Demonstration and provision of condoms and lubricants
- Referrals for testing, care, and treatment and other needed health services
- Information on violence and available services to respond to violence
- Information on services about psychosocial support, mental health, and substance abuse, as needed
- Information on safe spaces and drop-in centres, when available
- Community mobilization and empowerment

For further guidance on peer educator training and assessment, see Appendices B through D and Appendix F.

Peer navigation. One role for peer educators is to help HIV-positive KPs remain in care. Peer navigators are often (but not always) KPs who are HIV-positive themselves. They can help their peers navigate the complexities of seeking treatment for HIV and remaining in care. Peer navigators act as a liaison between facilities and their KP patients, and help their peers adhere to treatment plans through regular communication and support. Beyond the essential service of supporting HIV care and treatment, peer navigators can support treatment and care services for STIs, tuberculosis (TB), mental health, and psychosocial support.

Engaging unidentified KPs. Peer educators should be trained to enlarge their network through social networking and recruitment. Peer educators can ask people in their network to refer their friends and acquaintances to the programme in a type of snowball recruitment. This is designed to touch harder-to-reach KPs who may not otherwise receive or seek out HIV prevention services. For MSM, in particular, it may prove beneficial to engage men in a broader "men's health" approach that includes other tests, screening, and services beyond HIV testing.

Risk Assessment and Risk Reduction Counselling

Essential to any outreach to and counselling of KPs is a risk assessment and associated risk-reduction counselling. Risk reduction counselling is a tailored, client-centred behavioural activity designed to change a person's knowledge, attitudes, behaviours, or practices to reduce HIV risk behaviours Not only do counsellors need to be aware of their clients' risk to better help them, KPs need to be made aware of their own risk for HIV through a risk assessment. Peer educators and other health system staff who engage with KPs should share knowledge of interventions, tools, and materials that can advise on HIV risk reduction. KPs should be advised to develop strategies and skills to support risk reduction to which they can commit, whether it is through individual counselling or in a group setting. See the HIV and STI Risk Assessment Form in Appendix G.

Other Evidence-Based Behavioural Interventions

All other behavioural interventions should be evidence-based, and designed to support safer behaviours among KPs and help them sustain positive changes. Examples of other types of behavioural interventions that should be considered are outlined below.

Targeted information, education, and communication (IEC). IEC that addresses KP-specific issues and is presented in a way that appeals to them should be designed and widely distributed. These materials should present medically-accurate information and should be accessible to the target audience. IEC should be distributed through several channels, whether pamphlets, radio spots, posters, or text. Priority should be given to targeted Internet-based information sharing due to the increasing use by KPs of online dating sites or apps.

Social marketing. Social marketing is not being implemented in Guyana, but represents a best practice for future consideration. Social marketing programmes can be implemented to promote testing, treatment, and other services. Specifically, they can be used to make condoms and lubricants more desirable among KPs who may otherwise access standard free commodities or pay for full-price branded commodities. Social marketing can complement the existing government distribution of condoms and lubricants to fill a gap in desired commodities that are branded.

Venue-based outreach. Outreach should be conducted where KPs naturally congregate and socialize. They may be sex venues, bars, clubs, mining or logging camps, or other public places where KPs can be found. Venue-based outreach is another method to identify KP networks, who can then be linked to services that do not require them to deviate from their routine activities.

Virtual outreach. Different online avenues for contacting KPs should also be used to reach people who may not otherwise be found in public venues or traditional venues for outreach. Social media, such as WhatsApp, Facebook, Instagram, dating and hook-up apps, can be used to do outreach and provide quality information on HIV prevention.

Support groups. Support groups are a gathering of people with like needs and who offer support to one another through sharing, discussion, and empathy. These small groups can be convened around a specific topic or subpopulation group (e.g., HIV-positive KPs or sex workers). They are another means of sharing information, engaging KPs in programmes, and ensuring consistency in HIV risk reduction and treatment, depending on the group. Appendix E provides a guide for support groups.

Content of Educational Interventions

The primary component of educational activities for prevention is comprehensive condom and lubricant programming. The WHO recommends the "correct and consistent use of condoms with condom-compatible lubricants" to prevent sexual transmission of HIV and STIs among KPs (WHO, 2016a) One of the most effective tools for preventing HIV transmission, it is essential that male and female condoms and lubricants are accessible, affordable, and available to KPs.

Demand generation. Male and female condoms are only valuable if KPs recognize their utility and want to use them to protect themselves. Behavioural interventions at the individual and community levels should be implemented to generate demand for condoms by emphasizing safe sexual practices and condom use.

Minimum prevention package of services

A person is reached once they have received at least three of the following services:

(1) Basic information about HIV modes of transmission
(2) Distribution of water-based lubricants and condoms
(3) A risk reduction discussion
(4) Referral information

Access and supply. Demand can only be maintained if condoms are readily accessible and of a high quality. Barriers to access among KPs should be researched and addressed so that KPs can easily get male and female condoms and lubricants. These products should be forecasted so that there are no gaps in supply. Condoms and lubricants should be available in places that KPs frequent. Condoms and lubricants should be available from multiple distribution points to meet the needs of a diverse population. The products should be of a quality that is desirable to KPs and affordable, if not free.

Peer education. KPs need education to know how to use condoms and lubricants, in addition to knowing where to get them. KPs deserve medically accurate information on the protection that condoms provide and the most effective ways to use them for both vaginal and anal sex. This can be achieved through condom demonstrations that offer correct information on their use and also help to destigmatize the use of condoms and lubricants.

Enabling environment for condom use. Programmes should attempt to address norms and attitudes affecting condom use and the legal environment that may impact condom and lubricant use, especially for adolescents and stigmatized KPs. Advocacy and media support for condom use can normalize the practice and further create demand.

Biomedical Interventions

Biomedical interventions directly affect the proximate determinants of HIV infection, the physical mechanisms through which HIV can be transmitted. They are clinical interventions that can either reduce an individual's risk for getting HIV through their overall health or risk reduction, or decrease the opportunity for transmission of HIV among those who are already infected by ensuring that they are on treatment and healthy.

HIV Testing and Counselling

Routine voluntary HIV testing and counselling (HTC) are an essential component of any HIV prevention programme. They give KPs the knowledge they need to make healthy decisions for themselves based on their HIV status. Pre- and post-test counselling provides an opportunity to share information and educate on risk reduction strategies and skills. In addition to clinic-based or provider-initiated HTC, community-based HTC or self-testing is recommended for KPs (WHO, 2016a). HIV-positive KPs should also be linked to community-based services, such as peer navigators or peer educators, to enhance their linkages to care. HTC should follow WHO's 5Cs principles, which are Consent, Confidentiality, Counselling, Correct results, and Connection (linkage to prevention, treatment, and care services) (WHO, 2015b). HIV-negative KPs should be referred to risk reduction services to ensure that they maintain their negative status.

Types of HIV testing service delivery methods

- Provider-initiated/clinical setting in a health facility
- Mobile outreach
- Home-based index
- Events
- Campaigns
- Workplaces/schools
- Partner

Minimum components of pre-test counselling required

- Benefits of HIV testing
- Meaning of an HIV-positive and an HIV-negative diagnosis
- Services available in the case of an HIV-positive diagnosis, including where antiretroviral therapy (ART) is provided.
- Potential for incorrect results if a person already on ART is tested.
- Brief description of prevention options and encouragement of partner testing.
- The test result and any information shared by the client are confidential.
- The client has the right to refuse to be tested and declining testing will not affect the client's access to HIV-related services or general medical care.
- Potential risks of testing to the client in settings where there are legal implications for those who test positive and/or for those whose sexual or other behaviour is stigmatized.
- Opportunity to ask the provider questions.

(WHO, 2015a)

HIV Treatment and Care

A strong linkage between HTC and enrolment in HIV care and treatment is essential for a robust continuum of care. KPs may need support to enrol in care because of their fear of stigma, fear of the treatment itself, or they may feel that they are in good health. There may also be economic constraints or health system factors that prevent KPs from seeking treatment that should be addressed by KP programmes. The primary component of HIV treatment is ART, which is described below.

Antiretroviral Therapy

The use of ART for KPs should follow the same standards and guidelines that apply to all adolescents and adults in Guyana. (See the Ministry of Public Health, *Guyana National Guidelines for Management of HIV-Infected HIV-Exposed Adults and Children January 2014/15 Revision*.) KPs should have the same level of access as other populations. Any discriminatory practices that may affect access should be addressed. KPs may face barriers to care and retention in treatment, such as stigma, high mobility, and difficulty accessing services, in general. Approaches should be implemented to improve access to services and retention in care. Programme activities should encourage adherence among KPs who are HIV-positive and on treatment.

STI Screening and Services

Screening, diagnosis, and treatment of STIs are an essential component of HIV prevention and care for KPs (WHO, 2016a). STIs contribute to overall health and have been linked to susceptibility of HIV infection and transmission. KPs should be screened for STIs using a screening questionnaire (for gonorrhoea and chlamydia) and rapid tests for syphilis and hepatitis B following national guidelines. KPs found needing confirmatory tests and further care should be referred for clinical treatment. STI screening and testing should be confidential and voluntary.

Human papilloma virus (HPV) vaccination is recommended for girls and boys ages 9 to 16 years. HPV is associated with negative long-term outcomes, such as oropharyngeal and penile cancers. MSM bear a significantly increased burden of HPV-related disease and adverse outcomes compared with heterosexual men.

Prevention and Management of Coinfections and Comorbidities

For those KPs who are HIV-positive, care and management of opportunistic infections and other associated health problems are essential to ensure the best outcomes. KPs should be given the same treatment and access to treatment as other populations.

TB prevention, screening, and treatment. As the leading cause of death among people who are HIV-positive, TB should be given special attention among those who are infected and those who are at risk for infection. TB prevention, screening, and treatment should follow national guidelines for all adults with HIV or at risk for HIV. Inasmuch as possible, TB screening and treatment should be integrated with HIV screening, care, and treatment.

Hepatitis B and C prevention, screening, and treatment. Screening, prevention, and treatment for hepatitis B and C should follow standard procedures with equal access for KPs. Special screening can be provided for hepatitis B, as discussed in the previous section.

Mental health. Mental health comorbidities need to be addressed and treated the same as other physical comorbidities. KPs with HIV and their caretakers, similar to other populations with HIV, can suffer from anxiety or depression. The detection and management of mental health problems should be integrated in HIV care to ensure that they are addressed and do not interfere with HIV treatment adherence. The Peer Educator manual is currently being edited to include mental health support. KPs can also be referred to social workers at health facilities who can assist with linking them to services.

Antiretroviral-Related Prevention

WHO recommends that oral **pre-exposure prophylaxis** (PrEP) be offered as an additional prevention choice for KPs at substantial risk for HIV infection as part of combination HIV prevention approaches (WHO, 2016a). PrEP is an evidence-based best practice to substantially reduce the risk for infection among people who are uninfected. It is not currently supported by the Government of Guyana HIV prevention guidelines, but it is recommended for inclusion in future KP prevention programmes. PrEP for serodiscordant couples, irrespective of sexual orientation, will soon be piloted by the MOPH.

Similarly, **post-exposure prophylaxis** (PEP) should be available to eligible KPs after potential exposure to HIV. A counsellor should work with the KPs who have potentially been exposed to see whether PEP is appropriate in that particular circumstance. National guidelines recommend PEP for occupational exposure and rape within 72 hours of the incident.

Voluntary Medical Male Circumcision

With compelling evidence that voluntary medical male circumcision (VMMC) reduces the risk for acquiring HIV from penile-vaginal sex, VMMC is a valuable component of HIV prevention interventions. VMMC is recommended for prevention among men and provides an opportunity to address male sexual health more broadly. It is appropriate for male KPs, many of whom engage in heterosexual relationships (NAPS & MEASURE Evaluation, 2014). Guyana does not have a policy on VMMC for HIV prevention.

Harm Reduction for Substance Abusers

Although injecting drug use is not common among KPs in Guyana, alcohol and drug abuse are prevalent (NAPS & MEASURE Evaluation, 2014). "All people from key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice" (WHO, 2016a). KPs should be made aware of the risks associated with substance abuse and how substances affect decision making and in relation to HIV risk reduction. Although substance abuse services are not free in Guyana, subsidized services are available at private facilities and can be referred to.

Referral Mechanisms

Active referral pathways should be established to link KPs with healthcare needs to the appropriate services. Active referral versus passive referral leads to effective pathways linking KPs to HIV care and treatment and to STI testing and treatment. Active referral is a facilitated process where the service provider calls or interacts with the facility being referred to in the presence of the client to establish the relationship and share information. Passive referral is simply giving the client the information to make the connection to the new facility or service him or herself. Referrals should be followed up to ensure proper linkages between beneficiaries and the services they need. (See Appendixes I and J.)

Practices to encourage linkages to treatment

- Providing integrated services, where HIV testing, prevention, treatment, and care are delivered in a single facility.
- Providing CD4 testing onsite with immediate results.
- Assisting with transportation to the treatment site if it is far from the testing site.
- Providing decentralized or community-based ART.
- Peer navigators or peer educators offering support to people on treatment or reaching those who are lost to follow up.
- Offering enhanced post-test counselling by peer educators or community health workers.
- Engaging clients with adherence messages using communication technologies, such as text messaging and social media.
- Providing services outside an office setting and engaging clients in strengths-based case management.
- Encouraging partner testing and linkage to care.

(WHO, 2015a)

Critical Enabler/Structural Interventions

The structural elements affecting HIV prevention are far-reaching and sometimes difficult to address. They require concerted efforts to ensure that the overall environment is conducive to effective HIV prevention for KPs.

Reform of Laws, Policies, and Practices

Using existing reviews of current laws, policies, and practices, reform should be the next step in improving the legal and structural environment for KPs. The criminalization of KP behaviours, HIV transmission, age restrictions for medical consent, and restrictive policies toward gender expression can impact access to HIV prevention and services. Not only should KP behaviours be decriminalized, but protective policies should be put in place to reduce barriers to essential health services. The revision of laws should be conducted by policymakers, government leaders, and stakeholders from KP groups. On November 13, 2018, the Caribbean Court of Justice—Guyana's final court—declared laws that criminalized cross-dressing unconstitutional, striking them down. Sections 351 to 353 of Guyana's Criminal Law Offences Act Chapter 8:01 makes offences of anal sex and attempts to have anal sex (regardless of the genders of the consenting parties) and sexual intimacy between men, specifically illegal. These laws also need to be reviewed, with a view to repealing them.

In addition to decriminalization, other important enablers that should be addressed are recognition of TG persons in the law, legal support and access to justice for KPs in the legal system, awareness of rights to health among KPs, and protection of the human rights of KPs. The NAPS continues to partner with civil society organizations in their advocacy efforts.

Reducing and Addressing Stigma and Discrimination

KPs face stigma and discrimination at greater rates than the general population (NAPS and MEASURE Evaluation, 2014), especially when it comes to discrimination in healthcare. This can be exacerbated by an HIV-positive status, leading to amplified stigma and discrimination at the individual and systems levels. Antidiscrimination and protective policies and laws should be promoted at all levels. This is particularly important in the healthcare and legal systems. The policies and laws should be derived from global human rights standards and focus on completely eliminating discrimination, stigma, and violence against KPs. In healthcare, in particular, services should be "KP-friendly," meaning that they are "available, accessible, and acceptable to key populations" (WHO, 2016a). This may mean scheduling special hours for KPs, training providers, locating services where KPs can easily reach them, and involving the KP community in health programme design and implementation. Health workers and uniformed officers who interact with KPs should be offered sexual orientation and gender identity training to better understand and interact with KPs.

The national programme is working with civil society organizations to help reduce and address stigma and discrimination. A Stigma and Discrimination Policy exists that outlines what is acceptable and not acceptable in the national programme. Implementing partners have done extensive training with healthcare workers and the police force to ensure fair and equitable treatment of KPs, among other activities to address stigma and discrimination.

Community Empowerment

Health outcomes for KPs are reduced when they are unaware of their HIV risk and the services that are available to them, and when they lack the power to determine their own health choices. KP groups should be engaged in decision making that affects them, whether HIV programming or structural issues, more broadly. This can include having KP-led organizations playing major roles in designing programmes, conducting research, and training staff, and liaising with the communities they represent. When KP-led organizations are not taking the lead, they should have meaningful engagement in decisions that affect their communities and services that are designed to support KPs. Partnerships with KP communities can help them mobilize and engage with broader structures and systems beyond healthcare. The NAPS works closely with civil society organizations to ensure that they are represented in the work that the government does. No decision or policies should be made about KPs without their involvement.

Violence Prevention

KPs, especially female and TG KPs, are subject to higher rates of physical and sexual violence compared with other populations (NAPS and MEASURE Evaluation, 2014). The health sector, and law enforcement and the judicial sectors should be engaged to prevent and treat violence committed against KPs. Processes should be in place to document and report instances of violence against KPs, and support systems should be in place to ensure justice for those who are mistreated from a human rights perspective. Creative solutions for prevention should be implemented that engage law enforcement, community leaders, and health workers, ensuring awareness of the services that are available for victims and how these personnel can support them. KPs should have access to the same services available to other victims, such as post-rape care.

PROGRAMME MANAGEMENT

The efficacy of the public health response is only possible with an efficient and well-structured HIV prevention programme management to support it. This involves multiple players, institutional structures, and policies that should be managed to support a national programme of HIV prevention for KPs.

Strategic Information

The foundation of quality public health interventions is adequate data and information to inform decision making and programme planning. A wide variety of strategic information is beneficial to inform KP HIV prevention programmes (see text box). Collection of these data should be done on a routine basis, whether part of regular M&E activities or special assessments outside the routine information system. Data collection and reporting should answer questions related to the curbing of the epidemic (see Figure 4). Some of the strategic information requirements for the KP prevention programme are described below.

Key Population Indicators

Standard national KP HIV prevention indicators are outlined in the Guyana National HIV M&E Plan 2015–2020 (MOPH, 2015). KP programmes should report on the indicators listed below to feed into national routine reporting. These indicators fail to recognize the importance of reporting on TG women separately from MSM, so these guidelines include "TG" in the definitions.

- Pv1 Number and percentage of persons among KPs who were reached with the minimum prevention package of services: MSM, FSWs, TG persons, miners, and loggers
- Pv2 Number and percentage of persons who received an HIV test in the past 12 months and know their results: MSM, FSWs, TG persons, miners, and loggers
- Pv3 Percentage of KPs with confirmed syphilis: MSM, TG persons, and FSWs

Key information required for decision making and planning/source of information required

KP size
- Population size estimation

HIV prevalence among key populations
- Serosurveillance

KP location/geographic distribution
- Mapping exercises

KP characteristics, risk behaviours, and health concerns
- Demographic surveys
- Behavioural surveys
- General health surveys

Important structural factors, barriers to implementing a response to HIV, and the needs of KPs
- Audit of current legislation, policy, and practices
- Consultation with community members, community-led organizations, and other stakeholders
- Behavioural surveys

Accessibility, coverage, quality, outcome, and impact of interventions
- Programmatic (administrative) data
- Disease notification registries
- Integrated biobehavioural surveys

(WHO, 2016b)

- Pv4 Percentage of sex workers reporting the use of a condom with their most recent client
- Pv5 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
- Imp5 HIV prevalence among key affected populations

For the complete definitions and information on how to collect these indicators, refer to the full indicator reference sheets in Appendix A.

In addition to these national-level indicators, individual programmes can have programme-specific indicators for their specific activities, whether input, process, output, or outcome indicators (described in more detail in the next section). Programmes may also need to respond to donor-specific indicators, depending on their funding mechanisms.

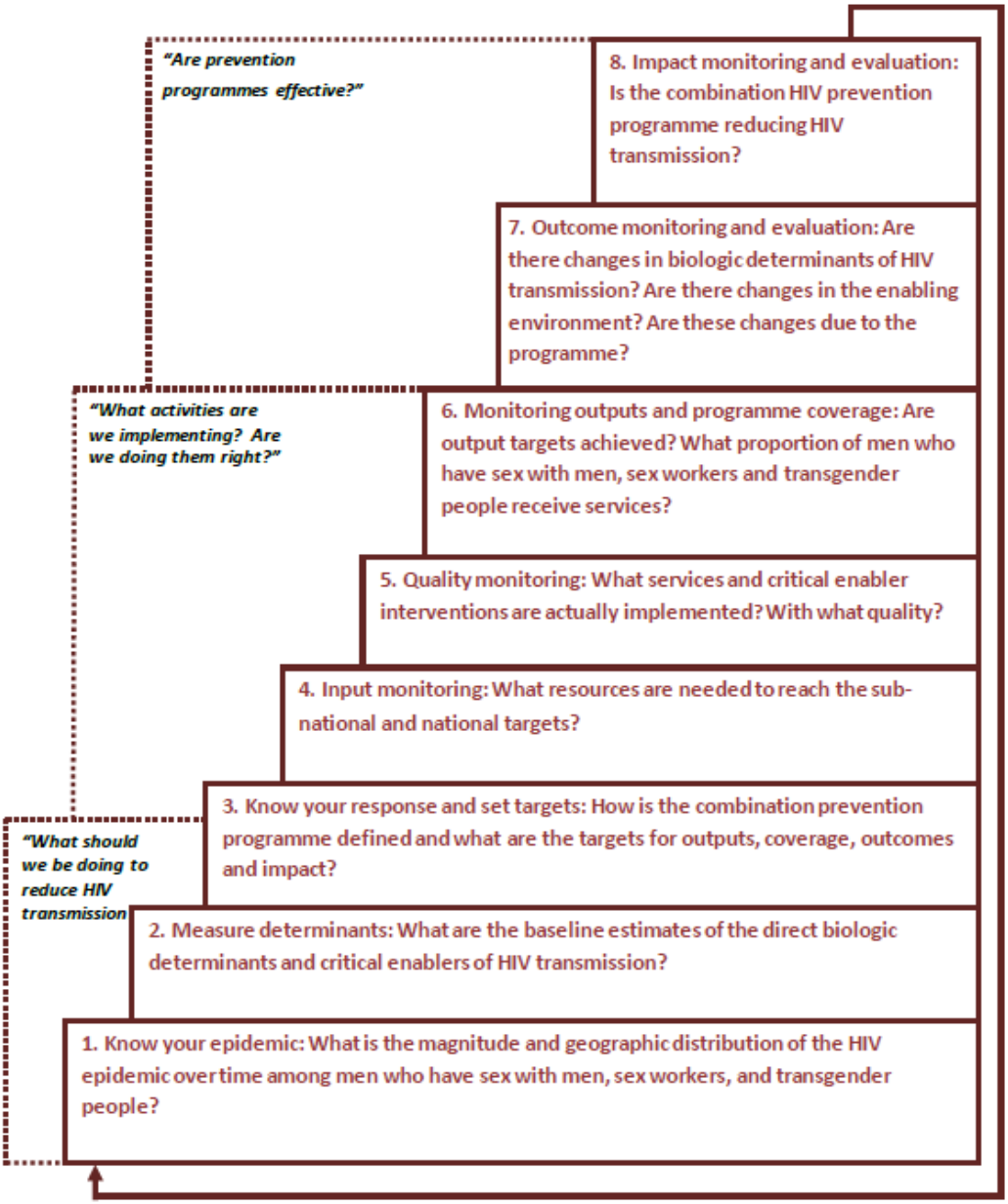
Routine Data Collection

The primary burden for routine data collection falls on the implementers of KP HIV prevention programmes. They provide inputs for programmes through their activities, and their activities should result in the associated outputs and outcomes. Their reporting can be aggregated at the national level for comprehensive reporting on KP prevention activities. Standard data collection tools can be found in the appendixes.

Routine data collection primarily falls into the categories of inputs, processes, and outputs. **Inputs** are the resources needed to complete activities, whether physical resources, human resources, or intangibles, such as data. Examples of inputs include supplies, equipment, training, and, at the national level, funding.

Process monitoring focuses on whether activities and interventions are completed and how they are completed. Examples of process monitoring are the number of KPs reached with services, the quality of services offered, and adherence of the activities to standards. **Outcome** and **impact** measurement does not often happen through routine data collection, but some outcome measures can be collected at the implementer level. These measurements seek to determine whether the programme is making a difference in the populations it is targeting. Outcomes are such things as changes in behaviour, and impact is the reduction of HIV among KPs. Such outcomes are better measured through nonroutine means, as described in the next section.

Figure 3. Public health questions model applied to the HIV epidemic among MSM, sex workers, clients, and TG persons



Source: UNFPA, 2013

Nonroutine Data Collection

Some data collection efforts fall outside the scope of the routine activities of HIV prevention implementers, but they are still essential to inform programmes and ensure that prevention activities meet stated goals. The following are examples of nonroutine data collection activities that should be included in national plans to ensure that adequate information is gathered to enhance programmatic decision making.

Mapping and size estimation of KPs: Mapping should be completed to show both the number and the location of KPs at the subnational level to guide where prevention activities should be focused. Previous mapping exercises in Guyana have shown both regional areas with large numbers of KPs and also specific spots where they can be reached with prevention activities. Mapping helps programmes efficiently target activities.

Size estimation goes hand-in-hand with mapping and can inform target setting at both national and subnational levels. It helps identify the resources needed to meet the population demands, estimate the burden of disease, and assess coverage of programmes. There are multiple methods for mapping and size estimation that should be evaluated for the best fit in Guyana. For example, Guyana has used the Priorities for Local AIDS Control Efforts (PLACE) method in several size estimation exercises, including the size estimation validation study in Region 4 (Reynolds, Rambarran, & Simpson, 2017).

Modes of transmission analysis: This UNAIDS tool uses HIV prevalence, size estimates for the at-risk population, and risk behaviour to estimate new HIV infections. It uses existing data and assumptions about HIV infectiousness and transmission probabilities to create the output. This model depends on existing quality data from other data sources.

Biobehavioural survey: A thorough biobehavioural survey can provide data on knowledge, attitudes, and behaviours of KPs, socioeconomic backgrounds of KPs, and prevalence data, if testing is included. When completed on a regular basis (every two to three years), it provides the opportunity to identify changes in behaviours and outcomes, if similar methods are applied from survey to survey.

Qualitative data collection and analysis: Although the data collection methods described above provide valuable quantitative data that show trends and help target activities, they rarely provide the "why" of KP knowledge, attitudes, and behaviours. Special qualitative data collection efforts can be applied to answer specific questions about KP knowledge, attitudes, and behaviours that affect HIV transmission and HIV prevention programmes.

Programme Planning

With quality data, programmes are able to design informed activities that specifically target the needs of KP groups at national and subnational levels. Activities and resources should be allocated based on the following criteria:

- Locations with high volumes of KPs
- Locations that lack any interventions
- Locations with high HIV prevalence and transmission
- Locations with high mobility
- Activities that have not reached the national targets of 90-90-90
- Methods and activities that access KPs where they can be easily reached (whether physical space or online)
- Methods and activities that are designed to meet the specific needs of KP subtypes
- Engage KPs in the planning and design of activities
- Address structural issues and not just behavioural issues
- Provide feedback on progress that can be adjusted based on new learning
- Use best practices and new technologies to address changing problems

To effectively address these criteria in programme planning, a solid management structure is needed. This is described in the following section.

Roles of Stakeholders

There are many stakeholders involved in KP prevention in Guyana; each stakeholder has a distinct role in the application of HIV prevention services. It is important for each entity to understand its role and the roles of other stakeholders to effectively work together to achieve national goals.

National AIDS Programme Secretariat

The NAPS in the MOPH is the leading government body for HIV prevention among KPs. As the primary entity responsible for the national HIV programme, it has special responsibilities. The NAPS is responsible for:

- Maintaining leadership in the direction of HIV prevention activities.
- Setting standards and guidelines for programmes to include quality standards.
- Managing relationships with external partners and donors, and coordinating among stakeholders.
- Monitoring reporting from implementing agencies across the country and providing the support structure for that reporting.
- Ensuring that programmes reach priority areas for KPs.
- Collating national indicators for reporting to the health management information system and donors.
- Supporting and ensuring nonroutine data collection, such as evaluations.
- Assuring the adequate provision of supplies and commodities for HIV prevention.
- Conducting quality assurance of HIV prevention programmes and their adherence to standards.

As a subunit in the MOPH, the NAPS is accountable to the Chief Medical Officer for the quality of its work. If KP communities feel that their needs are not being met by NAPS' programmes, concerns should be expressed to the NAPS, and they can then be elevated to the Chief Medical Officer level. Similarly, the NAPS is responsible for holding nongovernmental organizations (NGOs) accountable for the services that they are delegated by the government to provide to KPs. This is done through routine monitoring and responding to complaints. The NAPS is responsible for ensuring that KP clients know the mechanism by which they can submit complaints, and receive redress if their rights are abused or if they receive poor services from the NGOs serving the KPs. The NAPS should raise any significant issues with the KP Technical Working Group (TWG) (as discussed below).

Implementing Organizations

The implementing agencies that receive funding to provide direct HIV prevention services are at the frontline of programme implementation, under the guidance of the NAPS. They provide the following services:

- Outreach, peer navigation
- Commodity distribution
- Service delivery

- Crisis response advocacy
- Referral to services and monitoring quality
- Information on health and legal literacy

As new programmes and organizations are introduced into the Guyana KP landscape, organizations should collaborate with the NAPS to ensure that their activities fall in national goals and objectives.

KP implementing organizations are accountable to their funders and to the NAPS, as the coordinating body for KP prevention activities in Guyana. The implementing organizations are responsible for upholding the directives and the spirit of these guidelines. The NAPS is responsible for monitoring implementing organizations that report to it. Complaints about programme quality and content should be reported to the NAPS.

Key Population Technical Working Group

The NAPS should convene a KP TWG, bringing together representatives of all major players in the KP HIV prevention field. Participants should include representatives from NAPS' departments, other government entities involved in HIV or mobile populations, bilateral organizations, and implementing organizations, especially NGOs serving KPs. Convening a group with diverse experience and expertise will contribute to a comprehensive discussion of KP topics and activities. The role of the TWG should be the following:

- Be apprised of all major KP activities in the country.
- Contribute to and approve all national standards and guidelines produced by the NAPS.
- Review nonroutine data and reporting on KP HIV prevention.
- Share best practices and new research that can affect KP HIV prevention in Guyana.

The KP TWG should meet on a quarterly basis to ensure the timely sharing of information and preparation for upcoming activities.

Accountability

The NAPS is accountable for acting according to the goals and spirit of this document. Questions about the NAPS and other implementing partner activities should be brought to the KP TWG for investigation and recommendations for improvement.

Capacity Building

The strengthening of an organization's abilities to plan, execute, and manage KP HIV prevention activities is essential to effectively meet national goals for HIV prevention. Although Guyana has a robust community of organizations that work with KPs, as new organizations arise and as existing institutions seek to improve their capacity and sustainability, they require ongoing support. Whether organizations are KP-led or not, they need support to provide services to these unique populations. Although some of these activities need to be supported by the organizations themselves, others need outside assistance to ensure that national standards are met.

Capacity assessments and supportive supervision: To effectively strengthen the capacity of organizations, it is useful to assess their specific needs. A capacity assessment can identify the strengths and weaknesses of an organization and create an action plan to address the weaknesses. This goes hand-

in-hand with supportive supervision to ensure that the action plans are institutionalized and that changes are maintained. Supportive supervision can be provided by project managers or NAPS' programme staff, with a strong understanding of organizational needs and programme standards.

Training: An effective way to ensure that standards are adhered to is to implement national or organizational-level training activities that use standard curricula. Training topics can include peer education, monitoring systems, advocacy, and implementing the national guidelines. Training should be offered on a regular enough basis that new staff are oriented and programme consistency is maintained.

Institutional strengthening and mentorship: There are many management or organizational issues that need to be improved internally for an organization to successfully provide services to KPs. The issues can be governance, financial management and resource mobilization, goal and target setting, human resource management, monitoring systems, etc. Although these topics can be inward-focused, external mentors and organizational experts can be called on to assist new and fledgling organizations with these issues. Specifically, the NAPS KP Coordinator can be contacted for support (kpcnaps@gmail.com).

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APPENDIX A. INDICATOR REFERENCE SHEETS

Indicator Reference Sheet KP HIV Prevention
Programme Area: Key population (KP) HIV prevention
Name of Indicator: Pv1 Number and percentage of persons in key populations (KPs) who were reached with the minimum prevention package of services: MSM, FSW, TG, miners, and loggers
DESCRIPTION
Precise Definition(s): This indicator measures whether the target groups of key population members have been reached with prevention services. A person is reached once they have received at least three of the following services: i) Basic information about HIV modes of transmission ii) Distribution of water-based lubricants and condoms iii) A risk reduction discussion iv) Referral information The recipient should have received the service within the reporting period to be eligible for inclusion. Only those persons who fit to the categories of KPs measured should be included. They should fit to the standard national operational definitions of MSM, FSW, TG, miners, and loggers.
Numerator: The number of KPs who received the minimum package of prevention services. A person can be reached multiple times during the reporting period but is counted only once. A person reached in one reporting period can be counted as reached again in another period once they have received the prerequisite services.
Denominator: The estimated number of KPs in the catchment area.
Unit of Measure: Counts and percentage
Disaggregated by: KP population group (namely MSM, FSW, TG, miners, loggers), gender, age
Justification & Management Utility: As a key driver of the epidemic in Guyana KPs need to be reached for HIV prevention services for those who are HIV-negative, and appropriate testing and linking to care for those who are HIV-positive. It is a coverage indicator that helps programme managers identify successes in prevention, but also gaps in coverage where additional resources could be directed.
PLAN FOR DATA COLLECTION, COMPILATION, AND ANALYSIS
Data Sources/Method: This indicator should be measured using standard programme data collection tools. The main source of measurement is the *Prevention Log for Interventions Targeted to KPs* as outlined in the *Preventing HIV among Guyana's Key Populations: Guidelines*. If an individual client is offered HIV testing and counselling and one other prevention service, s/he should be included in the numerator or count for the indicator. The individual client's client code, KP group, and the partner that provided the service should be listed. The final list should be de-duplicated by the client codes to prevent double counting of clients. At the national level, data from the programme should be aggregated and once again de-duplicated by client code to prevent double counting between partners. To calculate the indicator as a percentage, the number of clients who have received the basic package of services should be divided by the population size estimates appropriate for the geographic region of the numerator data.
Frequency and Timing of Data Acquisition: This indicator should be collected routinely and reported to the programme managers and the National AIDS Programme Secretariat (NAPS) on a monthly basis based on the Government of Guyana fiscal year. The NAPS will aggregate the results for both monthly and semiannual reporting. The results will be stored in an Excel sheet for ease of analysis.

Individuals Responsible for Providing Data to the NAPS: Organizations implementing KP HIV prevention programmes are responsible for providing monthly data to the monitoring and evaluation (M&E) Unit at the NAPS. M&E staff complete the prevention Log for the nongovernmental organization (NGO) for each month. This is verified by the Advancing Partners and Communities (APC)/NAPS staff during data quality visits. A monthly narrative report is prepared by the Prevention Coordinator and submitted to the NAPS/respective funding agency.
Individuals Responsible for Providing Data to Donors: The NAPS M&E Unit will be responsible for reporting on this indicator to donors according to the reporting schedule of the individual donors.
Location of Data Storage: Electronic records will be stored on password-protected computers at the individual organizations providing the services and at the NAPS M&E Unit.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): The quality of the data for this indicator may be compromised in several ways. The first issue is the definitions of the KP groups and the difficulty of applying those definitions in an outreach setting (e.g., having clients self-identify as a KP). The second is the quality of the client code and the ability of clients to change their personal information for the client code leading to possible duplication of clients. The last is the potential for data entry error as the data are transferred from paper logs to Excel. Clients should only be reported in one KP category despite the sometimes fluid and changing nature of gender and sexual identify. These potential limitations may lead to over-reporting through duplication and slight errors through data entry. It is not expected that these issues will pose large barriers to effective reporting.
Actions Taken or Planned to Address Data Limitations: Actions to address potential data limitations include reinforcing the need for accurate client codes by clients to include the implementation of the updated client code (first initial, middle initial, last initial/sex/date of birth), relying on definitions of KPs through behavioural assessments rather than on assumptions for inclusion, and carrying out routine data quality assessments at the field and programme levels.
OTHER NOTES
Notes on Baselines/Targets: Baselines exist in prior reporting by the NAPS. Targets should be set in collaboration with donors and the NAPS.
Other Notes:

PERFORMANCE INDICATOR VALUES

Year	Target	Actual		Notes

THIS SHEET LAST UPDATED ON: 19 July, 2019

Indicator Reference Sheet KP HIV Testing
Programme Area: Key population HIV prevention
Name of Indicator: Pv2 Number and percentage of persons who have received an HIV test in the past 12 months and know their results: MSM, FSW, TG, miners, and loggers
DESCRIPTION
Precise Definition(s): This indicator measures whether the target groups of key population (KP) members have been tested for HIV in the past 12 months. Not only do clients need to be tested, they need to receive their results and know their status for inclusion in this indicator. The testing does not have to be completed by the programme collecting the data, but the programme should collect the date of testing and the confirmation that results were also received. Only those persons who fit in the categories of KPs measured should be included. They should fit in the standard national operational definitions of MSM, FSW, TG, miners, and loggers.
Numerator: The number of KPs who received an HIV test in the past 12 months before reporting.
Denominator: The estimated number of KPs in the catchment area.
Unit of Measure: Counts and percentage
Disaggregated by: KP population group (namely MSM, FSW, TG, miners, loggers), gender, age
Justification & Management Utility: To reach the national target of 90% of Guyanese knowing their status, this should include KPs who are at increased risk for acquiring HIV and being HIV-positive. Regular HIV testing is an essential component of HIV prevention among KPs, so that those who are HIV-negative can remain so and those who are HIV-positive can be linked to care. It is a coverage indicator that identifies successes in HIV testing coverage but also gaps in coverage where additional resources could be directed.
PLAN FOR DATA COLLECTION, COMPILATION, AND ANALYSIS
Data Sources/Method: This indicator should be measured using standard programme data collection tools, as available. The main source of measurement at the programme level is the *Client Intake Form,* as outlined in the *Preventing HIV among Guyana's Key Populations: Guidelines*. If an individual client reports having been tested in the previous 12 months and received the results on this form **OR** is tested by the implementing organization and received their results in the prior 12 months, they should be included in this indicator. The data collected for this indicator should be the individual's client code; the date of testing, if available; the KP group; and the partner that provided the service. The final list should be de-duplicated by the client codes to prevent double counting of clients. At the national level, data from the programme should be aggregated and once again de-duplicated by client code to prevent double counting between partners. To calculate the indicator as a percentage, the number of clients who have been tested and received their results in the past 12 months should be divided by the population size estimates appropriate for the geographic region of the numerator data.
Frequency and Timing of Data Acquisition: The data are aggregated monthly for the site summary report, which is submitted to the National VCT Coordinator. The NAPS will aggregate the results for both monthly and annual reporting. The results will be stored in an Excel sheet for ease of analysis.
Individuals Responsible for Providing Data to the NAPS: Organizations implementing KP HIV prevention programmes are responsible for providing monthly data to the monitoring and evaluation (M&E) Unit at the NAPS.
Individuals Responsible for Providing Data to Donors: The NAPS M&E Unit will be responsible for reporting on this indicator to donors according to the reporting schedule of the individual donors.
Location of Data Storage: Electronic records will be stored on password-protected computers at the individual organizations providing the services and at the NAPS M&E Unit.

DATA QUALITY ISSUES				
Known Data Limitations and Significance (if any): The quality of the data for this indicator may be compromised in several ways. The first issue is the definitions of the KP groups and the difficulty of applying those definitions in an outreach setting (e.g., having clients self-identify as a KP). The second is the quality of the client code and the ability of clients to change their personal information for the client code leading to possible duplication of clients. The last is the potential for data entry error as the data are transferred from paper logs to Excel. These potential limitations may lead to over-reporting through duplication and slight errors through data entry. It is not expected that these issues will pose large barriers to effective reporting.				
Actions Taken or Planned to Address Data Limitations: Actions to address potential data limitations include reinforcing the need for accurate client codes by clients, relying on definitions of KPs rather than on assumptions for inclusion, and carrying out routine data quality assessments at the field and programme levels.				
OTHER NOTES				
Notes on Baselines/Targets: Baselines exist in prior reporting by the NAPS. Targets should be set in collaboration with donors and the NAPS.				
Other Notes:				
PERFORMANCE INDICATOR VALUES				
Year	**Target**	**Actual**		**Notes**
THIS SHEET LAST UPDATED ON: 19 July, 2019				

Indicator Reference Sheet KP Syphilis
Programme Area: Key population HIV prevention
Name of Indicator: Pv3 Percentage of key populations with confirmed syphilis: MSM, TG, FSW
DESCRIPTION
Precise Definition(s): This indicator measures syphilis prevalence among key population (KP) groups. Only those persons who fit in the categories of KPs measured should be included. They should fit in the standard national operational definitions of MSM, FSW, and TG.
Numerator: The number of KPs who have a positive syphilis test.
Denominator: The number of KPs who have been tested for syphilis.
Unit of Measure: Percentage
Disaggregated by: KP population group (namely MSM, FSW, TG), gender, age
Justification & Management Utility: Other sexually transmitted infections, such as syphilis, have been associated with increased risk for HIV. KPs who have syphilis may indicate increased risk for HIV. Syphilis infection is also an indicator of high-risk sexual behavior, which is also a risk factor for HIV. Syphilis should be addressed in infected populations to prevent transmission and to prevent increased risk for HIV infection.
PLAN FOR DATA COLLECTION, COMPILATION, AND ANALYSIS
Data Sources/Method: This indicator should be measured through non-routine data collection, such as the Guyana Biobehavioural Surveillance Survey (BBSS), in which respondents are tested for syphilis. This is a more accurate measure than sexually transmitted infection self-reporting. For an accurate measure, the study should be a randomly-sampled, population-based, cross-sectional study.
Frequency and Timing of Data Acquisition: This indicator should be collected every three to five years through a biobehavioural survey.
Individuals Responsible for Providing Data to the NAPS: The organization responsible for collecting the data for a biobehavioural survey (if not the NAPS) is responsible for providing the data to the NAPS.
Individuals Responsible for Providing Data to Donors: The NAPS M&E Unit will be responsible for reporting on this indicator to donors, when available.
Location of Data Storage: Electronic records will be stored on password-protected computers at the organization collecting the data and at the NAPS M&E Unit.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): The quality of the data for this indicator is dependent on the quality of the study design and its implementation. If serology tests are completed according to national standards for syphilis testing, the testing results should have an adequate level of precision. It is important that study staff note any refusals to test because this may impact the syphilis prevalence rates if those who are already positive fail to retest.
Actions Taken or Planned to Address Data Limitations: The study design should follow best practices for population-based studies with random selection of participants. Refusals to participate should be recorded and reasons for refusals, if available.
OTHER NOTES
Notes on Baselines/Targets: Baselines exist in prior reporting by the NAPS in the BBSS. Targets should be set in collaboration with donors and the NAPS.
Other Notes:

PERFORMANCE INDICATOR VALUES				
Year	**Target**	**Actual**		**Notes**
THIS SHEET LAST UPDATED ON: 19 July, 2019				

Indicator Reference Sheet KP SW Condom Use
Programme Area: Key population HIV prevention
Name of Indicator: Pv4 Percentage of sex workers reporting the use of a condom with their most recent client
DESCRIPTION
Precise Definition(s): This indicator measures the use of a male or female condom during the last sexual encounter with a client among people engaged in sex work. A client is someone who gave cash or other goods in exchange for sex. Only those persons who fit in the category of sex worker should be included. They should fit in the standard national operational definitions of sex worker, which is a time-bound measure.
Numerator: The number of sex workers who used a condom at last sexual encounter with a client in the past 12 months.
Denominator: The total number of sex workers interviewed who had sex with a client in the past 12 months.
Unit of Measure: Percentage
Disaggregated by: Gender and age
Justification & Management Utility: As an effective means of HIV prevention, condom use in transactional sex is an important measure of prevention. Commercial sex workers have higher rates of HIV prevalence than the general population and are critical players in preventing transmission during high-risk activities. Programme managers can use these data to improve condom promotion, if necessary, and to teach sex workers about how to protect themselves and their clients.
PLAN FOR DATA COLLECTION, COMPILATION, AND ANALYSIS
Data Sources/Method: This indicator should be measured through non-routine data collection, such as the Guyana Biobehavioural Surveillance Survey (BBSS), in which respondents are asked about their sexual behaviour. For an accurate measure, the study should be a randomly-sampled, population-based, cross-sectional study. Ideally, sex workers would not need to self-identify, but could be categorized as sex workers based on their behaviour.
Frequency and Timing of Data Acquisition: This indicator should be collected every three to five years through a biobehavioural survey.
Individuals Responsible for Providing Data to the NAPS: The organization responsible for collecting the data for a biobehavioural survey (if not the NAPS) is responsible for providing the data to the NAPS.
Individuals Responsible for Providing Data to Donors: The NAPS M&E Unit will be responsible for reporting on this indicator to donors, when available.
Location of Data Storage: Electronic records will be stored on password-protected computers at the organization collecting the data and at the NAPS M&E Unit.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): The quality of the data for this indicator is dependent on the quality of the study design and its implementation. Questions about sexual behaviour can lead to respondent biases, such as under-reporting of stigmatized and illegal behaviour.
Actions Taken or Planned to Address Data Limitations: The study design should follow best practices for population-based studies with random selection of participants. Refusals to participate should be recorded and reasons for refusals, if available. Validated questions on sexual behaviour and sex work should be used to prevent bias inasmuch as possible.

OTHER NOTES				
Notes on Baselines/Targets: Baselines exist in prior reporting by the NAPS. Targets should be set in collaboration with donors and the NAPS.				
Other Notes:				
PERFORMANCE INDICATOR VALUES				
Year	**Target**	**Actual**		**Notes**
THIS SHEET LAST UPDATED ON: 19 July, 2019				

Indicator Reference Sheet KP MSM Condom Use
Programme Area: Key population HIV prevention
Name of Indicator: Pv5 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
DESCRIPTION
Precise Definition(s): This indicator measures the use of a male condom during the last anal sex encounter with a male partner among men. Only men should be included in this indicator and only those who have had anal sex with a man in the past six months.
Numerator: The number of men who used a condom at last anal sex with another man in the past six months.
Denominator: The total number of men who have had sex with men who were asked the question and had anal sex with a man in the past six months.
Unit of Measure: Percentage
Disaggregated by: Age
Justification & Management Utility: As an effective means of HIV prevention, condom use during anal sex is an important measure of prevention. Men who have sex with men (MSM) have higher rates of HIV prevalence than the general population and are critical players in preventing transmission during high-risk activities. Programme managers can use these data to improve condom promotion, if necessary, and to teach MSM about how to protect themselves and their partners.
PLAN FOR DATA COLLECTION, COMPILATION, AND ANALYSIS
Data Sources/Method: This indicator should be measured through non-routine data collection, such as the Guyana Biobehavioural Surveillance Survey (BBSS), in which respondents are asked about their sexual behaviour. For an accurate measure, the study should be a randomly-sampled, population-based, cross-sectional study. Ideally, MSM would not need to self-identify but could be categorized as MSM based on their behaviour.
Frequency and Timing of Data Acquisition: This indicator should be collected every three to five years through a biobehavioural survey.
Individuals Responsible for Providing Data to the NAPS: The organization responsible for collecting the data for a biobehavioural survey (if not the NAPS) is responsible for providing the data to the NAPS.
Individuals Responsible for Providing Data to Donors: The NAPS M&E Unit will be responsible for reporting on this indicator to donors, when available.
Location of Data Storage: Electronic records will be stored on password-protected computers at the organization collecting the data and at the NAPS M&E Unit.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): The quality of the data for this indicator is dependent on the quality of the study design and its implementation. Questions about sexual behaviour can lead to respondent biases, such as under-reporting of stigmatized and illegal behaviour.
Actions Taken or Planned to Address Data Limitations: The study design should follow best practices for population-based studies with random selection of participants. Refusals to participate should be recorded and reasons for refusals, if available. Validated questions on sexual behaviour and same-sex encounters should be used to prevent bias inasmuch as possible.
OTHER NOTES
Notes on Baselines/Targets: Baselines exist in prior reporting by the NAPS. Targets should be set in collaboration with donors and the NAPS.

Other Notes:				
PERFORMANCE INDICATOR VALUES				
Year	**Target**	**Actual**		**Notes**
THIS SHEET LAST UPDATED ON: 19 July, 2019				

Indicator Reference Sheet KP HIV Prevalence
Programme Area: Key population HIV prevention
Name of Indicator: Imp5 HIV prevalence among key affected populations
DESCRIPTION
Precise Definition(s): This indicator measures prevalence of HIV infection among men who have sex with men (MSM), female sex workers, transgender persons (TG), miners, and loggers
Numerator: The number of MSM, FSW, TG, or miners and loggers who test positive for HIV.
Denominator: The number of MSM, FSW, TG, or miners and loggers who were tested for HIV.
Unit of Measure: Percentage
Disaggregated by: Population type, age, and gender
Justification & Management Utility: MSM typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. FSWs typically have higher HIV prevalence than the general population. Reducing prevalence among these groups is important to the national programme because it measures progress of the response.
PLAN FOR DATA COLLECTION, COMPILATION, AND ANALYSIS
Data Sources/Method: This indicator should be measured through non-routine data collection, such as the Guyana Biobehavioural Surveillance Survey (BBSS), in which respondents complete serological tests of disease infection. For an accurate measure, the study should be a randomly-sampled, population-based, cross-sectional study. Ideally, key population (KP) members would not need to self-identify but could be categorized as KP based on their behaviour.
Frequency and Timing of Data Acquisition: This indicator should be collected every three to five years through a biobehavioural survey.
Individuals Responsible for Providing Data to the NAPS: The organization responsible for collecting the data for a biobehavioural survey (if not the NAPS) is responsible for providing the data to the NAPS.
Individuals Responsible for Providing Data to Donors: The NAPS M&E Unit will be responsible for reporting on this indicator to donors, when available.
Location of Data Storage: Electronic records will be stored on password-protected computers at the organization collecting the data and at the NAPS M&E Unit.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): The quality of the data for this indicator is dependent on the quality of the study design and its implementation. If serology tests are completed according to national standards for HIV testing, the testing results should have an adequate level of precision. It is important that study staff note any refusals to test because this may impact the HIV prevalence rates if those who are already positive fail to retest.
Actions Taken or Planned to Address Data Limitations: The study design should follow best practices for population-based studies with random selection of participants. Refusals to participate should be recorded and reasons for refusals, if available.
OTHER NOTES
Notes on Baselines/Targets: Baselines exist in prior reporting by the NAPS. Targets should be set in collaboration with donors and the NAPS.
Other Notes:

PERFORMANCE INDICATOR VALUES				
Year	**Target**	**Actual**		**Notes**
THIS SHEET LAST UPDATED ON: 19 July, 2019				

APPENDIX B. PEER EDUCATOR TRAINING GUIDE

Peer Education Training Requirements

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., sex workers (SWs), men who have sex with men (MSM), transgender, loggers, miners). Peer educators should be trained for a minimum of five days or 40 hours using a peer education manual that meets national standards, such as "Keep the Light On" or "Path for Life." (See the manuals referred to at the end of this appendix.)

Content of Peer Educator Training

The content of the training MUST include the following topics:

Definitions of key populations	Voluntary counselling and testing
Sexual orientation and gender identity	Referral processes
What is HIV and AIDS	Stigma and discrimination for key populations
Modes of HIV transmission	Reproductive health and family planning
Determinants of HIV risk	Alcohol and substance abuse
Sexually transmitted infections (STIs) and their symptoms	Mental health
Common health problems for MSM and SWs	Gender-based violence
Correct condom and lubricant use and negotiation	Legal rights and services

Certification of peer educators

- All peer educators should have at least 40 hours of training using the respective manual. (See the recommended manuals at the end of this appendix.)
- All peer educators should complete the recommended training (in-house or at the NAPS) and receive certification before conducting outreach activities.
- All peer educators should be observed by the peer education supervisor and peers alike, and should demonstrate the quality of communication skills required. See Peer Educator Assessment Form, Appendix D.
- Participation in seventy-five percent of scheduled group meetings and activities.
- A period of evaluation (for at least three months after the training) of their abilities as peer educators before they are officially certified.
- All peer educators should complete 20 hours of practice sessions and observation before certification as a peer educator.

After this initial evaluation phase, the supervisor should accompany and observe the peer educators bimonthly (six 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.

Recruitment of Peer Educator Trainees

Peer educators can be recruited from among the target population, with recommendations from gatekeepers and workshop facilitators. Individual institutions are responsible for recruitment.

Qualities to Look for in People You Hope to Train as Peer Educators

- Strongly motivated to work toward HIV risk reduction
- Demonstrate respect, care, compassion, tolerance, and sensitivity toward persons living with HIV and AIDS
- Representative of the target community
- Self-confident and show potential for leadership
- Demonstrate that they have the time and energy to devote to 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

Selection Criteria for Peer Educators

Once a peer educator trainee has received training, only those who reflect the criteria below should be selected to fulfil the role of peer educator:

- Ability to read and write proficiently and communicate effectively with his or her peers
- Ability to accurately complete required reporting formats
- Committed to the time requirements of outreach activities
- 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 behaviours

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 three days. At the end of the training, peer educators must submit an implementation plan to the nongovernmental organizations.

All initial trainings should be done by the MOPH/NAPS and technical partners. All refresher training and updating of peer educators' skills should be done by the respective nongovernmental organizations.

Resources:

Keep the Light On Training
National AIDS Programme Secretariat

Path for Life Training
National AIDS Programme Secretariat

Enhanced Peer Outreach Approach (EPOA) Training Curriculum for Peer Outreach Workers
LINKAGES Project, FHI 360
Three-day training curriculum
https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-enhanced-peer-outreach-training.pdf

Sex Positive Model for HIV Prevention & Promotion of Sexual Health
Caribbean Vulnerable Communities Coalition
Thirteen-day training curriculum
http://www.cvccoalition.org/content/sex-positive-model-hiv-prevention-promotion-sexual-health

APPENDIX C. PEER EDUCATOR'S CODE OF CONDUCT

Peer Educator's Code of Conduct

Each peer educator is an integral part of the prevention programme of NAME OF NONGOVERNMENTAL ORGANIZATION (NGO) and its mission. As a result, the NGO expects all staff to respect the rights and feelings of people participating in the NGOs' programmes and to exhibit a high degree of personal integrity and professionalism.

The following list sets forth the code of conduct for peer educators:

☐ I maintain the confidentiality of the individuals served.

☐ I work for the agreed on hours per day for the programme.

☐ I do not entertain customers while working for the programme.

☐ I do not develop sexual relationships with individuals served by the programme.

☐ I am not intoxicated or under the influence of drugs while working for the programme, and I do not carry any alcohol or drugs with me while working for the programme.

☐ I do not get involved with fights because of drunkenness or drugs or any other reason at any time, whether working for the programme or not.

☐ I respect the opinions of others and abide by programme 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 to, 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 programme 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 D. PEER OUTREACH TRAINING PRACTICAL AND ASSESSMENT FORM

Assessment Criteria for Peer Educators Engaging in HIV Outreach

Assessment Area	Criteria	Evidence
Introduction	Peer educator adequately introduces self and programme objectives	Did the peer educator share his/her name and organisation they are working for? Did they share the programme objectives (namely, to prevent HIV through education on risk and risk behaviour and to encourage the adoption of healthy sexual practices through regular and consistent condom use, reduction of alcohol and mind-altering drugs, reduction of multiple partners and to screen and assess the client for exposure to gender-based violence and sexually transmitted infections [STIs] risk)?
	Peer educator inquires whether client has ever received HIV prevention before	Did the peer educator inquire whether the client had ever been reached with HIV education before, and, if "yes," asked by which organisation and date?
Client Engagement	Client participates fully in discussion	Was the client asking questions? What type of questions? Why? Were there signs of an interest in the discussion?
	Client appears comfortable	What was the body language of the client? Was the client comfortable? Resentful?
Use of Reproductive Models	Condom demonstration done correctly	Did the peer educator check the expiry date on the package? Did s/he squeeze gently to make sure air is in the package? Did s/he indicate to the client how to open the package, rolling the condom to the side, and ripping along the rough edges? Did s/he explain the reason why the tip must be squeezed before rolling it on the penis? Did the peer educator explain how to take off a condom correctly? Was correct disposal of condom highlighted?
	Peer educator adequately explained reasons for using male/female condoms	Apart from protection from HIV, did the peer educator mention that condoms also provide protection against most STIs and also prevent unwanted pregnancy?
Technical Competence	Peer educator correctly communicates HIV prevention/risk behaviours	What is HIV/AIDS? How is HIV transmitted? Behaviours that increase the risk for infection (substance use/multiple partners/unprotected sex) and positive preventative behaviour and HIV preventative materials (condoms/lubes).
	Probing questions were asked to assess risk exposure	Did the peer educator ask for more information from participants to understand their clients' exposure?
	Peer educator has a mastery of technical content	Was the peer educator able to respond to questions about the technical content? Were

Assessment Area	Criteria	Evidence
		they able to provide referrals for content that they cannot respond to?
Decorum/Deportment	Peer educator dressed in a manner reflective of the work he/she is doing	Outreach uniform/badge (if available) or T-shirt with NGO emblem OR clothing that is appropriate for conducting such activities
	Peer educator was on time at the location	Was the peer educator there 10 minutes before the start of the outreach activity?
Flexibility	Peer educator was able to adapt information based on the client's knowledge	Did the peer educator communicate efficiently so that the client can understand, adjusting to the client's literacy level?
Job Preparedness	Peer educator was adequately prepared for field outreach	Was there an outreach tool kit with necessary tools: behaviour change communication materials, condoms, referral slips, peer education diary, models, etc.?
Communication Skills	The content was delivered adequately to the client	Was the client fully engaged in the discussion and did s/he demonstrate comprehension?
	Peer educator was an active listener	Did the peer educator give the client a chance to ask questions/make comments and did s/he respond to questions adequately?

Peer Educator Assessment Form

Date of Assessment: _____ Name of Peer Educator Assessed: _____

Name & Designation of Assessing Officer: _____

Assessment Area	Assessment Score					Observations Success and Challenges	Recommendations	Timeline
	1	2	3	4	5			
Introduction								
Client Engagement								
Use of Reproductive Models								
Technical Competence								
Decorum/ Deportment								
Flexibility								
Job Preparedness								
Communication Skills								
TOTAL SCORE								

Summary

Very good (31-40)		Other Comments
Good (21-30)		
Poor (11-20)		
Very poor (0-10)		

APPENDIX E. SUPPORT GROUP GUIDE

Support Group Guide

A support group is a gathering of people with a similar concern or life situation that enables them to talk about their issues without judgement, stigma, or blame for their situation. Key population-specific support groups enable people in the categories of men who have sex with men (MSM), sex workers, and transgender persons to come together to discuss their similar circumstances. The objectives of support groups are to provide an opportunity for key population members to:

- Receive factual information and support to increase awareness of risk and increase risk reduction behaviours, and/or
- Offer emotional, moral, and psychosocial support to each other and to exchange information.

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

Support groups are generally not guided by a pre-established curriculum and do not have specific behavioural outcomes associated with them. Support groups generally have "open" membership and do not usually have a specified end date. Each person is encouraged to participate to whatever extent s/he feels comfortable.

Types of Support Groups:

Educational Support Group: Facilitated by a peer educator with the aim of providing education on HIV and HIV risk reduction. This type of group is not meant to be long-term; rather, it is designed to offer a specific number of sessions to provide a set curricula. However, the number of sessions may vary depending on the needs of the group.

Psychosocial Support Group: Facilitated by a peer educator with the assistance of a social worker with the aim of providing a forum for emotional, moral, and psychosocial support for high-risk negative and/or HIV-positive key population members. 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 an unlimited number of sessions based on the needs of the members. These groups are guided by the following rules:

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.
- People are there to share their own feelings and experiences; they should try not to give advice.
- Each participant should share responsibility for making the group work.
- Participants 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 participants 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 participants are entitled to their own points 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 is everyone's responsibility to make the support group a safe place to share.

DON'T's

- It's okay not to share. Participants 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.

Guide to Support Group Planning and Member Mobilization

- Make a plan to recruit support group members. How will you let people know about the support group? Members can recruit peers, other nongovernmental organizations can refer, etc.
- Decide on the location of the support group meetings. The location must offer some privacy and 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) participants at a meeting. If the membership is larger than ten, it is expected that two (2) meetings will be held. Individuals can choose to attend one of the two.
- Education support groups: A minimum of once per week is recommended with a maximum of twenty (20) people 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 among the peer educators.
- Record attendance at the support group.

APPENDIX F. PEER EDUCATOR'S DIARY

NATIONAL AIDS PROGRAMME SECRETARIAT

Funding Agency (Please Tick): GLOBAL FUND [ ] APC [ ] OTHER [ ] _____

Name of organization:

PEER EDUCATOR DIARY MSM [ ] FSW [ ] OUTREACH

Name of Peer Ed: _____
Date: _____
Location: _____
Client Code(s): _____

Outreach Topic: _____

Life Skills Topic: _____

Risk Reduction Topic: _____

Persons Reached									
MSM		Transgender		FSW		Clients		Other Persons	
New	Old	New	Old	New	Old	New	Old	New	Old

Condom Distribution									
MSM		Transgender		FSW		Clients		Other Persons	
M	F	M	F	M	F	M	F	M	F

Lubricant Distribution				
MSM	Transgender	FSW	Clients	Other Persons
# of tubes	# of tubes	# of tubes	# of tubes	# of tubes

Number of BCC Materials Distributed: [ ]

Number of GBV Materials Distributed: [ ]

Services Covered in Outreach: (Please Tick)			
Risk Reduction		HIV Information	
Condoms Dist.		Referrals	
GBV Awareness			

Referrals: (Please Tick)			
STI Referral		HTC Referral	
C&T Referral		Other Specify: _____	

PEER EDUCATOR DIARY MSM [ ] FSW [ ] OUTREACH

Name of Peer Ed: _____
Date: _____
Location: _____
Client Code(s): _____

Outreach Topic: _____

Life Skills Topic: _____

Risk Reduction Topic: _____

Persons Reached									
MSM		Transgender		FSW		Clients		Other Persons	
New	Old	New	Old	New	Old	New	Old	New	Old

Condom Distribution									
MSM		Transgender		FSW		Clients		Other Persons	
M	F	M	F	M	F	M	F	M	F

Lubricant Distribution				
MSM	Transgender	FSW	Clients	Other Persons
# of tubes	# of tubes	# of tubes	# of tubes	# of tubes

Number of BCC Materials Distributed: [ ]

Number of GBV Materials Distributed: [ ]

Services Covered in Outreach: (Please Tick)			
Risk Reduction		HIV Information	
Condoms Dist.		Referrals	
GBV Awareness			

Referrals: (Please Tick)			
STI Referral		HTC Referral	
C&T Referral		Other Specify: _____	

NATIONAL AIDS PROGRAMME SECRETARIAT

Funding Agency (Please Tick): GLOBAL FUND [ ] APC [ ] OTHER[ ]_____

Name of organization:

PEER EDUCATOR DIARY -FSW/MSM OUTREACH
Client Code(s): Reached With GBV Services
Comments:

Client Code(s): Reached With GBV Services
Comments:

APPENDIX G. KP RISK ASSESSMENT TOOL AND SUPPLEMENT

HIV-STI RISK ASSESSMENT FORM

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. It is important to answer as honestly and accurately as possible. Your responses will remain confidential.

Client Code:	Date of Assessment:	Age:	Contact Information:

HIV Testing				
Question 1:				
Have you ever done an HIV test?	☐ Yes ☐ No			*If Yes, go to Question 2 If No, go to Question 5*
Question 2:				
When was your last HIV test?	☐ Less than 3 month	☐ 3-6 month	☐ More than 6 months	*For any response go to Question 3*
Question 3 :				
What was the result of your most recent HIV test?	☐ HIV +	☐ HIV -	☐ Don't Know	*If HIV +, go to Question 4. If HIV - / Don't know , go to Question 5*
Question 4:				
Have you seen a doctor for HIV care and treatment since your diagnosis?	☐ Yes	☐ No	☐ Don't Know	*If No, refer/case navigate to HTC Officer or Social Worker*

Signs and Symptoms				
Question 5: To the best of your knowledge, within the last 6 months have you experience or noticed any of the following?				
Discharge, odour or burning on urination	☐ Yes	☐ No	☐ Don't Know	*If Yes/Don't Know, to any questions refer/case navigate to HTC Officer/Supervisor or Social Worker*
Sores on your mouth, genitals or anus	☐ Yes	☐ No	☐ Don't Know	
Growth or constant itching in the genital area or anus	☐ Yes	☐ No	☐ Don't Know	

Sexual Risks and Behaviour				
Question 6:				
Have you had unprotected oral, vaginal or anal sex in the last six months?	( ) Yes	( ) No	( ) Don't Know	*If Yes or Don't Know, talk about "risk reduction" and refer to HTC Office/Supervisor or Social Worker*
Question 7 :				
Have you had sex with more than one partner in the last six months?	( ) Yes	( ) No	( ) Don't Know	
Question 8:				
Have any of your sex partners in the past 12 months had sex with other partners while they were still in a sexual relationship with you?	( ) Yes	( ) No	( ) Don't Know	
Question 8:				
Select all of the following persons that you have had or currently have sexual intercourse with	Men Only ☐ Women Only ☐ Both Men & Women ☐ Trans Women ☐ Other ☐.....(please specify)			
Question 9:				
Which do you most identify with?	Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Queer ☐ Straight ☐			

Guidance for Conducting HIV-STI Risk Assessment

From the initial encounter, obtain a sexual history as part of the initial information gathering session. It may need to be conducted repeatedly for clients in care. It is generally easier to conduct the risk assessment after rapport has been established.

Without coercion, try to identify the client's sex partners for referral to screening and treatment as well. Reinforce the importance of partner treatment and condom use to prevent reinfection.

Remember signs and symptoms may differ for males and females.

Screening for sexually transmitted infections (STI) is important because STIs increases the risk of contracting and transmitting HIV.

Steps to follow when conducting STI risk assessments:

1. Always conduct STI risk assessment on a 1:1 basis in private; it is not appropriate for group settings.
2. Keep information shared confidential, with limited identifying information so that confidentiality is assured.
3. Explain the purpose of the assessment to the client.
4. Inform the client that s/he has the right to choose not to answer any question.
5. Invite the client to ask questions.
6. Check your judgments at the door, judgments stigmatise and prevent honest answers from clients.
7. Link client to HTC or STI diagnosis and treatment as needed through bidirectional referrals to service providers identified by your organisation in its referral network directory.
8. Repeat the assessment quarterly for clients at higher risk.

HIV-STI Risk Assessment Form Supplement

Substance Abuse Screening			
Question 10:			
Have you consumed alcohol or used drugs other than those required for medical reasons in the past 6 months?	☐ Yes	☐ No	If Yes, go to question 11 If No, skip to question 15
Question 11:			
Have you ever felt you should cut down on your drinking or drug use?	☐ Yes	☐ No	
Question 12:			
Have people annoyed you by criticizing your drinking or drug use?	☐ Yes	☐ No	
Question 13:			
Have you ever felt bad or guilty about your drinking or drug use?	☐ Yes	☐ No	
Question 14:			
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐ Yes	☐ No	
If respondent replies "yes" to 2 or more of the last 4 questions, they should be referred for substance abuse support.			

Mental Health Screening			
Question 15:			
Are you **worrying** more than usual?	☐ Yes	☐ No	
Question 16:			
Have you been **anxious** (nervous) lately?	☐ Yes	☐ No	
Question 17:			
Have you had trouble **sleeping**?	☐ Yes	☐ No	
Question 18:			
Are you **tense** or irritable?	☐ Yes	☐ No	
If respondent replies "yes" to 2 or more of the last 4 questions, they should be referred for further anxiety screening support.			
Question 19:			
During the last month, have you been feeling down, depressed, or hopeless?	☐ Yes	☐ No	
Question 20:			
During the past month, have you been having little interest in things you used to like,	☐ Yes	☐ No	

find little pleasure in things you used to enjoy?			
Question 21:			
Are you eating a lot more or have no appetite?	☐ Yes	☐ No	
Question 22:			
Have you been jumpy or restless, or do you feel slowed down?	☐ Yes	☐ No	
Question 23:			
Have you had a drop in your sexual interest or energy?	☐ Yes	☐ No	
If respondent replies "yes" to 2 or more of the last 5 questions, they should be referred for further depression screening and support.			

Violence Screening			
Question 24:			
In the past year, has anyone punched, slapped, kicked, bit you, or caused you any type of physical harm? ("Anyone" can include your partner, a family member, friend, neighbour, a client, stranger, supervisor, colleague, police officer, or other persons.)	☐ Yes	☐ No	☐ No response
Question 25:			
In the past year, has anyone insulted you, ignored you, yelled at you, or made you feel ashamed or bad about yourself?	☐ Yes	☐ No	☐ No response
Question 26:			
In the past year, has anyone forced you to have sex or perform any sexual act, or touched you sexually in any way that you did not want?	☐ Yes	☐ No	☐ No response
Question 27:			
In the past year, has anyone made you feel afraid, unsafe, or in danger?	☐ Yes	☐ No	☐ No response
If respondent replies "yes" to any of the last 4 questions, conduct the full Gender-Based Violence Screening Tool.			

Prevention Log for Interventions with Targeted Populations

	NAME OF PLACE VISITED	DATE	MSM			FSWs			Transgender			Other			Summary			Referrals			
		dd/mm/yyyy	N	O	Total	N	O	Total	N	O	Total	N	O	Total	N	O	Total	STI	HTC	C&T	Other
1					0			0			0			0	0	0	0				
2					0			0			0			0	0	0	0				
3					0			0			0			0	0	0	0				
4					0			0			0			0	0	0	0				
5					0			0			0			0	0	0	0				
6					0			0			0			0	0	0	0				
7					0			0			0			0	0	0	0				
8					0			0			0			0	0	0	0				
9					0			0			0			0	0	0	0				
10					0			0			0			0	0	0	0				
11					0			0			0			0	0	0	0				
12					0			0			0			0	0	0	0				
13					0			0			0			0	0	0	0				
14					0			0			0			0	0	0	0				
15					0			0			0			0	0	0	0				
16					0			0			0			0	0	0	0				
17					0			0			0			0	0	0	0				
18					0			0			0			0	0	0	0				
19					0			0			0			0	0	0	0				
20					0			0			0			0	0	0	0				
21					0			0			0			0	0	0	0				
22					0			0			0			0	0	0	0				
23					0			0			0			0	0	0	0				
24					0			0			0			0	0	0	0				
25					0			0			0			0	0	0	0				
	Totals		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

APPENDIX H. PREVENTION LOG FOR INTERVENTIONS TARGETED TO KPS

[INSERT MONTH AND YEAR HERE]

[INSERT NAME OF ORGANIZATION HERE]

Prevention Log for Interventions Targeted to KAPs

	NAME OF PLACE VISITED	DATE dd/mm/yy	Number of BCC materials Distributed					Number of Male Condoms Distributed					Number of Female Condoms Distributed					Funding Agency		
			Miners	Loggers	Adj Pop	FSWs	MSM	Miners	Loggers	Adj Pop	FSWs	MSM	Miners	Loggers	Adj Pop	FSWs	MSM	Global Fur	APC	Other
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
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16																				
17																				
18																				
19																				
20																				
21																				
22																				
23																				
24																				
25																				
	Totals		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	TOTAL
Total Number of BCC Materials Distributed	0
Total Number of MALE Condoms Distributed	0
Total Number of FEMALE Condoms Distributed	0

APPENDIX I. MINISTRY OF HEALTH REFERRAL FORM

MINISTRY OF HEALTH REFERRAL FORM

Referred by	
Referred to	
Address of facility referred to	
Date referred (day/month/year)	
Client code (initials, date of birth, gender)	☐☐ ☐ ☐☐/☐☐/☐☐☐☐ Initials gender day / month / year

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:

☐ ART	☐ Social and peer support
☐ Home based and palliative care	☐ Legal support
☐ Family members are aware of client's status ☐ Yes ☐ No	☐ Welfare assistance
☐ Medical management	☐ Psychological support
☐ HIV testing	☐ Orphan support
☐ Reproductive/family planning service	☐ Other (please specify service required)
☐ Prevention of mother-to-child transmission service	

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

✂ -

Please cut off this section and store it carefully until it is collected by the health facility/organisation that referred this client.

Date referred:	Referred by:	
Client code (initials, date of birth, gender):		
Service(s) client referred for:		
Referral results	☐ Person never came to referral site ☐ Person came to referral site and does not need to return ☐ Person came to referral site and needs to return ☐ Person came and was referred elsewhere	Date seen:

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

APPENDIX J. REFERRAL LOG

Appendix X Referral Tracking Register

Date Referral Made	Client Code: Initials	Client Code: DOB (dd/mm/yyyy)	Gender	Referred by	Name of Referring Officer	Services referred for: (use codes below)	Referred to	Referral results	Date seen, if seen	Comments/Follow-up action

ART	1	FP/RH service	5	Welfare assistance	9
Home based and palliative care	2	PMTCT	6	Psychological support	10
Medical management	3	Social and peer support	7	Orphan support	11
HIV testing	4	Legal support	8	Other	12

APPENDIX K. REFERRAL SERVICE DELIVERY DIRECTORY

Please refer to the Advancing Partners and Communities *NGO Resource Directory*. For access, please email achievingzero@apcguyana.com.

APPENDIX L. VCT INTAKE FORM

CLIENT INTAKE/TEST RECORD

SOCIO - DEMOGRAPHIC AND IDENTIFICATION INFORMATION					
Name of Site	**Region**	**Site type** *Circle one* 1 = Health Center 2 = Mobile Facility 3 = Hospital 4 = NGO 96 = Other	**Management Authority** *Circle one* 1 = NGO 2 = Government 3 = Private	**Date of Visit** *(dd/mm/yyyy)*	**Return Visit** *Circle one* 0 = No 1 = Yes

Age in years	**Gender Identity** *Circle one* 1 = Male 2 = Female 3 = Trans-gender Male 4 = Trans-gender Female	**Ethnicity** *Ask client & circle answer given* 1 = Indo-Guyanese 2 = Afro-Guyanese 3 = Amerindian 4 = Portuguese 5 = Chinese 6 = Mixed Race 96 = Other	**Nationality** *Ask client & circle answer given* 0 = Guyanese 1 = Venezuelans 2 = Brazilian 3 = Surinamese 4 = Chinese If ***other*** please state _____	**Name of Village/ Community** *Ask client & record answer given* _____ _____	**Client Code** *(FI/MI/LI/Sex/D.O.B:dd/mm/yyyy)* **Counselor Code** **Partner code** (if Applicable)

SCREENING SESSION - (To be completed by provider)					
Session type *Circle one* 1 = Individual 2 = Couple 3 = Group 96 = Other	**Partner status** *Circle one* 1 = No partner 2 = Unmarried, several partners 3 = Steady partner 4 = Living Home 5 = Married, monogamous 6 = Separated / Divorced 7 = Widowed 8 = Casual	**Couple type** *Circle one* 1 = Married 2 = Premarital 3 = Pre-sexual 4 = Sex partner 98 = Not Applicable 96 = Other	**Education** *Circle one* 1 = None 2 = Primary 3 = Secondary 4 = Tertiary 96 = Other	**Occupation** *Circle one* 1 = Unemployed 2 = Civil Servant 3 = Private Sector 4 = Self Employed 5 = Student **Please record exact job** _____	**Is client pregnant** *Circle one* 0 = No 1 = Yes 97 = Don't know 98 = Not Applicable **If yes**, state the *Expected date of delivery (EDD)* _____

How did the client hear of service *Circle all that apply* 1 = Radio 2 = TV 3 = Newspaper/magazine 4 = Poster/sign	**Client referred by** *Circle one* 1 = Not referred 2 = Public Health Institution 3 = Private Health Institution 4 = Military Health Institution	**HIV & Other STIs Screening Initiatives** *Circle one* 1 = Client Initiative 2 = Provider Initiative	**Date of previous test** *Circle one* _____ *(mm/yyyy)*

LABORATORY RESULTS

Name of HIV RAPID Test	Name of HIV RAPID Test	Name of HIV RAPID Test - Tie Break Test	STI Screening Results *List type of screening provided and circle results in box*
_____ **Test Results** *Circle one* 0 = HIV Negative 1 = HIV Positive 98 = Not Applicable	_____ **Test Results** *Circle one* 0 = HIV Negative 1 = HIV Positive 98 = Not Applicable	_____ **Tie Break Test Results** *Circle one* 0 = HIV Negative 1 = HIV Positive 98 = Not Applicable	1. ..... P N 2. ..... P N 3. ..... P N 4. ..... P N 5. ..... P N

Tester's Signature :

POST - TEST COUNSELING SESSION

Couple Discordant	Received results	Risk reduction plan developed	Post - test partner notification planned
Circle one 0 = No 1 = Yes 98 = Not Applicable	*Circle one* 0 = No 1 = Yes 98 = Not Applicable	*Circle one* 0 = No 1 = Yes 98 = Not Applicable	*Circle one* 1 = Refused to notify 2 = Agreed to notify 3 = Unsure 98 = Not Applicable

Condoms & Lubricants accepted	Number of Condoms given	Number of Lubricants given
Circle one 0 = No 1 = Yes 98 = Not Applicable	_____	_____

Client referred to / for :
Circle all that apply
0 = No referral
1 = NGO for Community Home & Palliative Care
2 = Clinic / Hospital for Tuberculosis (TB) Treatment
3 = Clinic / Hospital for Antiretroviral treatment (ART)
4 = Clinic / Hospital for Sexually Transmitted Infection (STI)
5 = Psychosocial support
6 = Social Services
7 = Family Planning
8 = PLHIV group / organization
9 = Other

If ***Other***, please state : _____

98 = Not Applicable

Defined HIV Prevention Packages of Services rendered

Tick all that apply	*Yes*	*No*
HIV / STI Information	☐	☐
Risk reduction counseling	☐	☐
HIV Testing		
- Gave test	☐	☐
- Received results	☐	☐
STI Screening		
- Gave test	☐	☐
- Received results	☐	☐
Condoms distribution	☐	☐
Lubricants distribution	☐	☐
Referrals given		
- ART	☐	☐
- STI	☐	☐
- Tuberculosis (TB)	☐	☐
- Community Home & Palliative Care	☐	☐
- Psychosocial support	☐	☐
- Social Services	☐	☐

Comments

_____

_____

_____

Counselor's Signature :

Key

HIV & Other STIs Screening Initiatives

1 = Client Initiative
- Had unprotected sex
- Has multiple partners
- Partner has multiple partners
- Plan to have sex with a new partner
- Had an STI
- Don't trust partner
- Plan to get married
- Partner's request
- Retesting / Window period
- Curiosity / want to know

2 = Provider Initiative
- Referred by health care worker
- Occupational exposure
- Sexual assault
- Plan to get pregnant
- Is Pregnant
- HIV Exposed Infants

3 = Index Testing / Screening
- HIV & other STIs screening of household members of a PLHIV currently enrolled for HIV Care & Treatment management
- Contact tracing of STI clients
- Partners of known Positives (HIV & other STIs)

4 = Home Base Care
- Provision of any HIV & other STIs screening/testing for clients and their affected families at home

Pg 2

Partner Elicitation Form

Instructions: Ask the index client to tell you the names of all the people s/he has had sex with in the past 12 months, including both main/married partners and casual/unmarried partners and clients. If the client injects drugs, ask him/her to tell you the names of his/her injecting drug use partners. You may wish to start with the main sex partner and then ask about other partners, or you may wish to start by asking about the recent partner and working backwards in time.

List name(s) of partners (write "unknown" if name is unknown)	**Phone Number** (tick box if unknown)	**Alternative Phone Number** (tick box if unknown)
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐
6.	☐	☐
7.	☐	☐
8.	☐	☐
9.	☐	☐
10.	☐	☐

Sexual Partner Grid

Instructions: This sexual partner grid can be used to elicit the names of sexual partners. It can also be used as a discussion point to identify HIV transmission risk and protecting self and partners. This grid helps people recognize (1) their partners and partners of their partners; and (2) risk that they put themselves and others in based on sexual behaviours and infections.

The first column on the left-hand side refers to the individual's direct and indirect sexual relations. The top row refers to things about each individual's sexual risk and sexual behaviour. For example, if the client has a main partner, you can ask him/her if s/he knows his/her partner's HIV status. If s/he does know it, you can circle "K" for "know" or "DK" for "don't know." The grid should be filled out for each partner and each partner's partner, as needed.

Sexual Relationships	**HIV status**		**# of sexual partners**		**Has vaginal sex**		**Has oral sex**		**Has anal sex**		**Has STI(s)**		**Uses condoms**	
Me	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK
My main partner	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK
My other partner	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK
My main partner's partners	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK
My other partner's partners	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK
	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK	K	DK

Partner Information Form

Instructions: Ask the client to give you as much information as s/he can about each of the partners s/he named on the partner elicitation form. Write "N/A" for any information not available.				
Partner's name (last, first, middle):				
Partner's nickname:				
Partner's DOB (dd/mm/yyyy):				
Partner's gender:	☐ Male		☐ Female	☐ Transgender
Partner's mobile number (if known):				
Partner's physical address (including any landmarks):				
Partner's place of employment and work hours:				
How would you describe your relationship to this partner?	☐ Wife/husband/ fiancée		☐ Live together but are not married	☐ Girlfriend/ boyfriend
	☐ Someone I had sex with for fun		☐ Someone who pays me or gives me things to have sex with her/him	☐ Someone I paid to have sex with
	☐ Someone who forced or pressured me to have sex			
Do you currently live with this partner?	☐ Yes		☐ No	☐ Declines to answer
As far as you know, has this partner ever tested positive for HIV?	☐ Yes	☐ No	☐ Don't know	☐ Declines to answer
If yes, is this partner currently taking medications for HIV?	☐ Yes	☐ No	☐ Don't know	☐ Declines to answer
Screen for intimate partner violence (IPV)				
Because your safety is very important to us, we ask all clients the following questions:				
Has [partner's name] ever hit, kicked, slapped, or otherwise physically hurt you?			☐ Yes	☐ No
Has [partner's name] ever threatened to hurt you?			☐ Yes	☐ No
Has [partner's name] ever forced you to do something sexually that made you feel uncomfortable?			☐ Yes	☐ No

Determine Index Testing Plan
Instructions: Describe the options for getting your partner tested to the index client and review options. Ask the client which option they would prefer and record their chosen options below. If the client choses "contract referral," record the date (14 days from today's date) by which the partner should come for HIV testing services. If the client choses "dual referral" for partner notification, record the date when the joint disclosure session will occur.
Index client's plan for notifying this partner:
☐ Client Referral: Index client will notify partner
☐ Provider Referral: Health care provider will notify the partner

☐ Contract Referral: Both the index client and health care provider will notify the partner. The index client will first try notifying the partner no later than _ _ / _ _ / _ _ _ _ . After which the provider will contact the partner (with permission from the index client).
☐ Dual Referral: The index client and health care provider will jointly notify the partner. This joint session will occur on _ _ / _ _ / _ _ _ _ .
☐ Partner testing not recommended at this time due to safety concerns.
☐ No partner testing needed; partner is known positive.

APPENDIX M. INDEX TESTING FORMS

Script for Partner Testing Services: Phone Call

Good day. My name is _____ and I am a counsellor/health care provider at _____. Who am I speaking to?

[**IF NOT THE PARTNER**]: Is [partner's name] available?

[**IF PARTNER IS NOT AVAILABLE**]: Thanks, I'll try back later.

[**IF YES**]: I have some important information for you. Are you in a private space where you can talk?

[**IF NO**]: When would be a better time for me to call you?

[**IF YES**]: Before we begin, I just need to confirm that I am speaking with the right person. Can you please tell me your date of birth and home address?

[IF THE PERSON IS UNABLE TO CONFIRM HIS/HER DATE OF BIRTH AND HOME ADDRESS, ASK HIM/HER TO COME TO THE HEALTH FACILITY FOR THE INFORMATION. DO NOT PROCEED WITH THE NOTIFICATION UNTIL YOU CAN CONFIRM HIS/HER IDENTITY.]

[**AFTER CONFIRMING THE DATE OF BIRTH AND ADDRESS**]: We have recently learned that you may have been exposed to HIV. It is important that you come to _____ for an HIV test so that you can learn your HIV status. If you are HIV-negative, we can give you information about how you can remain free from HIV. If you are HIV-positive, we can give you medicines to treat your HIV. These medicines will help you live a long life and reduce your chance of passing HIV onto others.

HIV testing services are available ___(day)____ to ____(day)_____ from ___(time)____ to ___(time)_____. Alternatively, we can send a counsellor to your home for an HIV test. Which option would you prefer?

[**FACILITY TEST**]: What day this week would you like to come in for an HIV test? [Record preferred day]

[**HOME TEST**]: What date and time this week would you prefer for the counsellor to come to your home for an HIV test?

I understand that I have provided you with a great deal of information that may be upsetting to you. What questions can I answer for you now?

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