Standard Operating Procedures for Implementing HIV Programmes among Key Populations

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ACRONYMS

AIDS ..... Acquired Immunodeficiency Syndrome

ART ..... Anti-Retroviral Therapy

BCC ..... Behaviour Change Communication

CBO ..... Community-based Organisation

CHRAJ ..... Commission for Human Rights and Administrative Justice

CoC ..... Continuum of Care

CRIS ..... Country Response Information System

CRRS ..... Community Rapid Response System

CSO ..... Civil Society Organisations

DAC ..... District AIDS Committee

DHMT ..... District Health Management Team

DIC ..... Drop in Centre

DQA ..... Data Quality Assurance

FSW ..... Female Sex Workers

GAC ..... Ghana AIDS Commission

GHS ..... Ghana Health Service

GO ..... Government Organisations

HIV ..... Human Immunodeficiency Virus

HTC ..... HIV Testing and Counselling

PWID ..... People Who Inject Drugs

KP ..... Key Populations

M&E ..... Monitoring and Evaluation

MARP ..... Most at Risk Population

MIS ..... Management Information System

MoH ..... Ministry of Health

MP ..... Minimum Package

MSM ..... Men who have Sex with Men

ACRONYMS

NACP ..... National AIDS/STI Control Program

NAP+ ..... Networks of People Living with HIV

NGO ..... Non-Governmental Organizations

NSF ..... National Strategic Framework

NSP ..... National Strategic Plan

OB/GYN ..... Obstetrics and Gynaecology

OI ..... Opportunistic Infection

PE ..... Peer Educator

PEP ..... Post Exposure Prophylaxis

PEPFAR ..... President Emergency Plan for AIDS Relief

PLHIV ..... Person Living with HIV

PMTCT ..... Prevention of Mother to Child Transmission

QA ..... Quality Assurance

QAIDT ..... Quality Assurance and Improvement District Team

QI ..... Quality Improvement

RAC ..... Regional AIDS Committee

RHMT ..... Regional Health Management Team

SGBV ..... Sexual and Gender Based Violence

SOP ..... Standard Operating Procedures

STI ..... Sexually Transmitted Infections

SW ..... Sex Workers

TB ..... Tuberculosis

TSU ..... Technical Support Unit

TWG ..... Technical Working Group

UNAIDS ..... The Joint United Nations Program on HIV/AIDS

UNGASS ..... United Nations General Assembly Special Session UNGASS

FOREWORD

Ghana has achieved notable success in the response to the HIV epidemic by reducing the overall adult HIV prevalence from 2.4 percent in 1998 to 1.37 percent in 2012.The National HIV Prevalence and AIDS Estimates Reports for 2011 and 2012 show the national HIV response is making modest progress. The number of new HIV infections reduced from 12,077 in 2011 to 7,991 in 2012. Although this makes Ghana a relatively low-prevalence country, HIV adult prevalence varies substantially by geographic location and sub-populations.

This decline in HIV prevalence can be attributed to the advances made in National HIV Repose through a multi-faceted approach that engages all levels of government, academia, business sectors, civil society and development partners under the able leadership of the Ghana AIDS Commission through its Director General Dr. Angela El Adas.

The Ghana AIDS Commission has coordinated a robust National HIV Response to prevent HIV transmission and mitigate its impact on women, men and children. Part of that effort has been to ensure timely and evidence-informed prevention and care services for Key Populations (KPs), including female sex workers and their non-paying partners, men who have sex with men, people who inject drugs and prisoners. The National HIV Response is currently guided by NSP 2011-2015, and it outlines key objectives and activities to be achieved in preventing new infections among KPs by 2015. These are further expanded in the National MARP Strategic Plan 2011-2015.

There is need for sustained HIV prevention, care and treatment especially among KPs who contribute up to 40 percent or more of new HIV infections. As activities are scaled up and more stakeholders and actors are involved in the provision of KPs interventions, there is the need to ensure that a standardised set of services are provided to all KPs in a non-stigmatising and confidential manner. These Standard Operating Procedures (SOPs) have been developed as one of the essential and fundamental activities outlined in the National MARP Strategic Plan 2011 - 2015. They are designed to systematise the strategies employed under the NSP 2011 – 2015 and it's M&E Plan.

It is our hope that these SOPs will assist implementers and planners to provide quality services to KPs and better enable Ghana to reduce number of new HIV infections.

Dr Angela El Adas
Director General
Ghana AIDS Commission

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Dr Angela El Adas

Director General

Ghana AIDS Commission

INTRODUCTION

PURPOSE:

This document aims to provide standard operating procedures (SOPs) to effectively design, manage, implement and monitor quality, evidence-informed, rights-based, and community-owned HIV interventions in Ghana with female sex workers (FSW) and men who have sex with men (MSM) in a harmonized and coordinated manner. Although people who inject drugs (PWID) and prisoners are defined as key populations in Ghana, interventions are limited and there is not enough on the ground experience to informdetailed SOPs. These SOPs may be updated to include service delivery with PWID and prisoners at a later date.

BACKGROUND:

Ghana is experiencing a mixed HIV epidemic comprised of a low-level, generalized epidemic among the general population, coupled with a high prevalence epidemic among key populations. In 2012, the HIV prevalence among the general population was estimated at 1.37% and continues to follow a declining trend. However, HIV prevalence among FSW and MSM is more than ten times that of the general population. In 2011, the HIV prevalence rates among the FSW and MSM were 11% and 17.5% respectively. In addition to their increased risk for acquiring and transmitting HIV infection, MSM and FSWface formidable legal, social and institutionalized barriers that limit their access to health and social protective services because some of their behaviours are both criminalized and stigmatized.

Strategic interventions can reduce KP HIV risk and vulnerability as well as reduce the number of new HIV infections among the general population. In support of the national goal to reduce new HIV infections by 50% by 2015 as articulated in the NSP for 2011-2015, the GAC specifically developed a MARP Strategic Plan 2011- 2015 to provide a framework for the implementation of a comprehensive package of services designed specifically to reach the four KP subgroups mentioned above. The overarching goal of the strategy is to provide evidence-based prevention, protection, treatment, care and support services to 80% of all identified KP by 2015.

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1. Integrated Biological and Behavioural Surveillance Survey of Female Sex Workers, 2012; Ghana Men's Health Study Brief, 2013.
2. National Strategic Plan for Most at Risk Populations 2011-2015. Leveraging a Public Health Approach for Universal Access. GAC. August 2011. p.9.

Having identified the common goal and strategies regarding KP programming in the MARP Strategic Plan 2011-2015, there was a need to provide standardized programming guidelines for HIV and AIDS prevention programs targeting KP to ensure consistent quality of services within the national framework. This document was developed through a multi-sectoral collaborative process with leadership from the Government of Ghana, specifically the GAC, as well as active and meaningful participation of FSW, MSM and PLHIV, law enforcement officials, development and implementing partners.

OVERVIEW:

The goal of this document is to standardize the guidelines and operating procedures for implementing a harmonized multi-sectoral response against HIV among FSW and MSM, hereinafter referred to as KP, in a consistent manner based on the best available evidence. While the development of customized solutions and approaches to address local challenges is crucial for effective programming, the standardization of definitions, norms and expected outputs is also necessary to provide the foundation for assuring a minimum accepted quality standards and serves as a guidepost to inform continuous quality improvement activities.

The target users of these SOP are service providers, which includes any individual providing services to KP such as health care workers, peer educators, program staff and implementers, as well as policy makers.

The document is subdivided into four sections: The document is subdivided into four sections:

1. The ***Project Management*** section provides a series of SOPs that describe standards to guide KP focused programmes through the project cycle. This includes guidelines for designing tailored and customized programs for KP, ensuring adequate human and other resources are available, identifying capacity building needs, and developing systems for effective implementation, monitoring and evaluation (M&E), quality assurance and quality improvement, as well as guidelines for partner coordination. This section supports all other sections and SOPs in this document.
2. The ***Behavioural Interventions***section provides guidance on how to develop a behaviour change communications (BCC) strategy, including materials development; how to effectively establish and support a peer education network; and how to establish and support a DIC.
3. The ***Biomedical Interventions*** section outlines the procedures for establishing KP friendly clinical services to increase uptake both at facilities and through outreaches. Biomedical interventions for KP addressed in this section are STI management, HIV counselling and testing, and sexual and reproductive health. This section also specifies the step by step process to ensure occupational infection control, including infection prevention and biomedical waste disposal.
4. The ***Structural Interventions*** section provides SOP for addressing social, cultural, political, economic, and legal or policy aspects of the environment that increase the vulnerability of KP and contribute to the spread of HIV. Structural interventions should focus on creating an enabling environment for improving access to health services and commodities and the protection of rights. This includes establishing a robust referral network, community mobilization and establishing a system of redress in cases of identified human rights violations or sexual or gender based violence (SGBV).

A table overview of the SOPs can be found in Annex A.

Section 1 : PROJECT MANAGEMENT

This section describes the minimum national standards for effective planning and management of interventions with KP. It builds on the NSP for MARPs 2011-2015, and its Costed work plan and M&E plan. It is closely linked to and supports all other SOPs in this document.

Keys to planning and implementing successful projects include participatory and informed planning and program design; a focused and detailed implementation plan, identifying and ensuring availability of needed resources; a functioning M&E plan; a system for quality assurance and improvement; and strong coordination among partners and implementers. Ensuring the participation of the beneficiaries and community stakeholders during all stages of the intervention helps to ensure that programs are responsive to the particular needs of the KP and mobilizes community and stakeholder buy-in thus increasing both efficiency and effectiveness. Well-developed M&E systems will further improve the overall quality of programs through systematic gathering of standardized, quality data and a strong feedback mechanism. Instituting effective QA/QI systems helps to achieve efficient, cost-effective, quality program results, and helps to detect and address gaps in HIV service quality measured against established national standards in a timely manner. Coordination at all levels further increases efficiency by reducing duplication and ensuring harmonized approaches to implementation.

List of SOP:

- SOP 1.1 Planning and Designing Interventions
- SOP 1.2 Budgeting and ensuring adequate resources
- SOP 1.3 Human resources (HR) and capacity building
- SOP 1.4 Monitoring and evaluation
  - SOP 1.4.a Management Information System
  - SOP 1.4.b Data Quality Assurance
  - SOP 1.4.c Developing feedback mechanisms
  - SOP 1.4.d Program Reports
- SOP 1.5 Quality assurance and quality improvement (QA/QI)
- SOP 1.6 Establish coordination mechanisms
  - SOP 1.6.a Partner coordination
  - SOP1.6.b Clinical and Outreach Coordination

Keyreferences:

- National Guidelines for the Implementation of HIV Counseling and Testing in Ghana MOH 2008.
- National M&E Plan, GAC: Reference – GAC, National Strategic Plan, 2011 – 2015: http://www.ghanaids.gov.gh/gac/publications/viewdoc.php?docID=354
- Standardized M&E List: GAC, National Strategic Plan, 2011 – 2015: http://www.ghanaids.gov.gh/gac/publications/viewdoc.php?docID=354
- Data Quality Assurance Manual. A Guide to Ensuring Quality Production and Use of HIV and AIDS Data Management Manual for KP programs: GAC, Data Management Manual for Behaviour Change Communication, HIV Testing and Counselling.

SOP 1.1.PLANNING AND DESIGNING INTERVENTIONS

Purpose:

To set standard guidelines for the planning and designing of evidence-informed, rights-based, and community-owned HIV prevention interventions among KPs.

Target users:

Executive directors, program managers, program design teams

Overview:

This SOP presents critical components for effective planning: participatory planning, evidenced- based understanding the unique vulnerabilities of the focus KP and the intervention area characteristics, the development of a clear and thorough and realistic implementation plan. The work plan should outline key activities with time lines for implementation and serves as a basis for monitoring and evaluation. The budget identifies needed inputs. Ensuring that each of these components is considered when designing your implementation plan sets the stage for successful implementation from the beginning. The implementation plan serves as both a planning and management tool, providing a framework of how and when you will carry out the scope of work and serves as a basis for monitoring progress, reporting systematically, and making evidence-based and considered changes or adjustments to your plan as necessary.

Procedures:

1. **Ensure participatory planning.**
   A. Map out stakeholders and service providers connected with the KP interventions at district, site and hotspot levels. A stakeholder is anyone or any group, institution or individual that has any kind of stake in the project (e.g. beneficiaries, community leaders, gatekeepers, facility managers and staff, government officials or Community-based Organizations (CBOs).
   B. Identify existing KP and PLHIV coordinating mechanism, e.g.; National MARP TWG and Sub Committee, Regional AIDS Committee (RAC), District AIDS Committee(DAC), and Regional Health Management Team(RHMT).
   C. Identify other service providers in the area of HIV testing and counseling (HTC), care and treatment, Tuberculosis (TB), sexual and reproductive health/family planning (SRH/FP), sexual and gender based violence (SGBV), drug and alcohol use and mental health services both in private public institutions to avoid duplication of efforts. Invite KPs, service providers and other stakeholders to take part in assessments and planning sessions.
2. **Review existing data. Additional/updated information and data should be gathered through observations and mapping, in-depth interviews, focus groups, and short surveys.**
   A. Define location/ geographic scope. At minimum, identify the following :
      (a) Existing hot spots (locations with a concentrated presence and/or activities of KP, such as neighborhoods, streets, or bars, where KP meet or interact with clients);
      (b) Location and types of HIV and reproductive health services;
      (c) Existing resources/other interventions working with KP;
      (d) Locations of potential barriers to implementation (e.g. police stations); and
      (e) Identify key stakeholders/gatekeepers critical for the achievement of intervention goals and objectives.

ii. Define microsites within the larger intervention area: The ideal microsite should be concise geographical area that has one or more hot spots with between 30 to 60 enumerated KP, to which one peer educator (PE) will be assigned. For more information refer to SOP 2.2 Peer education and outreach strategy.

B. Identify key characteristics, risks and needs of KP within the intervention area. Use recent behavioural and biological surveillance results as a guide. At minimum, document the following:

(a) Characteristics (gender, age, ethnicity, marital status);

(b) HIV risk behaviours (unprotected vaginal/anal/oral sex);

(c) Typologies (e.g. for FSW: brothel-based, street based, home-based);

(d) Particular vulnerabilities (poverty, stigma, SGBV, that may facilitate HIV transmission);

(e) Typical clients, partners;

(f) Ability to access HIV/SRH services

(g) Availability and use of condoms and lubricant;

(h) Policy, legal and environmental factors; and

(i) Psychosocial needs.

3. Using gathered data, develop an implementation/ work plan.

A. Define the project goal and objectives.

i. A goal is the broad, long term result to which the intervention aims to contribute.

ii. Objectives should be SMART:

(a) Specific - specifies the characteristics of the target population;

(b) Measurable - can be measured, using available methods and tools;

(c) Attainable - can be realistically reached;

(d) Relevant - relates to the overall program goal; and

(e) Time-bound - includes an end date by which the objective is to be achieved.

iii. Defining the goals and objectives with the active participation of KP, stakeholders and other service providers will ensure that they are appropriate, acceptable and well-coordinated.

B. Define activities and strategies. Although all KP should be offered a complete package of services, the implementation of this package may differ depending on local needs, priorities and capacity of each implementing partner. It is not expected that every program should offer every component of the minimum package of services.

i. Refer to Annex C for details on the Ghana minimum package of services for KP.

ii. Typical approaches for implementing HIV programs among KP include, but are not limited to:

(a) Behavioural interventions

(b) Biomedical interventions

(c) Structural interventions

iii. Base the strategies and activities on findings from participatory assessments and planning activities.

iv. Organize activities by objectives helps to ensure that the planned activities remain focused on the overall goal and objectives of the project.

v. Map out the sequence of activities along a time line helps to ensure your plan is realistic within the given timeframe.

vi. Illustrative workplan template is available in Annex D .

vii. Develop a M&E plan.

(a) The M&E plan should include: qualitative and quantitative indicators, data collection instruments and systems, timetables, responsible parties, reporting channels, etc. Set achievable targets and timelines for each activity.

(b) Refer to SOP 1.4 Monitoring and evaluation (M&E) for more information.

4. Ensure adequate resources for implementation of each activity.

A. Identify necessary human and other resources.

B. Identify financial and human resources needed to deliver program activities (based on program needs).

C. Identify available resources and try to fill gaps. Include resources that are obtainable (it could be from government or another NGO or CBO working with similar populations and interested in supporting the service) as well as existing gaps requiring attention.

D. Cost all needed resources to ensure that they are realistic within the available financial and human resources.

E. Refer to SOP 1.2 Budgeting and ensuring adequate resources and SOP 1.3 Human resources (HR) and capacity building.

5. Coordinate and establish linkages with other programs.

A. Establish multi-sectoral involvement with key stakeholders, partners, and other programs through joint programming, coordination, and linkages of activities.

B. Refer to SOP 1.6 - Establish coordination mechanism - for further guidance.

6. Develop a plan for resource mobilization and sustainability.

A. Develop a plan for adequate and timely funding of program activities, along with a plan that fosters institutionalization, ownership, and other mechanisms to ensure that activities are sustained beyond the program's term.

SOP 1.2.BUDGETING AND ENSURING ADEQUATE RESOURCES

Purpose:

To provide standard guidelines to ensure adequate resources are available to effectively implement the KP interventions.

Target users:

Program Managers, Program coordinators, Program Team, HR Managers

Overview:

All KP interventions require a range of resources available so that activities can be implemented efficiently, within a given time and with desired quality. Budgeting is a crucial step in project planning and management to develop a detailed budget to ensure that sufficient funds are available to implement the workplan and ensure that the scope of work is realistic. The budget describes in detail the estimated cost of implementing the

program. Based on the work and M&E plan, budgets should include costs for activities; commodities to be procured; printing and publications; computers and Information Technology (IT) support; and office support and rent. There should always be a clear, justifiable relationship between the proposed project and the budget.

As a project moves forward, it is expected that the budget projections will change based on changing needs and realities of the project. It is critical, as the budget is adjusted, that you revise the project workplan, scale of activities, target figures, and staffing plan accordingly. Subsequently, budgets should be used for planning, organizing and directing activities throughout the life of project as means of guiding day-to-day management decisions and a mark to measure and compare actual performance.

Procedures:

1. Review workplan and determine resources needed for intervention. Consider the following

A. Human resources/staffing:
   I. Will you need additional staff (full-time, facilitators, or consultants)
   ii. Will existing or new staff need additional training?
   iii. What LOE do your need for each position?
   iv. Cost out staff salaries, benefits, allowances and severance.

B. Detailed guidelines concerning HR are covered in SOP 1.3 Human Resources and Capacity Building.

2. Procurement.

A. What assets are needed to carry out the intervention?
   i. Equipment: Functional/standard equipment that facilitate efficient working environment. For example computers, laboratory equipment.
   ii. Furniture: Standard office furniture that enhances /promotes effective work such as desks, chairs.
   iii. Means of transport: Appropriate and affordable means of transportation.
   iv. Communication tools: Access to office communication tools.

B. Location:
   i. Identify a dedicated space for administrative/management needs.
   ii. Identify space for service delivery, such as the DIC. Remember that this space should be easily accessible and acceptable for the targeted KP.
   iii. Identify & cost secure space for storing equipment, files.
   iv. Consider if space will need to be renovated, upgraded or adapted to meet the needs of the intervention. For example, a space that is intended for HTC services may need to be refurbished to ensure confidentiality.

C. Travel: Cost planned travel for regular monitoring visits, meetings, and workshops. This includes per diem (accommodations, allowances for travel and transport -(T&T)

D. Workshops/ trainings/ meetings: Consider the following: Do you need to rent a venue? Do participants need accommodations? Will you provide for coffee breaks and/or lunches? What training materials do you need? E. Refer to particular technical SOPs for guidance on required resources.

3. Identify existing available resources, e.g. in-kind contributions or donations from community leaders, stakeholders, and share resources with partners.

4. Cost out all inputs that are unavailable and need to be covered by the project.

5. Illustrative budget format can be found in Annex E.

SOP 1.3.HUMAN RESOURCES (HR) AND CAPACITY BUILDING

Purpose:

To set standard guidelines to ensure appropriate and adequate HR to implement the intervention.

Target users:

Program managers, coordinators, implementation teams

Overview:

Human resources are a valuable and essential component of any program. Successful programs require team members with a variety of skills. The particular composition (number and type of skills) of your team will depend on the types of services to be provided, the strategy for delivering those services, and the intended coverage of the program.

At minimum, each intervention should ensure adequate staffing (appropriate categories, level of effort, and numbers of staff) to assume responsibility for management, leadership, coordination, technical oversight, service delivery, outreach, M&E, finance and administration. It is important to define the necessary level of effort per position and to assign clear roles and responsibilities for different aspects of the intervention.

Procedures:

1. **Identify HR needs.**
   A. Refer to the relevant technical SOP for guidance on recommended staffing for HR needs for a particular intervention type or activity. Illustrative job categories include:
      i. Program manager: A trained individual who will lead the project team, design and manage the implementation of the program; will also ensure overall service delivery for the community and coordinate with other stakeholders for effective program implementation.
      ii. PE Supervisors/Field Officers/Outreach Worker/Program Officer: A trained individual who supervises a number PEs within a defined geographical area.
      iii. Peer Educators (PE): An individual trained to reach their peers with HIV information and services. They influence behaviour change among their peers. PEs can be engaged on a stipend or as fully paid staff basis depending on the financial capacity of the IP. It is recommended that one PE be assigned to 30 to 60 enumerated KP to balance workload with quality.
      iv. Coordinators/Zonal officers: A trained individual who coordinates all HIV continuum of prevention, care and support services.
      v. M&E Officer: A trained individual who guides data collection, reviews collected data and collates them to generate periodic reports.
      vi. Finance, administrative and support staff: These are trained individuals who provide administrative, finance and logistical support to the program.
      vii. Ancillary (part time or voluntary staff) staff: These are human resources that are engaged to provide specialized services e.g. Nurses, Psychologists, etc.
   B. Identify necessary level of effort (LOE) for each position.
2. **Develop job descriptions.**
   i. Each job description should define at minimum:

(a) Roles and responsibilities

(b) Expected LOE

(c) Minimum qualifications

(d) Direct supervisor (reporting line)

1. Develop an organogram to illustrate the various positions and reporting lines of reporting and supervisory structure.
2. Develop human resources plan.
   i. Budget: Establish the cost of the human resources needs. Remember to include cost of advertising, interviewing and training, staff salaries, benefits, allowances and severance.
   ii. Recruitment
      (a) Criteria
      (b) Advertisement
      (c) Schedule
3. **Develop a capacity building plan.**
   A. Refer to the relevant SOP for recommendations for particular technical areas.
   B. Trainings:
      i. All PEs must undergo training using the National PE training manuals.
      ii. All project coordinators and field staff should receive an induction training covering all elements of the intervention that are already covered in the PE manuals with additional modules on MIS formats, data quality assessment, supportive supervision, advocacy and coordination with supporting agencies.
      iii. Field staff will receive quarterly updates and refresher training once a year.
      iv. Project Cordinators will be trained on mentoring of PEs and field staff, problem identification and solving based on MIS, coordination of outreach, DIC and clinical services, public relations and leadership skills.
      v. All service providers and outreach workers should be trained on the linkages between HIV, gender and SGBV, incidence and risk factors associated with SGBV, and special considerations for working with SGBV survivors.
   A. Meetings:
      i. Convene monthly meeting of PEs with their field staff and project coordinator where additional reinforcement of training will be conducted on the basis of debriefing and feedback.
   B. Supportive supervision and mentoring:
      i. Peer educators: All the PEs will be regularly supervised by Field staff once a month. On site supportive supervision and/or mentoring will be provided using a checklist. Quarterly debriefing and training reinforcement will also be provided at the DIC.
      ii. Field staff will be mentored by project coordinators.
      iii. Project coordinators: Additional mentoring will be provided by Technical Support Unit (TSU) from the coordinating body (GAC) and Technical Support Agency staff during visits.

SOP 1.4.MONITORING AND EVALUATION (M&E)

Purpose:

To harmonize M&E (MIS, DQA, feedback and reporting) systems among implementers of KP interventions.

Target Users:

Program Managers, M&E officers and stakeholders

Overview:

A strong M&E system is based on robust health information system, skilled personnel, standardised tools and processes to collect, collate, analyse, disseminate and use information.Instituting an effective Management Information Systems (MIS) is a prerequisite for ensuring quality data at all levels of program intervention. The available quality data contributes to making informed decision to improve programming.

Routine data quality assurance (DQA) exercises ensure that collected and reported data are accurate, reliable, consistent and timely. DQA needs to be a participatory process involving program staff and or external assessors to verify the extent to which the reported data reflects the actual situations and their underlying M&E systems. Evidenced- based decision making depends further on a strong feedback system.

Experience has shown that data-driven programs achieve better results by being evidence- based and responsive to changing programmatic needs, more efficient and ultimately more effective. Routine reporting should be viewed as a management tool to ensure project objectives are being met as planned. It is an opportunity to regularly assess progress (monitoring) and improve activities through a reflection on challenges – what worked, what didn't and to reassess resource and capacity building needs. For purposes of uniformity and comparability between interventions, there is the need to have in place a standardized format to be used by all agencies to prepare status reports on KP interventions.

Establishing and implementing effective feedback mechanisms keeps service providers motivated when they see the results of their actions; maintains the interest and support of stakeholders and donors; provides information for program managers to re-strategize or re-organise activities if necessary; and ensures an opportunity for beneficiaries to identify what is and what is not working.

In the context of Ghana and KP programs, the NSP for MARPs 2011-2015 provides the framework needed to produce data for making decisions on KP interventions. The indicators in the framework were derived from the National HIV M&E Plan, United Nations General Assembly Special Session on HIV/AIDS (UNGASS), UNAIDS and President Emergency Plan for AIDS Relief (PEPFAR) and they have been further broken down separately for each KP category.

SOP1.4.a MANAGEMENT INFORMATION SYSTEM (MIS)

Procedures:

1. **Establish MIS**
   - A. Indicators
     - i. Develop data entry and management system/dashboard.
     - ii. Pilot test the system (Dashboard) and make necessary adjustments.
     - iii. Build consensus on core indicators for MIS dashboard.
     - iv. Indicators for KP programming can be found in Annex 1 .
     - v. Further information on the indicators is available in the National MARPS Strategic Plan 2011- 2015.
   - B. Define levels of data reporting
   - C. Define the data reporting flow between the different levels
   - D. Ensure all levels have the tools required to collect and collate data at their level

2. **Develop/ update tools and distribution. Use the standardized data collection and collation tools (refer to the Data Management Manual for KP programs).**
   A. MIS tools include
      i. PE daily activity sheet and referral forms
      ii. DIC attendance reporting forms
      iii. Summary report data collection forms
      iv. Indicator sheet
      v. Counselling and testing forms
      vi. SGBV screening and referral forms
      vii. Support group management
      viii. Defaulter tracing forms
   B. Make data management system/software available
      i. MIS software and data tools must be user-friendly at all levels.
3. **Train staff in the use of the tools and MIS software - Ghana Country Response Information System [CRIS]**
4. **Launch data collection process.**
   A. Establish a schedule for routine data quality assessment.
   B. Collect and collate data in a timely manner with standardized tools at all levels
   C. Ascertain the quality of collated data e.g. through the DQA process (see SOP 2.4.b Data Quality Assessment) at all levels
   D. Generate reports and disseminate to project staff and stakeholders.
5. **Ensure that data is analyzed and used at all levels.**
   A. Generate reports and disseminate data obtained to all levels.
   B. Every effort should be made to ensure that data is owned and used at the level of generation as well as at the higher levels such that the lower levels do not just serve as a source of data.
      - Establish medium and schedule for meetings where data is discussed and used in decision making.
      - Provide feedback to sources of data (see SOP 1.4.C Developing feedback mechanisms)
      - Track implementation of decisions arising from MIS.

SOP1.4.b DATA QUALITY ASSURANCE

Procedures:

1. **Refer to the National Data Quality Assurance Manual for specific details.**
2. **Prepare for DQA assessments.**
   A. Form DQA Team(s) comprising of at least 2 people, an M&E and program person. This can be implemented at various levels such that data at all levels is assessed.
   B. Develop Terms of Reference for the DQA Team.
   C. Develop tools for data collection, verification and reporting on the DQA conducted. Adapt to the specific situation if necessary.
   D. Train the DQA Team and how to implement DQA.
   E. Identify relevant sources of data.
   F. Select indicators to verify, a rationale of selection of indicators should be specified e.g. indicators of

greatest importance to the program need to be included in the selection, specific indicators that are linked to activities which receive a large investment (i.e. funding).

G. Select the period for which data will be reviewed.

H. Select sites to visit, agree on criteria for site selection. Where there are no specific reasons for selecting sites, random selection of sites can be applied covering priority and high volume sites.

I. Notify selected sites. These sites should be provided with advance notice and tools for DQA and sources of data to prepare for the exercise. However, the advance notice should not be such that implementers spend time to rectify errors before the arrival of the team such that the assessment is true picture of what occurred.

J. Ensure that all logistics for the visits are available.

3. Implement DQA.

A. Conduct briefing site meeting to orient the site staff on the purpose of the DQA.

B. Review source and secondary documents, these include relevant data collection tools and reporting or summarizing formats.

C. Onsite verification of data for the selected indicators.

D. Recalculate indicators using the primary source of data, numbers should be recalculated for each indicator being verified and then compared to what was reported

E. Undertake root cause analysis to identify the specific sources of identified errors e.g. errors may include calculation errors in totalling the results, transcription errors when entering data into computer data base.

F. Identify or areas of intervention: these are measures for correcting inaccuracies in data.

G. Develop an action plan and follow up: these are longer term measures taken to prevent the specified errors from recurring e.g. mentoring, TA, training, improved supervision and distribution of guidelines.

4. Analyse and follow up

A. Prioritize recommendations and develop a work plan

i. Findings from sites should be collated and the verification team should agree on recommendations.

ii. Prioritize the most important and prepare a work plan with activities, responsibilities and timelines.

B. Develop a report indicating methodology, collective findings, recommendations

C. Communicate findings and recommendation – conduct exit briefing onsite with program staff, reviewing findings, recommendations and correction action points and share the DQA report with the program team when it is available.

D. Follow up with sites to ensure necessary corrections are made.

SOP1.4.c DEVELOPING FEEDBACK MECHANISMS

Procedures:

1. Establish feedback, reporting & communication channels:

A. Peer Educator to/from Implementing Partner

B. Implementing Partners to/from intermediary principal recipient of funds

C. Principal recipient to/from funding/donor agency

D. Various principal recipients to/from national coordinating body

2. Define the mechanism for reviewing of reports to form basis of providing feedback

A. Review data quality assessment reports where available
B. Review narrative reports
C. Compare for trend analysis

3. **Mode of providing feedback**
   A. One on one discussion, small group discussion and review meetings recommended at Peer Educator and Implementing Partner level
   B. Written feedback, shared and discussed recommended for intermediary recipient and implementing partners
4. **Conduct follow up on the recommendations in the feedback**
   A. Agree on timelines/milestones to address weakness or improvement required and document them
   B. Issues arising from the feedback should be acknowledged, addressed and documented
   C. Agree on mode of reporting on the issues identified and addressed
   D. Specify support that will be provided to the PE if needed, who should provide the support and at what time

SOP1.4.d PROGRAM REPORTS

Procedures:

1. **Determine roles and responsibilities:**
   A. Who is responsible for collecting and verifying information;
   B. Who will collate information and write report; and
   C. Who submits reports and to whom.
   D. At the implementation level, monthly qualitative and quantitative reports should be documented and collated quarterly and submitted to the donor.
   E. At the regional level: all district reports should be compiled by the TSU and sent to the GAC.
   F. At the national level: Lead implementing organizations should submit quarterly reports to the GAC.
2. **Determine frequency for different types of reports**
3. **Prepare report**
   A. Reports should follow standard template (see Annex A)and include at minimum, the following information:
      i. activities implemented during the reporting period
      ii. key results achieved
      iii. challenges
      iv. lessons learnt
      v. recommendations/ next steps
   B. Compile and verify progress report information – quantitative and qualitative.
      i. See 1.4.b Data Quality Assurance for more guidance.
   C. Compare activities with workplan for the reporting period.
   D. Explain any variances between planned and actual activities.
   E. Identify challenges and proposed measures to address them.
   F. Highlight lessons learned, success stories, major achievements.

4. **Submit both qualitative and quantitative, soft and hard copy reports to appropriate persons and copy relevant officials (including district and regional coordinating bodies).**
5. **Ensure confidentiality of sensitive information by keeping all reports in secure location**.
6. **Establish a feedback mechanism. See SOP 1.4c Developing feedback mechanism for more guidance.**

SOP 1.5.QUALITY ASSURANCE AND QUALITY IMPROVEMENT (QA/QI)

Purpose:

To describes standard guidelines for instituting a quality assurance and quality improvement (QA/QI) system.

Target Users:

Program managers, coordinators, implementation teams

Overview:

Quality assurance (QA) is a means of establishing standards—for example, clinical protocols and guidelines, program and administrative standard operating procedures (SOPs)—and consistently using them as a basis for assessing performance. It includes all the actions taken to improve health care and providing support that enables KP to achieve their maximum in physical and psychosocial health.

Results from QA monitoring lead to the quality improvement (QI) process. QI is a means of establishing and using a client-focused, problem-solving approach to test and implement solutions to problems that affect quality. QI is a continuous process that identifies where gaps exist between services actually provided and expectations for services and then lessens these gaps not only to meet client's needs and expectations, but to exceed them and attain exceptional levels of performance. This SOP describes the steps required in integrating quality improvement into designing and implementing programmes for KP.

Quality assurance/quality improvement tools should be based on national standards, and project implementation should use and improve existing health system structures.

Procedures:

1. **Establish Quality Assurance and Improvement District (QAID)Teams**
   A. The personnel that will constitute the QAID teams have training, expertise and interest in Quality Assurance and Improvement (QAI).
   B. Identify QAID teams and assign responsibility. For example:
      i. Project director to assume overall responsibility
      ii. Program manager to act as the point person and oversee adherence to established SOPs for each activity
      iii. Other staff persons to assure implementation of specific activities according to SOPs
   C. Conduct an orientation and training workshop to build the capacity of the QAID teams to implement the SOPs, assess and monitor quality based on the QAID teams framework, and to take appropriate measures to improve performance and achieve standards.
   D. The team should meet quarterly to review reports using data quality and improvement tools.

2. **Operationalize SOPs - Conduct workshops to disseminate SOPs to relevant implementation staff.**

3. **Quality assurance monitoring**

   A. Periodically review, assess and monitor activities for adherence to SOP, guidelines, and protocols. Reviews may include various forms of communication channels such as E-mail; SMS and phone calls and site visits.

   Develop a schedule for assessing the quality of interventions/services using checklists. To be most effective these meetings and field visits should be conducted regularly utilizing standardized mechanisms developed for the quality assurance specifically for KP.

   B. Organize quarterly program review meetings.

   C. Conduct site visits to verify reports presented at program review meetings and to ascertain the quality of services provided at different sites.

      i. Select the site to be visited based on set criteria.

      ii. The site visited should be changed for each review, unless a specific site is of particular interest (e.g. Specific best practices or recurrent challenges are noted).

      iii. Develop a checklist (use GAC and NACP QA checklists where they exist) and use it during the visit to enable evaluators to easily describe the nature of the program/problem and location.

      iv. Start the process by preparing the scene (geographical site, exact location of activities).

      v. Prepare a draft program review agenda and share with key partners for review and finalization.

      vi. Organize follow-up to the location of the visit to ensure that the necessary ground work has being successfully carried out. This includes courtesy call on key stakeholders and a write up on the geographical site, location of the activity, some previous and current work of clients being visited, etc.

      vii. Prepare the scene setting.

      viii. Share with team members to finalize action on other forms of communication in the form of E-mail, SMS that may be used as part of the review process.

   D. Communicate achievements and shortfalls to all staff involved.

   E. Develop action plans to ensure that findings and shortfalls from assessments are addressed.

   F. Plan for subsequent programme / service review and assessments.

4. **Quality Improvement system.**

   A. Identify explicit improvement aim and objectives.

   B. Develop measurement system.

      i. Identify national standards to be used as guideposts.

      ii. Identify a few indicators that will be collected on a regular basis.

      iii. Collect data from select sites.

      iv. Collate results.

   C. Analyse results and generate ideas for change/ improvement.

   D. Test and implement the system change.

SOP 1.6.ESTABLISH COORDINATION MECHANISMS

Purpose:

To provide guidelines for coordination among different stakeholders and service providers of KP interventions.

Target users:

Program managers, coordinators, implementation teams

Overview:

Effective coordination between different stakeholders and service providers targeting KP with HIV services ensures cost effectiveness, reduces duplication, and encourages participation and representation by stakeholders at national, regional and district level. Information sharing between partners at all levels strengthens the evidence base, reinforces KP monitoring systems and generates strategic information to improve programmes.

Ghana has embraced the "Three Ones" principle of one national plan, one national coordinating authority, and one national monitoring and evaluation system. Currently, the GAC, through the MARP Technical Working Group (TWG) and its subcommittees, is responsible for coordinating the implementation of MARP Strategy 2011- 2015. At the regional and district levels, the RAC, DAC are responsible for local coordination in partnership with the TSU. The MARP TWG ensures that all relevant stakeholders from all sectors, including development partners and the private sector, are engaged at the appropriate levels. The MARP TWG further ensures that coordination among MARP sub-committees harmonizes the strategic responses and creates opportunities for cross-learning and sharing of experiences among the sub-committees.

Regular meetings between the clinical and outreach teams are required to ensure coordination between them. These coordination meetings will help to improve the quality and coverage of services and also help implementers to review progress, innovate on their strategies and rethink their resource allocations. Regular clinical and outreach coordination meetings will ensure that activity reports are compiled and documented based upon information from both field and clinic perspective.

SOP1.6.a PARTNER COORDINATION

Procedures:

1. **Define roles and responsibilities of the different partners.**
   A. Identify different agencies needed for the smooth functioning of an intervention.
   B. Provide coordination guidelines among these agencies.
   C. Form the group (total membership of the group, regions and districts to be decided).
   D. Nominate leaders.
2. **Review work plans (goals, objectives, and activities) of each stakeholder to identify areas of collaboration and coordination.**
3. **Collate and disseminate the reports, minutes, service statistics and issues concerning KP from implementers.**
4. **Institute quarterly coordination meetings.**
   A. Specify the rational, agenda and objective of the coordination meeting.
   B. Focus meeting discussions on the implementation of the MARP NSP.
   C. Running effective meetings:
      i. Fix day and time of the meeting.
      ii. Set the agenda for the meeting in advance.
      iii. Designate a person to take minutes and ensure registration of participants.

iv. Read and confirm minutes of previous meetings. (Minutes of the previous meeting should be documented and circulated to members several days before the next meeting).

v. Discussion points:

(a) Matters arising from the previous meeting.

(b) Agenda for the day.

(c) Any other topic on the agenda or requiring attention.

(d) Next steps.

D. Assign follow up on the Action points to group members and ensure updates of these action points form part of the agenda for the next meeting.

5. Coordination at the National Level:

A. At the National level the Ghana AIDS Commission will be responsible for coordination. The coordination will be done under the MARP Technical Working Group.

B. Participants should be drawn from GAC, governmental agencies and non-governmental agencies engaged in working with KPs; such as National AIDS/STI Control Program, Ghana Police Service, Ghana Prisons Services, Narcotic Control Board; stakeholders from Development Partners, Faith-Based Organizations, Non-Governmental Organizations, Community Based Organizations, Networks of People Living with HIV (NAP+).

C. Annually review terms of reference of MARP TWG and amend if required to facilitate coordination of strategy.

D. Facilitate input from Regional and District levels through representation through RAC and DAC.

E. Frequency of meeting should be at least bi-annually.

6. Coordination at the Regional Level:

A. Participation should be decided by the TSU regional coordinating body of GAC. This should include governmental institutions, NGO, and regional representatives of the participants at the national level as applicable.

B. Regional level or district level implementers should be invited to participate.

C. The meetings should focus on the implementation of the MARP NSP at the Region level and the level of program implementation as well as achievements by stakeholders and implementers. It should provide a platform for stakeholder to present their achievements.

D. Quarterly meetings are recommended. However, these meetings can be linked to other meetings for HIV coordination at the Regional level. It should be ensured that KP interventions are fully discussed.

7. Coordination at the District Level

A. The meeting should be organised on a quarterly basis.

B. Participants: should be decided by the district coordinating body of GAC (i.e. DAC) if functional, the district coordinating council in conjunction with support from the district health management team.

The meetings should focus on the coordination of HIV activities focused on KP and the implementation of the NSP and progress towards achieving the objectives at the district level.

SOP1.6.b CLINICAL AND OUTREACH COORDINATION

Procedures:

1. **Participants:** The clinic team comprising of providers such as doctor, nurse, counsellor and laboratory technician and the outreach team, where each site is represented by either the field staff or the PE. The Project coordinator should also participate when possible.
2. **Frequency:** Coordination meetings should be held once a month. Time and date should be fixed for the same time each month if possible.
3. **Location:** In the DIC, health facility or any other convenient location/site.
4. **Purpose of the Meeting / Agenda:**
   A. To discuss if the service delivery site is strategically positioned to meet the needs of key populations.
   B. To discuss follow up of key populations e.g. to provide treatment, to monitor compliance with treatment, to monitor progress of disease, to follow up on referrals made.
   C. To answer medical queries coming up in the field that cannot be answered by the outreach staff.
   D. To provide feedback to clinic as well as the outreach teams to improve services.
   E. Acceptability and effectiveness of counselling messages.
   F. To strategize for the forthcoming weeks to improve coverage and quality of services.
   G. Updates on referrals should be made available for discussion during these meetings.
5. **Prepare for the meeting:**
   A. Minutes of the previous meeting should be documented and circulated to members at least five days before the next meeting
   B. Set the agenda for the meeting in advance.
   C. Before the meeting, the clinic and the outreach teams should analyse their performance for the previous month and come prepared with data.
   D. Designate an individual to ensure registration of participants and take minutes.
   E. Matters arising from the previous meeting should be discussed first and this followed by discussion of the agenda of the day.
   F. At the end of the meeting, indicate the task that need to be done, who is responsible and timelines for actionable points.
   G. Special situations should be referred to appropriate service provider.
   H. Updates of referral services should be made available during these meetings.

Section 2 : BEHAVIOURIAL INTERVENTIONS

Strategic behaviour change communication (BCC) strategies, approaches, and methods enable KP to play an active role in achieving, protecting and sustaining their own health, empowering them to make decisions, modify behaviour and change social conditions by transferring knowledge, skills and techniques. To be effective, BCC strategies must be community-centred and acceptable to the KP. Well-developed BCC materials play an important role in supporting BCC goals.

Peer education programs are a key component of the behavioural interventions. PE, themselves trained KP, offer direct outreach through one-to-one or small group communication sessions. These outreach sessions aim to assessspecific risks and vulnerabilities including risk of SGBV; deliver correct information regarding transmission of HIV and means of prevention, including condoms and water-based lubricants; and provide referrals as appropriate. DICs provide safe places for KP to access information/education, resources and services in the prevention of HIV/STIs, to offer compassionate support services for persons affected by HIV; and to support community building activities in a safe and confidential environment. Furthermore, DIC play a pivotal role as part of the referral network to ensure that KPsare able to access necessary services.

List of SOPs:

SOP 2.1 Developing a BCC strategy
SOP 2.1.a Advocacy / Sensitization
SOP 2.1.b Develop BCC messages and materials
SOP 2.2 Peer education and outreach strategy
SOP 2.2.a Establishing peer education program
SOP 2.2.b Support peer education program
SOP 2.2.c Micro-planning and individual tracking
SOP 2.3 Condom and water-based lubricant demonstrations and promotion
SOP 2.4 Establishing and supporting a drop-in centre

Key references:

- DIC SOP. USAID Ghana SHARPER Project, FHI 360, 2012.
- Training Manual for Peer Educators MSM HIV Prevention (It's My Turn). USAID Ghana SHARPER Project, FHI360, 2011.
- Training Manual for Peer Educators of FSW in HIV Prevention. USAID Ghana SHARPER Project, FHI360, 2011.

SOP 2.1.DEVELOPING A BCC STRATEGY

Purpose:

To provide guidelines in the development of coordinated BCC strategy tailored to the specific needs of key population sub-groups

Target Users:

Program managers, clinic staff, Peer Educators, Behavioural Change Communications (BCC) Officers

Overview:

This SOP aims to guide BCC practitioners and programmes to develop and implement a BCC strategy that is participatory and in accordance with community customs and traditions. The communication strategy should promote the process of behaviour change at the individual, community and societal levels as well as support and encourage the maintenance of positive behaviours. Effective interventions must recognise that individual behaviour is influenced by many factors and thus, the development of a BCC strategy requires careful analysis of a problem situation at the individual, community, system and policy levels. Key steps to developing an effective BCC strategy include: identifying target audience, involving stakeholders, determining behavioural objectives, deciding what messages and materials are needed, distribution and dissemination of materials.

Procedures:

1. **Conduct situational assessments. Assess HIV prevention, care and treatment, and other health needs, barriers and identify all the components of a possible solution (e.g., communication as well as changes in policy, products, or services).**
   A. Identify the problem behaviours and circumstances in which they take place that affect your priority audience. Priority areas may include unsafe sexual behaviours that increase risk of HIV transmission or poor health seeking behaviours that affect access, utilisation of key HIV/SRH products and services.
   B. Identify barriers at the individual, community, system, or policy maker levels that need to be addressed for your priority audience. Barriers include low risk perception, lack of confidence and skills at the individual level, peer, partner, and family pressure, harmful cultural and gender norms, and stigma at the community level, lack of friendly and accessible health products and services, or supportive, workplace policies and programs at the system level, and criminalization of KPs or lack of supportive policies, in place at the policy level.
   C. Do a literature review through existing literature, formative assessment, surveys, and informal means to help identify knowledge, attitudes, and practices; specific needs of KP; and gaps in existing interventions, materials.
2. **Identify target audience(s). Define and learn about intended audiences. Segment the intended audience into homogeneous sub groups.**
3. **Define BCC goal and objectives.**
   A. Set a broad statement of what you would like to accomplish with the target audience.
   B. Establish behavioural objectives that will contribute to achieving the goal.
   C. Conduct workshops to develop appropriate BCC messages that are tailored for KP using consultative and participatory process.
      i. Mobilize target population.
      ii. Conduct formative assessment.
      iii. Design content of the curriculum for BCC messages workshop.
      iv. Pre-test and revise as appropriate.
      v. Train in the use of the messages and the materials.
      vi. Deploy the messages and materials.

SOP2.1.a ADVOCACY/ SENSITIZATION

Procedures:

1. **Identify a team of individuals responsible for the planning and implementing the working with KP**

sensitization strategy.

2. **Conduct stakeholder mapping (including listing and categorization) which can include:**
   A. Commission for Human Rights and Administrative Justice
   B. Ghana Police Service
   C. Civil Society Organisation
   D. KP friendly political and opinion leaders
   E. Bar and hotel owners and managers
   F. Law enforcement
   G. Civil society groups
   H. Peer leaders
   I. Traditional Health Practitioners
   J. Bartenders/security guards in the bars
   K. Taxi drivers
   L. Clients/regular partners
   M. Brothel keepers/managers
   N. Pimps/non-paying partners
   O. Lodge managers/owners
3. **Develop community mobilization/advocacy plan**
   A. Analyse stakeholder information needs.
   B. Identify potential challenges that could be expected from each category of stakeholder.
   C. Plan strategies to minimize the challenges and gain support from stakeholders.
   D. Establish tailor-made sensitization and communication strategies.
   E. Package tailored messages for each "target" stakeholder.
4. **Sensitize stakeholders and gatekeepers.**
   A. Initiate contact with stakeholders, maintain and monitoring contact.
   B. Dispatch messages through appropriate communication medium e.g. one-on-one, small group, etc.
   C. Conduct follow-up.
   D. Conduct regular stakeholder meetings to give project updates and get their inputs and support to resolve problem facing the project implementation.
   E. Invite stakeholders regularly to project activities and events and acknowledge their contributions to the project.
5. **Conduct stigma and discrimination reduction training for stakeholders and service providers.**
   A. Training should include SGBV, legal issues, stigma and discrimination.
   B. The goal of training is to provide services that are acceptable to KP and that address the needs of the KP while respecting their health and human rights.

SOP2.1.b DEVELOP BCC MESSAGES AND MATERIALS

The design and production of BCC materials typically occurs after a behavioural communication strategy has been developed based on a formative assessment and in consultation with program stakeholders. A well-thought-out BCC strategy should segment the intended audiences, develop targeted messages and approaches using a variety of communication channels to promote positive behaviours; generate demand for and sustain

individual, community and societal change; and support the maintenance of healthy behaviours.

Procedures:

1. **Use participatory approach to define messages and develop materials.**
   i. Discuss with stakeholders (at one-to-one meetings or in workshop settings) BCCmaterials development plan.
   ii. Involve KP in message and materials development at every phase.
2. **Determine messages**
   A. Identify factors inhibiting and enabling optimal behaviours through rapid assessment and utilization of existing behavioural data
   B. Based on behavioural needs and intervention objectives, work with key populations to develop, test and finalize key behavioural messages.
3. **Determine appropriate BCC channels.**
   A. People access information in various ways, at different times of the day, and for different reasons. Explore settings, channels, and activities best suited to reach intended audiences.
   B. Determine what communication channels will most effectively reach the target audience based on messages selected. Match the needs of the target audience with the tools that best support the objectives and resources.
      i. Examples of communication channels include: Print (Posters, billboards, leaflets), radio/TV, mobile phone, social media, one-on-one (e.g. peer education, HelpLine counselling).
      ii. Decide what materials are needed based on assessments. It is helpful to do this with implementing partners and selected target audience who have had experience with the use of existing materials.
      iii. Choose materials that will best promote the objectives of the strategic behavioural communication strategy for the budget available and specific key population.
      iv. Identify potentials partners, resources and other forms of support for the development of the BCC materials.
      v. Using social media tools has become an effective way to expand reach, foster engagement and increase access to credible, science-basedhealth messages. Social media and other emerging communication technologies can be used to facilitate and connect KP, especially the hidden KPs, to health and protection information and empower them to make safer and healthier decisions.
4. **Adapt or develop BCC materials.**
   A. Gather relevant existing BCC materials to adapt.
   B. Modify materials as appropriate. While technical information and main ideas may remain unchanged, modifications in language and localization of images and styles may probably be necessary.
   C. Design materials as needed, based on the above steps
   D. Pre-test materials.
      i. Chose appropriate method for pre-testing. For example, arrange for a two-person team: a facilitator and a note-taker. A two-person team can effectively interview 5-6 people a day or conduct 2 pre-testing focus group discussions per day.
      ii. Ensure that participants match the profile of the key population as closely as possible. Make sure that the same respondents do not participate in more than one round of pre-testing.
      iii. Materials required: draft materials (e.g., pictures and text separately), audio recorder, pens, paper for taking notes.

iv. If pre-testing in groups, for print materials, make a copy of messages/ materials for each participant.

v. Number all messages and images to be pre-tested for easy reference.

vi. At least two rounds of pre-testing should be conducted: one for draft versions and one for almost-final versions.

vii. Ensure privacy and confidentiality by conducting pre-tests in a secure environment and assuring participants of complete confidentiality. Discourage onlookers to facilitate the process free of interference.

viii. Interviewers should ask questions measuring the following variables:

(a) Comprehension: Do respondents understand messages?

(b) Attractiveness: Do respondents find messages/materials/images appealing?

(c) Acceptance: Do respondents find messages culturally/socially acceptable?

(d) Involvement: Do respondents perceive materials to relate to people like them?

(e) Inducement to action: Do respondents feel motivated to act after exposure to messages / materials?

(f) Ask open-ended questions that elicit detailed comments. Ensure that questions do not lead participants to specific answers.

ix. Compile summary results. Once all parts of messages and materials have been pre-tested, compile a summary of results for the graphic artist and BCC team and make necessary revisions to the prototype.

x. Obtain approval from stakeholders and relevant staff. This includes collaborating institutions, organizations interested in using materials, agencies with authority to approve materials or stop them from circulating and donors.

5. Produce Materials.

A. Determine pictorial and textual messages as specifically as possible before contacting vendors.

B. Relevant staff should draft text or copy of print materials as appropriate and possible.

C. Contact three or more vendors to find the one most suitable for the intended production of materials.

D. Describe the proposed job and including a creative brief, a short paper outlining project needs to the vendors. The brief should include: expected graphic content, messages, colour, type of paper, number of copies and project background. Request creative and financial proposals by a certain date from prospective vendors. Request samples of past relevant work.

E. Hire appropriate vendors (e.g., graphic designers, writers, production vendors).

F. Make sure all selected vendors have the information needed to do their work. This may include technical information that they may not have access to, sample images, finalized messages, and donor / stakeholder logos.

G. Deliver requested changes to vendors after pre-testing.

H. Make sure production timing is clear to all parties concerned. Your contract with vendors should include penalties for delays in production.

I. Coordinate production schedules so that all materials are completed in time for a launch, intervention start or major event.

J. Monitor progress of vendors' work throughout the development process.

K. Always demand to see “proof” of products to sign off on before final production. For print materials, this may be the very first copy of an item right off the presses to review before the full print run is executed.

6. Distribution of materials:

A. Develop inventory for all available materials. It should include quantity, goal and objective, target

population of each material. Check all materials regularly to ensure quantity and availability of materials.

B. Develop a distribution plan and share with all parties concerned (include the amount of space required for storage at facilities where materials will be stored).

C. Develop and use receipts/forms for recording distribution.

D. Train material users such as BCC practitioners, peer educator, outreach or relevant staffs how to use materials, including goals and objectives, target audience, and content of the materials. Ensure that they are well prepared for using the materials. Conduct refresher training as possible.

7. Establish feedback mechanisms

A. Incorporate channels through which key populations and stakeholders can share their views about the materials and make suggestions for improvement.

8. Plan and implement for M&E. Use appropriate M&E for different type of materials and target groups. Periodically, assess whether:

i. Activities are being completed at scheduled times;
ii. Your intended audiences are being reached;
iii. Certain activities or materials are more successful than others;
iv. Certain aspects of the program need to be altered or eliminated; and
v. Your expenditures are within budget.

B. Use process evaluation to track the following (depending on focus of BCC strategy):

i. The functioning and quality of your BCC interventions
ii. Partner/coalition involvement
iii. The effectiveness of publicity, promotion and other outreach efforts
iv. Media response
v. Intended audience participation, inquiries and other responses
vi. Adherence to schedule
vii. Expenditures and adherence to budget

C. The following are examples of ways to gather the information needed for process evaluation:

i. Use activity tracking forms.
ii. Ask callers what prompted their call (e.g., for HelpLine counselling).
iii. Gather feedback cards from or make follow-up phone calls to television and radio stations.
iv. Review telephone responses for accuracy.
v. Follow up with teachers, physicians or other gatekeepers to check their preparedness and interest.
vi. Gather regular status reports from staff, contractors and partners.
vii. Meet in person or by telephone with partners to review your program's progress.
viii. Track traffic to project Web sites.
ix. Review publication requests and distribution

Refer to Annex J for tips in producing successful materials.

SOP 2.2.PEER EDUCATION AND OUTREACH STRATEGY

Purpose:

To provide a standardized guide to establishing and implementing an effective peer education programmes.

Target Users:

Program managers, peer educators, outreach workers

Overview:

Reaching KP with HIV prevention and care information and services is important in reducing their risk to HIV. Peer education is a structured, interpersonal form of communication where trained key populations peers influence their peers to maintain positive behaviours or undertake behaviour change to improve or protect their health. Peer education is often used to effect changes in knowledge, attitudes, beliefs, and behaviours at the individual and community level. They may also be involved in the protection of the rights of their peers and in linking peers to key health, protection and psychosocial services. Peer educators are an essential link between the community and NGO and facility-based services, and are most effective when they maintain contact with peers over time. Peer educators may interact with peers on a one-on-one or group setting.

Micro-planning is a crucial approach to ensure that planning, implementing, monitoring and strategizing service delivery for community outreach interventions is effective, relevant and efficient recognizing that each "hotspot" and each KP in every hotspot have unique risks and needs. Micro-planning enables a PE to do individual-level assessment, planning and tracking/ follow up on service uptake based on their individual risk, vulnerability and profiles; gives a visual picture of the site; and enables a PE to monitor and track individual FSW to ensure that all services and follow-ups are provided.

Before individuals can reduce their level of risk or change their behaviours, they must first understand basic facts about HIV, adopt key attitudes, learn a set of skills, and be given access to appropriate products and services. This is often done through communication sessions led by a PE. Effective communication sessions facilitate and enhance participation of the peers to initiate dialogue with the community, enhance participation of KP to improve self-risk perception of STI/HIV transmission and to identify the ways and means to reduce the risk, improve skills and sense of self-efficacy and promote services for prevention, care and support. Communication sessions may be conducted one-on-one (one PE to one KP) or small group sessions (one PE to group of maximum four to eight KP).

SOP2.2.a ESTABLISHING PEER EDUCATION PROGRAM

Procedures:

1. **Design the PE outreach intervention. Refer to Section 1 Project Management for detailed procedures.**
   A. Ensure relevant representation of each KP is included all steps so that their needs and preferences are identified and used to define the peer education program.
   B. Identify and assess specific needs of KP through existing literature, formative assessments surveys, and informal means.
   C. Mobilize key stakeholders. Ensure that relevant stakeholders (including KP, relevant government officials, civil sector leadership, health professionals, opinion leaders, etc.) are informed and encouraged to support peer education efforts.
   D. Consider cross-cutting issues. Incorporate key contextual concerns (such as sexuality, socio-economic and cultural factors, vulnerability and risk factors, age, gender).
   E. Establish feedback mechanisms. Incorporate channels through which key populations and stakeholders can share their views about the program and make suggestions for improvement. Refer to SOP1.4.c Developing feedback mechanisms for more guidance.

2. **Recruit peer educators. PE refers to someone who has been trained to be a source of reliable information, assess peer needs, provide referrals to health, protection and psycho social services and model healthy behaviours.**

   A. Identify sources and channels for recruiting peer educators. Work with partner organizations, workshop participants, influential persons within the target groups and community leaders to develop a plan to identify recruitment sources and channels (word of mouth, announcements, internet, etc.).

   B. Develop and agree upon selection criteria for peer educators. Criteria should include representativeness of population, size of social network and degree of respect among peers, availability over period of intervention, commitment to working as a peer educator, personal traits (team player, volunteer spirit, potential for leadership, etc.), and ability to lead, and other characteristics deemed relevant for a particular population or program.

   C. Set clear expectations. Document the clear expectations of both the program and prospective peer educators. Expectations for peer educators' activities and performance need to be clarified and documented in writing. This should be agreed upon by all partners at the beginning.

   D. Establish a standardised and transparent interview and selection process. Standardise and document the interview forms and processes, including establishment of a credible recruitment panel. The selection process needs to be documented in writing, made available to all interested parties, and should be implemented fairly.

3. **Train PEs.**

   A. Use existing or develop new training curricula. Select training curricula that are consistent with the topics, approach of the program/BCC strategy, culturally appropriate and gender sensitive, interactive and participatory, and well-structured and sequenced in feasible time allocations.

   B. Arrange for qualified trainers. Engage trainers that are well informed, prepared with knowledge and skills relevant to their responsibilities, flexible and able to improvise, experienced in peer education, and sensitive to cultural and gender issues.

   C. Arrange for appropriately sized trainee groups. Training workshops should not exceed 15-25 participants to allow for effective participation, full interaction among peers and trainers. This group size also offers opportunities for leadership and skills practice.

   D. Provide relevant materials and hand-outs. Provide participants with materials in advance and during training sessions, as appropriate, including practical hand-outs and materials for exercises. Copies of reference and review materials should also be provided at the conclusion of the training.

   E. Use interactive, participatory, and skills development approaches. Use participatory training approaches that maximize trainee participation, such as interactive exercises, opportunities to practice new (or important existing) skills, and role play situations participants are likely to encounter as peer educators.

   F. Implement tools and methods to evaluate training and training participants. Include mechanisms for assessing trainees' knowledge and skill development from the onset of training (as a baseline) and used at the conclusion of the training (post-training evaluation). Tools for trainees to evaluate the training should also be included.

   G. Discuss ethical issues. Highlight and discuss ethical issues (such as confidentiality, power balance, gender equity) that are likely to arise in connection with peer educators' activities as part of the training.

   H. Involve target population at all stages. Key populations need to be involved in all aspects of the training design, implementation, and evaluation, and should also help plan future training.

SOP2.2.b SUPPORT PEER EDUCATION PROGRAM

Procedures:

1. Establish means for continuous communication, including feedback. Establish open and continuous communication mechanisms between peer educators and the program supervisors and managers, including regular feedback via supervision, regular peer educator/ management meetings, and an annual retreat (if possible).
2. Implement a PE incentives system. Create a system of reinforcement of financial and non-financial incentives depending on the context, geographic area and resources available, including T&T, recognition; awards; social and recreational opportunities; exchange (and travel) opportunities; and advancement within the group as appropriate.
3. Offer opportunities for increasing involvement and responsibility. Encourage peer educators to become more involved and take on additional responsibilities where possible, including assumption of some program operation tasks (co-trainer, management assistant, recruiter etc.). Develop and implement a peer progression system that offers opportunity for interested PE to move up the ladder (peer educator, peer leader, supervisor and program officer etc.).
4. Establish supervisory and mentoring systems. Set up an effective supportive supervision system, with mentoring provided as possible.
   A. Arrange for trained supervisors. Hire/recruit supervisors who have been trained in supportive supervision skills, program expectations, and peer education content and approaches.
   B. Ensure that peer educators are well prepared. Supervisors have to ensure that peer educators have received adequate preparation (through training and skills acquisition/practice) before they begin their work. Updates of knowledge and skills should be provided as needed and with expansion of roles.
   C. Continually reinforce motivation and ethical behaviour. Supervisors should continually reinforce the personal or professional motivation of peer educators (via rewards, meetings, etc.), reinforce compliance with the code of ethics, and monitor sensitivity to gender and cultural concerns. Where possible, supervisors should promote opportunities for personal development, such as workshops and conferences.
   D. Manage the group dynamics and encourage team building. Supervisors need to manage the group dynamics, encourage team building, promote a safe environment and stay aware of personal relationships.
   E. Share responsibility with peer educators. Supervisors should build ownership by involving the peer educators in the decision-making process, sharing supervision and responsibilities with peer educators and involving them as active participants in the supervision process, with feedback regularly invited.

   PE performance should be reviewed monthly against program indicators related to number of contacts, communications sessions, condom distribution, and referrals.

SOP2.2.c MICRO-PLANNING AND INDIVIDUAL TRACKING

Procedures:

1. **Field staff train PE to develop, implement and update micro plans for their sites.**
2. **Develop the micro-plans.**
   A. Define the geographical area of operation for each PE. This should be a PE-led activity with support from their supervisor.

B. The Supervisors should aggregate the micro plans of the PEs under them to produce his/her micro-plan at his/her level.

C. The supervisor support PEs to make their specific area map, enrol and track peers individually using unique identification code (UIC).

3. Monitor and document the implementation of the micro-plan.

A. Implementation of micro-plans is to be documented by the PE in the form of daily activity sheets and weekly reports.

B. Micro-plans should be updated on a monthly basis. PEs should update, at minimum, the following information on monthly basis:

i. Number of registered KPs in the site
ii. Number of new and drop out KPs
iii. Number of KPs accessing services
iv. Number of KPs who are members of self-help groups
v. Key stakeholders in the site
vi. Number and location of condom depots
vii. Number of condoms and water-based lubricants sold (or distributed)
viii. Location of DIC and referral facilities such as HTC in the site.

SOP2.2.d CONDUCTING COMMUNICATION SESSIONS

Procedures:

1. Keys components of successful communication sessions:

A. Build rapport with KP before initiating a discussion on STI/HIV, fostering a sense of solidarity and support.

i. Use appropriate language and dialect while communicating with KP.
ii. Have appropriate body language and tone of voice during the sessions.
iii. Be respectful and non- judgmental.
iv. Treat every peer (under her/him) with equality and confidentiality

B. Conduct individual risk assessment. Elicit the KP's knowledge, perceived risks of STI/HIV and barriers for accessing services.

C. Give correct technical information related to STI/HIV or other relevant related issues such as substance use and mental health issues as well as about available services and record the unanswered queries raised by KP

i. Teach KP peers how to correctly use condom and water-based lubricants with the help of demonstration and re-demonstration on the penis model.
ii. Use relevant BCC material in an interesting way.
iii. Address the myths and misconceptions related to HIV/STI.

D. Refer peers to the DIC and other health institutions as per their needs.

2. Minimum responsibilities of each PE: Behaviour change by a peer should be facilitated through the use of the BCC minimum package which includes provision of information/education on HIV/STI prevention (HIV/STI transmission and behaviours based on 10 key behaviours below), conducting a risk assessment based on behaviour and referring for the appropriate HIV/STI related service(s). Service includes STI, HTC, GBV and drug and alcohol counseling.

Ten Key behaviours:-

A. Use condoms consistently and correctly
B. Use non-oil-based lubricants correctly
C. Get tested and know HIV status
D. Disclose HIV status to regular partners
E. Promptly seek appropriate and effective treatment for STIs, HIV/AIDS and OI
F. Adhere to treatment (STIs, OIs and ART)
G. Reduce number of multiple and concurrent sexual partners
H. Eat healthy
I. Protect against other infectious diseases such as TB, Malaria and diarrhoea and
J. Get information on mitigating drug and alcohol use.

3. **Conduct initial communication session:**
   A. Plan your agenda before approaching peer(s).
   B. Identify the peer(s) and establish contact.
   C. Establish rapport introducing yourself and your project.
   D. Ask for permission to discuss the planned agenda.
   E. If not convenient, ask for an appointment with peer(s) for time, place and possible topics of interest to be discussed.
4. **Conduct subsequent communication sessions.**
   A. The PE should make prior appointment at a time and place convenient to KP.
   B. Identify appropriate place to conduct one-on-one or small group sessions keeping in mind privacy and proper visibility and audibility.
   C. Decide on the appropriate BCC material or message to be discussed based on the prior session; prepare speaking points for the session with the KP.
   D. Initiate a dialogue with the KP on risk reduction.
   E. Thank the peer(s) for their time and participation.
   F. Fix an appointment for the next session.

SOP 2.3.CONDOM & WATER-BASED LUBRICANT DEMONSTRATIONS & PROMOTION

Purpose:

To provide a standardized approach to the demonstration and promotion of male and female condoms, water-based lubricants and other commodities.

Target Users:

Program managers, peer educators, strategic behaviour change officer, field staff

Overview:

Correct and consistent condom use is one of the best methods for HIV prevention. Demonstrations and promotion of female and male condoms, as well as water-based lubricants and other commodities such as gels are important components of an HIV program among KP. Condoms, water-based lubricants and other commodities should be made available and accessible through KP focused programs. There needs to be a

consistent and adequate supply of condoms and lubricant. PEs should demonstrate and encourage the correct and consistent use of condoms and water-based lubricants and provide KP with the skills to negotiate their use with clients and partners.

1. **Demonstrate correct condom usage. PEs and clinical service providers must be trained to demonstrate the proper use of condoms and water-based lubricants.**
2. **Promote use of and create demand for condoms.**
   A. Demand creation for condoms can be done by PEs and through BCC materials including media outreaches. Details can be found in
   B. Condom and lubricant outlets should be opened in hotspots. These could include shops, bars or guest houses.
   C. Condom promotion must be done without coercion. Advocacy with law enforcement agencies is important to ensure that possession of condoms is not used as evidence of sex related criminal activity.
3. **Build capacity in condom use negotiation skills among KP. PEs and other service providers should provide KP with the skills in negotiating condom use with clients and partners.**
4. **Distribute/sell condoms and water-based lubricants.**
   A. Peer educators will distribute/sell condoms and water-based lubricants whenever possible to KP during education sessions and contacts according to need of KP (to minimize wastage).
   B. Condom and lubricant outlets should be opened in hotspots. These could include shops, bars or guest houses.
   C. Static, outreach and referral clinics need to distribute/sell condoms and water-based lubricants to KP.
   D. Monitor quality of condoms (e.g. expiration dates, reports of breakage) and report problems to implementing partners and/or the Ghana AIDS Commission.

SOP 2.4.ESTABLISHING AND SUPPORTING A DROP-IN CENTRE

Purpose:

To provide standard procedures to establish, implement and sustain services at a drop-in centre.

Target Users:

Program managers, clinic staff, peer educators, BCC Officer

Overview:

Drop in centres established by CBOs and NGOs working with KPs provide safe places for KP to access information/education, resources and services in the prevention of HIV/STIs, to offer compassionate support services for persons affected by or living with HIV; and to support community building in a safe and confidential environment. A variety of educational, social, capacity building activities can be organized. In some settings, and in-line with national policy and guidelines, the establishment of clinical services could be also integrated.

Overarching aims of any DIC are to provide high quality, easily accessible services to clients; increase demand and utilization of services; act as a hub for services for KP and PLHIV; establish a continuum of prevention and care with a strong referral mechanism referring client to/from DICs; provide basic protection including support and referrals for gender-based violence through peers and MARP-Watchers and MARP-Friends.

Procedures:

1. **Conduct formative assessment and a participatory consultation**
   A. Assess specific needs of key populations through formative assessments or secondary data from previous surveys, and informal means. Make sure relevant representation of each key population (e.g. MSM who identify as homosexual, bisexual, and heterosexual including male sex workers) is included in the assessment.
   B. Identify possible locations for DICs based on mapping, available data and importantly, discussions with key populations.
   C. Review relevant government policies and legislation that may impact on service establishment and operation.
   D. Mobilize key stakeholders. Identify and bring together through a workshop various stakeholders to initiate a community dialogue, seek input on establishing the drop-in centre and generating "buy-in" for the activity. This stakeholder meeting should include representatives from Government/NGOs/CBOs working with MSM. Representatives from NACP in charge of HIV/STI service provision and other relevant health and welfare services in catchment area should be also invited as collaborative partners since the service will offer a referral.
   E. Actively involve key populations in the planning process so that their needs and preferences are identified and used to define the referral network.
2. **Develop DIC workplan.**
   A. Identify the services to be provided:
      i. This will vary considerably, according to the availability of resources and the findings of the assessment.
      ii. At a minimum you will need to implement the following key activities:
         (a) Individual and group-level peer interventions
         (b) Social activities/community mobilization activities
         (c) Provision of relevant information/education (printed materials)
         (d) Distribute/sell condoms and water-based lubricants.
         (e) Assessment for HTC and STI service needs and referrals
      iii. Other activities that may be provided at a DIC include:
         (a) Support group meetings
         (b) Counselling services (HIV counselling, psychosexual and psychosocial counselling)
         (c) Community-based clinical services (HIV testing, STI clinic, family planning counselling and services, general health exams) or venue for hosting mobile clinic services
         (d) Hot line or internet service
         (e) Non-formal education, literacy/numeracy programs, language classes
         (f) Classes on beauty tips, nutrition and self-care
         (g) Showers and laundry facilities/lockers to store belongings while community members are working
         (h) crèches (child care) for children of sex workers.
   B. The DIC workplan should include site selection, hours of operation, minimum services to be offered, training plans, an advocacy and mobilization strategy, periodic meetings with the referral network, printed materials/tools development or adaptation, community involvement, and a monitoring and evaluation plan.

3. **Select site/venue**
   A. Identify the criteria for site selection.
      i. The development of the site selection criteria should be informed by the community discussions and assessments, the type of the services/activities to be implemented, and the available resources.
      ii. The list of criteria should be validated by key populations representatives and the staff.
      iii. The criteria should include structural safety & security such as availability (continuity of tenancy), accessibility, continuous electricity supply, exit issues in case of fire, potential for, or availability of multiple dedicated phone lines; cost of rental premises, flexibility to modify physical structure of premise, internet access, and, very importantly, proximity to the specific areas where KP live or gather.
      iv. Depending on the available resources, a DIC could be a venue either rented on specific daily or monthly basis integrated into the office of the NGO/CBOs or stand alone in another location/venue. Where possible, seek donated space.
   B. Visit and assess potential sites. Document site selection criteria that are both acceptable and unacceptable at each ptential location. Make the final selection in partnership with key population representatives.
   C. Finalize rent agreements. Note in the agreements the site modifications will be required, if any. Ensure that funds are secured prior to sign the agreement and the duration of the lease should match with the duration of the contract with the donor to avoid interrupted service provision.
4. **Prepare site including the development of DIC management procedures.**
   A. Ensure the functionality of the DIC (based on the services provided):
      i. Required furniture and equipment
      ii. Decoration
      iii. Development of a DIC "membership" system and tools to monitor daily activities
      iv. Ensure sufficient telephone lines are available if a hotline service will be established
      v. Ensure internet access is available, if relevant
      vi. If "face to face" counselling services are offered these should be conducted in rooms offering visual and auditory privacy to clients
   B. Ensure building security and structural safety: exits , extinguishers, instructions in case of emergency such as fire or injury should be displayed and accessible for the beneficiaries and staff. Emergency telephone numbers (police, hospitals…) should be also displayed as well as 'M-Friends and M-Watchers'.
   C. Ensure the provision of materials and commodities, such as condoms and water-based lubricants, dildos for IEC materials, data collection tools etc. needed to support the implementation of the activities.
   D. Ensure the DIC is integrated into a referral system. See SOP 4.1 Establishing and supporting referral networks.
   E. Develop DIC management procedures. The policy should clearly ensure that confidentiality and anonymity are respected and grievance procedures should be in place for beneficiaries who feel their confidentiality was breached. This aspect is crucial when working for example with MSM where male-to-male sex is criminalized, or with FSW when sex work is considered illegal, or when establishing a community-based clinical services. The policy should be accessible for all the members and/or read to the members.
5. **Recruit personnel.**
   A. Develop and agree upon selection criteria for recruitment or assignment.
      i. Develop a list of criteria for selecting personnel to be trained to be staff (either full-time or part-time for the activities of the DIC). Volunteers, if any, could be also selected but under the mentoring of the assigned staff.
      ii. Advertise shortlist, interview and select applicants (external or internal).
      iii. Recruitment process must be transparent and free of coercion. A selection panel could be set up as well.

iv. Standardized, interview questions should be drafted and applied to all recruitment interviews.

6. Train staff.

A. All staff, including volunteers, must agree to attend all training workshops and supervision sessions offered prior to, and after commencement of duty.

B. Each new employee should undergo a formal orientation to the DIC including the training of the DIC SOP, and basic peer support counselling, the internal policy and the basic training on HIV and STI outreach for peer educators/worker. USAID Ghana SHARPER Project has developed an initial and refresher DIC staff training that can be made available.

C. All staff should attend annual refresher training and other available and relevant training organized for the NGO/CBO.

7. Launch the DIC: invite local authorities/stakeholders, beneficiaries, and partners for the launch of the DIC.

8. Promote and implement services

A. Develop a strategy to promote the DIC.

i. Identify ways to let key populations know about the service. This could include materials disseminated by peer educators, through SMS or social media. Ensure promotion is conducted in a way which is discreet and targeted towards key populations and organizations working with key populations only.

ii A specific name and logo could be also designed (branding strategy).

iii. Ensure that the promotion of the DIC is consistent and integrated in the other activities/interventions established by the CBO/NGO.

iv. DIC can also be promoted by different partners such as social services of hospital, STI/HTC clinics, hotline, and any other services that are included in the 'referral system" (see SOP "Establishment of community-based referral system"), and specific entertainment venues.

v. Review the promotion/communication strategy every year based on the feedback from monitoring.

B. Develop a weekly or monthly agenda to plan DIC services.

i. The agenda should be available to the beneficiaries and peer educators/outreach workers to promote upcoming services during the outreach activities.

ii. If the CBO/NGO or DIC has a website, the agenda could be also posted on their website.

iii. Use SMS and social media to promote specific DIC activities or events.

C. Mobilize the communities/groups to use and support the services at the DIC. Undertake intensive community mobilization and promotional activities to increase the demand of services.

9. Monitor the DIC activities (e.g., services offered, attendance) and use the findings to improve the system: strengthening/adapting the current services, and identifying new services.

A. The monitoring should include quantitative and qualitative data.

B. Feedback from the beneficiaries should be also regularly collected and monitored.

C. Organize periodic meetings with the staff and the beneficiaries using the DIC. These meetings provide a venue for on-going communication, exchange of information about the services provided, discussion of challenges and gaps in terms of services and updating the service network directory.

D. Ensure compliance with program standards. Management staff needs to systematically monitor and assure compliance with standards and policy and initiate corrective action when shortfalls are identified. Refer to for further guidelines.

E. Use M&E for decision-making. Findings from timely reporting on program activities, as well as from any evaluation that takes place, should be used to make adjustments in program operations. Refer to for further guidelines.

Section 3 : BIOMEDICAL INTERVENTIONS

Biomedical interventions (those that directly influence the biological systems through which the virus infects an individual, such as blocking, decreasing infectiousness, or reducing acquisition/infection risk) for KP specifically involve testing and diagnosis of infections, treatment, family planning and other clinical services that improve their health. Biomedical interventions for KP addressed in this section are STI management, HIV counselling and testing, and sexual and reproductive health.

Stigma and discrimination create barriers to KP access to clinical services. Effective clinical services (STI treatment, HTC) among KP is however an important strategy to reduce biomedical HIV transmission. Service providers and other social workers should be trained to provide friendly services to key populations to promote uptake of STI/HIV and related services. Health workers' attitudes greatly influence the acceptability of services provided.

In addition, this section provides guidance on occupational infection control to minimize the spread of infection between patients, and between service providers, staff and patients (nosocomial infections).

List of SOP:

SOP 3.1 Establishing KP-friendly clinical services

- SOP 3.1.a Facility-based clinical services
- SOP 3.1.b Outreach clinical services

SOP 3.2 Provide KP-Friendly clinical services

- SOP 3.2.a STI management services
- SOP 3.2.b HIV testing and counselling
- SOP 3.2.c Sexual and reproductive health screening services

SOP 3.3 Occupational infection

- SOP 3.3.a Infection Prevention
- SOP 3.3.b Biomedical waste management.

Key references:

- DIC SOP. USAID Ghana SHARPER Project, FHI 360, 2012.
- Training Manual for Peer Educators of FSW in HIV Prevention. USAID Ghana SHARPER Project, FHI360, 2011.
- Training Manual for Peer Educators MSM HIV Prevention (It's My Turn). USAID Ghana SHARPER Project, FHI360, 2011.
- Guidelines for Management. Sexually Transmitted Infections. National AIDS/STI Control Programme, MOH. Ghana. May 2013.National Guidelines for the Implementation of HIV Counseling and Testing in Ghana (MOH 2008).
- Illustrative DIC ScreeningTool for FSW and MSM. USAID Ghana SHARPER Project, FHI360, 2013.
- Policy and Guidelines for Infection Prevention and Control in Healthcare Facilities, Ministry of Health, Ghana. June 2009.
- Key Population and PLHIV Stigma Reduction Training for HIV Testing and Counselling and STI Care Providers. USAID Ghana SHARPER Project, FHI360.

SOP 3.1.ESTABLISHING KP-FRIENDLY CLINICAL SERVICES

Purpose:

To provide standard guidelines for establishing KP-friendly facility-based and outreach clinical services.

Target Users:

Service providers, program managers.

Overview:

KP face on-going challenges in accessing the health services they need, even when motivated to engage in healthier behaviours including seeking treatment for STIs and/or testing to know their HIV status. KP in Ghana tend to be highly stigmatized and discriminated against in their daily life due to cultural and legal prohibitions against commercial sex and homosexuality, and inadequate understanding of HIV transmission. Young KP are particularly vulnerable as they are further marginalised by health workers because of their age.

Health care providers have been known to stigmatize and discriminate against KP. Limited information about them, lack of requisite skills to work with them as well as limitation in the number of friendly facilities all contribute to this dilemma. This combined stigma leads to significant barriers to accessing comprehensive prevention, care and treatment services. Providing high quality, non-judgmental and supportive KP friendly clinical services (STIs, HTC) in both facility settings and through outreach clinics will help to increase uptake of clinical services by KP.

Procedures:

1. **All staff (clinical, outreach, assistants, receptionists, etc.) should be trained to be KP-friendly and have a non-judgmental attitude towards the key populations served by the clinic.**
   A. Conduct stigma and discrimination reduction trainings for all staff and service providers using the KP and PLHIV stigma training guide for HIV testing and counselling and STI care providers (produced by the USAID Ghana SHARPER Project).
   B. Train providers on the linkages between SGBV and HIV, specifically how violence or the fear of violence can prevent women and MSM from assenting to HTC or returning for results; the importance of confidentiality; potential negative outcomes of disclosure, and incidence of anxiety, depression, and stress when learning about HIV status during pregnancy.
   C. Identify the additional training needs of the staff and, if necessary, seek assistance for training.
2. **Plan for on-going technical support and supervision of staff.**
3. **Establish strong linkages with referral network and all activities targeted at KP to create demand for the services and ensure diverse needs are met. See SOP4.1 Establishing and supporting referral networks .**

SOP3.1.a FACILITY-BASED CLINICAL SERVICES

Procedures:

1. **Establish facility-based clinic team.**
   A. Refer to National HIV Counselling Guidelines and National STI Guidelines (NACP 2013) for detailed information.

B. Team Composition: Ideally, the team should be composed of a doctor, nurse, midwife and counsellor.

C. Clear roles and responsibilities for each member of the clinic team should be outlined and followed. Illustrative roles for clinic team can be found in Annex L .

2. **Sensitization/training. The Clinic should provide a KP friendly environment. The staff should be well trained and ensure that all KPs are cared for respectfully.**

A. Train or otherwise sensitize management and key staff of the health facility on need to provide KP friendly services.

B. Team should have appropriate qualifications: training in the syndromic management of STIs, testing and counselling for HIV, provision of family planning services and detecting and managing cases of sexual violence to perform their assigned tasks. The staff should be well qualified and competent to carry out medical, nursing and laboratory procedures according to GHS/MOH/NACP guidelines

3. **Ensure appropriate clinic structure, equipment and supplies. Full description of needed infrastructure, equipment supplies is described in the National HIV Counselling Guidelines and National STI Guidelines (NACP 2013).**

A. Clinic buildings and rooms should be properly maintained to ensure a comfortable, safe and hygienic environment.

B. Clinic space must provide and ensure privacy and confidentiality for history taking, physical examination including internal examination, individual, couple and group counselling and record keeping.

C. The internal structure of the clinic should include the following:

i. Waiting and registration area

ii. Consultation and examination room

iii. Laboratory area (if available)

iv. Counselling room.

D. Ensure availability of occupational infection control materials. See 3.3 SOP Occupational Infection for detailed guidance.

4. **A client flow chart should be developed and clearly followed for the clinic.**

5. **Establish participation in referral network. See SOP 4.1 Establishing and supporting referral networks for more information.**

6. **Provide a mechanism for KP client feedback regarding the quality of clinical services.**

SOP3.1.b Outreach clinical services

Procedures:

1. **Establish outreach clinic team:**

(a) Clinic Team comprising of a health care provider who is KP friendly. Build the capacity of the health workers to be KP friendly at the provision of HTC/STI/ART/SRH services, if necessary.

(b) Outreach Team comprising of the PE and community volunteers (peers, bar or spot owner), field supervisors of the site/s.

B. Clinic structure is not fixed and can be held at any convenient and suitable place at the site e.g. DIC, brothel, home of a PE/KP, or bar.

C. The day and timing of the clinic is again not fixed and is decided jointly by the outreach service team and leadership of the KP in the community.

i. The outreach team informs the KP well in advance about the day, place and timing of the outreach service.

ii. On the day of the service, the outreach team will visit the site a few hours before the outreach service begins and motivate the KP to access clinical services.

2. **Determine and plan for services to be provided.**
   A. HIV testing and counselling.
   B. Individual or group STI counselling.
   C. Thorough history taking and physical examination. Internal examination,if the clinic facility allows.
   D. Syndromic case management for symptomatic STIs.
   E. Treatment for a symptomatic STIs, if first visit.
   F. Screen for family planning, pregnancy and other SRH needs.
   G. Screening and care for SGBV.
   H. Treatment of general ailments.
   I. Referrals for higher STI services or services not provided at the outreach clinic. Referrals for ART, SRH and other services.
   J. Syphilis screening may be added
   K. Verbal screening for TB could also be done.
3. **Ensure necessary resources:**
   A Equipment required for physical examination of the patients as well as for internal examination, wherever the clinic facility is conducive for it.
   B Infection control materials such as soap for hand washing, disposable gloves, and bleach solution for disinfection of gloves and speculums and garbage bags for infectious and non-infectious waste. See SOP 3.3 Occupational Infection for detailed guidance.
   C Counselling / teaching aids such as BCC material, speculum, penis model, condoms and water- based lubricants.
   D Documentation material such as HTC Forms, Referral and Registration forms.
   E Space that will provide facility for history taking, general examination, group counselling at the minimum. Ideally it should provide auditory and visual privacy for internal examination and individual counselling too.
   F Commodities/supplies: adequate supply of test kits, condoms and lubricants.

SOP 3.2.PROVIDE KP-FRIENDLY CLINICAL SERVICES

Purpose:

To provide standard guidelines for providing KP-friendly clinical services.

Target Users:

Doctor, nurse, counsellor, laboratory technician, outreach workers, program manager

Overview:

Whether at the facility, at DIC, or during outreaches, clinical services for KP focus mainly on the prevention and management of sexually transmitted infections; HIV testing and counselling; and sexual and reproductive

health; This SOP focuses mainly on these services and does not focus on the more general clinical care that KPs may require.

Please note that the full package of clinical services (including internal examination and treatment) should only be provided in facilities designated for such services. These are public health facilities and private health facilities and health workers certified by the Ghana Health Service. All the services should thus have strong referral networks with other health facilities that provide specific clinical and other psychosocial services as required.

SOP3.2.a STI Management Services

Procedures:

1. **Syndromic Management: In Ghana, syndromic management is utilized for the management and treatment of STI for KPs. Clinics should use the revised National STI Guidelines (NACP 2013) for STI management. This includes the following key components:**
   A. Sexual health history-taking.
   B. Adequate and appropriate physical examination, including a speculum and bimanual examination of the genital tract for all female KPs and rectal examination (including proctoscopy, if indicated) for all KPs practicing receptive anal sex.
   C. Treatment of syndromes: For the management of symptomatic sexually transmitted infections use the flow charts in the national STI guidelines and the treatment regimen.
   D. Education and Counselling.
   E. Partner Management.
2. **Laboratory testing: In specialized clinics where laboratory services are available, the following can be performed:**
   A. Basic microscopy (Gram stain for vaginal and cervical specimens and wet-mount slide preparation for vaginal specimens): this is performed for women with vaginal discharge. This can also be conducted for men with urethral discharge.
   B. Vaginal pH testing: for women with vaginal discharge when bacterial vaginosis is suspected.
   C. Syphilis serology: testing on-site RDTs syphilis screening and or RPR or VDRL and referral for TPHA for positive syphilis serology where possible.
   D. HIV testing. HTC will be offered to all KP visiting the clinic for management of STI as is recommended in the national STI guideline.
   E. It should be noted that since most laboratories are not equipped to provide testing for all STI for a particular syndrome, positive tests for one condition does not exclude other aetiologies for the same syndrome. Therefore for various syndromes it is still recommended that all drugs for the specific syndrome is used in treatment of the condition despite the laboratory results.
3. **Biennial syphilis screening: Where funds and test kits are available KPs should benefit from regular HIV and syphilis screening. Implementing partners should link-up with the laboratory for the provision of these services where available. However, this is not a national policy at this time.**
4. **Regular medical check-ups: This check-up should be on general health and well-being and be done so as to promote health seeking behaviour, reinforce preventive messages.**
   A. At each check-up:
      - Provide educational information.
      - Take general health history and sexual history.

- Conduct general and internal examination (proctoscopy/ speculum examination) to screen for asymptomatic STI.
- Provide opportunity for syphilis and HIV testing.
- Include screening for anaemia (looking out of pallor).
- Monitor weight gain or weight loss.
- Screen for TB (cough for more than 3 weeks, weight loss, night sweats etc.) and/or malaria.
- Screen for Hep B vaccination and provide services as needed
- Screen for family planning needs, pregnancy or fertility concerns and other SRH issues including screening for SGBV.
- Where feasible, provide hepatitis B vaccine.
- Screen for HIV and STI. During regular check-ups HTC will be discussed with the clients to determine whether specific risk behaviour occurred after the last test warrant HIV testing.

B. Depending on the type of service being provided and sources of funding half yearly check-up should be adequate.

C. All KPs should be referred for routine examinations on a regular basis through active outreach.

SOP3.2.b HIV TESTING AND COUNSELLING

Procedures:

1. **For detailed guidelines on HTC, refer to the National Guidelines for HIV Counselling and Testing in Ghana (MOH 2008).**
2. **HTC can be done in clinics as well as in outreach settings as long as the provider has been trained and certified by the Ghana Health Service/NACP.**

   A. Depending on the availability, tests could be offered on site or the client will be referred to a nearby HTC centre.

   B. During outreach or when offering HTC at DICs, clients who require additional services will be referred to nearest STI clinic/HTC/ART/FP sites as per their need. For more details, refer to SOP 4.1 Establishing and supporting referral networks

   C. Integrate SGBV screening, care and support into HTC services.

      i. Train and support HTC providers to understand the link between HIV and SGBV; to identify possible survivors of SGBV and those who fear there will be possible violence meted out to them as a result of testing or disclosure and how to counsel them on how to address these fears.

      ii. Refer to SOP 4.2 Establishing and sustaining a Community Rapid Response System for more information.

SOP3.2.c SEXUAL AND REPRODUCTIVE HEALTH SCREENING SERVICES

Procedures:

1. **Provide family planning and contraceptive counselling, including short and long-term methods. Dual protection: While condoms used consistently and correctly, are the best prevention against transmission of STIs, they are less effective in pregnancy prevention. Dual protection can be achieved by using a highly effective contraceptive method for pregnancy prevention, and the male or female condom for STI/HIV prevention.**

   A. Provide information on the variety, use and side-effects of contraceptives to all KP, tailored to their individual needs, motivation and barriers to dual protection.

B. Provide contraceptive counselling to determine pregnancy intention of sex worker and discuss available methods.

C. Determine medical eligibility for desired family planning method.

D. Refer for family planning method. If female sex worker is also HIV-positive, refer them to their ART clinic for further counselling on family planning options.

E. Promote and provide condoms.

F. Emergency contraception (EC) can be provided to a woman who has had unprotected vaginal sex is not currently using a contraceptive method and is not pregnant.

   i. It should be provided as soon as possible after unprotected sex, ideally within 72 hours, with a limit of 120 hours (5 days).

   ii. EC should be accessible to sex workers, and frequency of EC use should be monitored.

   iii. However, since EC is not completely effective in preventing pregnancy and might not be efficient if used frequently, it is important to encourage sex workers to use a long-term family planning method.

2. Provide abortion and post-abortion care. In Ghana, abortion is legal when conducted by a qualified doctor in a registered public or private health facility (e.g. Marie Stopes) and hence linkages to safe abortion services should be established.

A. Appropriate referrals should be made utilizing the Illustrative DIC Screening tool.

B. Sex workers should have access to appropriate post-abortion care to reduce morbidity and mortality related to abortion.

C. Post-abortion complication care should be ensured.

D. KP should be counselled on family planning to prevent future unwanted pregnancies.

3. Provide cervical cancer screening. Human papilloma virus (HPV) is an STI and leads to cervical cancer. Cervical cancer screening leads to early detection of pre-cancerous and cancerous cervical lesions and can prevent serious morbidity and mortality.

A. Information on cervical cancer screening should be provided using the Illustrative DIC Screening tool. It is recommended that cervical screening be performed for every woman 30-49 years of age. Screening can be done through visual inspection with acetic acid, conventional Pap smear or HPV testing.

B. Women who are HIV-positive should be screened for cervical cancer regardless of age.

C. Priority for screening should be given to maximizing coverage of the risk target age group and to assure complete follow-up of women with abnormal screening test results.

D. Effective referrals should be provided in appropriate cases. Ensure immediate referral and treatment of pre-cancerous and cancerous lesions.

E. FSW should be referred to health facilities where these services are available.

4. Provide Sexual and Gender based violence (SGBV) screening.

A. It is recommended that Gender Based Violence Screening should be done for all KP visiting the service delivery points.

B. Universal Screening tool should be used for the screening process and appropriate referrals should be made.

   i. Refer to SOP 4.2 Establishing and sustaining a Community Rapid Response System for more information.

SOP 3.3.OCCUPATIONAL INFECTION PREVENTION

Purpose:

To provide guidelines on basic standards of occupational infection prevention.

Target Users:

Service providers, program managers

Overview:

Standards for occupational infection control should be in place for all healthcare settings at all levels-in hospitals, clinics, health posts, mobile/outreach clinics, and community health centres. Infection control principles can be adopted in all healthcare settings, even in settings where water and electricity supply is not constant. Every healthcare setting should adopt a set of practices to minimize the spread of infection between patients and between staff and patients (nosocomial infections).

Standard precautions are designed for use by all people (patients, health workers, ancillary staff, and laboratory staff), regardless of whether or not they are infected. These include good hygiene practices such as washing hands before and after patient contact, wearing gloves and other protective devices, following aseptic techniques, safe handling of sharps, cleaning treatment and care areas, and disposing of medical waste. Precautions should be implemented in the context of creating a safe work environment and provision of on-going prevention education for all employees. Precautions should always be applied when handling blood (including dried blood), all other bodily fluids, secretions, and excretions (excluding sweat), regardless of visible blood.

Hazardous bio-medical waste as may be produced from clinical procedures must be disposed safely, in a manner that eliminates any possibility of infecting clinic staff or community members. Proper waste management begins in the clinic with safe handling of waste and continues until its safe final disposal. It is the responsibility of the clinic to dispose of waste in a safe manner. In most cases, this means contracting with a commercial waste-disposal service or making an arrangement with a nearby hospital facility. In either case, it is the responsibility of the clinic staff to know the disposal procedures of the commercial service or hospital and to use only those services that follow recommended procedures.

SOP3.3.a INFECTION PREVENTION

Procedures:

1. **Hand washing is the single most effective form of infection prevention. (Policy and Guidelines for Infection Prevention and Control in Healthcare Facilities, Ministry of Health, Ghana; June 2009).**
2. **Wash hands:**
    i. Before and after direct contact with clients and potential infected bio-hazardous material.
    ii. After touching blood, bodily fluids, secretions, excretions, and contaminated items
    iii. Before and immediately after removing gloves; and before contact with next patient.
3. **Use personal protective material when at risk of contact with bio-hazardous material.**
    A. Gloves: For contact with blood, bodily fluids, secretions, and contaminated items; and for contact with mucous membranes and non-intact skin.
    B. Masks, goggles, face masks: Protect mucous membranes of eyes, nose, and mouth when contact with

blood and bodily fluids are anticipated.

C. Gowns: Protect skin from blood or bodily fluid contact; and prevent soiling of clothing during procedures that may involve contact with blood or bodily fluids.

D. Linen: Handle soiled linens so that they do not touch skin/mucous membranes; and do not pre-rinse soiled linen.

4. **Patient Care Equipment:**

   i. Handle soiled equipment in a manner to prevent contact with skin or mucous membranes and to prevent contamination of clothing or the environment; and

   ii. Disinfect reusable equipment before reusing it.

5. **Environmental Cleaning: Routine care, cleaning, and disinfection of equipment and furnishings in patient care areas.**

6. **Sharps:**

   i. Avoid recapping used needles;

   ii. Avoid removing used needles from disposable syringes;

   iii. Avoid bending, breaking, or manipulating used needles by hand; and

   iv. Place used sharps in puncture-resistant containers.

   Patient Resuscitation: Use mouthpieces, resuscitation bags, or other ventilation devices to avoid mouth- to-mouth contact during resuscitation.

7. **Protective barriers are used to minimize the risk of transfer of bodily fluids and microorganisms from patient to staff member and from staff member to patient. Barriers include gloves, face masks, protective gowns, caps, aprons, and eye goggles.**

   A. Gloves are not required for all patient procedures, only for those procedures where it is likely that the health worker or clients will come in contact with mucous membranes or bodily fluids such as blood, urine, faeces, or other fluids.

   B. Standard gloves should be worn when:

      i. Examining mucous membranes or non-intact skin (e.g., genital examination);

      ii. Drawing blood (phlebotomy), finger sticks/heel sticks or establishing intravenous access, but no required for giving IM injections;

      iii. Handling soiled instruments, equipment, or linens; and

      iv. Disposing of contaminated medical waste (e.g., cotton, gauze or dressings).

      v. Health staff should change gloves between patients and between procedures on the same patient. Health staff should wash hands with soap and free-flowing water immediately after removing their gloves (after each patient) and before touching anything else.

      vi. Gloves should be worn for all genital examinations.

         (i) Two types of gloves should be available:

            (a) Examination gloves to wear when coming in contact with bodily fluids or mucous membranes.

            (b) Heavy-duty utility gloves to wear when cleaning equipment or handling hospital waste.

8. **Safe handling of needles and other sharp instruments. Healthcare staff can be exposed to viruses such as hepatitis B or HIV through accidental cuts from sharp instruments or through needle-stick injuries (although the risk is very small). Small amounts of blood and other bodily substances can remain on used instruments or in the hole inside the needle. All healthcare settings should have in place a system for the safe use and disposal of sharp instruments, including needles.**

   A. Sharp instruments should not be passed directly from one staff member to another; that is, a safe zone

should be used (e.g., place the sharps in a tray and allow the other staff member to pick them up from the tray);

B. Needles should be used once only;

C. Best practice is that needles are not re-capped;

D. Puncture-proof containers should be placed in all areas where needles are used. Used needles and syringes should be placed in the containers whether or not a needle destroyer is used;

E. If specially manufactured sharps containers are not available, other puncture-proof buckets or containers with lids should be used;

F. The sharps container should be sealed and removed when it is three quarters full; and

G. Containers should be disposed of by incineration.

9. **Processing instruments and equipment. All instruments that are involved in invasive procedures (i.e., those that cut or pierce the skin or touch the mucous membrane) have the potential to transmit microorganisms and infections. A three-step method is used to process instruments and equipment:**

- Step 1 : Decontamination
- Step 2 : Cleaning/washing
- Step 3 : Sterilization and high-level disinfection (HLD) to remove any blood or bodily fluids and secretions and to prevent microorganisms from passing from one patient to another.

A. All reusable items should be decontaminated, cleaned, and either sterilized or disinfected using high-level disinfection techniques. This applies to re-usable gloves, surgical instruments, and any re-usable equipment that comes in contact with tissue under the patient's skin or with mucous membranes.

B. Instruments that come into contact with intact mucous membranes may be either steam-sterilized (if possible), undergo HLD, or be processed under low temperature automated chemical sterilization systems.

C. Maintain separate bench space for clean equipment and dirty equipment.

D. Store sterilized instruments in a dry, clean, dust-free and covered space until next use and sterilization.

10. **Aseptic techniques are designed to reduce the chances of microorganisms entering the body during surgery, when dressing wounds, when using catheterization, or during any other procedures that involve breaking the skin or mucous membrane. Any health worker performing surgery, carrying out a procedure that breaks the patient's skin or enters the patient's body, or dressing a wound should use aseptic techniques.**

A. Surgical scrub hand washing;

B. Using instruments and dressings that have been sterilized or undergone high-level disinfection;

C. Wearing a mask and sterile gloves;

D. Setting up and maintaining a sterile field; and

E. Properly preparing the patient's skin or the area involved in the procedure by using antiseptic and sterile gauze to disinfect.

SOP3.3.a BIOMEDICAL WASTE MANAGEMENT

Procedures:

1. **The waste management must comply with Policy and Guidelines for Infection Prevention and Control in Healthcare Facilities, Ministry of Health, Ghana (June 2009).**
2. **There are various types of hazardous waste generated at the clinic level. These wastes should be**

segregated and disposed of in a manner that does not cause risk of infection or injury to clinic staff or the general public. The types of hazardous waste generated at the clinic level include sharps, infectious medical waste, and pharmaceutical waste and other hazardous waste.

- Sharps waste: Single-use disposable needles, needles from auto-disable syringes, scalpel blades, disposable trocars, sharp instruments requiring disposal and sharps waste from laboratory procedures.
- Other infectious medical waste: Waste contaminated with blood and other bodily fluids, including gloves, cotton, dressings, linens, disposable intravenous sets, catheters and so on. This also includes infectious laboratory wastes such as waste from laboratory tests and other items that were in contact with the specimens, such as gloves.
- Pharmaceutical waste: Expired, damaged or otherwise unusable medicines and items contaminated by or containing medicinal substances.
- General waste: Waste that is not infectious, sharp or toxic can be handled like domestic refuse for disposal.

3. **Waste segregation and storage. Waste segregation reduces the volume of waste that requires special handling.**
   A. Segregation is the responsibility of the waste producer and should take place at the first disposal point.
   B. Under no circumstances should clinic staff attempt to sort waste or correct waste segregation after it has been placed in disposal containers.
   C. If hazardous waste is accidentally thrown into a non-hazardous container, treat the entire container as hazardous waste.
   D. Waste should be segregated and placed in color-coded bags according to National guidelines and labelled with the biohazard symbol as shown below. Colour coding of healthcare waste containers:

Category	Container and Colour
General Waste	Black Plastic Bags/and or bins
Sharps	Yellow Puncture resistant containers
Other infectious waste Pharmaceutical and chemical containers	Yellow Plastic bags and or bins Brown plastic bags and or bins

Source: Policy and Guidelines for infection Prevention and Control in Healthcare Facilities, Ministry of Health, Ghana. June 2009.

   A. Appropriate containers with plastic bag liners should be placed at all locations where particular categories of waste are generated.
   B. Containers should be emptied when they are three-quarters full. Waste bags should be tightly sealed, either by tying the neck or by using a self-locking bag; waste bags should not be stapled.
   C. Replacement plastic bags should be available at all locations where waste is produced.

2. **Storage of waste. A separate area or room should be designated for storage of full waste bags. The storage area should be:**
   A. Easy to clean and disinfect; and have a hard, impermeable floor;
   B. Have readily available cleaning supplies and protective clothing;
   C. Locked to prevent access by unauthorized persons;

D. Inaccessible to animals, insects and birds;

E. Protected from the sun; and

F. Easily accessible to waste collection vehicles.

3. **Disposal of Sharps.**

A. Use sharps disposal containers. Sharps disposal containers are puncture and water-resistant impermeable containers. When used correctly, they reduce the risk of skin-puncture injuries that potentially can spread disease. Sharps disposal containers can be commercial or can be home-made of strong plastic or metal.

B. Do not recap syringes before disposal;

C. Place the syringes and needles in the sharps box immediately after use;

D. Keep the sharps container where the injections are given;

E. Do not overfill the sharps containers (maximum about ¾ full);

F. close and seal the container when the container is ¾ full;

G. Store the container in a safe and secure location until ready for final disposal;

H. Do not empty and refill sharps boxes. Fill once and discard immediately; and

I. Place filled and sealed sharps disposal containers in disposal bags that are labelled or color-coded for highly infectious waste.

4. **Pharmaceutical waste. Improper disposal of pharmaceutical waste can result in contaminated water supplies and the use and resale of expired or inactive medicines, or improperly incinerated products, which can result in releasing toxic pollutants into the air.**

A. Small quantities of pharmaceutical waste can be incinerated (if < 1% of total waste), encapsulated, disposed of in a secure landfill, or buried.

B. It is not acceptable to dispose of even small quantities of pharmaceutical waste into slow-moving or stagnant water bodies. Antibiotics should never be disposed of in slow-moving or stagnant water.

C. The following should be considered in selecting options for waste treatment and disposal at the clinic:

i. The quantities of waste produced daily in the clinic;

ii. Availability of appropriate sites for waste treatment and disposal:

iii. Space for pit burials;

iv. Distance from water source, residential areas;

v. Presence of available legally recognized central facility for waste treatment within a reasonable distance; and

vi. Availability of resources (human, financial and material).

5. **Other infectious medical waste. Infectious medical waste should be sterilized by autoclaving, microwaving, or incinerating, and then buried or disposed of in a secure landfill.**

Key References:

- National Guidelines for the Implementation of HIV Counseling and Testing in Ghana MOH. 2008.
- Comprehensive Family Planning Learning Guide. Ghana Health Service. 2013.
- Policy and Guidelines for Infection Prevention and Control in Healthcare Facilities. Ministry of Health, Ghana. June 2009.

Section 4 : STRUCTURAL INTERVENTIONS

The vulnerabilities faced by FSW relate not only to their individual risk behaviours but also to the broader societal and community factors, which include cultural norms, social marginalization and criminalization which limit their opportunities and access to services and make them vulnerable to discrimination and violence (sexual, physical, and emotional). Stigma and discrimination by society and the health care system, as well as the structural and policy barriers, gender economic and power inequalities, cultural norms, sexual and gender based violence (SGBV), and mobility are some of the factors that increase KP vulnerability to HIV.

Structural interventions aim to address social, cultural, political, economic, and legal or policy aspects of the environment that increase the vulnerability of KP and contribute to the spread of HIV. Structural interventions should focus on creating an enabling and abuse free environment that supports improved access to health services and commodities and the protection of rights. For HIV prevention, an enabling environment includes the social, economic, and legal determinants that facilitate the behaviour change process and encourage KP to participate in all levels of the response to the epidemic and increase access to appropriate, affordable, acceptable and assessable health services.

Since programs are rarely designed to provide all components of the HIV/STI package, service providers need to establish an effective collaboration to ensure each KP has access to each component of the HIV/STI package. A strong referral network is needed to ensure that programs effectively collaborate to deliver the package of services. Establishing a community based rapid response system helps KP to seek re-dress for human rights abuses and SGBV and helps to create an abuse-free environment.

List of SOPs:

SOP 4.1 Establishing and supporting referral networks

SOP 4.2 Establishing and sustaining a Community Rapid Response System

Key references:

- National HIV & AIDS Strategic Plan 2011-2015: Towards Achieving Universal Access to Comprehensive HIV Services. Ghana AIDS Commission. 2010.
- National Strategic Plan for Most at Risk Populations 2011-2015.Leveraging a Public Health Approach for Universal Access. Ghana AIDS Commission. August 2011.

SOP 4.1 ESTABLISHING AND SUPPORTING REFERRAL NETWORKS

Purpose:

To provide standard procedures for establishing effective referral networks.

Target Users:

Program managers, service providers.

Overview:

Since a single project, facility, agency or community group can rarely deliver all of the services needed by KP, a well-established referral network is vital to link the different organizations providing prevention care, treatment, support and protection services. Meeting the needs of KP requires the collective effort of many facilities and organizations, both clinic- and community-based. Strengthening access to a comprehensive package of HIV-related services for KP in need and promoting communication among service providers requires a formalized

referral network, e.g. from the drop in centres to health facilities. In the context of HIV, a referral is the process by which immediate client needs for comprehensive HIV care and supportive services are assessed and clients are helped to gain access to services. Referral should include reasonable efforts at follow-up.

A referral system entails a process of coordinating service delivery to ensure that:

- Access to needed services is expedited;
- Confidentiality is maintained;
- Referrals between organizations can be tracked;
- Referrals and their outcomes are documented; and
- Gaps in services can be identified and steps taken to address identified gaps.
- Follow up to ensure KP has received the service(s)

Procedures:

1. **Plan for the establishment of the referral networks.**

   A. Identify a team of service providers (program, clinical, community) responsible for the planning and implementation of the referral network. Usually this will include members of the DIC as well as health facilities and KP representatives.

   B. Mobilize key stakeholders. Identify and bring together through a workshop various stakeholders to initiate a community dialogue, seek input on establishing a referral network and generating "buy-in" for the activity. Other GO/NGOs/CBOs working with KPs in the same catchment area should be also invited as collaborative partners since the referral network could also serve their populations and also because some populations have cross-cutting issues e.g., MSM who inject drugs.

   C. Ensure active participation of key population. Actively involve key populations in the planning process so that their needs and preferences are identified and used to define the referral network.

2. **Conduct a participatory mapping exercise.**

   A. List services in (within a 15 – 30 minutes walking distance) and outside the project area (nearest possible location) including: health posts/centres; government hospitals (STI, ART, HTC, FP services); NGOs/CBOs; and other support systems. Services may include any or all of the following:

Health care (STI, HTC, FP, ART and general health)	Nutrition and food security	Economic support/employment
Mental health	PLHIV support group	Child support
Recreation and leisure	Transportation	Legal assistance
Psycho-social & spiritual support	Material support, linkageto social welfare	Home-based care / palliative care

   A. Develop and agree upon selection criteria for services. The criteria should include availability, accessibility, attitudes of health care providers, supportive staff and counsellors, acceptability by key population, previous experience in serving specific populations, confidentiality, privacy, existing protocol, cost of the provided services, and other characteristics deemed relevant for the referral system.

   B. Develop topic guides for the interview of the services and tools to map the identified services: A range of questions should be developed to assess the service as per the criteria developed in the above section. A map could be drawn to pin the identified services. Note that the mapping is not intended to assess the quality of the services provided by the identified and visited agency. This activity required a more sophisticated and specific assessment.

   C. Identify the team to conduct the mapping exercise. The team should be diversified as much as possible and should include GO/NGO/CBO workers, beneficiaries and health care providers. Avoid large team when visiting a service.

D. Organize training for the mapping team, explaining to them the objectives of the referral network, criteria, and a set of question for the interview of the services.

E. Implement the mapping exercise during a short timeline.

F. Documenting the findings of the mapping exercise.

3. Establish the Referral Network.

A. Organize workshop with key stakeholders to disseminate the findings, to map the referral network, to identify key contact(s) of each identified service, and determine role and responsibilities of each organization in the network.

B. Develop an official document such as meeting minute, letter of agreement, or Memorandum of Understanding (MOU) between organizations. It should include the role and responsibilities identified in the previous step. It is also important to address the issue of confidentiality and shared confidentiality within the referral network in this MOU.

C. Identify a unit or organization to coordinate and oversee the referral network. This could be the DIC or health facility or an NGO.

D. Adapt standardized forms, tools and procedure that will ease the referral procedures and also help for the monitoring of the referral network, including referral forms and client tracking forms.

E. Develop/adapt a referral directory of facilities providing a list of facilities that provide clinical care and non-clinical services for PLHIV including the details of the type of services provided in each facility. See USAID Ghana SHARPER Project website www.fhi360.org for examples.

F. Outline an appropriate mechanism to document the process for the referrals and follow-up.

G. Hold sensitizing meeting with each agency to explain the referral network and the tools, to approve the MOU, and identify key contact (focal point) representing the agency for the referral network.

H. Train key contacts of the concerned services on the procedures for the referral system, utilization of documents, monitoring, and also sensitize them on specific issues of the served populations.

I. Establish a system to update the list of services. Services could be added or removed as per the needs of the population served, the availability of these services in the catchment area, and the evolution of public health and social policies in the country.

4. Implement referral process.

A. Screen all clients during their DIC visits to identify their need for specific services using checklist for referrals. Refer to the DIC SOP for checklist.

B. Develop individualized service plans: The referring staff and the KP should jointly develop a service plan that defines his/her needs and the steps to meet those needs. The plan should be updated in accordance with progress made and new needs identified.

C. Refer clients: The referring staff will make referrals and coordinate delivery of services, track referral requests and follow-up to ensure that the needs are met.

D. Clinical follow-up should be according to the National Guidelines. However, the referral facility will continue to have regular contact with the KP.

E. When a KP is tested and is positive, s/he is referred to government health centres which provide comprehensive ART care and support.

F. If a KP is on ART, the referral staff should monitor ART adherence and also assist the KP+ in managing side effects. The same information should be provided to the Government clinic staff.

G. The facility staff should provide information about existing PLHIV support groups and in turn assist to join the support groups.

H. If needed, provide accompanied referrals (peer led) to KP for other services like nutrition support, legal assistance, economic support, skill development activities, PMTCT services, getting admission in school and hostels for their children etc.

I. The referral staff should assist the KP and the adherence monitor in determining needs and will also provide referrals to other KPs in need of services. For further details on adherence monitor, refer to the Guidelines for Antiretroviral Therapy in Ghana.[NACP 2011]

J. The clinical care team should send back information on the action taken for the KP clients to the referring staff at the DIC. It could include the date certain tests (e.g. CD4 counts are done) and the date for the next test. The clinical care team should also state whether the KP living with HIV is on OI or ART medication. There is no need to state the details of the medication or the test results.

5. Record keeping:

A. The referral staff will maintain a record of meetings with the KP living with HIV, the referrals made for the KP, and the outcomes of the referrals. This documentation will be maintained in the KP referral record.

6. Ensure confidentiality:

i. All referrals and records should be kept under lock and key and made available only to authorized persons to maintain privacy and confidentiality.

ii. Clients' HIV test results must be kept confidential. However, there are circumstances when other professionals, such as counsellors and health staff at organizations where the client is being referred, might also need to know the person's HIV status in order to provide appropriate care. Approval must be sought from the client before status is shared with a professional. This shared confidentiality is encouraged. Shared confidentiality also refers to confidentiality that is shared with others at the discretion of the person who will be tested. These might include family members, loved ones, health and social service providers, care givers and trusted friends.

7. Monitor and sustain the referral network

i. Mobilize the communities/groups to use and support the network. Undertake intensive community mobilization and promotional activities to increase the demand of services.

ii. Maintain and update tools and forms as needed. This includes the referral directory, referral forms, Referral tracking forms and referral register.

iii. Monitor the network's activities and use the findings to improve the system. The monitoring should include quantitative and qualitative data. Feedback from the beneficiaries but also from service providers of the referral network should be also monitored.

iv. Organize periodic meetings with the key contacts and the beneficiaries of the network. These meetings provide a venue for on-going communication, exchange of information about the referral process, discussion of challenges and gaps in terms of services and updating the service network directory.

v. Ensure compliance with program standards. Management staff (internal and/or external) need to systematically monitor and assure compliance with standards (as per the MOU) and initiate corrective action when shortfalls are identified.

vi. Use M&E for decision-making. Findings from timely reporting on program activities, as well as from any evaluation that takes place, should be used to make adjustments in program operations.

8. Forge linkages with non-health facilities at government and local levels.

A. Identify stakeholders and service providers in the community: Health facilities, legal and human rights services, local NGOs, women welfare associations, forums and community based groups, faith based groups including prayer and spiritual camps.

B. Establish linkages with existing human rights and sexual/gender based violence (HR & SGBV) reduction services providers and networks: Develop mutually reinforcing partnerships and referral networks among HIV-service and HR & SGBV organizations and promote bidirectional integration of HIV and HR & GBV prevention and response efforts. Make sure KPs are aware of the human rights violation reporting system through the Commission on Human Rights and Administrative Justice. (CHRAJ)

C. Build rapport with the organizations through regular visits. Recognize their importance in HIV care and

support. Keep them updated on key activities of the KP intervention. It is recommended that two individuals be appointed to focus on each relationship (to ensure continuation in case one individual is not available.

D. Invite key staff or representatives from each organization to attend regular stakeholder meetings as members of the referral network.

E. Identify staff/key community members responsible for linkages to accompany KP in need of services.

SOP 4.2 ESTABLISHING AND SUSTAINING A COMMUNITY RAPID RESPONSE SYSTEM (CRRS)

Purpose:

To provide standards for establishing and sustaining a Community Rapid Response System (CRRS) to address human rights abuses and sexual/gender-based violence.

Target Users:

Overview:

KP face discrimination, harassment, violence, human rights abuses, sexual and gender based violence and coercion which directly affect their health seeking behaviours. This ultimately makes them vulnerable to HIV. In many instances, abused key populations cannot easily access help to address the abuse that is inflicted on them. To partly address the problem, MARP-Friends and MARP-Watchers (M-Friends & M-Watchers) are trained across the country to set up a community based networking system called the CRRS to identify and direct abused KPs to seek services (health, legal, psychosocial).

An M-Watcher is a trained peer educator who has received further training in how to identify and assist abused KP to seek immediate redress. An M-Friend is an individual within the site, known to the NGOs/CBOs, who has been trained and has empathy to KP issues. M-Friends are normally persons of high standing that have connections with service providers and decision makers (e.g. lawyers, doctors, police officers, traditional authorities). The M-Friend is not usually a KP.

Procedure

1.Establish the Community Rapid Response System.

A. Train M-Friends and M-Watchers to be part of the Community Rapid Response System.See USAID Ghana SHARPER Project website www.fhi360.org for the Training Curriculum.

B. NGOs/CBOsshould allocate resources to support KP who will need financial support to seek redress.

C. List of trained M-Friends and M-Watchers is made available to all stakeholders (NGOs/CBOs, key populations, health care workers, DICs, etc.) working with KP and regularly updated.

D. NGOs/CBOs working with KP within the sites have identified focal persons to coordinate work with the trained M-Friends and M-Watchers.

E. KP should be oriented by peer educators on the role of the Community Rapid Response System.

F. As per, SOP 4.1, ensure referral directory includes services related to managing human rights violations and SGBV. These include: legal aid, access to PEP and emergency contraception, and shelter.

2. Implement the CRRS.

When a KP suffers an abuse and or violence due to his/her sexual preference/orientation, gender and/or their behaviour, the following crisis response should be initiated to seek redress:

A. First stage of support: M-Watcher

i. The abused KP communicates to the M-Watcher immediately when an abuse or violence occurs.

ii. Immediate support is to be provided by those contacted. The M-Watcher immediately (within 30 minutes to an hour of the report) meets up with the abused KP to ascertain the situation, agree with the abused the type of redress required and assures him/her of their support and follow up.

iii. The M-Watchers communicates with the most appropriate M-Friend within the site who can connect them to the required service point. The M-Watcher and M-Friend agree on the approach to seek redress and confirms this with the abused key population.

B. Second stage of support: M-Friend

i. The M-Friend, upon being contacted by the M-Watcher, immediately solicits support from the required service provider using his/her own network of colleagues. The M-Friend should within 24 hours (or day) assist the abused KP to seek the required services.

ii. The M-Friend either accompanies the abused KP and the M-Watcher or directs them (as the case and the situation may require) to seek redress from the appropriate service provider (as shown below).

iii. The M-Watcher should follow up with the M-Friend within an hour to ensure abused KP is linked to a service provider immediately.

iv. The M-Friend follows up with the abused KP to ensure he/she is satisfied with the services to redress he/she has gone to seek.

v. The M-Friend documents the abuse and the services required as well all other processes required to undertaken to get the services.

vi. The M-Friend sends the report to the NGO/CBO he/she is affiliated with.

C. Third loop of support – NGO/CBO focal person who is trained to coordinate the M-Friends and M-Watchers.

i. The NGO/CBO focal person should within 48 hours follow up to the KP to ascertain the quality of service provided and suitability of the redress as well as any other follow ups required.

ii. The NGO/CBO focal person collates the reports from the M-Friend.

iii. The NGO/CBO focal person follows to the abused KP through the M-friend and M-Watcher to verify the report and address any follow ups.

iv. The NGO/CBO focal person collates the reported KP case, and with approval from the KP, submits the case to the local Commission for Human Rights and Administrative Justice (CHRAJ) representative.

D. The levels of support as mentioned above are designed to ensure sustainability of the Community Rapid Response Systems and ensure that assistance reaches the KP from an established source on time and appropriately. The levels are flexible and can be adapted to suit the prevailing local situation.

E. Illustrative sources of redress by abuse type:

i. Harassment, including threats and violence:

(a) M-Watcher and M-Friend should seek assistance from the police station and/or any traditional authority within the site as appropriate.

ii. Unlawful arrest by Police

(a) M-Friend and M-Watcher should seek the support of lawyers [e.g., from Human Rights Advocacy Centre or Federation of Women Lawyers (FIDA)] to visit the KP in question at the police station or place of arrest.

iii. Medical emergency

(a) In the case of a medical emergency(considering the type of emergency) the M-Friend and M-Watchers should take the abused with injuries to Police station, make a statement, take a medical form and go to the nearest hospital or medical centre.

(b) If the emergency is of a minor nature (e.g. minor cuts, bruises etc.) M-Watcher and M-Friend can seek assistance from nurse within the site.

iv. Rape

(a) In the case of rape, do the following immediately:

(i) Provide emotional support to the survivor, through peer, M-Watcher, and where desired link the survivor to an M-Friend;

(ii) report to the nearest Police Station to make a statement and pick up a Medical Report form;

(iii) Proceed to the nearest designated medical facility where PEP is administered for PEP and emergency contraception to be administered and ensure that the Medical Report form is completed.

(b) If the survivor consents, return the completed Medical Report form to the Police Station and pursue redress through the legal system.

(c) Provide on-going emotional, social and material support and assist the survivor to be better protected.

v. Other emergencies (other forms of SGBV; family disputes and disagreements; death of loved ones)

(a) In cases where the abused KP will require counselling and support, the M-friend and M-Watcher can contact the NGO/CBO to arrange for these specialized support services.

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ANNEXES

ANNEX A. Table Overview Of SOP

No.	Section/ SOP	Purpose	Target Users	When to use the SOP
1 Program Management				
1.1	Planning and designing interventions	To set standard guidelines for the planning and designing of evidence-informed, ights-based, and community-owned HIV prevention interventions among KPs.	Executive directors, program managers, program design teams	When planning and designing interventions targeting KP
1.2	Budgeting and ensuring adequate resources	To provide standard guidelines to ensure adequate resources are available to effectively implement the KP interventions.	Program Managers, Program coordinators, Program Team, HR Managers	When planning the intervention to ensure adequate resources are available
1.3	Human resources and capacity building	To set standard guidelines to ensure appropriate and adequate HR to implement the intervention.	Program managers, coordinators, implementation teams	When planning the intervention to ensure appropriate HR are available and determining capacity building needs
1.4	Monitoring & Evaluation a) Management M&E information system b) data quality assessments c) Developing feedback mechanisms d) Program reports	To harmonize M&E (MIS, DQA, feedback and reporting) systems among implementers of KP interventions.	Program Managers, M&E officers and stakeholders	When designing and implementing the system intervention
1.5	Quality assurance and quality improvement	To describe standard guidelines for instituting a quality assurance and quality improvement (QA/QI) system.	Program managers coordinators, implementation teams	When designing interventions & reviewing implementation results.
1.6	Establish coordination mechanisms a) Partner coordination b) Clinical and outreach coordination	To provide guidelines for coordination among Different stakeholders & service providers of KP interventions.	Program managers, coordinators, implementation teams	When designing and implementing programs to ensure harmonization

No.	Section/ SOP	Purpose	Target Users	When to use the SOP
2	**Behaviourial Interventions**			
2.1	Developing a BCC strategy a)advocacy/sensitization b) Develop BCC materials	To provide guidelines in the development of BCC strategy tailored to the specific needs of key	Program managers, clinic staff, peer educators, BCC officers	When designing the BCC strategy of the intervention
2.2	Peer education & outreach strategy establishing a PE program a) support PE program b) micro-planning and individual tracking c) conducting communication sessions	To provide a standardized strategy to guide establishing and implementing an effective peer education programmes.	Program managers, peer educators, outreach workers	When designing the PE component of the intervention
2.3	Condom and water based lubricant demonstrations and promotion	To provide a standardized approach to the demonstration and promotion of male and female condoms water-based lubricants and other commodities.	Program managers, peer educators, BCC officer, field staff	When planning for condom/lubricant demonstrations and promotion.
3	**Biomedical Interventions**			
3.1	Establishing KP-friendly Clinical Services A) Facility-based Clinical b) Outreach Clinical services	To Provide Standard Guidelines for establishing KP-friendly facility-based and outreach clinical services.	Service Providers, Program Managers	When Designing Clinical Interventions Targeting KP
3.2	Establishing KP-friendly Clinical Services a) STI Management Services b) HIV Testing And Counselling c) Sexual And Reproductive Health Screening Services	To Provide Standard Guidelines For Providing KP-friendly services	Service Providers, Program Managers	When Implementing Clinical Interventions Targeting KP
3.3	Occupational Infection Control a) Infection Prevention b) Biomedical Waste Management	To provide guidelines on basic standards of occupational infection control.	Service Providers, Program Managers	When Implementing Clinical Interventions Targeting KP

No.	Section/ SOP	Purpose	Target Users	When to use the SOP
4	**Structural Interventions**			
4.1	Establishing and supporting referral	To provide standard procedures for establishing effective referral networks	Program managers, service providers	When designing tnterventions kp to ensure access to continuum of care
4.2	Establishing & sustaininga community rapid response system (CRRS) System	To provide standards for establishing and sustaining a Community targeting KP to (CRRS) to address Human rights abuses & sexual /gender-based violence. abuses	Program managers, service providers interventions	When designing and implementing Rapid Response establish a system of redress for identified/ reported abuses

ANNEX B. Glossary Of Key Terms

Catchment area : The geographic coverage area of a program.

Formative Research : Formative research is a research that is done before a programme is designed or implemented with a focus on understanding the needs of population going to be covered through the intervention. Formative research has three stages of action: 1. Mapping location (focusing on identifying risk sites and spots and providing an estimation of KP); 2. Situational Assessment - detailed assessment within the identified risk site on actual intervention needs of the target community); and 3. Baseline Study (provides information on status of biological and behaviour indicators at the start of the project which will be compared after a period of intervention to assess whether any progress has been achieved through the services provided.)

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

Hotspots : Places where high-risk behaviour occurs. Areas within a site where there is significant concentration of KP where they may solicit, cruise, and interact with other KP members or have sex or share injecting drugs.

Key Populations (KP): This is the new nomenclature for MARPs and replaces MARPs.Individual who are at the risk of contracting of HIV due to risk behaviours (unprotected non-regular-partner sex behaviour, sharing injecting equipment) that these groups are exposed to or engage in. For the purpose of HIV prevention programming Ghana has defined four KPs. These are Female Sex Workers (FSW) and their partners, Men having Sex with Men (MSM), People who Inject Drugs (PWID) and Prisoners.

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

Outreach : Outreach is one of the key delivery mechanisms within targeted intervention focused on providing information and services (including BCC) at the convenience of the KP – that is reaching out to location where KP can be reached. Outreach is a process and not a one-time activity. Outreach consists of the following sub-activities - registration, repeat contact, risk assessment and risk reduction inputs through one to one and one to group BCC sessions, referral for HTC, STI management, FP, TB/OI, SGBV and to the drop in centre, and distribution of condoms and lubricants.

Participatory process : Active participation of the target population in program planning, management, implementation and evaluation.

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

Peers : KP who are reached by KP PEs.

Referral : The process through which the HIV, STI and other HIV-related needs of the KP are assessed and s/he is helped to access the identified services.

Risk assessment : A process to gather information about KPs' behaviours that could increase their risks of

acquiring or transmitting HIV or STIs. The goal of an individualized risk assessment is to provide the KP with insight into his or her high-risk behaviours and to help him or her minimize the likelihood of acquiring or transmitting HIV or STIs. Information from risk assessments helps service providers to individualize prevention messages and health services.

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

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

Sex work : The exchange of money or other favours/goods for sexual services.

Sex workers : Individuals (male, female, and transgender) who exchange sexual acts for something of value (cash, material items, etc.) that would otherwise not be extended to them by their sexual partners.

Sexual and gender based violence : Violence that is directed at an individual based on his/her biological sex and/or based on gender norms. This violence is targeted at women because they are women or to men because they do not meet the stereotype of a "real man". It includes physical violence, sexual abuse/assault, and abuse that hurt or threaten the individual, application of force to get the individual to do something or deprive them of their freedom; and deliberately depriving the individual of money and other resources. These can occur in private or public life.

Site : A site is referred to as an "intervention site" which is a contiguous geographical area demarcated by a definite boundary such as a locality. Each site will be in itself independent geography for planning intervention – particularly for outreach planning. Within a district there could be more than one intervention site depending on number of towns or cities that needs to be covered for reaching out to the KP.

Stakeholders (Primary and Secondary) : Primary stakeholder - Direct beneficiaries of the project (KP) secondary stakeholders - Who are engaged with the project indirectly and have influence (positive or negative) on the project deliverables - but are not beneficiaries of the project (Police, Health Care Providers, Local Leaders, etc.).

Targeted Interventions : Targeted Intervention is a cost effective method of activities implemented by and with the KP primarily due to risky behaviour they engage in. Targeted interventions provide prevention services that include, but not limited to, information focusing on behaviour change (through educative sessions, peer education, counselling etc.), providing treatment services for STIs, supply of condoms and lubricants, facilitating enabling environment.

ANNEX C. Minimum Package Of Services For KPs

At minimum, the following services are proposed for KP on an annual basis. Tracking these services and frequency of their provision will help in annual assessment of program coverage and quality.

Suggested minimum package of services for FSW	
Roamers	
Regular risk assessment and referrals through PE outreach	At least 50% receive 6 PE contacts in a year
HTC	At least 60% receive HTC once in a year; At least 40% receive HTC twice in a year
STI screening and treatment	At least 30% receive STI screening and treatment once a year; At least 20% receive STI screening and treatment twice in a year
Condom and lubricant distribution	No condom or lubricant stock out at hotspot outlets
Screen for SGBV	100% of registered KPs screened for SGBV at least once a year
HIV care	75% of identified FSW+ referred for and enrolled in care, support and treatment services
Seaters	
Regular risk assessment and referrals	At least 80% receive 6 PE contacts in a year through PE outreach
HTC	At least 70% receive HTC once in a year; At least 50% receive HTC twice in a year
STI screening and treatment	At least 70% receive STI screening and treatment once a year; At least 50% receive STI screening and treatment twice in a year
Condom and lubricant distribution	No condom or lubricant stock out at hotspot outlets
Screen for SGBV	100% of registered KPs screened for SGBV at least once a year
HIV care	90% of identified FSW+ referred for and enrolled in care, support and treatment services

Suggested minimum package of services for MSM	
Regular risk assessment and referrals	At least 50%receive 4 PE/ICT contacts in a year through PE and ICT outreach
HTC	At least 40% receive HTC once in a year; At least 20% receive HTC twice in a year
STI screening and treatment	At least 30% receive STI screening and treatment once a year; At least 15% receive STI screening and treatment twice in a year
Condom and lubricant distribution	No condom or lubricant stock out at hotspot outlets
Screen for SGBV	100% of registered KPs screened for SGBV at least once a year
HIV care	60% of identified MSM+ referred for and enrolled in care, support and treatment services

ANNEX D. Illustrative Workplan Template

Geographic location:						
Program dates:						
Program goal:						
OBJECTIVE: 1. To support increased access and improved coverage of HIVprevention, treatment, care and related services for key populations.						
No.	**Activity Title**	**Activity details**	**Responsible**	**Timeline**	**Targets**	**Input Resources**
1.	*Limit this to one sentence.	In responding to this column, always apply the 5 "Ws" (*What, why, who, when and where)* and 1 "H" (*how*)	This column should provide information on specific persons, institutions or partners responsible for a particular task.	This column should provide information on month, phase etc. Number of days required to complete each tasks.	This column should provide information on number of to be reached & deliverables.	This column should provide information on staff time, consultants, procurement, operational expenses,
2.	Example: Conduct training for clinical staff	Example: Train staff at 8 clinics to provide KP friendly services	Example: STI specialist and training consultant	Example: To be completed during month 2 of the project. : 1 week, residential training	Example: 5 staff per clinic trained. Total 40 persons trained	Example: 2 months staff time. 2 weeks local consultant time. Venue, food, per diem, travels, training materials, etc.

ANNEX E. Illustrative Budget Format

Title of Activity :
Venue :
Period of Activity :

Budget

Description	Qty.	# of Days	Rate (GH¢)	Total Cost (GH¢)	Comments
T&T					
Sub Total					
Materials					
Sub Total					
Accomodation					
Sub Total					
Sub Total					
Total Amount					

Prepared by : _____

Reviewed by : _____

Approved by : _____

ANNEX F. Illustrative Job Description For Peer Educators

The peer educators are responsible for the day-to-day community outreach activities; providing information, education, and services to their peers in project sites; compiling weekly narrative reports; and mobilizing KP for prevention, care, and / or treatment educational programmes.

The specific tasks of peer educators will include but are not limited to the following within the project period :

1. With routine and targeted close supervision from the project officers, each PE will reach at least *** new KP within the project period. As a PE you will:
   - Provide peers with one-on-one and small group sessions on HIV and its prevention, condom and lubricant demonstration and sales, conduct a basic risk assessment, and provide information on recommended referrals to HTC, STI, ART and other services.
   - In addition, provide information on SGBV, reducing drug and alcohol use and building self-esteem.
   - Participate in the refresher training using the current KP training and support supervision manuals to ensure quality PE activities and accuracy of messages.
   - Refer at least *** KP for STI services, with weekly performance reporting to the project officers (to monitor progress).
   - Accompany at least *** KP directly to facilities providing STI services.
   - Refer at least *** KP for TC services, with weekly performance reporting to the project officers (to monitor progress).
   - Accompany at least *** KP directly to facilities providing HTC services.
   - Refer all KP that test HIV-positive to the ART clinic of their choice for enrolment.
   - Promote the existence of KP HIV+ support groups, including the one that will be developed at the drop-in centre within the KP community.
   - Organize *** one-on-one monitoring sessions, using peer education tools to promote BCC among KP.
   - Organize *** small group discussions with clear, pre-planned topics for discussions, including the use of picture cards on discussions targeting promotion of HTC, STI treatment, and consistent condom and lubricant use.
   - Organize no fewer than *** condom and lubricant use demonstrations each month (for KP at the condom activation/outreach events, where condoms and water-based lubricants will be sold to the KP).
   - Distribute and use BCC materials among KP communities.
2. With close supervision and monitoring by the project officers, promote access to other HIV services such as psychosocial support, family planning, SGBV related services, ART counselling, etc. through increased referrals and networking.
3. Work within specified operational sites/immediate environs (as much as is practical) that will not involve excessive travel.
4. With close supervision and monitoring by the project officers, ensure that proper documentation (using project monitoring forms, field note books, etc.) is kept on a regular and consistent basis.
5. Actively participate in the implementation of ICT (HelpLine, LifeLine, SMS Healthy Living, MSM.net) services to provide information, referrals, and counselling services supporting KP behaviour change interventions.
6. Participate in all monthly programme review meetings as well as PE monthly performance analysis reporting. In attendance will be the KP- friendly service providers where, each month, the peer educators will let the facility providers know how many people they have referred and discuss how many people have actually accessed the services. Strategies will be discussed as to how to address the gap between referrals and actual use to increase uptake.
7. Contribute to the development and submission of timely quarterly narrative and monthly financial reports.
8. With the project team, identify other non-monetary incentives to attract more KP and their sexual partners to one-on-one and/or small group discussion.

***Numbers may vary from one program and peer educator to the other.

ANNEX G. Illustrative Progress Report Format

TITLE PAGE	Report title: Name of report writer Submission date:
EXECUTIVE SUMMARY	Brief overview of subject matter
DEFINE LIST OF ABBREVIATIONS	
TABLE OF CONTENTS	List of numbered sections in report and the page numbers
INTRODUCTION	• Terms of reference/background information • Objectives of KP intervention outline of report's structure
ACTIVITIES IMPLEMENTED	• Headings and sub-headings which reflect key activities undertaken within the reporting period. • Use clear pictures.
KEY RESULTS ACHIEVED	• Discuss key outputs and outcomes of your KP interventions • Use tables & figures where applicable to summarise achievements.
CHALLENGES	Outline factors affecting/militating against smooth implementation.
LESSONS LEARNT PRACTICES	• States key observations you have made which affect project implementation. • Shares good practices show desired outcomes
CONCLUSION	States the major inferences that can be drawn from the discussion
NEXT STEPS	Indicate any further work that needs to be done or identify the alternatives you think best solves or improves the problem
APPENDIX	This is information that supports your reports but is not essential to its explanation

ANNEX H. Data Collection Tools For KP Intervention

Annex Ha : Drop In Centre Registration Form

DIC CLIENT REGISTER

Year ____________ Month ____________ District____________ Partner____________________ DIC Name____________

S/N	Date	Client Code (UIC)	Age	Sex	Population					Services Provided								Referrals								
				M/F	FSW	MSW	MSM	Non-PP	PLHIV	HTC	STI	Male or Fem Condoms	Water-based Lubricants	Edutainment	Psychosocial Supp.	SGBV	Other (Specify)	HTC	STI	OI/ART	Family Planning	Health Care	Mental Health Care	Spiritual Care	Legal Support	Other
1																										
2																										
3																										
4																										
5																										
7																										
8																										
Total																										

Outreach/ Mobile TESTING AND COUNSELING (CT) Form 1

Name of Organization : .....

Type of Organization : Public ☐ Private Formal ☐ Private informal ☐

Date_____ Region _____ District _____ Community_____

Target Population : General Pop ☐ Youth ☐ MSM ☐ MSW ☐ FSW ☐ IDU ☐ Non-PP ☐

No.	AGE	SEX	CONTACT	NGO	CODE	PRE	TESTING	POST	TELEPHONE

Annex Hc : Mobile Testing & Counselling Form 2

Outreach/ Mobile TESTING AND COUNSELING (CT) Form 2

Name of Organization : .....

Type of Organization : Public ☐ Private Formal ☐ Private informal ☐

Date_____ Region _____ District _____ Community_____

Target Population : General Pop ☐ Youth ☐ MSM ☐ MSW ☐ FSW ☐ IDU ☐ Non-PP ☐

No.	Code No.	Test Result	Ref. For Other Services	F. Fup	Counselling Issues	Name Counselor

Annex Hd : Mobile Testing & Counselling Summary Form

National HIV Monitoring & Evaluation System, Ghana

Summary Outreach/Mobile CT-Prevention Programmes

Name of Organization : .....

Type of Organization : Public ☐ Private Formal ☐ Private informal ☐

Date_____ Region _____ District _____ Community_____

Target Population : General Pop ☐ Youth ☐ MSM ☐ MSW ☐ FSW ☐ IDU ☐ Non-PP ☐

*NB:Use one form for each target group

Indicators		Age Groups (Years)					
		0-9	10-14	15-19	20-24	25+	Total
Number receiving pre-test							
Number tested							
Number receiving Results							
Number receiving positive testresults	Male						
	Female						
	Total						
Number receiving post-test counseling							

Annex He : Client Referral Form

NAME OF ORGANISATION CLIENT REFERRAL		
Part A: Referral Slip: To be filled out by the organization/ department , DIC /STI Clinic making the referral (referringorganization/department)		
Date:	PE Code/officer code:	Client Code: Age: Sex
District:	Region:	Referred to:
Referring Organization / Department / Partner :		
Contact Person / Referral focal point person:		
Services provided(if any)by referring person/department/organization : HIV/AIDS information(ABC) Condom Lubricant Psychosocial support Specify		
Services needed : CT STI treatment Condom Lubricant OIs Other Specify		
Additional notes:		
Signature:	Tel. #:	

Annex Hf : Monthly STI Report Form

STI Monthly Summary Report Form

Name of Organization: .....

Region District Location: .....

Year Month: .....

Types		Number of services														
		FSW		MSW		MSM										
	STIs (total of all STIs)															
	Growth															
	Discharge															

Name of Coordinator:.....

Signature:..... Date:.....

Annex Hg : Monthly DIC Service Record Form

Monthly DIC/Wellness Centre activity Summary Report – HIV Prevention Programs

DIC/ Wellness Centre name: .....

Name of managing organization: .....

Reporting period: .....

Indicator	Sex	FSW		MSM		MSW		Non-PP		PLHIV	
Number of KP who received peer counselling services at the DIC	M										
	F										
	Total										
Number of KP or PLHIV Spouse /Partner who received TC services at this DIC or Wellness Centre	M										
	F										
	Total										
Number of KP or PLHIV who received STI services at this DIC or Wellness Centre.	M										
	F										
	Total										
Number of KP or PLHIV referred for other services	M										
	F										
	Total										
Number of PLHIV who successfully disclosed to their partner	M										
	F										
	Total										
Number of condoms and water-based lubricants distributed at the DIC or Wellness Centre	Male condom		Female condoms		Total		Water-based lubricants				

ANNEX I. Indicators for Key Populations

Below is the list of indicators that should be measured based on the minimum package of services. Further indicators are found in the National MARPs Strategic Plan 2011- 2015.

Annex Ia : Indicators for Female Sex Workers*

Achievement of Goal Achievement of objectives	• Reduction of new HIV infections among female sex workers by 50% by 2015 • % of FSW who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission • Number of FSW reached by interventions disaggregated by i) prevention, ii) treatment, care and support, iii) psycho-social • Number of FSW referred to other services (illustrative examples include: STI, HTC, ARV, Car and Support, PMTCT, Family Planning/Reproductive Health (FP/RH), Antenatal Care (ANC), Life Skills, Drug Treatment)/total number of individuals receiving intervention • Total number of referrals/total number of referred • Number of prevention commodities distributed (condoms, water-based lubricants, needles) • Number of targeted condom service outlets, disaggregated by new and continuing sites • Number of dedicated FSW drop-in centers • Number of peer support groups formed • Number of healthcare workers trained as FSW-friendly Number of peer educators recruited and trained
Achievement of strategies	• % of FSW surveyed reporting the use of a condom with most recent client, by age • % of FSW surveyed reporting use of condom with every client in the last month • % of FSW (by age) surveyed who received an HIV test in the last 12 months and know results • % of FSW reporting the use of a condom with NPP at last sex-act • % of HIV positive FSW surveyed by age • % of HIV positive FSW surveyed receiving care services • % of HIV positive FSW surveyed receiving ARV treatment

Below is the list of indicators that should be measured based on the minimum package of services. Further indicators are found in the National MARPs Strategic Plan 2011- 2015.

Annex Ib : Indicators for Men who have sex with Men*

Achievement of Goal	• Reduction of new HIV infections among men who have sex with men by 50% by 2015
Achievement of objectives	• % of MSM who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission • Number of MSM reached by interventions disaggregated by i) prevention, ii) treatment, care and support, iii) psycho-social • Number of MSM referred to other services (illustrative examples include: STI, HTC, ARV, Care and Support, Life Skills, Drug Treatment)/total number of individuals receiving intervention • Total number of referrals completed/total number of referrals • Number of prevention commodities distributed (condoms, water-based lubricants) • Number of targeted condom service outlets, disaggregated by new and continuing sites • Number of dedicated MSM drop-in centres • Number of peer support groups formed • Number of healthcare workers trained as MSM-friendly
Achievement of strategies	• % of MSM surveyed who have had anal sex with more than one male partner in the last 6 months • % of MSM surveyed who received an HIV test in the last 12 months and know results, by age • % of MSM surveyed reporting condom use at last insertive anal sex with male, by age (n) • % of MSM surveyed reporting condom use at last receptive sex with male, by age (n) • % of MSM surveyed reporting consistent condom use during anal sex with a male during the past three months, by age (n) • % of HIV positive MSM surveyed who are HIV positive • % of HIV positive MSM surveyed receiving care services • % of HIV positive MSM surveyed receiving ARV treatment

ANNEX J. Keys To Producing Successful Materials

1. The lower the literacy level of key populations, the more emphasis should be placed on pictorial images and the less on text. Use short and simple text.
2. Messages should be positive, not fear-based, and discriminated.
3. If the materials feature a source, ensure that the source is authoritative and credible for the key population (doctors, celebrities, officials, traditional healers.)
4. Make sure the main message is repeated within a single material for maximum effect.
5. Limit the number of messages to avoid confusion.
6. Be careful not to use language or images that could stigmatize specific population. Include target audience in the design and review process.
7. Concern about copy right of the text and picture.
8. Get approval from key organizations such as Broadcasting Committee, Ministry of Culture, etc.
9. Establish feedback mechanisms if there is sensitive issue in the materials.
10. Materials should be visually appealing and eye-catching.
11. Messages should be presented in a way that is both logical and rational and emotionally compelling.
12. Materials should clearly reflect the reality of everyday lives of key populations. Use familiar faces, buildings, streetscapes, etc.
13. It should be clear who the key population is when looking at the materials.
14. Include a call to action.
15. Present one message per illustration/page/graphics. The more white space on a page, the more inviting it is to the eye. The simpler the TV/radio messages, the more likely they will be remembered.
16. Ensure that materials are free of confusing and culturally inappropriate messages and images.
17. Don't be too abstract. Avoid overly sophisticated messages.
18. Ensure quantity and availability of materials.
19. Think about where to distribute materials

ANNEX K. Illustrative Roles And Responsibilities For Drop In Centre Staff

The role of each member should be as follows:

Peer educator

- Map peers in their area of operation and regularly update this information.
- Identify new peers as soon as they come into their site and register them with the project.
- Actively promote DIC services among peers.
- Provide quality one-on-one peer education in the community and in DICs.
- Support condom and lubricant promotion activities.
- Actively manage and participate in DIC and community outreach activities and events.
- Ensure that services (e.g. TC/STI) are provided to new peers within one week of registration at the DIC.
- Ensure that services are provided to peers as per the Minimum Package.
- Ensure that services are provided with priority to those with a higher risk profile.
- Provide support to peers in their site in times of crisis within 30 minutes (M-Friends/M-Watchers).
- Prepare and regularly update their weekly plans and reporting forms.
- Act as eyes and ears of the project and keep it updated on developments in their site.
- Provide feedback from the peers to the project and voice their concerns.

NGO staff at the DIC

- Provide oversight of all services and functions of the DIC.
- Ensure all services are provided according to the DIC SOP.
- Supervise work of peer educators, nurses and others providing services through the DIC using standardized checklists; mentor staff in key skills as needed.
- Ensure that services are provided with priority to those with a higher risk profile.
- Ensure correct and confidential client records are maintained.
- Track commodities and supplies at the DIC and notify your organisation three (3) months before stock-outs.
- Support crisis response (M-Friends/M-Watchers) and take responsibility for managing complex cases; notify your organisation of all cases of rape, violence and harassment within 24 hours of them taking place.
- Prepare and regularly update weekly/monthly plans.
- Prepare monthly reports; review reported service data and check its quality.
- Meet with peers/nurses on a routine basis to review monthly workplan.
- Provide opportunities for peers to advance and become peer leaders, M-WATCHERS or NGO staff.
- Perform annual performance reviews of all staff/peers.

Nurse (HTC/STI provider)

- Provide quality HTCand STI services tailored to the specific needs of MSM and FSWs.
- Conduct a clinical screening of all clients.
- Conduct SGBV screening for all clients
- Provide basic health services including vital sign monitoring, screening for TB and counselling and referrals for and family planning.
- Offer health care support to the children of clients as needed.
- Make referrals to key health facilities for HIV care and treatment, PMTCT, ANC, SRH/FP, TB and other services; follow-up to ensure referrals successfully made.
- Provide health education for group activities on a range of topics.
- Track clinical commodities (e.g. gloves, speculums) and report to the NGO staff at least three months before supplies are projected to disappear.
- Clearly document services provided to clients using the appropriate tools.

ANNEX L. Illustrative Roles And Responsibilities For Clinic Team

The role of each member should be as follows:

Doctor:

1.Lead the team and oversee the overall clinical services

2.Conduct consultations for KPs

- Thorough history taking (general ailments, HIV/STI related, TB screening and family planning needs assessment)
- Physical examination including internal examination including vaginal and rectal examination
- Individual HIV and STI counselling including risk-assessment and reduction
- Syndromic case management for symptomatic STIs
- Provision of HIV testing and counselling
- Provide SGBV screening for all clients
- TB and/or family planning counselling and referrals as needed
- Referrals for higher STI services or services not provided at the DIC
- Referrals to TC/ART site for confirmation HIV testing
- Referrals to TB, family planning, PMTCT and other relevant services

3. Be responsible for reporting on activities of the clinical
4. Ensure that high quality of services are provided by all staff

Nurse:

1. Receive all KPs into the clinic.
2. Ensure that all KPs are registered
3. Record and store all data in a confidential a manner
4. If accredited, provide clinical services for KPs when required (or in the absence of the doctor)
   - Thorough history taking (general ailments, HIV/STI related, TB screening and family planning needs assessment)
   - Physical examination including internal examination
   - Individual HIV and STI counselling
   - Syndromic case management for symptomatic STIs
   - Provision of HIV testing and counselling
   - Provide SGBV screening for all clients
   - TB and/or family planning counselling and referrals as needed
   - Referrals for higher STI services or services not provided at the DIC
   - Referrals to TC/ART site for confirmation HIV testing
   - Referrals to TB, family planning, PMTCT and other relevant services
5. Provide a link to the peer educators and the community activities
6. Documentation

Counsellor:

1. Provide a conducive atmosphere for counselling

2. Ensure that all required information is provide to the KP, pre-test information (or counselling) for specific test e.g. HIV
3. Conduct HIV tests when rapid test are available
4. Provide follow up counselling where needed
5. Please note that the nurse may also serve as a counsellor depending on the set up.
6. Provide follow up support for victims of SGBV

Laboratory Personnel : (where available in large facilities; in smaller facilities some of test can be conducted by other members of the team such as counsellors and doctors).

1. Provide testing services for HIV
2. Provide screening/ testing services for other STI e.g. syphilis, Gonorrhoea.
3. CD4 count

ANNEX M. Checklist for Referral for the Clinical services

Item	Parameters for screening	Yes	No	Required Action	Action taken
TB -	• Sudden loss of weight • Evening rise of temperature • Cough history for more 2 weeks			Refer to the hospital	
Malaria	• Fever with rigors and chills • Vomiting, retching etc			Send to the hospital	
Diarrhoea	Present			• Reinforce hydration • Refer to hospital	
Currently	If yes, is the pregnancy wanted?			• If yes, refer to PMTCT and ART centres; • If no, refer to safe abortion service provider pregnant	
Family planning service needed				If yes, refer to FP service provider.	
OIs*	On OI medication?			Check for Adherence	
ART	On ART?			Check for Adherence	
CD4 count	CD4 counts should be done every 6 months;			check that this is done	
Side effects of medications	Enquire for any reports on side effects to medication.			If yes, report to the clinic staff	
Safe sex, PWID, positive prevention, substance abuse	Enquire and reinforce healthy lifestyle				

*Adherence to OI medication is a prerequisite for ART treatment, this should be monitored.

REPUBLIC OF GHANA

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FROM THE AMERICAN PEOPLE

GHANA AIDS COMMISSION
Under the office of the President

BRIDGE PROJECT
LINK - LEARN - LEVERAGE
Africa-India-Asia : HIV Learning Network