Guidelines for Implementing HIV Prevention Program among Most at Risk Population (MARP)

August 2009

Family Health International (FHI) Nepal

USAID | NEPAL
FROM THE AMERICAN PEOPLE

ASHA
Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS

Family Health International/Nepal
USAID Cooperative Agreement #367-A-00-06-00067-00
Strategic Objective No. 9 & 11

FOREWORD

Family Health International (FHI) Nepal is pleased to present the Guidelines for Targeted HIV Prevention Program among Most at Risk Populations (MARPs) 2009.

These guidelines include process for implementing prevention activities for Project Coordinators, Field Supervisors, Outreach Educators and Community Mobilizers. Every effort has been made to include accurate, complete and reliable information based on the most recent experiences and best available information and evidence. Nevertheless, these guidelines may be revised as needed as new investigations, analyses and approaches are performed and as new information and evidence arises regarding the situation of MARPs and the HIV prevention strategies and approaches throughout Nepal.

FHI Nepal would like to express its sincere appreciation to all contributors to this manual. We hope that these guidelines will be useful to ensure high quality HIV prevention programs among MARPs in Nepal.

Jacqueline McPherson

Jacqueline McPherson
Country Director
Family Health International (FHI) Nepal

Table of Contents

Introduction/Background:

Nepal currently has a concentrated HIV/AIDS epidemic with an HIV prevalence of more than 5% among injecting drug users (IDUs). The National Center for AIDS and STD Control (NCASC) with technical assistance from Family Health International (FHI) Nepal, USAID, Joint United Nations Program on HIV/AIDS (UNAIDS), and the World Health Organization (WHO), estimated that there are as many as 70,000 people (including about 1,800 children) living with HIV/AIDS (PLHA) with adult prevalence rate at 0.49% in Nepal in 2007. The HIV prevalence among female sex workers (FSWs) and their clients, male sex workers (MSW), men having sex with men (MSM) and returning migrant workers remains between 1.5 and 2%.

Estimated HIV Cases in Nepal 2005

Population Sub-Group	Estimated Infections
Children (0-14)	1,857
Adults (15-49)	64,585 (0.49% of total adult population)
Adults (50+)	3,348
Total	69,790
Women (15-49)	19,061 (29% of total estimated infections)

Prevalence of HIV in Different Sub Populations

Intravenous Drug Users	23.02%
Female Sex Workers	1.45%
Men Having Sex with Men	1.71%
Migrant Workers	1.90%
General Adult Population	0.49%

All modes of HIV transmission have been reported in Nepal; however, sexual transmission and the sharing of unclean needles remain the most common. Most-at-risk populations (MARP), particularly female sex workers (FSWs) and injecting drug users (IDUs), are the bulk of the concentrated HIV epidemic in Nepal. Injection drug use appears to be extensive in Nepal and it significantly overlaps with commercial sex. Another important factor is the high number of sex workers who migrate or are trafficked to Mumbai, India to work, thereby increasing HIV prevalence in the sex workers' network in Nepal more rapidly. There are many risk factors that put Nepal in danger of experiencing a widespread epidemic. One problem is the cultural, social and economic constraints to condom use, especially among sex workers. The large number of internal and external migrants in Nepal is another worrisome factor.

As Nepal has a concentrated epidemic, the National HIV/AIDS Strategy 2006-2011 and Action Plan (2008-2011) emphasize the intensification both in scale and scope of the prevention program, focusing on the MARP (FSW, clients of FSW, IDU and migrants) as the main targets. It is a globally established fact that the rising trend of the HIV/AIDS epidemic can only be reversed if effective HIV prevention programs are intensified in scale and scope.

FHI Nepal, with financial support from the United States Agency for International Development (USAID), has been providing technical assistance to Government of Nepal and implementing partner agencies (IA), including non governmental organizations (NGO) and the private sector,

for designing, planning, implementing, monitoring and evaluating HIV/AIDS prevention, care, support and treatment program since 1993.

The HIV prevention program and strategies have evolved by building on 15 years of FHI's work in Nepal, beginning first with Safe Highways and then the additions of Safe Cities and Safe Migration strategies. Beginning with the AIDS Prevention and Control Program 1993-97 (AIDSCAP I) and continuing through AIDSCAP II (1997-2002), FHI Nepal expanded its targeted HIV prevention program to include the full continuum from HIV prevention to care services through Implementing AIDS Prevention and Care Project (IMPACT) in 2002-2006. FHI Nepal is currently implementing ASHA[1] Project for HIV programs including strengthening national capacity, advocacy, policy reform, surveillance, and prevention to care service delivery for PLHA and MARP. The ASHA Project is designed to directly contribute to Nepal's efforts to achieve Millennium Development Goal no. 6 (halting and reversing the spread of HIV by 2015) and USAID's Strategic Objective 9 (Enhancing Stability and Security, through averting a destabilizing HIV epidemic and addressing humanitarian needs related to HIV). FHI Nepal currently works with over 50 IAs in 38 districts nationwide including those along the highways, in Kathmandu, in the Pokhara valley and in the Far West.

Over the last 15 years, FHI Nepal has clearly demonstrated the effectiveness of targeted community-based interventions in promoting safer behaviors among MARP thus reducing HIV transmission and increasing access to HIV related care, support and treatment services among MARP and PLHA.

HIV Prevention Program Guiding Principles:

A. Community and peer based outreach tailored to each MARP

The prevention program and activities should be tailored for each MARP in each location and be implemented through community and peer based outreach. This is so that the specific HIV prevention, care, support and treatment related needs of the MARPs are met, while ensuring socio-cultural appropriateness for optimal program effectiveness. The prevention team consists of the combination of professional staff, Community Mobilizers (CM) and volunteer Peer Educators (PE) as representatives of MARP community.
The staff and volunteer PE get adequate training and materials to provide accurate and complete information to the MARP. The staff is paid for their work.

B. Focus on positive health impact through positive behavior change and maintenance

The prevention program focuses on positive behavior change and maintenance to achieve a positive health impact. In the context of FHI Nepal's program goals, positive health impact is defined as reduced HIV transmission among MARP. All activities undertaken by IAs for HIV prevention should clearly contribute to this positive health impact through positive behavior change and maintenance.

[1] Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS

C. Prevention program based on evidence and behavioral theory

The prevention program and activities are designed, planned and implemented based on evidence and behavioral theories. FHI Nepal uses theoretical frameworks to achieve positive health impact which includes risk perception, efficacy (self-efficacy/solution efficacy), social support and linkages with services and products. See **annex 1** for the framework.

D. Assure linkages with services and products

Once MARP are identified by the prevention team, they should be provided with accurate and complete information and referred for quality services and given the products necessary for the positive behavior change and maintenance. This might include condoms, STI diagnosis and treatment services, HIV counseling and testing (CT) services and care and support and treatment (CST) and other services such as gynecological and obstetrical, income generation family planning based on the need of MARP. The team should ensure the functional linkages and coordination with the appropriate service providers in order to increase access to necessary services and products.

E. Ensure Confidentiality

MARP's information is kept confidential at all times. MARP's information will be shared within project team and the concerned individuals/organizations only for recording, reporting, monitoring and referral purpose and ensuring care, support and treatment. The prevention team staff signs the oath of confidentiality. Records are managed by the concerned staff only; files are kept within a locked cabinet in secure a location and ensure that information is accessible only to those authorized to have access.

F. Ensure Quality

The quality of prevention programs and activities are ensured through evidence based program designs, planning and implementation using strategic behavioral communication strategies and continuous supportive supervision and monitoring of field activities, and through developing and ensuring the use of guidelines, defining standards and measuring performance.

Target Audience of the Guidelines:
The guidelines are intended for use by the following:
1. Project Coordinator
2. Filed Supervisor
3. Outreach Educator
4. Community Mobilizer
5. Volunteer Peer Educators
6. FHI Nepal program and technical staff

Objectives of the Guidelines:
The primary objective of the Prevention Guidelines is to provide guidelines and information on procedures to ensure the quality of HIV prevention activities. Specific objectives are to:

1. Provide the above mentioned staff with essential information on how to give accurate and complete HIV prevention related information.
2. Provide staff with operational information about how to organize and deliver prevention activities.
3. Ensure the delivery procedures of prevention activities are performed consistently to maintain quality.
4. To serve as training documents to prepare new staff and reinforce standards for existing staff that need additional training.
5. To serve as a quality assurance tool for management to evaluate service delivery and reinforce performance in accordance with national and FHI standards and guidelines.

Prevention Guidelines (PG) 1: Prevention Team Structure and Responsibilities

A) General consideration:

A team for a prevention program should consist of the following team members:

- Project Coordinator (1) (if there are only one-two teams)
- Field Supervisor (1) (only if there are 3 or more teams)
- Outreach Educator (1)
- Drop In Center (DIC) Operator (1)
- Community Mobilzer (3)
- Volunteer Peer Educators (3-6)

Community Moblizers and Volunteer PE should be from a beneficiary group. Deepening on availability of the resources, Volunteer PEs get minimal incentives based on their performance.

There is no specific dress code for OE and CM but OE and CM should carry outreach bags with IEC materials during outreach education. All staff including volunteer PE are required to carry their organization identity card with BISHWAS logo.

All staff is required to sign a commitment to providing complete and accurate information as well as a commitment to confidentiality.

The number of MARP (FSWs, clients of FSWs, IDUs and Migrants) reached by the team depends on the concentration of FSWs, clients of FSWs, the distance and time needed to travel and availability of transportation facilities. The Filed Supervisor and OE, with the help of Project Coordinator and FHI Nepal Program Officer, need to calculate the minimum number of MARP to be reached per month by the team, based on the factors listed.

B) Number of MARP to be reached and number of repeated educational contacts

The average number of MARP to be reached by a prevention team is as follows. The number includes both new contacts and repeat contacts with individuals who have been previously identified.

City Area

1) FSW: 295-350 per month (85-100 per month per CM + 40-50 per OE); (30-40/PE)
2) Clients of FSW: 470-595 per month (135-170 per month per CM + 65-85 per OE) (50-65/PE)
3) IDU: 350-470 per month (100-135 per month per CM + 50-65 per OE) (40-50/PE)

Highway and Adjoining Area:

1) FSW: 175-245 per month (50-70 per month per CM + 25-35 per OE) (20-25/PE)
2) Clients of FSW: 350-470 per month (100-135 per month per CM + 50-65 per OE) (40-50/PE)

3) Migrants: 350-470 per month (100-135 per month per CM + 50-65 per OE) (40-50/PE)

Number of repeated educational contacts (REC):

In order to motivate MARP for positive behavior change and maintenance, educational sessions with MARP are conducted in the following frequency:

1) First contact (a new individual identified as a MARP).
2) Conduct one-on-one repeated educational contact (REC) every month after identification (first contact) for six months with FSWs and IDUs and 3 months with clients of FSWs. Conduct one-on-one REC every quarter after identification for two quarters with spouses of migrants.
3) Conduct repeated one-on-one educational contacts once in every two months after the initial six months with FSW and IDUs are over; once in a quarter after the initial 3 months with clients of FSWs are over and once in every four months after the initial 2 quarters with spouse of migrants are over.
4) After this, conduct group educational sessions with the MARP. A MARP should participate in a group education session at least once every quarter either in a DIC or outside the DIC.
5) At least 80% of FSWs and 50% of clients of FSWs reached by outreach within the catchment area of a DIC should visit and participate in DIC activities at least once every 2 months, if DIC facilities are available.
6) One-on-one educational sessions can be planned according to the needs identified during group education session.

C) General responsibilities:

Volunteer PEs are responsible for Integrated Health Services (IHS) referrals, DIC referrals, condom distribution and social marketing, condom demonstration and helping CM identification of MARP

CMs are responsible for the identification of MARPs, with the help of PEs, as well as risk assessment, HIV/AIDS and STI education, condom use demonstration and distribution referral and follow up and counseling

OEs are responsible for daily/micro planning, supervision, coaching/mentoring and monitoring, education on complicated topics, counseling and planned group discussions

DIC Operators are responsible for the day-to-day operation of DIC activities

Field Supervisors are responsible for monthly/quarterly planning, reporting, supervision, training, coaching/mentoring and monitoring, coordination and collaboration at field level, and organization of meetings with stakeholders.
(See **annex 2** for detail JD)

D) Minimum Qualifications of the Staff:

Volunteer PEs should be from the MARP and should be literate. However, this criteria will be flexible depending upon local context and availability of candidates of such level.

CMs should be from MARP and should have passed grade 6-8. However, this criterion will be flexible depending upon local context and availability of candidates of such level.

OEs should either be MARP or other community member, should have at least passed the SLC and should have relevant experience. Priority will be given to those who have paramedical background (community medical assistance and auxiliary nurse midwife)

Field Supervisors should be at least 10+2/intermediate passed with relevant experience.

Project Coordinator should have at least a bachelor's degree and have relevant experience.

E) Training requirement (basic, refresher):

Volunteer PEs should be trained on basic HIV/AIDS peer education for 2 days. Refresher and on the job training session will be incorporated into quarterly review and planning meetings.

CMs and OEs should receive a 5 day basic strategic behavioral communication (SBC) training and a 2 day refresher training once in a year.

FHI Nepal will manage and organize trainings for OE/CM using standard training curriculum, guidelines and materials. FHI Nepal implementing partner agency (IA) will mange and organize training for PE with technical assistance from FHI Nepal.

F) Work plan (quarterly, monthly and daily/micro planning)

Project Coordinator with the help of Field Supervisor and in consultation with the OE, CM and PE should develop quarterly and monthly work plan using the standard format given in **annex 3.** Sub-agreement documents, including monitoring and evaluation (M&E) matrix and Gantt chart, should be used for quarterly work plan preparation.

Finance and administrative staff should also prepare a quarterly budget projection based on the quarterly plan using standard format.

The quarterly plan along with the quarterly budget projection should be prepared and sent to FHI Nepal Program Officer for review and approval at least two weeks prior to commencement of the upcoming quarter.

Daily/Micro planning:

Based on the monthly plan, the OE and CM are required to prepare a daily/micro planning using the standard format given in **annex 4.**

To ensure the effective coverage of MARP, a system and tool for micro planning will be set up. Micro planning is a system and a tool which helps OE and CM to prepare, implement and follow up of prevention activities for individual MARP based on their risks and vulnerability. Furthermore, education provided, number of condoms distributed, IHS referrals and follow up made for MARP and utilization of services by MARP will be tracked. See **annex 5** for coverage tracking sheet.

A geographical area for each CM will be demarcated and the number of MARP to be reached by each CM will be defined. Each CM with the help of OE and Field Supervisor will prepare and update operational and mobility mapping of their area on a regular basis. CM along with PEs are responsible for managing the program within their geographical area with regular support from the OE and the Filed Supervisor.

Monthly review, sharing and planning meeting

The monthly sharing and review meeting should be organized with the project staff. The purpose of these meetings is to review achievements of the previous month and plan for the upcoming month. The review and sharing meeting with the FHI Nepal Program Officer should be organized every two months (bi monthly review meeting: BRM).

The structure of the meeting should be two fold, 1) sharing and reviewing the (bi)-monthly targets vs. achievements, success stories, lesson learned, weakness and areas for improvement and budget projected vs. the actual expenditure and 2) to get updated on program and technical topics with help of the FHI Nepal Program Officer

Minutes of the meeting should be kept. Issue and action matrix should be prepared.

PG 2: Commitment to Confidentiality and Quality of Information

All prevention program staff must sign the Commitment to Confidentiality and Quality of Information. The original copy is kept in the staff or volunteer PE personnel file (kept by Finance and Admin Unit) and a copy is given to the prevention program staff member.

I,_____, commit to protect the confidentiality of my clients by:
(name)

- Not discussing my client or anything about his/her condition or situation with anyone unless required for referral. Information regarding my client will only be shared for a referral with approval from my client.
- This includes not discussing my client's sexual orientation, relationship and history and STI and HIV status with anyone including family members of the client unless given clear approval from the client to speak openly about their status with some or all of the client's family members
- Using code numbers instead of names for client files, forms, etc.
- Not leaving client files, diary, recording forms and formats in public view
- When not using the client file, ensuring it is kept in a locked cabinet

I also commit to do the following:

- Provide complete and accurate information to my clients to the best of my ability
- Not provide information which is not known to me and beyond my ability or training. To refer clients when I am unable to provide the complete and accurate information they need.
- Do not abandon or reject clients who need care, but to refer or accompany for services.
- If I am a supervisor, I will closely monitor the activities implemented by my team to ensure that this commitment to confidentiality is followed.

As a staff, I have the right to:

- Receive training to upgrade my skills and capacities as a OE or CM
- To receive supportive supervision from my supervisors and to provide supportive supervision to my team

_____ _____

Name **Date**

PG 3: Identifying Most at Risk Population (MARP)

MARP are the groups of people who are at high risk of getting HIV and STIs because of unsafe behaviors such as having multiple sex partners without using condoms and sharing syringes and needles. FSWs, clients of FSWs, IDUs, man having sex with man (MSM) and transgender (TG) having multiple sex partners and migrants including spouse of migrants are the MARPs identified in Nepal. Since MARPs are the beneficiaries or target groups of the HIV prevention program, identifying people who are part of the MARPs is the entry point of the prevention program. Because of the stigma and discrimination associated with HIV and risk behaviors, FSWs, IDUs and clients of FSWs are difficult to identify and contact for prevention programs.

Approaches to MARP Identification:

1) Approach to MARP identification in new project areas:

A Rapid Community Assessment (RCA) should be conducted if the HIV/AIDS prevention program is being launched or expanded in new areas.

RCA is the process of gathering, reviewing, exploring and analyzing the information (current status, situation and needs) of a community for the planning and implementation of HIV/AIDS/STI prevention, care, support and treatment programs.

RCA includes gathering and analyzing information about:

- Information on demography, socio-economic status, cultural and health related services/organizations,
- MARP, their demography and socio-economic status,
- Risky and safer behaviors, potential risk factors and behavioral determinants, motivating factors and barriers (individual, peer/community and socio-economic, service and products)
- MARP's level of knowledge on HIV/AIDS, Condom, etc…
- Attitude of MARP toward HIV/AIDS, STIs and condoms
- Perception of risk, susceptibility and severity
- Self efficacy and skills to practice safer behavior
- Perceptions of peers/community norms,
- Availability of HIV related service sites and facilities such as STI diagnosis and treatment, HIV counseling and testing (CT) and care, support and treatment (CST)

RCA Process:

1. Review of relevant literature, study reports and records
2. Contact with non-governmental and governmental organizations working in the field of HIV/AIDS, STIs, sexual and reproductive health, family planning and health services in the district to get secondary information.
3. Key informant interviews: key informants includes formal and informal community leaders, local authorities including police, NGO/CBO personnel, health service providers, transport workers including rickshaw pullers, owners of establishments such as hotel, lodge, restaurant, local youth, pimps/brokers etc.

4. Mapping of the areas
5. Semi-structured observation of the high risk areas/hot spots, See **annex 6** for some of the identified criteria for high risk area/hot spots
6. Approach suspected MARPs (FSWs, clients of FSWs, IDUs, MSM/TG and migrants), build rapport, explore the information on risk behaviors (risk assessment) using risk assessment tools given in **PG 6** and identify the MARPs. (Follow guidelines for first educational contacts, **PG 4 A 1)**

The Project Coordinator and Field Supervisor are primarily responsible for RCA. RCA should be well designed, planned and prepared and staff involved in RCA should be trained for RCA prior to RCA in coordination with FHI Nepal Strategic Information Unit and Program Officer.

2) Approach to MARP identification in existing project areas:

MARPs in existing and adjoining parts of the projects areas can be identified through previously contacted MARPs, PEs and CMs, and through the analysis of peer, sexual and injecting behaviors and social networks.
Risk assessment should be done using risk assessment tools given in **PG 6**

Criteria and indicators for identification of MARPs:

1) The first and foremost criteria to identify MARP is that s/he should identify as an FSW/client of FSW/IDU/MSM/TG, see **annex 7** for definition of the different categories of MARPs and target groups.
2) Observed sharing of needles for drug use.

Other supporting criteria and indicators that need further exploration and verification from the individual to be part of a MARP:

- Information provided by identified FSW, clients of FSW, pimps, IDU, MSM/TG and PE
- An unmarried and/or single woman/girl (age above 16 years) or man with an STI

PG 4: Educational Contact

Educational contact refers to the systematically planned process of providing essential, correct and complete information to one or more members of a beneficiary group through the effective use of various information, education and communication tools to change their risk behaviors. An educational contact can be used to promote positive behavior change in individuals. During an educational contact the CM/OE considers existing knowledge, skills, attitudes, practices and behaviors of the person contacted and provides education according to the individual's needs. The CM/OE uses different IEC tools for facilitating the development of skills towards behavior change; promoting health seeking behaviors; referring for integrated health services (STI and CT); providing condoms and different IEC materials.

Based on the number of people contacted, educational contacts can be divided in two types:

1) **One-on-one educational contacts:** contacting beneficiary group members individually
2) **Group educational contacts:** contacting beneficiary group members in a group (two or more members)

Based on the time of the contact, educational contacts can be divided in two types:

1) **First educational contacts:** contacting beneficiary group members for the first time
2) **Repeated educational contacts (REC):** contacting beneficiary group members after the first educational contact

Topics for educational contacts include, but not limited to, the following:

- Basic information on HIV, AIDS and STI
- Safer sexual behaviors, need and importance including alternative sexual practices
- Consistent and correct condom use skills
- Condom negotiation skills
- Risk assessment and risk reduction plan
- Referral for of STI diagnosis and treatment (every month) for FSWs and every quarter for clients of FSWs and IDUs
- Follow up of clients referred for STIs (4 C Complete treatment/compliance, contact tracing/partner notification, condom use and counseling/education for those who diagnosed any types of STI and 2 C: consistent and correct use of condoms and counseling/education for those who do not have any STI)
- Referral for CT services (every three months)
- Follow up of CT services
- Sexual and reproductive health (menstruation, pregnancy, family planning, maternal and child health)
- Personal hygiene, beauty and environmental sanitation
- Human rights including women rights and sexual and reproductive rights

Procedures of conducting educational contacts:

Educational contacts should be an interactive process. The emphasis should be given to listening to and understanding of the risks and vulnerabilities, needs, feelings, attitudes, knowledge,

beliefs, practices and behaviors of the beneficiary group members. The role of OE and CM should be to:

- Help the beneficiary group members to reflect upon and assess their risks and vulnerabilities, needs, feelings, attitudes, knowledge, beliefs, practices and behaviors through providing accurate, clear, concise and relevant information and skills to make and implement an action plan for behavior change and maintenance.
- Provide alternatives or options for safer behavior
- Help them to choose the option
- Develop necessary skills to implement or act or practice safer behavior
- Link with services and products
- Review and reflection of the action

If awareness is not translated into action, the awareness will be worth very little and will cause frustration among the beneficiary group members. Therefore the role of OE/CM will be:

1) Raising awareness and enhancing skills
2) Motivate for action
3) Support and guidance for action
4) Help for review and reflection

Frequency of repeated educational contact: See PG 1 B

A) One-on-one educational contact:

A.1) First contact:

A.1.1) Pre visit (before the visit):

1) Prepare detailed plan using the standard daily planning format **(annex 4)**
2) Prepare for the visit according to the detailed plan
    a. Make sure that the diary, recording forms, referral cards, IEC materials, condoms and other required materials are in the outreach bag.
    b. Study reference materials and IEC related to educational contact topic
    c. If required, discuss with your Supervisor and colleagues

A.1.2) During the visit:

1) Conduct educational contact as planned

1.1) Rapport building and maintenance

- Greet as culturally appropriate
- Introduce yourself, organization and programs
- Explain objective(s) of the visit
- Be gender and socio-culturally sensitive
- Start with general topics/situations (Ask: How are you? How is your family and, children? How is your crop?) situation of the village/*tole*, weather, agricultural and household activities, health situation, study/education of children as appropriate
- Be polite, listen attentively and show interest in her/him, her/his situation, issues and concerns

- Praise and express gratefulness for sharing
- Assure confidentiality
- Show respect to her/him
- Express empathy
- Ensure enough time has been spent on rapport building before starting main topic

1.2) Start discussion on main topic as per your plan

- Assess her/his knowledge of and attitude toward HIV/AIDS, STIs and condoms. (Sample question: "Have you heard of HIV/AIDS?" then follow with other questions) If it is difficult to start with HIV/AIDS, start with women's health, sexual and reproductive health then link with HIV/AIDS and STIs.

- **Conduct risk assessment:**
  - Risk assessment is an assessment to determine if someone is at risk of becoming infected with HIV and STIs. This can be done through several mechanisms including counseling, questionnaires and games. Risk assessments should be conducted to make an individual realize her/his high risk behaviors, not to blame the individual.
  - Conduct risk assessment using risk assessment tool given in **PG 6**. Help the individual to realize and identify her/his risk behavior (s)
  - Explore and analyze the reasons behind the high risk behavior

- **Help to make risk reduction plan:**
  - Support to identify the safer behavior(s) that can protect her/him from HIV and STI transmission (consistent and correct use of condom with FSW or clients of FSW, reduce number of non-regular sex partner, seek STI diagnosis and treatment service monthly and seek HIV counseling and testing service quarterly)
  - Support to identify obstacles/barriers to adopting safer behaviors
  - Discuss options for safer behaviors and skills and products needed for safer behaviors
  - Training on skills required for adopting safer behaviors. Perform condom demonstration. Perform role play on condom negotiation. See **annex 8 (A)** for steps of condom use demonstration and **annex 8 (B)** for condom negotiation.
  - Provide condoms. See **annex 8 (C)** for number of condoms required for each MARP per month
  - Refer for STI diagnosis and treatment service (see **PG 5** for detail guidelines)
  - Refer for CT service (see **PG 5** for detail guidelines)

1.3) Wrap up and closing:

- Ask if there are any question and/or concerns
- Summarize the educational session. Highlights key points and action items
- Set date, time and place of next (follow up) visit
- Give thanks for time

1.4) Reflection:

- Review and reflect on strengths and weaknesses of the educational session
- Identify action points for improvement
- Get feedback from colleagues and/or supervisor if they are present during educational contact
- Fill in all the required recording tools (daily diary, coverage form, daily log sheet)

A.2) Repeated educational contact (REC):

A.2.1) Pre visit (before the visit):

3) Select individual MARP and location for repeated educational contact based on previous educational contact sessions and individual coverage tracking sheet and prepare detailed plan using the standard daily planning format. (**See annex 4**).
4) Prepare for the visit according to the detailed plan
    a. Make sure that the diary, recording forms, referral cards, IEC materials, condoms and other required materials are in the outreach bag.
    b. Study reference materials and IEC related to educational contact topic
    c. If required, discuss with your supervisor and colleagues

A.2.2) During the visit:

1) Conduct repeated educational contact as planned

1.1) Rapport building and maintenance

- Greet as culturally appropriate
- Be gender and socio-culturally sensitive
- Start with general topics/situations (Ask: How are you? How is your family and, children? How is your crop?) situation of the village/tole, weather, agricultural and household activities, health situation, study/education of children as appropriate
- Be polite, listen attentively and show interest in her/him, her/his situation, issues and concerns
- Praise and express gratefulness for sharing
- Show respect
- Express empathy

1.2) Start discussion on main topic as per your plan

- Follow up of the previous educational session. Ask s/he to remember key information and action points of the previous session.
- Review/ask if the action point was implemented.
- If implemented
    - Praise, appreciate, express happiness and encourage continuation
    - Ask to tell experience. Ask if there were any difficulties/barriers, if yes discuss it and help to make plan to address these difficulties/barriers.

- Discuss maintenance of the positive/safer behavior. Provide further knowledge, skills, materials and products for the maintenance of these behaviors

- If not implemented
  - Ask the reasons, do not blame and do not lose temper
  - Discuss the benefits (immediate and long term) of adopting safer/positive behavior
  - Discuss the negative consequences of continuing high risk behaviors but do not exaggerate the negative consequences to create unnecessary fear. Always link negative consequence messages with availability of products, services and behaviors to help and call for action
  - Help s/he to decide to implement safer/positive behaviors. Discuss skills, support and materials needed to adopt safer/positive behaviors and provide accordingly.
  - Refer for STI diagnosis and treatment (see **PG 5** for detail guidelines)
  - Refer for CT, if it has been three months since the last HIV test (see **PG 5** for detail guidelines)

Topics for follow up in REC:

- STI clinic attendance, examination, diagnosis and treatment (self and sex partners)
- Consistent and correct condom use
- CT site attendance, counseling and testing, result of the CT
- Reduction of non regular sex partners
- Any other action items

1.3) Wrap up and closing:

- Ask if there are any question and/or concerns
- Summarize the educational session. Highlights key points and action items
- Set date, time and place of next (follow up) visit
- Give thanks for time

1.4) Reflection:

- Review and reflect on strengths and weaknesses of the educational session
- Identify action points for improvement
- Get feedback from colleagues and/or supervisor if they were present during the educational contact
- Fill in all the required recording tools (daily diary, tracking sheet, daily log sheet)

See annex 9: for expected behavior/practices and key messages

PG 5: Referral for and Follow Ups of Different Services

Referrals are a process by which OE/CM/PE assesses and prioritizes the immediate HIV/STI prevention and other needs of a client and provide assistance in identifying and accessing the required services. Referrals for different services for MARP are essential to meet HIV/STI prevention and other needs of the MARP. Referrals for different services include STI diagnosis and treatment, CT and other services like family planning, general health care, income generation, gynecological and obstetrical, legal and trafficking in person (TIP)[2] related services.

A. OE/CM/PE should do the following when referring a client for:

1) STI diagnosis and treatment services:

- Assess the risk of the client
- Explain the need and importance of regular monthly STI check ups and follow ups for FSWs and quarterly for clients of FSWs. Explain that regular checkups are important even when no symptoms are present. Many STIs are asymptomatic and may only be detected from an examination. Regular visits to the clinic accomplish more than just STI treatment – they provide an opportunity for education and counseling, and promote health awareness and wellness.
- Explain location with a map, days and hours of operation and approximate time to be taken (about 2-3 hours, depending upon flow of clients it may take shorter and longer)
- Explain the meaning of the 5 petals of BISHWAS logo (Reliable, Dependable, Friendly, Secure and Comfortable) **(see annex 10)** to highlight the quality of services available from IHS site
- Explain the reward/benefit package, beside health benefits, such as beauty coupons for those who attended the IHS site
- Highlight that confidentiality will be strictly maintained. Information provided by the clients will be recorded, filed with a code number and kept in a locker. Information provided will not be shared with anyone else unless required for referral and treatment purpose.
- Inform the IHS ID card (see **annex 11 A** for IHS ID card) is given and ask to keep the card safely and to carry the card with her/him during follow up visit. ID card is important for recording, tracking previous illness and treatment history and rapid services.
- Explain that risk assessment will be done by the clinician (doctor/HA/staff nurse)
- Explain that staff (doctor/nurse/HA) asks the client to undress for examination of genital areas. Speculum examination will be done for female clients. Blood will be drawn for necessary tests.

---

[2] **Severe forms of trafficking are defined as follows:**

- ***sex trafficking in which a commercial sex act is inducted by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or***
- ***the recruitment, harboring, transportation, provision, or obtaining of a person for labor or service, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.***

- Promote examination of genital areas including speculum examination by giving example of a rotten pumpkin and/or using information, education and communication (IEC) material given in **annex 12.** A rotten pumpkin is seen as good/fresh from outside.
- Explain the need of regular blood check up for follow up of titer for reactive cases and regular (3 monthly) screening for non reactive cases.
- Ask male clients not to urinate for at least one hour before the examination and, if possible, he should show any discharge to the clinician.
- Ask female clients to urinate at least one hour before the exam so that the genital speculum examination will be easy
- Use body mapping or IEC materials (illustration of sexual and reproductive organ) to show which organs STIs most frequently affected and how the STI examination will go
- Explain that whether or not medicine is proscribed is up to the clinician and based on the diagnosis. Highlight that all clients who attended the clinic should not expect medicine/treatment.
- Explain that s/he should follow 3 Cs (1) Complete treatment, (2) contact tracing/partner notification, (3) if possible not to have sexual intercourse during the treatment; if not possible consistent and correct condom use.
- Provide referral card (see **annex 11 B** for referral card) and explain that the referral card is important for recording, tracking and rapid services.

2) HIV Counseling and Testing (CT) services:

- Assess the risk of the client
- Explain the need and importance of regular quarterly CT services both for FSWs and clients of FSWs. Explain the window period (Rapid test detects HIV antibody in the blood (does not detect HIV) and detectable amount of HIV antibodies in the blood will develop after 3 months of HIV infection)
- Explain location with a map, days and hours of operation and approximate time needed, including time taken for counseling and lab test results (20-30 minutes for pre test counseling, 20-60 minutes for test results and 20-60 minutes for post test counseling)
- Explain the meaning of the 5 petals of BISHWAS logo (Reliable, Dependable, Friendly, Secure and Comfortable) to highlight the quality of services available from IHS sites
- Highlight that confidentiality will be strictly maintained. Information provided by the clients will be recorded, filed with a code number and kept in a locker. Information provided will not be shared with anyone else unless required for referral and treatment purposes
- Inform the IHS ID card is given and ask to keep the card safely and to carry the card with her/him during follow up visit. ID card is important for recording, tracking previous illness and treatment history and rapid services.
- Explain reward/benefit package, beside health benefits, such as a beauty coupon to those who attended IHS sites
- Explain that group education on HIV/AIDS will be provided in some cases.
- Explain that pre test counseling including risk assessment will be done individually by the counselor.
- Explain the possible results of the test:

i. **Negative test results:** means that the person is either not infected with HIV, or so recently infected that the test could not detect the HIV antibodies (window period). **If the test result is negative**
   - **a.** Highlight that s/he can adopt safer behaviors and protect her/him from HIV infection in future.
   - **b.** S/he can be assured and freed from fear and doubt.

ii. **Positive test results:** means that HIV antibodies have been detected, and the person is infected with HIV and can transmit HIV to others. **If the test result is positive**
   - **a.** Highlight that the essential package of care (EPC) services, antiretroviral treatment (ART) services, community and home based care (CHBC) services and PLHA support group are available which can be accessed in time if required.
   - **b.** Highlight that knowledge and skills can be developed for self care, positive and healthy lifestyles and to prevent opportunistic infection through prophylaxis which leads to a healthier, longer life.
   - **c.** Explain that their sex partners can avoid HIV infection through safer behaviors. For this explain the need, importance of and ethical obligation for notification of HIV status to sex partners.
   - **d.** Transmission of HIV from positive mother can be prevented.

- Provide referral card and explain that the referral card is important for recording, tracking and rapid services.

3) DIC:

- Explain location on a map and give the days and hours of operation
- Explain the services and facilities available from the DIC (TV, video, movie mania, educational and skill building session on various topics, IEC, creative creation, painting, rest, bath, first aid, basic make-up...)
- Explain benefit/promotional package for DIC visitors (reward for frequent visitors and first visitors)
- Explain the meaning of the 5 petals of BISHWAS logo (Reliable, Dependable, Friendly, Secure and Comfortable) to highlight the quality of services available from DIC site
- Provide referral card and explain that the referral card is important for recording, tracking and rapid services.

4) Family Planning Counseling (where applicable) at IHS:

- Explain that family planning counseling services are available at IHS site. Explain that counselor/clinician will refer for family planning services after counseling.
- Provide referral card and explain that the referral card is important for recording, tracking and rapid services.

5) Referral for care support and treatment (CST):

- OE/CM should refer contacted PLHA for care, support and treatment (CST) services
- Provide referral card and explain that the referral card is important for recording, tracking and rapid services.

6) Other services including TIP related services:

- Based on need of the clients, provide information on the organization including the telephone number, location address, available services and process for getting services using referral directory.
- Inform Project Coordinator about the referral.
- Project Coordinator should contact the referral organization, inform them of the referral cases and request support.
- If any staff of the IA encounters, or becomes aware of, victims of severe TIP, it should be reported to ASHA Project through the Program Officer and referred for appropriate service providers available at the local level.

B. Follow up of Referral:

- OE/CM should follow up of referral services on the next repeated educational contacts and ensure whether the service received or not.

1) STI services

- Ask and ensure the following during follow ups of STI referral:
  - Ask whether s/he went for STI services or not.
  - **If s/he went,** praise, appreciate and encourage a visit every month.
  - Ask for the result.
    - If s/he is not diagnosed any STI, express happiness and encourage maintenance of safer behavior.
    - If s/he has been diagnosed with any STI,
      - Show empathy (e.g. I am sorry to hear about it, I can see that you are feeling sad and in pain) and emphasize that STIs are treatable if instruction given by the clinician are followed
      - Emphasize 3 Cs and ask whether s/he has followed the 3 Cs or not.
      - If followed, praise/appreciate. Ask whether the STI is cured or not. If cured, express happiness and encourage safer behavior. If not cured even after the treatment, explore whether the 3Cs were followed or not. Perform condom demonstration, if required. Provide condoms.
      - If the 3 Cs were not followed explore the reasons. Emphasize that the 3 Cs should be strictly followed during STI treatment. Explain possible consequences and complications of not following the 3 Cs.
      - Ask for the follow up visit date given and refer for follow up visit. Explain the importance and need of monthly STI check for FSWs
      - Ask to keep IHS ID card safely and to carry the card with her/him during follow up visit. ID card is important for recording, tracking previous illness and treatment history and rapid services.

- Ask client to tell of her/his experience visiting the STI clinic. Ask for feedback and suggestions for improvement (STI site staff's behavior, way of interaction and providing education, counseling)

- **If client did not go for service, ask for the reason.**
- Highlight the importance of timely diagnosis and treatment of STIs, possible consequences and complication of STIs if not diagnosed and treated on time.
- Refer for STI diagnosis and treatment.
- Give referral slip and explain that the referral card is important for recording, tracking and rapid services.
- Perform condom demonstration, if required. Provide condoms.

2) CT services

- Ask and ensure the following during follow up of CT referral:
  - Ask whether s/he went for CT services or not.
  - **If s/he went,** praise, appreciate and encourage visiting CT every quarter.
  - Ask for the result.
    - If s/he is diagnosed HIV negative, express happiness and encourage maintenance of safer behavior.
    - If s/he is diagnosed HIV positive,
      - Show empathy (e.g. I am sorry to hear that, I can see that you are feeling sad) and emphasize that there are many people living with HIV and that there are case, support and treatment services available for PLHA.
      - Refer for EPC services and support group.
      - Give referral slip and explain that the referral card is important for recording, tracking and rapid services.
      - Ask the client to tell of her/his experience of visiting the CT site. Ask for feedback and suggestions for improvements (CT site staff's behavior, way of interaction and providing education, counseling)
  - Ask to keep IHS ID card safely and to carry the card with her/him during follow up visit. ID card is important for recording, tracking previous illness and treatment history and rapid services.

  - **If the client did not go for the service, ask for the reason.**
  - Highlight the importance of counseling and testing services.
  - Refer for CT services.
  - Give referral slip and explain that the referral card is important for recording, tracking and rapid services.
  - Perform condom demonstration, if required. Provide condoms.

3) Other services:

- Ask and ensure the following during follow up of referral for other services:
  - Ask whether s/he went for services or not.
  - If the client went, praise, appreciate and encourage for visit. Ask whether s/he received services or not.

- Ask the client to tell of her/his experience of visiting the service site. Ask for feedback and for suggestions for improvements (staff's behavior, way of interaction and providing education, counseling)
- If the client did not go for the service, ask for the reason.
- Highlight the importance of these services.
- Refer and give referral slip.

PG 6: Risk Assessment and Risk Reduction Plan:

Risk assessment is done to determine if someone is at risk of becoming infected with HIV and STIs. This can be done through several mechanisms including counseling, questionnaires and games. Risk assessment should be conducted to make an individual realize her/his high risk behaviors, not to blame the individual. During the risk assessments an individual should be encouraged to realize and identify her/his risk behavior (s). In order to initiate behavior change, client must "realize" and "own" his/her risk behaviors. Reasons behind the high risk behavior should be explored and analyzed.

Key questions for risk assessment are given below. Before asking the key questions for risk assessment, rapport must be established and/or maintained with the clients. See guidelines for first educational contact **PG 4 in page 11**

After establishing and maintaining rapport start risk assessment.

- Explain the objectives of the risk assessment session. The main objective of the risk assessment is to provide a client with insight into his/her HIV/STI related risk behaviors and to help client realize and personalize his/her risk for STI/HIV transmission and to make a risk reduction plan. The objective of the risk assessment is not merely to gather data, but to provide a forum for OE/CM and client to discuss the client's behaviors as they relate to HIV/STI risk and help him/her in gaining a better informed perspective of his/her risk.
- Conduct risk assessment on a one-on-one basis
- Assure the confidentiality. Explain that the information shared and discussed will not be recorded and shared with other staff within the organization and is confidential. The information obtained will be used only for educational contacts and referral for HIV and STI related services.
- Explain that risk assessments look into individual and sensitive issues such as sexual behavior and drug use. Even though some people find it difficult to talk openly about these sensitive topics, we need to discuss them for your benefits. If you feel uncomfortable while discussing, please let me know.
- Ask the client to participate in discussion and answer the question as honestly as possible. Explain that the risk assessment is for the benefit of the client and his/her personal use.
- Explain the time needed for the risk assessment. The total time required is about 30-60 minutes.
- Be non judgmental
- **Play risk assessment game as follows:**
    - Discuss HIV/AIDS and STI: ways of transmission and non-transmission by showing the flash cards. If the client already knew about it or it was already discussed with the client, review it.
    - Keep the risk assessment cards on the ground/table and display the picture.
    - Ask the client to select a card.
    - Ask the client to read the brief story written on the card and ask the client whether the story on the card matched with his/her behavior.

- If the story matched with his/her behavior ask the client to briefly explain her/his story. when? where? how? and current status?
- Play the game until the cards finish.
- Give an opportunity to ask questions, if the client has any.
- Discuss with the client and summarize his/her HIV/STI transmission related risk behavior. Avoid saying whether the client is at a very high or low risk of HIV/STI transmission.
- Explain risk to clients in terms of significant risks or appearing to have limited risks of HIV/STI transmission.
- If client realized and accepted that s/he has high risk behaviors, identify him/her as a specific MARP as appropriate such as FSW, client, IDU etc. But do not tell him/her that s/he is identified as the specific MARP.
- Remind client that the only way to know if s/he has HIV and/or STIs is by having an HIV test and an STI examination.
- Discuss ways of HIV/STI prevention by showing flash card on
  - Consistent and correct use of condoms
  - Reducing non regular sex partner
  - Safer injecting practices (do not inject drugs or use new or clean syringe and needle)

- **Help to make a risk reduction plan:**
  - Help to select safer behavior (behavioral objectives) as appropriate
    - Consistent and correct use of condoms
    - Reduce non regular/multiple sex partners
    - Safer injecting practices
    - Visit STI diagnosis and treatment services (monthly for FSW and quarterly for Clients/IDUs) and CT services (quarterly)
  - Help to identify and analyze motivating factors for and barriers to adopting safer behaviors
  - Help to increase self efficacy and skills required for safer behaviors (Condom negotiation skills, correct condom use skills, safer injecting skills)
  - Provide condoms and/or help to access condoms, both free and socially marketed, by providing information on available condom outlets
  - Help to access HIV testing and STI diagnosis and treatment services through referrals (see **PG 5** for guidelines for STI and CT referral)

Key Questions for Risk Assessment (Optional and Alternative to Risk Assessment Game)

Though this form appears in a checklist format, use it as a guide not as a script. Using open-ended and nonjudgmental questions on the topics listed is an ideal way to obtain the information.

1) In the past 12 months, have you had sex with anyone? No Yes
   (If no, go to question 7)

2) If yes, with whom?
   Wife, Girl friend, Regular partner (FSW) Non-regular partner (FSW)
   Husband, Boy friend, Regular partner (client) Non-regular partner (client)

3) In the past 12 months, have you had more than one sexual partner? No Yes

4) In the past 12 months, do you think your sexual partner(s) had sex with any other partners? No Not sure Yes

5) In the past 12 months, have you had sex with a new partner? No Yes

6) In the past 12 months, how often have you used condoms during vaginal or anal intercourse? Always Most of the time Some of the time Never

7) Are you currently planning on having sex with a new partner? No Not sure Yes

8) In the past 6 months, have you been diagnosed with any STIs or had any yellowish foul smelling discharge from genitalia, vaginal itching, and genital ulcers? No Yes

9) In the past 12 months, have you received a blood transfusion in hospital? No Yes

10) Have you ever injected drugs? No Yes

11) If yes, do you use new syringes and needles?
    Always Most of the time Some of the time Never

12) In the past 12 months, have you shared needles and syringes with others for using drugs?
    Always Most of the time Some of the time Never

Interpretation

If answered “Yes” to questions 3-6, 8-9, 11-12, "not sure" to questions 3, 4& 6 and "Never" to question 6, the client is at higher risk for STI and HIV infection. If the client is at high risk, identify which MARP s/he fits into and refer for STI and CT services.

PG 7: Planned Group Discussion (PGD)

A planned group discussion (PGD) is a group discussion planned, prepared and implemented to explore the information, knowledge, attitudes and behaviors of MARPs and stakeholders on any identified issue, problem or topic. They also provide an opportunity to change the attitudes of MARPs and stakeholders. PGDs can also be conducted to pre-test the IEC materials and research questionnaires as well as to assess/evaluate the intervention.

The number of participants for a PGD should be 8-10. The participants should be homogenous in terms of sex, age, socio-economic status, occupation, interests, issues and problems. The PGD should be conducted over a 1-2 hour period. There should be a facilitator and a note taker for the PGD.

Topics for PGD include, but are not limited to, the following:

- Knowledge and attitudes on HIV/AIDS,STI and condoms
- Risk perception (HIV and STIs)
- Risk behavior (multiple sex partners, sex without a condom)
- Self efficacy (confidence for condom use, adoption of new behaviors like consistent and correct condom use)
- Condom negotiation skills, including skills for pleasurable sex
- Safer behaviors (consistent and correct condom use, decreasing number of non-regular sex partners, seeking STI and CT services), motivating factors and barriers
- Availability and accessibility of services including IHS (CT, STI) and condoms
- Poor health seeking behavior (not attending IHS site for STI and CT services)
- HIV related stigma and discrimination reduction
- Sharing experiences of IHS attendees and non-attendees
- Quality of IHS
- Personal hygiene and basic beauty

Process of PGD is divided in to three steps.

1) Planning and preparation
2) Facilitation
3) Analysis and report preparation

1) Planning and preparation

- Based on the existing issues and problems, select a topic for discussion in the PGD
- Set objectives of the PGD
- Identify the participants
- Set date, time and venue for the PGD and give this information to participants
- Brainstorm and list possible key questions
- Select 2-3 questions for each type of question (i.e. objective questions, reflective questions, interpretative questions and decisional questions (ORID))
- Prepare session plan for PGD. See **annex 13 A** for session plan format.

- Identify resource person from the target group members. Inform resource person about the PGD and his/her roles. Support resource person so s/he is prepared for his/her role.
- Understand the background of the participants taking part in the PGD (educational status, age, occupation, types of target group, experience, knowledge, attitude and behavior on issue/problem/topic)
- Rehears PGD
- Prepare materials, stationary, budget, etc… as required

2) Facilitation

- Arrive to PGD venue 15-30 minutes before the starting time
- Manage seating arrangement. The seating arrangement should be informal and in full circle so that all participants including facilitator and note taker can see each others. The venue should be confidential, have auditory and visual privacy and no distraction so that participants feel comfortable to share their feelings, experiences and information.
- Start PGD once all participants arrive.

a) Starting PGD

- Welcome and thank all participants for their interest in and time
- Introduce yourself and the note taker.
- Ask each participant to introduce themselves by telling their name and address.
- Ask participants to write their names and sign on the register list. See **annex 13 B** for registration format
- Briefly introduce the organization (name and program).
- Explain objectives of the PGD. Ask participants to share their views, feelings, experiences, understanding and information without any hesitation. Everyone has his/her own experience, understanding, views and feeling and all these are important.
- Assure that the name of the participants and information shared in the PGD will be strictly confidential. The information will be used for HIV/AIDS prevention and care purposes only.
- Let the participants know that the note taker is there so that memory, and the errors that come with it, are not the sole reference. No name will be quoted.
- Inform participants that the PGD will take 1-2 hours.
- Ask all participants to share their experience, understanding, views and feelings in turn. Ask all participants to respect each other.

b) Initiate and conduct PGD

Exploration of participants' views, experiences, understanding and feelings on issue/problem/topic:

- Ask questions sequentially. Probe or ask supplementary questions, if required.
- Ask one question at a time.
- Give adequate time for sharing and discussion but do not pause for more 30-45 seconds.
- Take thorough notes (See **annex 13 C** for guidelines for note taker)
- Summarize at the end of each step before moving to the next step.

- Ask for clarification, if there is a new word, proverb, phrase or abbreviation.
- Probe until the issue/topic is clear.
- Ask for examples, facts, figures and evidence
- Be careful about time
- Make sure that all key questions/points are discussed
- Make sure that all participants equally and actively participate in the discussion
- Ask open ended (wh-) questions; do not ask close ended (yes/no) and leading questions (question with answer).
- Establish eye contact with all participants.
- Be careful about non verbal communication (both facilitator's and participants')
- Listen more (80%) and speak less (20%), speak to listen (i.e. ask questions)
- Handle discussion monsters appropriately and quickly (See **annex 13 D** for handling discussion monsters)

Information and knowledge on issue/problem/topic:

- After exploring participants' views, experiences, understanding and feelings on issue/problem/topic, provide information and knowledge on issue/problem/topic using already prepared session plan.
- Mobilize resource person from the target group members.

c) Conclusion and closing PGD

- Summarize the discussion.
- Ask participants if they have any questions and concerns.
- Thank all participants for their time and active participation
- Provide tea, snacks, if policy and budget allows.

d) **Reflection on PGD**

- Reflect on strengths and weaknesses

3) Analysis and report preparation:

- Go through the notes taken during PGD. Collate and summarize the key points under key questions. Highlight key points as quoted by the participants.
- Prepare report using suggested reporting format **(**See **annex 13 E)**

PG 8: Drop in Center (DIC) Operation

DICs are safe space where the MARPs and can visit and participate in DIC activities including accessing HIV/AIDS, STIs and condom related information and varieties of condoms. The DIC should be co-located with the IHS site (static and/or satellite). Stand alone DICs can also be operated in the strategic locations with high concentrations of MARPs and potential MARP (1 DIC for at least for 250 MARP within 5-7 km and 20-30 minutes travel time)

DICs should be desirable and safe places to spend time and to get quality services and accurate information.

All DICs across FHI Nepal funded project areas should maintain uniformity with basic set up and services adhering the BISHWAS strategies and guidelines. **See BISHWAS strategy and guidelines for details.**

Minimum requirement for a DIC set up:

1. **Deliver basic necessities**: Make available basic facilities like drinking water, clean lavatory and rest areas. Make spending time in the centers comfortable and desirable.

2. **Maintain a clean environment:** Introduce the concept of keeping the surroundings clean. Any unnecessary papers, posters, books and anything else which is not contributing to the center should be removed from location.

3. **Maintain consistency** of minimum set up of all DICs and service sites throughout the ASHA Project. Display standard signboard with BISHWAS logo and branding strip in and outside the DIC and service sites (see **annex 14**).

a) Room/space: 2 rooms (1 large adequate for 10-15 people at a time and 1 small)

b) Materials/equipments

- Mirror with message
- Scale
- Scissor (small)
- Nail cutter
- Carom board with message
- Minimum package for beauty (comb, nail polish, fairness cream, bindi, perfume)
- Minimum package for cleanliness: soap, shampoo, towel
- Water filter, mug and glasses
- IEC materials including games, dildo, AV (published by FHI and others)
- Condoms (male and female if available)
- Condom box (dispenser and display rack)
- First aid box
- TV, VCD/DVD
- Table, chairs, cupboard/rack
-

- Cushions
- Flooring and furnishings (carpet, doormat, curtain, wall clock)
- National and local daily newspaper (Nepali)
- Books and magazines (health, occupational safety, beauty, cooking, baking, arts and crafts, map of Nepal)
- White board, push pin board
- Suggestion box
- Stationery (markers, ballpoint pens, note books, news prints, meta cards, glue sticks, masking tapes, push pins)
- IEC display board
- Recording and reporting book
- Waste paper/dust bin
- Fan/heater
- Electric water boiler
- Tea/sarbat as appropriate
- Games for children (children's corner) as appropriate

c) Staffing[3] and Operational hours:

- The DIC operator should have SLC passed; priority should be given to MARPs. However, this criterion will be flexible depending upon local context and availability of candidates of such level
- The DIC and/or other sites should be staffed by a trained employee at all operational hours.
- The operator/s should take the initiative to plan and organize regular and special activities of educational events as well as entertainment events.
- The operator/s should be available and easily accessible to clients.
- The receptionist/operator (for establishments that don't have receptionist) should be in charge of updating the display board and informing clients about planned activities date, time, venue etc.
- The DIC operators and all staff should be suitably trained for their jobs (HIV/AIDS, outreach education and communication, BISHWAS branding, IEC including TV, VCD player use and first aid)
- DIC operator should be friendly, welcoming, patient, caring, trustworthy, non-judgmental and able to respect DIC visitors and maintain confidentiality.

Increase demand and utilization of DIC:

In order to increase demand and utilization of services, it is vital to include engaging activities which will be enjoyed and appreciated by the clients. Consult with clients and prepare and display monthly activity plan for DIC activities that help build a deep rooted association with the centers.

1. **Paint with me:** Develop an easy to create branding strip which includes the BISHWAS logo

[3] See BISHWAS strategy and guideline appendix 3 for detail guideline for staff

along with five other images that reinforce the idea of trust. Encourage the clients to work creatively on them, for instance cut, paste and color the images. Provide them with paper, crayons and other necessary equipments required for the activity and get them involved in creating the branding strip. Later have them put up the branding strip in the center. This activity will help them build an emotional association with the brand.

2. **Client Generated Content:** Encourage clients to get involved in DIC activities through creative activities such as making a wall magazine with news, views, poems, songs, articles, case studies, success stories, art work and paintings. Organize fortnightly/monthly contest on client generated content.

3. **Movie Mania**: View commercial movies once a week. Make it a social event where they can come with family and friends. Inform them well ahead of time about the dates and time of the movie viewing so they can inform people. Before the movie viewing, give a short presentation on services available as well as HIV/AIDS, STIs, condoms, sexual and reproductive health and other topics. Refer to list of topics in serial number 6.

4. **Provide board games**: Make sure the centers are equipped with games for the client's entertainment; these activities will encourage client interaction which will build up relationships. This activity will help build a sense of community.

5. **Story telling**: Make story books, case studies (refer to the PE manual, Stigma toolkit) and comics (photo novella) available, and encourage the clients who know how to read, to read out aloud to their peers. This again is an activity which helps people to come together and get familiar and comfortable.

6. **Group discussions/Topic Talk**: Provide a topic. Encourage group discussion. People tend to retain information better if it is told to them in the form of a conversation rather than lecture. Invite expert for topic talk and practical demonstration

Suggested topics for discussion include, but are not limited to, the following:

- HIV/AIDS, STIs and condoms (prevention, care, support and treatment),
- Reproductive and sexual health,
- Beauty, personal hygiene, wellness, including yoga and mediation,
- Cooking/baking,
- First aid,
- Home based care of minor illness,
- Literacy class,
- Creative artwork/painting/knitting and weaving
- Fashion design/show
- Life skills (positive thinking, problem solving, decision making, negotiation skills)
- Performance arts (dancing, singing)

7. **Formation of DIC Club**: Form DIC clubs and distribute memberships to MARPs. Membership is required to participate in DIC activities and use services and facilities.

Establish and operate saving and credits scheme among DIC club members.

8. **Formation and mobilization of DIC management committee:** Form and mobilize DIC management committee consisting of representatives from MARPs to involve them in planning, implementation, monitoring and evaluation of DIC activities. Keep suggestion box to collect feedback. See community mobilization for details **(PG 10)**

9. **Acknowledge** the first DIC visitor of the month, frequent DIC visitors and three individuals who bring highest number of peers.

10. **Organize inter DIC (inter and intra IAs) contests** on creativity, quality, number of DIC visitors and other topics.

11. **Prepare monthly schedule** of DIC activities with regular and special activities. See **annex 15** for sample plan for DIC activities

Note: If any activity from the above mentioned list (1-6) conducted along with discussion or review of HIV/AIDS, STI and condom related topic, then reporting can be done as participation on DIC activity.

Recording and reporting of DIC activities:
DIC activities should be recorded in daily log sheet for DIC activities (see **annex 16)** and summarized in coverage form (see **annex 5**)

PG 9: Guidelines to Use and Distribute Information, Education and Communication (IEC) Materials

IEC materials refer to the tools developed and used for influencing and motivating targeted audiences such as MARPs for positive behavior change and maintenance. IEC materials play a crucial role, if used interactively, to inform, educate and communicate HIV/AIDS, STI, condom use and other public health topics. IEC materials are not meant to replace educational sessions or interactions. IEC materials should be used as complimentary and/or supplementary tools for the educational session or interactions. Some of the IEC materials such as flip charts, booklets, and posters are used as job aid tools and some of the IEC materials such as brochures, flyers and booklets are for distribution to the target group members.

Use of IEC materials visually reinforces the verbal communication and is helpful for long term retention. It also attracts the MARPs for discussion and increases interest in learning. It makes the learning process participatory by encouraging clients to participate in discussions and the learning process. In addition, IEC material enhances logical thinking. Use of IEC materials make it possible to demonstrate the objects and activities that are difficult to demonstrate in real life situations. For example, things that are very big and small such in size can be shown in smaller or bigger size respectively according to its necessity.

Guidelines for using IEC materials are divided in to 3 steps.

Step 1: Prior to use

- Identify the specific IEC materials that are going to be used for the educational session (based on plan)
- Study the materials and guidelines for using the materials before use.
- Be clear on the key messages of IEC materials.
- If necessary note main points.
- If the materials are being used for the first time or if the method of using IEC material is not clear enough, do a rehearsal or get an orientation,.
- Supervisor and Project Coordinator should ensure that OE, CM and PE are competent enough to use the materials.

Step 2: During the time of use

- Display IEC materials (especially posters) on the wall or board or ask colleague to hold it. The material should be displayed at the eye level of the participants. Do not show the poster by standing behind it because it makes it difficult to see the contents of materials and it hampers the eye contact as well as interaction with the participants.
- Make sure that the letters of the picture/illustration and messages are not covered while displaying the IEC material.
- If the IEC material is being used with a small group (approximate 3-5 participants), the material can be shown by putting it on the ground and turning it so the participants can see it.

- Look at the participants while showing them the IEC material. Make sure that the pictures and messages are shown to the participants properly and make sure they are clearly visible to all the participants.
- Make sure that all the participants can hear your voice clearly.
- To use IEC materials interactively, give participants sufficient time to see the materials, ask open-ended questions and explain the massages and information clearly.
- Discuss the pictures/illustrations and messages one-by-one.
- If flash cards or serials of IEC materials are being used, put them by facing down after using it so that they will be arranged in order.

While using IEC materials, the following questions should be asked sequentially. Examples given are generic questions. The questions should be adapted based on the main messages of the IEC materials.

O-R-I-D

1) Objective questions (O) (Questions related to facts and figures that can be seen, touched and counted)

Examples:

a. What do you see in this picture or material?
b. What is happening in this picture or material?
c. Does the problem/issue/incident/picture/message shown in the material or picture happen in your day to day life?
d. Have you seen or heard of the incident shown in the material/picture in your community. **(Relate with real life situation:** Messages/pictures/illustrations on the IEC materials should be related with real life situation)

2) Reflective questions (R) (Questions related to attitudes, feelings and perceptions)

Example:

a) How did you feel when you see/hear of the problem/issue/incident/picture/messages? Why?

3) Interpretive Question (I) (Questions related to effects and outcomes)

Examples:

a) Why did the problem/incident happen?
b) What could be the effect or outcome of the problem/incident?

4) Decisional Question (D) (Questions related to decisions and action plans)

Example:

a) What can you do to solve the problem?

Step 3: After use

- Keep/arrange the material in its proper place/packet.
- Reflect on strengths and weaknesses of the IEC materials used. Get feedback from colleagues and/or supervisors (if they were present at the time the IEC materials were used).

- Once a year, collect feedback from the participants about the quality, effectiveness, appropriateness, attractiveness (pictures, message, color, design, size) of IEC materials using guidelines for feedback collection **(**see **annex 17 A)**.

Things to be considered before and after distributing IEC materials to the target group members:

- Highlight the importance of IEC materials by describing the information that can be obtained from the materials and the average cost.
- Give IEC materials only if asked for them.
- Ask the client to inform her/his friends about the information learned from the materials. Ask clients to give the materials to their friends when they are done reading/using them.
- Follow up to see if they read/used the materials. Ask what information they got from the materials.

PG 10: Community Mobilization

Community mobilization is the process of involving the MARPs, local institution, local leaders, community groups and members of the community to organize collective action toward a common purpose. Community mobilization seeks to create supportive environments for positive behavior change and maintenance among the MRAPs.

Community mobilization activities include:

1) Organizing community events
2) Training on stigma and discrimination using S&D toolkit
3) Mobilization CM and volunteer PE from the most at risk community
4) Operation of community information point (CIP)
5) Formation and mobilization of DIC management committee

1) Community events:

Community events are an edutainment activity conducted in public places, which convey specific prevention messages. Community events include community discussions, video shows, theatrical shows, street dramas, musical performances, debates, quizzes, oratory contests, and celebrations on special days such as National Condom Day, World AIDS Day, and International Candlelight Memorial Day.

The following points should be ensured when organizing community events:

Before the event:

- Select an area for the event. Criteria for selection of area for community event:
  - High concentration of suspected or identified MARPs
  - Area where S&D against MARPs and PLHA exists.
- Organize meeting with stakeholders (CBO/NGO/GO), local authorities, celebrities and MARPs for planning community events. Set date, time and venue for the event. Inform local community about the event.
- Prepare for the event (prepare schedule (see **annex 18 A**), attendance sheet (see **annex 18 B**), inform performers, arrange materials and equipment)

During the event:

- Arrive at the venue at least one hour before the event.
- Arrange the venue, materials and equipment
- Conduct community event as planned in an edutainment and interactive way. Intersperse/mix/link health education messages appropriately with entertainment.
- Engage audience in interaction (Give opportunity to ask questions, raise issues, concerns, share feelings and respond the questions appropriately, accurately and quickly)
- Display and distribute appropriate IEC and promotional materials including condoms
- Provide information and/or refer audience members for relevant services and/or additional information as applicable.
- Wrap up the event.

After the event:

- Prepare a summary report (see **annex 18 C** for recording and **annex 18 D** for reporting (narrative) format) and enclose all supporting documents (schedule, meeting minute, materials, attendance sheet, and photo) and submit to Field Supervisor and Project Coordinator.
- Organize meeting with the organizer of the event to review and reflect on strengths and weaknesses.
- Follow up for identification of the MARPs or conduct one-on-one educational contact to identify MARPs.

2) Training on stigma and discrimination reduction using S&D toolkit

HIV/AIDS-related stigma can be described as a "process of devaluation" of people either living with or associated with HIV and AIDS. This stigma often stems from the underlying stigmatization of sex and intravenous drug use—two of the primary routes of HIV infection. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status or being perceived to belong to a particular group.

The following points should be ensured for organizing training on S&D reduction:

Before the training:

- Identify the target audiences/participants of the training. The target audiences could be MARPs, PLHA, community leaders (formal and informal), representatives of both HIV related and non HIV related institutions and service providers
- Set date, time and venue for the event. Inform the participants.
- Identify and select the session from the S&D toolkit based on the types, level and need of the participants. Prepare training attendance sheet (see **annex 19**) and other materials.

During the training:

- Arrive to the venue at least one hour before the event.
- Arrange the venue, materials and equipments
- Register the participants on training attendance sheet.
- Facilitate the training as per session plan. Make the training participatory and interactive. Give participants opportunity to ask questions, raise issues, concerns, share feelings, experiences and respond the questions appropriately, accurately and timely)
- Prepare action plan
- Collect feedback from the participants on the training (content and process)
- Wrap up the training.

After the event:

- Prepare a summary report (see **annex 18 D**) and enclose all supporting documents (session plan, schedule, materials, attendance sheet, and photo) and submit to Field Supervisor and Project Coordinator.
- Follow up of training and action plan

3) Mobilization Community Mobilizers (CM) and Peer Educators (PE) from the most at risk community

A peer refers to "one that is of equal standing with another; one belonging to the same societal group, especially based on age, grade or status." In the HIV/AIDS context, peer education means providing education on HIV/AIDS/STIs to members of the educator's own social circle. Peer educators often serve as role models for their peer group. Peer pressure or support has a great influence on individual's behavior.

A peer educator (PE) is trained in subject matters voluntarily provides knowledge, enhances skills and motivates/influences for positive behavior change and maintenance within his/her circle of peers.

PEs and CMs should be mobilized from the most at risk community. CMs are full time staff whereas PEs work as volunteers. Depending upon availability of resources, PEs get minimum incentives for their time involvement and contribution to the project. A system of peer progression should be designed to promote experienced PE to CM and CM to OE which generate greater community ownership of the program. Skilled PEs and CMs have the opportunity to progress to new levels of responsibility and oversight in the program.

PEs are responsible for IHS referral and follow up, DIC referral, condom distribution and social marketing, identification of MARPs and operation of community information points (CIP). CMs are responsible for identification of FSWs with the help of PEs', risk assessments, HIV/AIDS education and referral and follow up and counseling.

Incentive to PEs

The following incentive will be provided to PEs

- Travel cost for attending meetings and trainings
- Reward for outstanding PE (monthly basis)
- Priority involvement in condom social marketing program
- Promotional materials

Criteria for selection of PEs

The PE should be selected based on the following criteria:

1) Should be from most at risk community and should have a socio-cultural background similar to that of the target audience (this may include age, sex and social class).
2) Should have the ability to communicate clearly and persuasively with peers.
3) Should have good interpersonal skills, including listening skills.
4) Should be accepted and respected by the target group (their peers).
5) Should be strongly motivated to work toward HIV risk reduction.
6) Should demonstrate care, compassion and respect for peers, MARPs and PLHA.
7) Should be self-confident and show potential for leadership.
8) Should have the time and energy to devote to this work.
9) Should have the potential to be a role model for safer behavior

Capacity development requirement for PEs

- Basic training on HIV/AIDS peer education for 2 days
- Quarterly review and planning meeting with a refresher session
- Weekly supportive supervision by CM and quarterly supportive supervision by OE and Field Supervisor

Basic contents of the HIV/AIDS peer education training:

- Concept, need and importance of peer education, role of peer educators
- Sex and sexuality including reproductive organs
- Basic facts of HIV/AIDS(ways of transmission, non transmission and prevention)
- Basic facts of STI (sign and symptoms, complication of STI)
- Condom use and negotiation skills
- Referral for counseling and testing, STI and other services
- Communication, IEC use, behavior change and maintenance
- Reporting and recording

4) Operation of community information point (CIP)

Community information point (CIP) is a place from which MARP, potential MARP and other vulnerable people can access basic information on HIV/AIDS, STI including IEC materials and free and socially marketed condoms.

CIP should be located at strategic location with high mobility and concentration of potential MARP and vulnerable population and concentration of MARP (20-65 within 1-2 km and/or 10-20 minutes walking distance). CIP should be co-located with existing setting such as home/workplace of PE, hotel/restaurant, and transport union office etc. PE will be responsible for the CIP operation.

One time establishment and set up cost up to NRs.5000 should be provided as required. Additional cost such as rent and remuneration will not be provided. IEC materials on HIV/AIDS, STI including games and free and socially marketed condoms should be available in the CIP.

6) Formation and mobilization of DIC management committee

DIC management committee consisting representatives of MARP community should be formed and mobilized to involve them in planning, implementation and monitoring of DIC activities. DIC Operator will be the member secretary and Field Supervisor will be the advisor of the management committee.

The organize committee should organize review and planning meeting of management committee. The frequency (monthly or bi-monthly or quarterly) of the meeting can be decided by the management committee based on the need. Minute of the meeting which includes key discussion and decision points should be documented. No incentive except travel cost will be provided to the management committee members.

PG 11: Coordination and Collaboration

Coordination is the act of making different individuals or institutions work together or cooperate or collaborate for a common goal or effect. HIV related service can not be provided in isolation and uncoordinated manner as HIV/AIDS requires multi-sectoral response. Different service providers as per the need of MARP should be indentified and functional referral relationship with them (both ASHA Project funded and others) should be established as an integral part of the HIV prevention program. Project Coordinator and Field Supervisor are responsible for identifying the appropriate stakeholders and service providers available in the district and local level and establishing coordination and collaboration to increase access to HIV related care, support and treatment services and to ensure responsive linkages and complimentary programs and effective use of resources.

A referral directory should be prepared (see **annex 20** for a format for referral directory) and displayed on office wall and every OE/CM should carry the referral directory with them. A written memorandum of understanding for referral and providing services either free of cost or minimal cost should be signed.

Coordination should not be limited to coordination meeting event. Regular communication through phone, email and meeting in person should be done among the stakeholders and service providers.

Some institutions recommended for coordination and collaboration are, but not limited to, as follows:

- Integrated Health Service (IHS) team or implementing agencies (IA)
- District AIDS Coordination Committee (DACC), Municipality Coordination Committee (MACC), Village Coordination Committee (VACC)
- District Public Health Office (DPHO)
- District Development Committee, municipalities, village development committees
- Regional/zonal/district hospitals, primary health care centers and health posts
- PLHA groups and networks
- Other key stakeholders working in HIV/AIDS, trafficking in person issues, sexual and reproductive health, family planning, saving and credits/income generation
- NGOs and private sectors working for condom social marketing.
- Media
- Private sectors such as transport entrepreneurs' and workers association, hotel and restaurant association, trade unions

1) Coordination and collaboration with IHS team or IA

- Prevention team or IA should coordinate and collaborate with integrated health service (IHS) team or IA for STI diagnosis and treatment, HIV counseling and testing for MARP and essential package of care (EPC) services for PLHA.

- Prevention team or IA should also coordinate with IHS team or IA for satellite and/or mobile IHS site.
- Project Coordinator, Field Supervisor and OE should conduct organize monthly meeting with IHS team or IA to share referral verses IHS site attendees and identify, share and address issues and problems related to MARP need and concern, referral, service provision and follow up in timely manner. CM should also be invited in the meeting as and when required.

2) Coordination and collaboration with other stakeholders and service providers:

- Project Coordinator and Field Supervisor should establish linkages, coordinate and collaborate with other service providers for other services such as medical needs other than HIV/AIDS and STI, family planning, legal and trafficking in person related services.
- As no condoms can be purchased with the USAID funded project, prevention IA should coordinate and collaborate with DPHO for condoms for free distribution and other NGOs and private sectors for socially marketing of condoms.

3) Organizing and participating coordination meeting with stakeholders

The coordination meeting should be organized with the stakeholders and service providers on regular interval based on need. The meeting should be issue based and action oriented.

- Project Coordinator is responsible for organizing and participating district level coordination meeting.
- Field Supervisor is responsible for organizing and participating local level coordination meeting.

The main objectives of the coordination meeting are, but not limited to:

- To introduce and share the project activities in the inception and end of the project.
- To establish and strengthen the referral and follow up mechanism for various services
- To plan and organize community events including special days and events
- To sensitize the stakeholders and make them aware of HIV/AIDS related issues in the community and make them realize their role and responsibility as a member of the community in addressing these issues.

3.1) Prior to the meeting

- Prepare a list of the stakeholders and service providers to be invited for the meeting
- Set date, time and venue for the meeting. Send invitation letter/email along with agenda and follow up with the invitees.
- Prepare a schedule, list of agenda, materials and equipment for the meeting.

3.2) During the meeting:

- Arrive to the venue at least one hour before the event.
- Arrange the venue, materials and equipments
- Register the participants on meeting attendance sheet (see **annex 18 B**).

- Welcome all the participants and ask participants to introduce themselves and their organization.
- Briefly present the objectives, schedule and agenda of the meeting. Ask participants to add the agenda if they want to.
- Facilitate sharing and discussion according to the agenda. Ensure that the meeting is interactive. Ensure that every participant has had an opportunity to ask questions, raise issues, concerns, share feelings, experiences and respond the questions appropriately, accurately and quickly
- Document main discussion and decision/action points.
- Read aloud the minute and get the signature of the participants on the minute.
- Wrap up and close the training. Thank all participants for their invaluable time and contribution.

3.3) After the meeting

- Prepare a summary report (see **annex 18 D**) and enclose all supporting documents (schedule, materials, attendance sheet, photo) and submit to Field Supervisor and Project Coordinator.
- Follow up the decision and action points

PG 12: Supportive Supervision and Monitoring of Prevention Programs:

Regular and ongoing supportive supervision and monitoring should be conducted by the IA's Project Coordinator, Field Supervisor, FHI Nepal Program Officer and SBC Officer to identify the strengths and weaknesses and provide onsite coaching and mentoring to ensure the following:

- the programs are running smoothly
- quality of information and skills provided
- the prevention guidelines are followed
- proper use of IEC materials

Roles and responsibilities:

A) Role of IA staff:

Project Coordinator: The role of the Project Coordinator is to supervise and monitor the prevention team on a regular basis (at minimum accompany the team members for field visit/outreach education, DIC and CIP visit once a month), provide constructive feedback, coaching and mentoring to the team and ensure that the team follows these guidelines. The Project Coordinator is responsible for contacting FHI Nepal Program Officer and SBC Officer for further assistance, if required.

Field Supervisor: The Field Supervisor is the immediate supervisor for the prevention team. S/he has a primary responsibility for planning and ensuring the delivery of quality prevention activities at the field level. The Supervisor accompanies the OE and CM for field visit and visits DIC/CIP at least once in a month and will identify strengths and areas of improvements for the team and provide onsite coaching and mentoring as required.
See **annex 21** for checklist for Supervision for Project Coordinator and Field Supervisor

Outreach Educator: The OE accompanies the CM on field visits at least once in a month to ensure the quality of prevention activities at the field level and provides onsite coaching and mentoring as required. The OE is expected to be a role model for providing quality prevention activities.

Community Mobilizer: The CM meets the PE for at least once a week and provides support for recording, reporting and onsite coaching and mentoring. CM is expected to be a role model for providing quality prevention activities.

B) Role of FHI staff members

Program Officer*:* The FHI Program Officer will be responsible for providing routine supervision for prevention activities at minimum once in a quarter using standard SBC supervision and monitoring checklist **(**see **annex 22).** The FHI Program Officer will provide

constructive feedback, coaching and mentoring to the team and ensure that the team provides accurate and complete information and follows these guidelines

SBC Officer: The FHI SBC Officer will be responsible for overall supervision and monitoring of prevention activities at minimum once in a year. The SBC Officer will use standard SBC QA/QI checklist **(annex 22)** to assess the quality of prevention activities and onsite coaching and mentoring. The SBC Officer will provide constructive feedback, coaching and mentoring to the team and ensure that the team provides accurate and complete information and follows these guidelines.

II) Procedures and tools

The IA Project Coordinator and Field Supervisor will use a standard checklist for supervision and monitoring of prevention activities **(**see **annex 21).** The Project Coordinator and Field Supervisor, with the supervised OE and CM, will jointly prepare supervision issue and action matrix for each staff after the visit (see **annex 23** for issue and action matrix)

The FHI Program Officer and SBC Officer will use standard SBC QA/QI checklist **(**see **annex 22)** and jointly prepare issues and action matrix at the end of the visit.

PG 13: Recording, Reporting and Maintaining Files:

All the records of the clients should be documented and reports should be prepared on standard formats provided by FHI Nepal. The recording and reporting formats are given in **annex 23 (A-F)**. For detailed guidelines and recording forms and formats see Recording and Reporting Tools for Prevention Programs Project Management Information System, Updated – December, 2008

1) Recording tools:

1) Daily diary (daily)
2) Coverage form (daily)
3) Daily log sheet (daily)
4) Collation sheet for Field Supervisor (Monthly)
5) Training form (after the training)
6) Meeting form (after the event)
7) Community events form (after the event)
8) Daily log sheet for DIC activities and coverage form

2) Reporting tools:

1) Fortnightly program update
2) Fortnightly security update
3) Prevention PIF (monthly)
4) Training and meeting PIF (monthly)
5) Operational capacity PIF (monthly)
6) Internal and external environment PIF (monthly)
7) Quarterly coverage PIF (quarterly)
8) Quarterly narrative report with at least one success story and case study

3) Organizing and maintaining files

- All identified MARP need to be given a target group code number on all recording forms. MARP categories, such as FSWs, clients of FSWs, IDUs should not be written on the recording forms.
- All the recording forms are kept in a locked cabinet to which only the concerned staff will have access. Files should not be left out in the open due to confidentiality.
- Filing of coverage forms and daily log sheets should be created according to the staff.
- Filing of training forms, meeting forms, community event forms and DIC summary sheets should be created separately.
- Filing of every reporting tool (PIF) should be created separately.
- Files should be kept in hanging files so they are easy to organize and use.
- Confidentiality protocols should be strictly followed. All prevention team staff members are required to read and sign a "Commitment to Confidentiality and Provide Complete and Accurate Information" form **(Refer to PG 2).** These are to be filed within staff personnel files by the Project Coordinator or Finance and Admin Associate.

4) Transferring records out from the central filing system

- Transfer records out if the client has not had contact for over five years.
- Transfer records out if more than three months have passed since the date of death.
- Store transferred records in a secure place for a maximum period of five years.
- Maintain confidentiality of the stored records.
- Transfer all the records and files (hard and electronic copies) to FHI Nepal or FHI Nepal's authorized representatives or IA, if the funding is discontinued or the project is closed out.

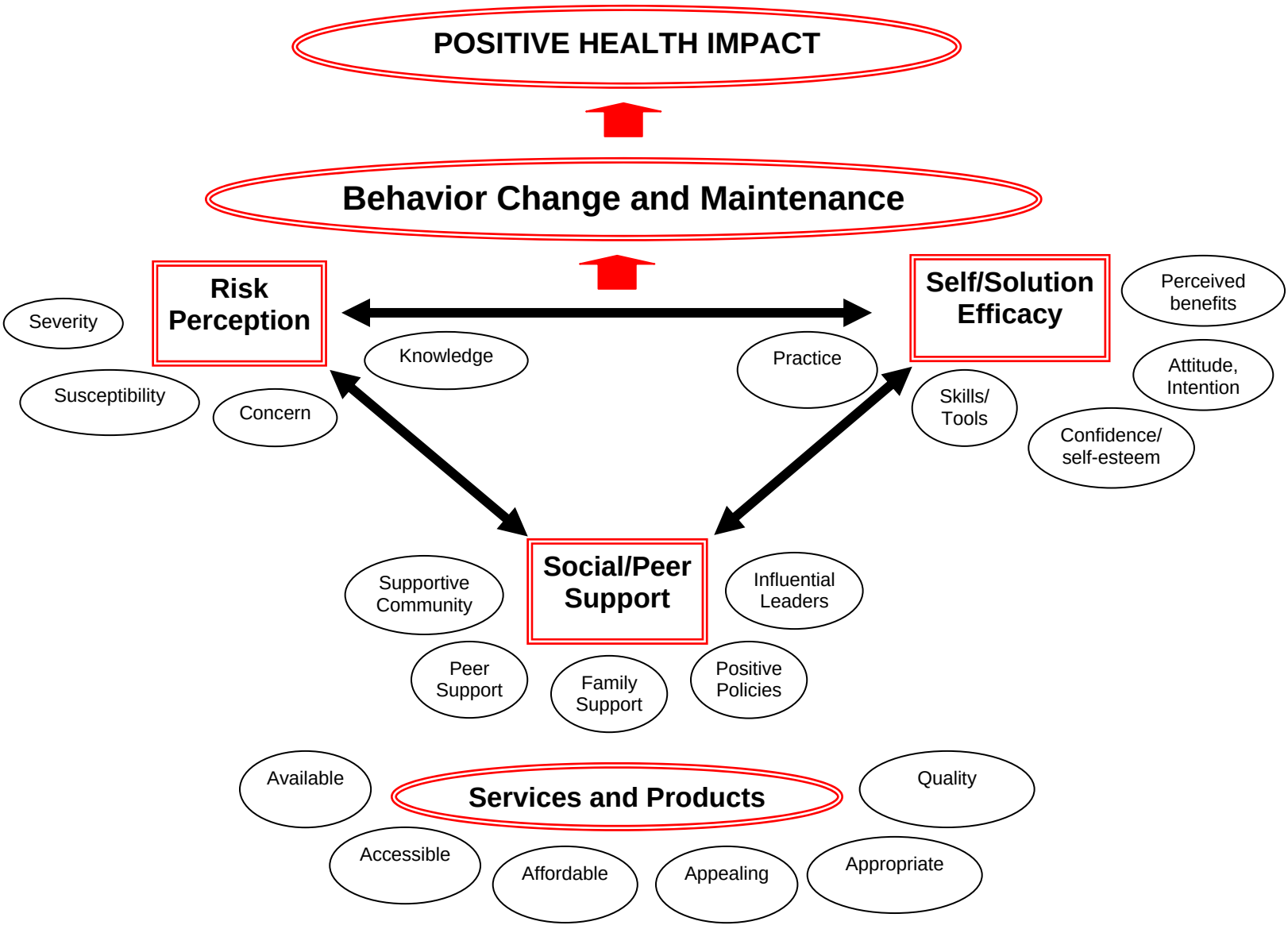
5) Disposal of clients' records

- Dispose of unclaimed records that have been stored for three years after being transferred from the central files.
- The IA should appoint a committee to supervise the destruction of the records.
- Committee members must sign and date a formal statement testifying to the destruction of the records.
- Never recycle/reuse records.

6) Study Records

- Unless stated otherwise in national rules and regulations (not present to date), FHI's policies will be followed.

Annex 1: The Theoretical Framework for Positive Health Impact (FPHI)



The Theoretical Framework for Positive Health Impact has four major elements that are felt to lead to new desired behavior change and maintenance: 1) high perception of risk 2) high efficacy (both self and solution efficacy) 3) positive social and peer support 4) linkages with services and products.

Risk Perception

- **Appreciation of Severity – Does the target audience appreciate the seriousness of the threat of STIs/HIV/AIDS?**
- **Appreciation of Susceptibility – Does the target audience appreciate their own susceptibility/ risk of contracting STIs/HIV/AIDS?**
- **Concern – Is the target audience concerned about this particular threat?**
- **Knowledge – Does the target audience know basic facts about HIV/AIDS, STI and condom?**

Efficacy

Self-Efficacy

- **Attitude – Does the target audience have a positive attitude towards the behavior?**
- **Confidence – Does the target audience have the confidence to practice the behavior?**
- **Skills/Tools – Does the target audience have the skills/tools to practice the behavior?**

Solution Efficacy

- **Beliefs – Does the target audience believe that doing the behavior will have a positive effect?**
- **Perceived benefits - Does the target audience believe that doing the behavior will have benefits?**

Social Support

- **Peer Support – Does the behavior have the support of many in the target audience?**
- **Community Support – Does the behavior have the support of the wider community?**
- **Positive Policies – Do policies support the behavior?**
- **Influential Leaders – Are there any influential leaders or role models that support the behavior?**
-

Services and Products

Are the services and products that support the behavior accessible, affordable, appropriate, and appealing to the target audience?

Annex 2: Detailed Job Description of the Staff

Project Coordinator

- Prepare or review quarterly work plan based on sub agreement and send to FHI for review and approval.
- Review recording and reporting forms and formats filled in by OE, DIC Operator and CM
- Review or prepare monthly project indicator form (PIF) and event reports (narrative) and submit to FHI Nepal on time.
- Prepare quarterly narrative reports, end of project reports, TIP report and submit to FHI Nepal.
- Organize and conduct review and sharing meeting (monthly with staff and bi monthly with FHI Nepal)
- Plan, organize and manage capacity building activities for project staff
- Organize and participate in district level coordination and networking meeting, events, biannual coordination meeting

Supervise, provide feedback, coach and mentor Supervisor, OE, DIC Operator and CM

- Review and monitor quarterly work plan, sub agreement text, M&E matrix, gantt chart, budget and ensure timely implementation of all planned activities.
- Oversee admin and financial activities
- Assess and update security situation
- Coordinate with stakeholders (government and non government organizations, donors, private sectors, DACC, Reproductive Health Coordination Committee (RHCC), CBOs)
- Provide updates/reports to DACC/DPHO/RHCC
- Conduct internal data quality audit
- Keep management (Project Manager, Executive Board) informed and updated about progress of the project.
- Ensure quality of the project activities and deliverables
- Review monthly and daily/micro plan including operational and mobility mapping

Field Supervisor:

Prepare quarterly and monthly plan according to sub agreement

Supervise, provide feedback, coach and mentor OE, DIC Operator, CM and PE and support OE and CM to deal with field level problems and challenges

- Review recording and reporting forms and formats filled in by OE, DIC Operator and CM
- Review monthly and daily/micro plan including operational and mobility mapping

Organize basic and refresher training to OE, DIC Operator, CM and PE

Strengthen coordination and networking with local level stakeholders and organize stakeholder meeting at local level

Support OE to conduct planned group discussions, community events and interactions.

Support OE, DIC Operator and CM to prepare reports in prescribed forms and formats and operational mapping
Compile and prepare reports (PIF, narrative reports)
Support OE and CM to prepare success story and case study
Organize review and sharing meeting with IHS team
Support Project Coordinator to organize and conduct monthly and bi-monthly review and sharing meeting.
Conduct or assist internal data quality audit.
Conduct rapid community assessment with support from Project Coordinator and in coordination with FHI Nepal.
Review and verify work plan and time sheet of OE/CM

Outreach Educator:
Support CM and conduct educational contacts with MARP
Identify MARP
Conduct PGD, community events and interactions
Supervise, provide feedback, coach and mentor CM and PE and support CM and PE to deal with field level problems and challenges
Assist Supervisor to conduct rapid community assessment of new project area
Keep records and prepare reports in prescribed forms and formats and operational mapping
Support CM to keep records and prepare reports in prescribed forms and formats
Support CM to prepare daily/micro plan of the area including preparation and update of operational and mobility mapping
Ensure all planned activities by CM are implemented in time
Ensure quality of outreach activities including referral and follow up for IHS and recording and reporting
Prepare and support CM to prepare success story and case study

DIC Operator:
Operate DIC

- Plan and organize regular and special activities of educational as well as entertainment events
- Update the display board of DIC

Keep and update IEC materials logistics
Keep DIC clean and tidy and DIC equipments in right condition
Keep records and prepare reports in prescribed forms and formats
Support to organize PGD, community events and interactions
Distribute condoms to MARP
Prepare success story and case study
Assist in IHS registration including risk assessment of the clients who walk-in to HIS site (self referred client)
Refer MARP (DIC visitors) for IHS and other services

Community Mobilizer (CM)
Contact (identify) MARP with the help of PE

Conduct repeated one on one educational contacts with MARP
Conduct risk assessment and support to prepare risk reduction plan
Provide basic facts of HIV/AIDS, STI and condom to MARP
Train MARP on correct use of condoms and condom negotiation skills
Refer and follow up MARP for STI, CT, DIC and other services
Support to organize PGD, community events and interactions
Distribute condoms to MARP
Keep records and prepare reports in prescribed forms and formats
Prepare daily/micro plan of the area including preparation and update of operational and mobility mapping
Assist OE to prepare case study and success story

Annex 3: Quarterly Work Plan Format

Name of Organization:
Name of Project:
Project District(s):
Quarterly Work Plan for the Quarter of: XXXX to XXXX, Year: XXXX

SN	Activities	Months and Weeks												Quarterly Target	Allocated budget	Budget Line Item	Remarks	Status (Completed or not)
		Month XXXX				Month XXXX				Month XXXX								
		1	2	3	4	1	2	3	4	1	2	3	4					
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		

Prepared by (name & position): Date:
Verified by (name & position): Date:
Approved by (name & position) Date:

Annex 4: Daily/Micro Planning Format

Name of OE/CM: **District:** **Working Area:**
Month: **Week:**

SN	Name	Activities (What)	Where	When	Materials/ Support	Status (Done/Not done/Post-poned)

Prepared by: **Date:**
Verified by: **Date:**

Annex 5: Coverage Form

S. N	Name	Age	If new, were they contacted before? If old, number of contacts and month and year of last contact *		2009			2010												2011								
					Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep
Number of new individual contacted (A)																												
Number of both new and old individual contacted (B)																												
Number of contacts with both new and old (C)																												
Prepared by																												
Verified/approved by																												
Verified/approved date																												
New= (B)-(A)-number of individual contacted by other units and friends														Note: Please use one register for one target group only														

Annex 6: Criteria for High Risk Areas/Hot Spot:

High risk areas/hot spots are areas in which behaviors that can lead to HIV/STI transmission, such as sexual contact, drug use and needle sharing, happen or where the solicitation and negotiation for these behaviors take place.

Examples of High Risk Areas:

- Areas with a high concentration of establishments such as dance and cabin restaurants, massage parlors, hotels and lodges, tea stalls, *bhatti pasals*, and *ghumti pasal*
- Areas with factories and settlements for factory workers
- Rest areas for truck drivers
- Bus park/stop, rickshaw stand
- Areas along construction sites
- Tourist areas
- Areas with a high concentration of people who travel abroad for work
- Settlement area of identified and suspected sex workers and clients
- Areas near police/military camps/barracks
- Parks
- Settlements of landless people
- Settlements of migrant workers
- Nepal India boarder towns

Annex 7: Operational Definition of Target Group

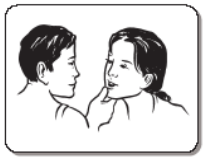
Code	Target group	Definition
01	Female Sex Workers	Females who exchange sex for money and/or goods
02	Clients of Sex Workers	A client is a person who visits a FSW and gives money and/or good in exchange for sex. A client is a person who uses money, goods, gifts, false assurance, entertainment, and/or threats for sex with a FSW.
2.1	Transport worker	A client of sex worker who works for transport sector such as driver, helper or conductor
2.2	Rickshaw puller	A client of sex worker who works as a Rickshaw puller
2.3	Uniform services	A client of sex worker who works for uniformed services such as police, armed police, Nepal Army
2.4	Labor	A client of sex worker who works for industries, garments, factories / Brick factory / daily wages
2.5	Other clients	A client of sex worker who works for other business (other than transport worker, Rickshaw Puller, Uniformed services and Labor)
03	Male IDUs	A man who injects drugs for non medical reasons or without doctor's advice (and thereby raises his risk of HIV infection).
04	Female IDUs	A woman who injects drugs for non medical reasons or without doctor's advice (and thereby raises her risk of HIV infection).
05	Male Migrants	Men who have spent at least three months in India, or another country, for work and have returned home within the last 3 years
06	Female Migrants	Females who have spent at least three months in India, or another country, for work and have returned home within the last 3 years
07	Spouse of Migrants – Female	Spouse of male migrants as indicated in 05 above
08	Spouse of Migrants – Male	Spouse of female migrants as indicated in 06 above
09	MSM	Men who engage in anal or oral sex with other men on a regular basis but do not sell sex
10	MSW	Men who have sold anal and/or oral sex to another man in exchange for money or other commodities
13	Transgender	A person whose gender identity, outward appearance, expression and / or anatomy do not fit into the conventional gender framework of male or female. A biological male who perceives his gender (outward appearance, expression and / or anatomy) as a female.

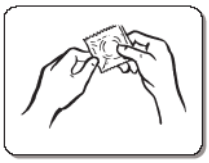
Code	Target group	Definition
66	Other Male	Others **male** may include spouses of FSWs, spouses of female IDUs and other risk groups not mentioned above. Please describe the "other" types in the quarterly narrative report, or in the notes/remarks page.
67	Other Female	Others **female** may include spouses of clients, spouses of male IDUs and other risk groups identified not mentioned above. Please describe the "other" types in the quarterly narrative report, or in the notes/remarks page.

Annex 8 A: Steps of Condom Use Demonstration

Store condoms in a cool and dry place. Extreme temperatures and body heat weaken condoms, so don't store them in your wallet, trouser pocket or glove compartment for more than a couple of weeks. Oil-based jellies and creams, such as Vaseline, will damage condoms. However, water-based lubricants such as KY Jelly are safe.

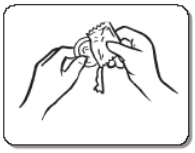
Step 1: Discuss or negotiate with sex partner for condom use

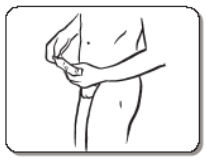




Step 2: Check the expiry date of the condom. This should be clearly printed on the box and on the condom wrapper. If one can not read the expiry date, move inside the condom from outside corner of the condom wrapper. If the condoms moves inside the wrapper and is not sticky, it can be usable.

Step 3: Open the package carefully and don't use sharp objects like scissors or your teeth to open the wrapper. Take care that the condom is not damaged with fingernails, jewelry etc.



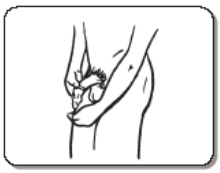


Step 4: Press out the air at the tip of the condom before putting it on — an air bubble in the condom could result in the condom tearing or falling off. Make sure the foreskin is pulled back before you put on the condom.

Step 5: With the rolled rim on the outside, put the condom over the erect penis. Be careful to put the condom on before there is contact with your partner's vaginal area.

Step 6: Unroll the condom down over the entire erect penis. If there is a reservoir tip, first squeeze out the air. If there is no tip, leave a half-inch space at the end for semen and squeeze the air out. Smooth out any air bubbles and check that the condom fits securely.

Step 7: After ejaculation, but before the penis is soft, hold the condom firmly at the rim and carefully withdraw from your partner. This is to ensure that semen is not leaked. Slide the condom off, avoiding spilling semen.



Step 8: Dispose the used condom safely. Wrap the condom in its package and put in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.

Annex 8 B: Steps of Condom Negotiation

1) Know basic facts of HIV/AIDS and STI (How HIV and STI transmitted, not transmitted and can be prevented)
2) Be prepared for condom negotiation. Always have at least 2 condoms with you for one sexual act.
3) Discuss about condom use with your partner.
4) Four options for negotiation:
    a. Client agrees to use condom (Use condom correctly and consistently)
    b. Client denies because of dissatisfaction issue (Assure the client condom is pleasurable. Assure that you can put the condom on with pleasure and you can give full pleasure with condoms. Assure client that condom is both for pleasure and protection. Tell the client we can have pleasurable sex with protection)
    c. If client does not agree yet and offer more money for sex without condom: delay for sexual activities. Try to divert the sex related conversation to another topic. Inform and try to persuade the client: health is wealth, health is the first priority.
    d. If client does not agree, say NO! (No Condom No Sex, Ask the client to go for another lady for sex without condom)

Annex 8 C: Number of Condoms Required for Each MARP per Month

Calculation based on National HIV/AIDS Action Plan, Nepal (2008-11)

- 1 FSW needs 30 condoms per month
- 1 client needs 9 condoms per month
- 1 IDU needs 7 condoms per month
- 1 migrant needs 3 condoms per month

Annex 9: Expected Behaviors/Practices and Key Messages

MARP	Expected Behaviors/Practices	Key Messages
Female Sex Workers	• Negotiate for condom use assertively • Use condoms correctly and consistently	• HIV and STI are transmitted through sex with multiple sex partners without using condoms • Consistent and correct use of condoms can protect a person from HIV and STIs as well as unintended pregnancy • Condom use can make sex not only safer and but also pleasurable • Demonstrate correct use of condoms (step by step) • Using one condom correctly at a time of sexual contact is enough to protect from HIV and STI. No need to wear more than one condom at a time. • Role play and video, followed by discussion on condom negotiation skills • A healthy looking person can be infected with HIV and STIs • Condom can protects both from HIV/STI and unwanted pregnancy • There are different types of condoms with different flavor in the market. • Always have at least 2 condoms • Don't drink and have sex. Do not have sexual contact when you are drunk
	• Seek regular checkups and treat STIs (monthly) • Refer sexual partners for STI checkups	• Regular checkups (monthly) for STIs are important even when no symptoms are present. Many STIs are asymptomatic and may only be detected upon examination. Regular visits to the clinic accomplish more than just STI treatment – they provide an opportunity for education and counseling, and promote health awareness and wellness. • Many STIs are curable if treated in a timely manner and properly by skilled clinicians. • Having STI might increase risk of HIV transmission • 3 Cs (Consistent and correct condom use, complete treatment/compliance and contact tracing/partner notification, check ups and treatment) should be followed during STI treatment. • Complications of STIs if not treated quickly and completely • A healthy looking person might have HIV and/or STIs • **(See PG: 5 referral for STI)**

MARP	Expected Behaviors/Practices	Key Messages
	• Seek Counseling and Testing (CT) services (quarterly) • Refer sexual partners for CT	• The only way to know HIV status is HIV counseling and testing. FSWs who are not using condoms consistently and correctly need HIV counseling and testing every three months. • Window period—the Rapid test detects HIV antibodies in the blood (does not detect HIV) and it take 3 months for the body to build up enough antibodies for the test to detect them • Healthy looking person might have HIV and/or STIs • If diagnosed HIV negative, one can protect oneself form HIV • If diagnosed positive, no need to worry, there are several ways to protect and improve your health. Care, support and treatment services are available **(See PG:5 referral for CT)**
	• Reduce the number of sexual partners	• Unsafe sex with multiple partners increases the risk of getting HIV and STIs. It also increases the chance of unintended pregnancy. • Number of sex partners can be decreased without decreasing income (Role play on negotiation skills, tips on hygiene and beauty, safer and pleasurable sex)
Clients of Sex Workers	• Be faithful to one partner • Reduce the number of sexual partners	• Someone is waiting for you. Be responsible. You have responsibility of your family including children. • You can save money and invest for your family and future • Unsafe sex with multiple partners increases the risk of getting HIV and STIs. It also increases the chance of unintended pregnancy.
	• Use condoms correctly and consistently	• Consistent and correct use of condoms can protect a person from HIV and STIs as well as unintended pregnancy • Condom use can make sex not only safer and but also pleasurable • Demonstrate correct use of condoms (step by step) • A healthy looking person can be infected with HIV and STIs • Condom can protects both from HIV/STI and unwanted pregnancy • Using one condom correctly at a time of sexual contact is enough to protect from HIV and STI. No need to wear more than one condom at a time. • There are different types of condoms with different flavor in the market. • Always have at least 2 condoms • Don't drink and have sex. Do not have sexual contact when you are drunk

MARP	Expected Behaviors/Practices	Key Messages
	• Seek regular checkups and treat STIs (quarterly) • Refer sexual partners for STI checkups	• Regular checkups (quarterly) for STIs are important even when no symptoms are present. Many STIs are asymptomatic and may only be detected upon examination. Regular visits to the clinic accomplish more than just STI treatment – they provide an opportunity for education and counseling, and promote health awareness and wellness. • Many STIs are curable if treated in a timely manner and properly by skilled clinicians. • Having STI might increase risk of HIV transmission • 3 Cs (Consistent and correct condom use, complete treatment/compliance and contact tracing/partner notification, check ups and treatment) should be followed during STI treatment. • Complications of STIs if not treated quickly and completely • A healthy looking person might have HIV and/or STIs • **(See PG: 5 referral for STI page 20)**
	• Seek CT services (quarterly) • Refer sexual partners for CT	• The only way to know HIV status is HIV counseling and testing. Clients who are not using condoms consistently and correctly need HIV counseling and testing every three months. • Window period—the Rapid test detects HIV antibodies in the blood (does not detect HIV) and it take 3 months for the body to build up enough antibodies for the test to detect them • Healthy looking person might have HIV and/or STIs • If diagnosed HIV negative, one can protect oneself form HIV • If diagnosed positive, no need to worry, there are several ways to protect and improve your health. Care, support and treatment services are available **(See PG:5 referral for CT)**
Injecting Drug Users	• Reduce the number of sexual partners • Use condoms correctly and consistently	• Don't have sexual intercourse when you are in hallucination/under the influence of drugs • Unsafe sex with multiple partners increases the risk of getting HIV and STIs. It also increases the chance of unintended pregnancy. • Consistent and correct use of condoms can protect a person from HIV and STIs as well as unintended pregnancy • Condom use can make sex not only safer and but also pleasurable • Demonstrate correct use of condoms (step by step) • A healthy looking person can be infected with HIV and STIs • Condom can protects both from HIV/STI and unwanted pregnancy • Using one condom correctly at a time of sexual contact is enough to protect from HIV and STI. No need to wear more than one condom at a time. • There are different types of condoms with different flavor in the market.

MARP	Expected Behaviors/Practices	Key Messages
	• Seek regular checkups and treat STIs (quarterly) • Refer sexual partners for STI	• Regular checkups (quarterly) for STIs are important even when no symptoms are present. Many STIs are asymptomatic and may only be detected upon examination. Regular visits to the clinic accomplish more than just STI treatment – they provide an opportunity for education and counseling, and promote health awareness and wellness. • STIs are also transmitted through needle and syringe sharing. • Many STIs are curable if treated in a timely manner and properly by skilled clinicians. • 3 Cs (Consistent and correct condom use, complete treatment/compliance and contact tracing/partner notification, check ups and treatment) should be followed during STI treatment. • Complications of STIs if not treated quickly and completely • A healthy looking person might have HIV and/or STIs • **(See PG: 5 referral for STI)**
	• Seek CT services (quarterly) • Refer sexual partners CT	• The only way to know HIV status is HIV counseling and testing. Clients who are not using condoms consistently and correctly need HIV counseling and testing every three months. • Window period—the Rapid test detects HIV antibodies in the blood (does not detect HIV) and it take 3 months for the body to build up enough antibodies for the test to detect them • Healthy looking person might have HIV and/or STIs • If diagnosed HIV negative, one can protect oneself form HIV • If diagnosed positive, no need to worry, there are several ways to protect and improve your health. Care, support and treatment services are available **(See PG:5 referral for CT)**
	• Use new syringe and needle every time	• HIV and STI are transmitted through sharing needle and syringes and sex with multiple sex partners without using condoms • HIV can be prevented by using new syringe and needle every time of injecting drugs. • Don't use syringe and needles used by others. • Don't share needles and syringe with others • Seek help of health care service providers to access to rehabilitation, recovering, treatment and oral substitution therapy • Don't mingle with friends who use drugs and force you to use drugs
	• Avoid using drugs	•

MARP	Expected Behaviors/Practices	Key Messages
External Migrants and their spouse	• Abstain from all sexual activity • Be faithful to one partner • Reduce the number of sexual partners • Use condoms correctly and consistently	• Abstain from sexual contact as much as possible when outside from home/country. • Do not have sex with other than your wife or husband. Someone is waiting for you. Be responsible. You have responsibility of your family including children. • You are away from your home for earning. You can save money and invest for your family and future • There are several ways to enjoy while you are away from home • If not possible to abstain and be faithful to your wife or husband, keep the number of sex partner only one. Use condoms correctly and consistently • Unsafe sex with multiple partners increases the risk of getting HIV and STIs. It also increases the chance of unintended pregnancy.
	• Seek regular checkups and treat STIs (quarterly) • Seek CT services (quarterly) • Refer sexual partners for STI checkups and CT	• Same as clients and FSWs (for those who involved in high risk behavior)

Annex 10: BISHWAS Logo and Strip (Meaning of 5 Petals)

गुणस्तरीय सेवा


विश्वसनीयता


भरपर्दो


मैत्रीपूर्ण


सुरक्षित


आरामदायी

Annex 11 A: IHS ID Card

Annex 11 B: Referral Card from Community to IHS

Annex 12: IEC Material to Sensitize the Need and Importance of STI Examination

(See attached guidelines booklet with the materials for using the materials and facilitating discussions)

Annex 13 A: PGD Session Plan Format

Name of Organization and Project:
Name/Title of the event:
Date: **Time:** **Venue:**
Type of Participants:
Number of Participants: Total: **Female:** **Male:**

Main Objectives of the PGD:
1)
2)
3)

Time	Topic/Sub-topic	Methodology	Materials	Facilitator

Prepared by: **Date:**
Verified by: **Date:**
Approved by: **Date**

Annex 13 B: Participant Registration Format

Name of Organization and Project:
Name/Title of the event:
Date: **Time:** **Venue:**

SN	Name	Age	Sex	Signature	Code

Annex 13 C: Guidelines for Note Takers:

- Give/assign a number (1, 2, 3) to each participant starting from the participant next to the facilitator. Note down the opinion expressed by the participants by using the number assigned.
- Note the key points, feelings, experience shared by the participants. Do not interpret or add your opinion while taking notes.
- Be an attentive and active listener
- Take notes clearly and legibly
- Do not handover the note taking job to another person
- Note non verbal communication as well
- Note correctly and completely
- Do not interrupt discussion
- Do not ask question during the discussion. If you have a pertinent question, write on a piece of paper and give it to the facilitator
- To prepare the report, go through the notes and collate and summarize the key points. Do not procrastinate. Prepare the report within 1-2 days.

Annex 13 D: Handling Discussion Monsters

1. **Overly talkative:** Interrupt with "That's an interesting point. Now let's see what the rest of the team thinks."
2. **Highly argumentative:** Honestly try to find the merit in his/her statements. Try humor: "I respect your right to be wrong." Try sarcasm: "I hate people who beat around the bush."
3. **Rambler:** Say: "Your point is interesting, but we need to move on to the next agenda item."
4. **Obstinate, rigid:** Throw his/her point to the team for consideration. Say that time is short and ask that the group's viewpoint be accepted for the moment. Say you'll be glad to discuss it later.
5. **Griper, whiner:** Point out that organizational policy cannot be changed at the meeting; "So let's try to figure out how we can best operate under the present system."
6. **Side conversation:** Call one of them by name, restate the most recent opinion and ask for his/her opinion. Refer to your team norms about no side conversations. Request to share their discussion "Can you also share your points with us/group?"
7. **Definitely wrong:** Try: "That's one way to look at it," or "I see your point, but did you know that (HIV does not transmit by caring PLHA)?"
8. **Off the subject:** Try: "Something I may have said may have lead you to think we are discussing _____, but right now we are considering _____."
9. **Silent:** Ask the person next to him/her a question and then ask the silent person to comment on the answer. If the silent person is near you, ask his/her opinion on a subject that you are sure he/she knows a great deal about.
10. Request to speak turn by turn if two or more than two participants speak at a time.

(Parker GM and Kropp RP Jr, 50 Activities for Self-Directed Teams, HRD Press, 1994)

Annex 13 E: Suggested Reporting Format

1) Introduction (information on: issue/problem/topic of PGD, objectives of PGD, date, time and venue, number and types of participants, facilitator, note taker)
2) Methods of PGD
3) Findings of PGD: Summarize key findings under key questions
4) Learning/reflection: Key learning points on issues/problem/topic, planning and preparation, facilitation process, time management, note taking, logistics.

Annex 14: Signboard with BISHWAS Logo and Strip

Annex 15: Sample Plan for Monthly DIC Activities

Name of IA: **Location of DIC:**
Month: **Year:**

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 -- Regular activities	**2** -- Paint with me -- DIC management committee meeting -- Reward first visitor of the month and frequent visitors of the month	**3** -- Client generated content -- Publish monthly wall magazine	**4** -- Topic talk	**5** -- Regular activities	**6** -- Movie Mania	**7** -- Holiday
8 -- Topic talk -- Intra DIC competition (monthly) -- Inter-organization (Quarterly)	**9** -- Regular activities	**10** -- Regular activities	**11** -- Topic talk	**12** -- Regular activities	**13** -- Movie Mania	**14** -- Holiday
15 -- Topic talk	**16** -- Paint with me	**17** -- Client generated content	**18** -- Topic talk	**19** -- Regular activities	**20** -- Movie Mania	**21** -- Holiday
22 -- Topic talk	**23** -- Regular activities	**24** -- Regular activities	**25** -- Topic talk	**26** -- Regular activities	**27** -- Movie Mania	**28** -- Holiday
29 -- Topic talk	**30** -- Paint with me					

Annex 16: Daily Log Sheet for DIC Activities

Name of Organization:
Type of Centre: DIC
Location of DIC: **Month:** **Year:**

S.N	Date	Name	Age	Sex	Address	Target Group	Types of Activities**	Contacts		Education Provided				Condom Demonstration	# Condom Distributed	Referral				Visits	
								One-on-one	Group	HIV/AIDS	STI	CT	Others (specify)			STI	CT	CST	Other (specify)	First (New)	Repeated
	Total																				

** 1) Paint with me, 2) Client Generated Content, 3) Movie Mania, 4) Games, 5) Story telling, 6) Group discussions/Topic Talk

Annex 17 A: Indicators and Sample Questions for IA Staff for IEC Materials Assessment

1. Design: Ask the beneficiaries/target audience/project staff:

- Are the pictures/illustrations used in this material appropriate to illustrate the message?
- Are the illustrations used in this material simple and realistic? Or if cartoons, are they recognizable to the target audience?
- If symbols are used in this material, are they appropriate and does the target audience understand them?

2. Recognition: Ask the beneficiaries/target audience:

- Have you seen/heard/used this material?
- Where have you seen/heard/ used it?
- When have you seen/heard/used it?

3. Comprehension: Ask the beneficiaries/target audience:

- What does the picture/logo/message mean?
- Is this meaning/message/logo important? Why or why not?
- For whom do you think this message is meant?
- Is the message telling people to do anything? If so, what?
- Which message/picture is difficult to understand? Why?

4. Language and Tone: Ask the project staff, beneficiaries/target audience and local expert:

- Are the language and terms (both technical and non technical) used easily understandable? If not, specify.
- Are the language, terms and pictures used socio-culturally appropriate and acceptable? If not, specify.
- Are the messages phrased in a positive way? If not, specify.

5. Message: Ask the target audience/beneficiaries:

- What is the main message?
- Is the message clearly promoting positive behavior? If yes, specify.
- Is the message in this material actually do-able? If not specify
- Is the message relevant for the target audience? If not specify.
- Does the message get attention of target audience?
- Is the message offering something of value? If yes, specify.
- Is the message phrased in a positive way?
- Is the message directed to the objective of the strategic behavioral communication?
- Is the message accurate? Does it give the correct information?
- Is the message easy to understand? If not specify.
- Is the message socio-culturally acceptable and appropriate? If not specify.

6. Usage: Ask project staff members who use the material and also beneficiaries/target audience who use the material:

- Where is the material used?
- When is the material used?

- How often is the material used?
- How is the material used?
- What and how did the material help on educational session?

7. Distribution: Make observations to check whether materials have been distributed properly. Ask project staff:

- Was there a written distribution plan?
- How was this plan carried out? By whom?
- Have the materials actually been distributed?
- Was the distribution one time only or is it on going?
- Have any inappropriate people received the material?
- Do you have enough materials for distribution?

8. Durability: Ask project staff who used the material in their work or beneficiaries/target audience who used the material:

- How long have you been using this material?
- Is the material still in good shape?
- In your opinion, is it of adequate quality?
- Is the material in appropriate size and easy to carry and use?

9. Appeal: Ask project staff and also beneficiaries/target audience:

- Do you like this material? Why or why not?
- Do you think this material is attractive? Why or why not?
- What do you like very much in this material? Why ?

10. Outcome: Ask the project staff and also beneficiaries/target audience:

- Has the target audience reported a positive change in the behavior that is promoted in this material? (e.g., improved condom use skills; positive attitude toward PLHA, clearer understanding of STI symptoms, got HIV tested, got STI diagnosis and treatment services)
- If the material clearly promotes some action to be taken, what is it? Have you or other members of the target audience taken this action (yet)? Give examples.

11. What elements do you want to **a) keep, b) delete, c) add and d) modify,** if the material is reprinted?

Report Template for IEC Assessment and Feedback

The following is a suggested outline for a report (1-2 pages)

- Introduction (2-3 sentences)
- Name of materials assessed: 1 line
- Methods – include the methods that were used to assess the materials (2-3 bullets)
- Results – include results of assessment (1/2 – 1 page)
- Recommendations for future material development (1/2 page in bulleted list)
- Appendix: Tools used for assessment

Annex 17 B: Creative Brief Template

ASHA Project
Family Health International Nepal
Creative Brief

1. Target Audience: *Describe the person that you want to reach with your materials. What do they value? How do they see themselves? What are their aspirations? Include a primary & secondary (influencer) audience if appropriate.*

2. Background:
Explain need for material:

Objective of the material: *What do you want your target audiences to think, feel, or do after using the materials?*

Obstacles: ***What beliefs, cultural practices, pressure, misinformation stand between your audience and the desired behavior?***

Where will it be used? How will it be used?

3. Main Message (word this as a Key Promise or Benefit Statement) in the material
Select one single benefit that will outweigh the obstacles in the mind of your target audience. Suggested format: If I (desired behavior), then (immediate benefit).

4. Other Supporting Statements to be included in the material
This is the substantiation for the key promise; i.e.; the reasons why the promise is true. Oftentimes, this will begin with a 'because'.

5. Tone and language
What feeling should your material have? Should it be authoritative, humorous, emotional, inspirational, motivational, scary…?

6. Type of Material –Explain what type of material you would like to produce including description and quantity.

- **Type of material**: **Size:** **Color:** **Paper:**
- **Content:** **Number of copies:**

7. Any Other Creative Consideration: *Any other critical information for the writers & designers? Will the communication be in more than one language or dialect? Should it be tailored to a low-literate audience? Are there any political considerations? Any red flags/words or visuals to stay away from? Should there be space or time available to include local contact information?*

Annex 18 A: Schedule Format for Community Events

Name/Title of community event:
Name of organizer(s):
Type of event:
Date: **Time:**
Venue (including district):
Types of participants:
Expected number of participants: Total: **Male:** **Female:**

Objectives of the event:

Time	Activities	Materials	Responsible person

Prepared by: Date:
Verified/Approved by: Date:

Annex 18 B: Attendance Sheet for Community Events/Meeting

Name/Title of community event/meeting:
Name of organizer(s):
Date: **Time:**
Venue (including district):

SN	Name	Sex (male, female and others)	Organization	Designation	Address	Signature

Annex 18 C: Recording Format for Community Event

Name of IA and Project:
Month: **Year:**

SN	Date	Type of Event	Total participant													# Condom distributed	Remarks
			General People		TG participation												
			Male	Female	FSWs	Clients of FSWs	IDUs		Migrants		Spouse of Migrants		MSM	Transgender	Total		
							Male	Female	Male	Female	Male	Female					

Codes for type of event:
1 = Video show
2 = Folk Media
3 = Street Drama/theatre
4 = Demonstration
5 = Special days and events such as condom day, AIDS day, candlelight memorial day
6=Others

Annex 18 D: Reporting (Narrative) Format for Event (Community/Meeting/Training)

- **Title** of the event
- **Objectives** of the event
- **Organizer/s** of the event
- **Number of organizations** participated (can be IA/Governmental organization/ hospital/ stakeholder/ CBO etc)
- **Number and types of participants** (from IA/Governmental organization/ hospital/ stakeholder/ CBO, MARP etc) (disaggregate by sex)
- **Date and venue (including district)** of the event
- **Brief description** of the event (what activities performed (types of the event), who involved and how)
- **Constraints, lesson learned and recommendations** (in brief)
- Attach photo and other supporting documents

Annex 19: Training Attendance Sheet

Name of the Training:

Name of the training/workshops organizer:

Date of the Training: **Venue of the training:** **District:**

ATTENDANCE SHEET

SN	Name	Organization	Designation	**Participant** (please write male or female or transgender or as appropriate)	**Have you received a similar training before this training in the same year** (please put tick mark √ as appropriate)		**Is any other people from your organization received a similar training before this training in the same year** (please put tick mark √ as appropriate)		Signature	Remarks
					Yes	No	Yes	No		
Total										

Summary of the attendance sheet

(Reference sheet for the person who is leading training / orientation and responsible for the reporting too)

Summary sheet of the training / orientation attendance:

Particular	Total
1. Total number of participants	
2. Total number of new participants	
3. Total number of organizations participated	
4. Total number of new organizations participated	

Code for indicator: People trained on (please put tick mark √ in the appropriate code/s or indicator/s)

01 = Stigma and Discrimination	02 = HIV/AIDS Prevention
03 = Counseling and Testing	04 = STI Management
05 = ART	06 = HIV Palliative Care
07 = Home Based Care	08 = Lab Activities
09 = Monitoring and Evaluation	10 = Policy
11 = Institutional Capacity (Mgmt. HR, Finance)	12 = Community Mobilization

Notes for the calculation:

1. Total number of participants: Total number of head counts in the training
2. Total number of new participants: Total number of people for whom this is the new or first training.
3. Total number of organizations participated: If more than one people participated from one organization, please count one organization irrespective of number of people participated in the training / orientation.
4. Total number of new organizations participated: Reduce the number of organizations which have already taken part in the training / orientation and only count total number of organizations for whom this is the new and first training. If there are two participants from one organization (as listed in the above attendance sheet), please count one organization.

Annex 20: Format for Referral Directory

Name of IA
Name of Project and Project Districts:
Updated date:

Referral Directory

SN	Name of Organization	Contact Person	Contact Telephone No.	Location Address	Available Services	Opening Hours	Cost for Services	Any other Special Instruction

Annex 21: Supervision Checklist for Project Coordinator and Field Supervisor

Site Name:

Assessment team member:
Date:

Indicators	Method	Score				Observations/rationale for score
1. Outreach education session (one-on-one/group contacts)						
Before visit/outreach education session						
1.1 Each OE/CM prepared plan (monthly/daily) for outreach education (one-one one and planned group discussion)	SI/O	NA	0	1	2	
1.2 OE/CM had adequate IEC materials including condoms to conduct outreach education session	SI/O	NA	0	1	2	
1.3 OE/CM arrived at the planned outreach sites on time.	SI/O	NA	0	1	2	
During the visit/outreach session						
1.4 Outreach educational sessions are conducted as planned. If not, appropriate justifications are provided	MI/SI/O	NA	0	1	2	
1.5 OE/CM used appropriate communication with the audience						
1.5.1 Rapport building (greeted the clients, asked for general topic/situation, news, happenings, health and wellness including family and children, business as appropriate)	SI/O	NA	0	1	2	
1.5.2 OE/CM introduced new individuals if anyone went with him/her to see the clients and OE/CM asked for introduction with the clients, if anyone new to him/her	SI/O	NA	0	1	2	
1.5.3 OE/CM introduced the organizations and program	SI/O	NA	0	1	2	
1.5.4 OE/CM explained the objectives, activities and tentative time to be taken for the visit/interaction	SI/O	NA	0	1	2	
1.5.5 OE/CM identified and reported MARP (FSW and client of FSW) in accordance with standard definition	SI	NA	0	1	2	
1.5.6 OE/CM were polite, showed respect, listened attentively/actively and showed interest to her/him, her/his situation, issues and concern	SI/O	NA	0	1	2	
1.5.7 Educational session were held in an appropriate location (away from distraction, and with auditory and visual privacy and confidentiality as required and appropriate)	SI/O	NA	0	1	2	
1.5.8 OE/CM were seated with the clients at appropriate	SI/O	NA	0	1	2	

Indicators							
	distance and in seat (not too far and near, OE/CM and client did not sit on different seating arrangement such as client on floor, OE/CM on chair/cushion/mat)						
1.5.9	Participants were seated comfortably and in informal setting (semi-circle/circle). All participants could clearly see and hear each others as well as discussions/demonstration	SI/O	NA	0	1	2	
1.5.10	OE/CM talked loudly and clearly enough for the client(s) to listen and understand. OE/CM used appropriate tone and language friendly to the client	SI/O	NA	0	1	2	
1.5.11	OE/CM discussed/reviewed the previous visit and action points. Appreciated for action/implementation and asked client for their feelings, improvements, issues and concern. If not implemented, explore the reasons and ask if any help is needed for implementation	SI/O	NA	0	1	2	
1.5.12	OE/CM assessed level of knowledge and understanding of the client before providing information	SI/O	NA	0	1	2	
1.5.13	Client was engaged in discussion and asked question for clarification.	SI/O	NA	0	1	2	
1.5.14	OE/CM did not talk more than 50% of the time during the interaction/session	SI/O	NA	0	1	2	
1.5.15	OE/CM reflected questions back to the client to encourage talking	SI/O	NA	0	1	2	
1.5.16	OE/CM listened actively and attentively to the questions and concerns of the clients and responded appropriately, accurately and quickly	SI/O	NA	0	1	2	
1.5.17	OE/CM used paraphrasing regularly	SI/O	NA	0	1	2	
1.5.18	OE/CM summarized the key points of each topic before moving to another topic	SI/O	NA	0	1	2	
1.5.19	OE/CM used non verbal communication (body language) appropriately	SI/O	NA	0	1	2	
1.5.20	OE/CM asked open ended questions of the client	SI/O	NA	0	1	2	
1.5.21	All participants were given an equal opportunity to ask questions and to share their experiences, feelings and concerns	SI/O	NA	0	1	2	
1.5.22	Meeting/group discussion monsters (talkative, silent, whiner, rambler, argumentative, off subject, rigid, side conversation and wrong) were dealt with appropriately	SI/O	NA	0	1	2	
1.5.23	OE/CM provided relevant, appropriate, accurate, complete and clear information on the topic	SI/O	NA	0	1	2	

Indicators						
1.5.24	OE/CM provided appropriate examples relevant to their context to increase the understanding of the topic	SI/O	NA	0	1	2	
1.5.25	OE/CM helped client to relate the discussions to the clients real life situation	SI/O	NA	0	1	2	
1.5.26	OE/CM used appropriate IEC materials to the outreach session appropriately and interactively as planned	SI/O	NA	0	1	2	
1.5.27	When OE/CM was not sure of answer/information, OE/CM told the client that s/he would find out and get back to the client	SI/O	NA	0	1	2	
1.5.28	OE/CM did risk assessment of the client and helped client to make risk reduction plan based on the risk assessment	SI/O	NA	0	1	2	
Referral to IHS Site and DIC							
1.5.29	OE/CM provided accurate and complete information about (IHS- STI, CT, EPC and CHBC services) to the client. OE/CM explained that all the services available in the IHS are free of cost and will be referred to other service sites if services are unavailable.	SI/O	NA	0	1	2	
1.5.30	OE/CM gave the location, hours of operation and contact person's information for DIC/IHS site	SI/O	NA	0	1	2	
1.5.31	OE/CM explained the services and facilities available from the DIC (TV, video, movie mania, educational and skill building session on various topics, IEC, creative creation, painting, rest, bath, first aid, basic make-up...)	SI/O	NA	0	1	2	
1.5.32	OE/CM explained benefit/promotional package for DIC visitors (reward for frequent visitors and first visitors, beauty coupon)	SI/O	NA	0	1	2	
1.5.33	OE/CM explained the meaning of 5 petal BISHWAS logo (Reliable, Dependable, Friendly, Secure and Comfortable) to highlight the quality of services available from DIC/IHS sites	SI/O	NA	0	1	2	
1.5.34	OE/CM explained the reasons and importance of monthly STI check ups for FSW and quarterly for their clients	SI/O	NA	0	1	2	
1.5.35	OE/CM explained the approximate time required, risk assessment questions and the types of examination	SI/O	NA	0	1	2	
1.5.36	OE/CM explained importance of 4 Cs (Consistent and correct Condom use, complete treatment, counseling/education, contact tracing (partner's notification) and treatment) during STI treatment	SI/O	NA	0	1	2	
1.5.37	OE/CM explained the reasons for and importance	SI/O	NA	0	1	2	

Indicators						
	of quarterly CT service utilization					
1.5.38	OE/CM explained possible results of CT and its interpretations (if –ve: can be assured and protected from HIV in future by adopting safer behaviors and if +ve: can access to care, support and treatment and can protect their partners from HIV) while referring for CT	SI/O	NA	0	1	2
1.5.39	OE/CM explained the availability of care, support and treatment services, such as EPC, CHBC and support groups, through ASHA/FHI, ART, CBPMTCT through government, crisis care and other NGOs	SI/O	NA	0	1	2
1.5.40	OE/CM explained reward/benefit package beside health benefits such as beauty coupon to those who attended IHS site	SI/O	NA	0	1	2
1.5.41	Time for outreach session was adequate	SI/O	NA	0	1	2
1.5.42	OE/CM provided IEC materials to the client	SI/O	NA	0	1	2
1.5.43	OE/CM performed condom use demonstration using a dildo (assess condom use skill, demonstration by OE/CM and clients ability to demonstrate condom use)	SI/O	NA	0	1	2
1.5.44	OE/CM provided condoms to the client based on need	SI/O	NA	0	1	2
1.5.45	Action points were identified during the session	SI/O	NA	0	1	2
1.5.46	OE/CM summarized the key points discussed and action items made during the outreach session	SI/O	NA	0	1	2
1.5.47	OE/CM set the date, time and location of the next visit	SI/O				
1.5.48	OE/CM expressed his/her gratitude for time given and information shared by the clients OE/CM bid farewell as appropriate	SI/O	NA	0	1	2
After the visit		SI/O	NA	0	1	2
1.5.49	OE/CM recorded all the data/information in appropriate forms/formats correctly (consistent and coherent with standard forms/formats) (Daily diary, form 1 and form 2, TIP)	MI/SI/O	NA	0	1	2
1.5.50	OE/CM reviewed the outreach session to identify strengths and weakness	SI/O	NA	0	1	2
2	**Community events**					
2.1	Community event was well planned (schedule), prepared (materials/venue arrangements) and conducted Supporting documents of the event (schedule, meeting minute, materials, attendance sheet and brief report)	MI/SI/O	NA	0	1	2

Indicators						
were in place						
2.2 Community events were planned, prepared and conducted in coordination and collaboration with MARP, local stakeholders (CBO/NGO/GO), local authorities and celebrities	MI/SI/O	NA	0	1	2	
2.3 Community event was conducted in an edutainment way. Health education messages were adequately and appropriately mixed in and balanced with entertainment.	SI/O	NA	0	1	2	
2.4 Community event was conducted in an interactive way. Audience was engaged in interaction (asked questions, raised issues, concerns, shared feelings and the questions were responded appropriately, accurately and quickly)	SI/O	NA	0	1	2	
2.5 Location, timing, venue, setting of the event were appropriate and conducive to the audience considering the local circumstances	SI/O	NA	0	1	2	
2.6 Contents, specially health education, of the event were appropriate to the local need and context and were adequate, accurate and up to date	SI/O	NA	0	1	2	
2.7 Appropriate IEC and promotional materials, including condoms, were displayed and distributed	SI/O	NA	0	1	2	
2.8 Action points were identified and planned for implementation	SI/O	NA	0	1	2	
2.9 Audience was referred for relevant services/facilities and/or additional information	SI/O	NA	0	1	2	
2.10 Meeting was conducted among the organizer of the event to review and reflect strength and weakness	SI/O	NA	0	1	2	
3 Drop In Centers (DIC)						
3.1 Service areas are easy for clients to find and access, DIC operating hours are appropriate for the clients and the DIC opens on time.	MI/SI	NA	0	1	2	
3.2 DIC signboard with BISHWAS logo and branding strip and IEC materials are displayed appropriately. Logos and strip were visibly displayed.	O	NA	0	1	2	
3.3 DIC rooms, toilets and premises were neat , clean and clutter free	O	NA	0	1	2	
3.4 IEC materials including AV materials and condoms were available	O	NA	0	1	2	
3.5 Appropriate IEC materials were displayed appropriately	O	NA	0	1	2	
3.6 Clients were greeted warmly followed by a good morning/afternoon or Namaste or in local custom (see strategic goal# 1 of BISHWAS manual)	SI/O	NA	0	1	2	
3.7 Monthly DIC activity plan is prepared and displayed	SI/O	NA	0	1	2	

Indicators						
(see strategic goal # 2 of BISHWAS manual)						
3.8 DIC is equipped with minimum set up criteria and requirements (see strategic goal#3 of BISHWAS manual)	MI/SI/O	NA	0	1	2	
3.9 Information provided is accurate, clear, concise and up-to-date in conveying details about the scope of the services provided. (see strategic goal#5 of BISHWAS manual)	SI/O	NA	0	1	2	
3.10 Clients are dealt with promptly and fairly through suitable queuing arrangements	SI/O	NA	0	1	2	
3.11 Waiting clients are acknowledged while still giving priority to the client being dealt with.	SI/O	NA	0	1	2	
3.12 Staff personalize their dealings with the client by introducing themselves and by using (if appropriate) the client's name	SI/O	NA	0	1	2	
3.13 Staff is tidy and are dressed appropriately.	O	NA	0	1	2	
3.14 Staff is genuinely friendly and courteous	SI/O	NA	0	1	2	
3.15 Attentive interest is shown by asking questions and listening to the answers (Don't be too attentive or pushy though, as clients may get annoyed)	SI/O	NA	0	1	2	
3.16 Staff is fully knowledgeable about all available services	SI	NA	0	1	2	
3.17 Clinet interactions end by saying good bye and asking them to visit again	SI/O	NA	0	1	2	
3.18 Daily DIC log sheets and other recording and reporting formats are up to date	SI/O	NA	0	1	2	
3.19 Unnecessary, irrelevant or information which is already in the records were not asked for (except for verification purposes)	SI/O	NA	0	1	2	
3.20 When using records, ensure the client that all information remains confidential	SI	NA	0	1	2	
3.21 Simple, understandable language with no technical jargon, codes or abbreviations is used	SI/O	NA	0	1	2	
3.22 The client is treated with genuine empathy, courtesy, patience, honesty and fairness at all times	SI/O	NA	0	1	2	
3.23 When faced with a complaint from a client, staff listens in order to understand the issue to resolve it—staff does not jump to conclusions or become defensive	SI/O	NA	0	1	2	
3.24 Input/feedback is obtained from beneficiary groups periodically to ensure that services are accessible and acceptable. This type of input/feedback is used to improve services Suggestion box is kept to collect suggestions/feedback	MI/SI/O	NA	0	1	2	

Indicators						
3.25 DIC operator explained the meaning of the 5 petals of BISHWAS logo (Reliable, Dependable, Friendly, Secure and Comfortable) to highlight the quality of services available from DIC/IHS site	SI/O	NA	0	1	2	
3.26 DIC log sheets, summary sheets and other records were stored in a secure filing cabinet and only specifically designated staff have access to them During operating hours, files are not left in areas where clients and non-authorized staff members can readily access them	SI/O	NA	0	1	2	

TOTAL SCORE:	/91			

Note: MI= Management Interview
SI= Staff Interview
O= Observation
EI= Exit Interview
NA=Not Applicable
0= No
1= Yes Partially
2= Yes

Annex 22: SBC/Prevention QA/QI Checklist

Site Name:

Assessment team member:
Date:

Indicators	Method	Score				Observations/Rationale for Score
1. General Understanding and Competency of the Staff OE/CM						
1.1. All staff (OE/CM) received a basic training on outreach education including effective use of the outreach bag and other IEC materials	MI/SI	NA	0	1	2	
1.2. OE/CM had knowledge and skills on effective use of IEC materials including outreach bag materials and condom use demonstration	SI/O	NA	0	1	2	
1.3. All staff, including OE/CM, had knowledge and skills on recording and reporting forms/formats	SI	NA	0	1	2	
1.4. All staff, including OE/CM/DIC operator, had understanding of BISHWAS branding (5 strategic goals and activities and meaning of 5 petals)	SI	NA	0	1	2	
1.5. All staff, including OE/CM, had understanding of the purpose of the project, strategies and main activities	SI	NA	0	1	2	
1.6. All staff, including OE/CM, had common understanding of the definitions of key terms such as MARP, indicators in PIF and TIP	SI	NA	0	1	2	
1.7. All staff, including OE/CM, had up to date knowledge on HIV/AIDS related issues including TIP	SI	NA	0	1	2	
1.8. Supportive supervision was planned and conducted with every staff member at least once every 15 days	MI/SI	NA	0	-	2	
2. Training/Meeting						
2.1 Training session plan (consistent with standard format) and materials were prepared and the training was conducted accordingly Supporting documents of the training events (session plan, materials/handouts, attendance and brief report) were in place	MI/SI/O	NA	0	1	2	
2.2 Training was conducted in a participatory way-- various methods such as brain storming, interactive mini lecture/presentation, small group work, role plays, case study etc. were used	MI/SI/O	NA	0	1	2	
2.3 Schedule for the meeting was prepared and the meeting was conducted accordingly	MI/SI/O	NA	0	1	2	

Indicators						
Supporting documents for the meeting (schedule, materials/handouts, meeting minute, attendance sheet and brief report) were in place						
3. Outreach Education Session (one-on-one/group contacts)						
3.1 Each OE/CM has been assigned to an outreach area	MI/SI/O	NA	0	1	2	
Before Visit/Outreach Education Session						
3.2 Each OE/CM prepared a plan (monthly/weekly/daily) for outreach education	SI/O	NA	0	1	2	
3.3 OE/CM had adequate IEC materials including condoms to conduct outreach education sessions	SI/O	NA	0	1	2	
3.4 OE/CM arrived at the planned outreach sites on time	SI/O	NA	0	1	2	
During the Visit/Outreach Session						
3.5 Outreach educational sessions are conducted as planned. If not, appropriate justification is provided	MI/SI/O	NA	0	1	2	
3.6 OE/CM used appropriate communication with the audience						
3.6.1 Rapport building (greeted the clients, asked for general topic/situation, news, happenings, health and wellness including family and children, business, etc… as appropriate)	SI/O	NA	0	1	2	
3.6.2 OE/CM introduced any new individuals if anyone went with him/her and OE/CM to be introduced to any new clients	SI/O	NA	0	1	2	
3.6.3 OE/CM introduced the organizations and program	SI/O	NA	0	1	2	
3.6.4 OE/CM explained the objectives, activities and tentative time for the visit/interaction	SI/O	NA	0	1	2	
3.6.5 OE/CM identified and reported MARP (FSW and client of FSW) in accordance with standard definition	SI	NA	0	1	2	
3.6.6 OE/CM they polite, showed respect, listened attentively/actively and showed interest in clinets situation, issues and concern	SI/O	NA	0	1	2	
3.6.7 Education session was held in an appropriate location (away from distraction, and in a location that maintained auditory and visual privacy and confidentiality)	SI/O	NA	0	1	2	
3.6.8 OE/CM were seated an appropriate distance from the clinet and seated in a similar arrangement (such as client on floor, OE/CM on chair/cushion/mat)	SI/O	NA	0	1	2	
3.6.9 Participants were seated comfortably and in informal setting (semi-circle/circle). All	SI/O	NA	0	1	2	

Indicators							
	participants could clearly see and hear each others as well as the discussions/demonstration						
3.6.10	OE/CM talked loudly and clearly enough for the client(s) to listen and understand. OE/CM used appropriate tone and language with the client(s)	SI/O	NA	0	1	2	
3.6.11	OE/CM discussed/reviewed the previous visit and action points. Appreciated for action/implementation and asked client for their feeling, improvement, issues and concern. If implementation did not take place, explore the reasons and ask id client needs any help	SI/O	NA	0	1	2	
3.6.12	OE/CM assessed the level of knowledge and understanding of the client before providing information	SI/O	NA	0	1	2	
3.6.13	Client was engaged in discussion and asked questions for clarification	SI/O	NA	0	1	2	
3.6.14	OE/CM did not talk for more than 50% of the interaction/session	SI/O	NA	0	1	2	
3.6.15	OE/CM reflected questions back to the client to encourage talking	SI/O	NA	0	1	2	
3.6.16	OE/CM listened actively and attentively to the client's questions and concerns and responded appropriately, accurately and quickly	SI/O	NA	0	1	2	
3.6.17	OE/CM used paraphrasing regularly	SI/O	NA	0	1	2	
3.6.18	OE/CM summarized the key points of each topic before moving to another topic	SI/O	NA	0	1	2	
3.6.19	OE/CM used non verbal communication (body language) appropriately	SI/O	NA	0	1	2	
3.6.20	OE/CM asked the client open ended questions	SI/O	NA	0	1	2	
3.6.21	All participants were given an equal opportunity to ask questions and share their experiences, feelings and concerns	SI/O	NA	0	1	2	
3.6.22	Meeting/group discussion monsters (talkative, silent, whiner, rambler, argumentative, off the subject, rigid, side conversation and wrong) were dealt with appropriately	SI/O	NA	0	1	2	
3.6.23	OE/CM provided relevant, appropriate, accurate, complete and clear information on the topic	SI/O	NA	0	1	2	
3.6.24	OE/CM provided appropriate examples relevant to the context to increase the understanding of the topic	SI/O	NA	0	1	2	
3.6.25	OE/CM helped client to relate the discussions to the clients real life situation	SI/O	NA	0	1	2	

Indicators						
3.6.26	OE/CM used IEC materials appropriately and interactively during the outreach session	SI/O	NA	0	1	2	
3.6.27	When client had question OE/CM could not answer, OE/CM told the client that s/he would find out and get back to the client	SI/O	NA	0	1	2	
3.6.28	OE/CM did risk assessment with the client and helped client to make risk reduction plan that reflected the assessment	SI/O	NA	0	1	2	
Referral to IHS Site and DIC							
3.6.29	OE/CM provided accurate and complete information about IHS- STI, CT, EPC and CHBC services to the client. OE/CM explained that all the services available in the IHS are free of cost and will be referred to other service sites if services are available	SI/O	NA	0	1	2	
3.6.30	OE/CM explained location, operating hours and contact information for the DIC/IHS site	SI/O	NA	0	1	2	
3.6.31	OE/CM explained the services and facilities available from the DIC (TV, video, movie mania, educational and skill building session on various topics, IEC, creative creation, painting, rest, bath, first aid, basic make-up...)	SI/O	NA	0	1	2	
3.6.32	OE/CM explained promotional package for DIC visitors (reward for frequent visitors and first visitors, beauty coupon)	SI/O	NA	0	1	2	
3.6.33	OE/CM explained the meaning of 5 petals of the BISHWAS logo (Reliable, Dependable, Friendly, Secure and Comfortable) to highlight the quality of services available from DIC/IHS site	SI/O	NA	0	1	2	
3.6.34	OE/CM explained the reasons and importance of monthly STI check ups for FSWs and quarterly for clients	SI/O	NA	0	1	2	
3.6.35	OE/CM explained the approximate time it would take, the risk assessment questions and the types of examination to be done by the STI doctor/nurse	SI/O	NA	0	1	2	
3.6.36	OE/CM explained the importance of the 4 Cs (Consistent and correct Condom use, complete treatment, counseling/education, contact tracing (partner's notification) and treatment) during STI treatment	SI/O	NA	0	1	2	
3.6.37	OE/CM explained the reasons for and importance of quarterly CT service utilization	SI/O	NA	0	1	2	
3.6.38	OE/CM explained the possible results of CT and its interpretations (if –ve: can be assured and protected from HIV in future by adopting safer behaviors and	SI/O	NA	0	1	2	

Indicators							
	if +ve: can access to care, support and treatment and can protect their partners from HIV) while referring for CT						
3.6.39	OE/CM explained the availability of care, support and treatment services such as EPC, CHBC and support groups through ASHA/FHI, ART, CBPMTCT through government and crisis care and support groups from other NGOs	SI/O	NA	0	1	2	
3.6.40	OE/CM explained the reward package such as a beauty coupon to those who attended IHS site	SI/O	NA	0	1	2	
3.6.41	Time for outreach session was adequate	SI/O	NA	0	1	2	
3.6.42	OE/CM provided IEC materials to the client	SI/O	NA	0	1	2	
3.6.43	OE/CM performed a condom use demonstration using a dildo (assess condom use skill demonstrated by OE/CM and client)	SI/O	NA	0	1	2	
3.6.44	OE/CM provided condoms to the client based on need	SI/O	NA	0	1	2	
3.6.45	Action points were identified at the end of the session	SI/O	NA	0	1	2	
3.6.46	OE/CM summarized the key points and action items made during the outreach session	SI/O	NA	0	1	2	
3.6.47	OE/CM set the date, time and location of the next visit	SI/O					
3.6.48	OE/CM expressed his/her gratitude for time given and information shared by the clients OE/CM bid farewell as appropriate	SI/O	NA	0	1	2	
After the Visit		SI/O	NA	0	1	2	
3.6.49	OE/CM recorded all the data/information in appropriate forms/formats (consistent and coherent with standard forms/formats) (Daily diary, form 1 and form 2, TIP)	MI/SI/O	NA	0	1	2	
3.6.50	OE/CM reviewed the outreach session to identify strengths and weaknesses	SI/O	NA	0	1	2	
4	**Community Events**						
4.1	Community event was well planned (schedule), prepared (materials/venue arrangements) and conducted Supporting documents of the event (schedule, meeting minute, materials, attendance sheet and brief report) were in place	MI/SI/O	NA	0	1	2	
4.2	Community events were planned, prepared and conducted in coordination and collaboration with MARP, local stakeholders (CBO/NGO/GO), local authorities and celebrities	MI/SI/O	NA	0	1	2	

Indicators						
4.3 Community event was conducted in an edutainment way. Health education messages were adequately and appropriately interspersed /mixed/linked in and balanced with entertainment.	SI/O	NA	0	1	2	
4.4 Community event was conducted in an interactive way. Audience were engaged in interaction (asked questions, raised issues, concerns, shared feelings and the questions were responded appropriately, accurately and timely)	SI/O	NA	0	1	2	
4.5 Location, timing, venue, setting of the event were all appropriate and conducive to the audience considering the local circumstances	SI/O	NA	0	1	2	
4.6 Contents, especially health education, were appropriate to the local needs and context and were adequate, accurate and up to date	SI/O	NA	0	1	2	
4.7 Appropriate IEC and promotional materials including condoms were displayed and distributed	SI/O	NA	0	1	2	
4.8 Action points were identified and planned for implementation	SI/O	NA	0	1	2	
4.9 Audience was referred for relevant services and/or additional information	SI/O	NA	0	1	2	
4.10 Meeting was conducted among the organizer of the event to review and reflect strengths and weaknesses	SI/O	NA	0	1	2	
5 Drop In Centers (DIC)						
5.1 DIC was located in accessible and appropriate location for the MARP	O	NA	0	1	2	
5.2 Service areas are easy for clients to find and access, DIC operating hours are appropriate for the clients and the DIC opens on time	MI/SI	NA	0	1	2	
5.3 The DIC signboard with BISHWAS logo and branding strip and IEC materials are appropriately and visably displayed	O	NA	0	1	2	
5.4 Staff is fully trained, competent and available to deal with clients in a responsive manner	MI/SI/O	NA	0	1	2	
5.5 DIC rooms, toilets and premises were neat , clean and clutter free	O	NA	0	1	2	
5.6 IEC materials including AV materials and condoms were available	O	NA	0	1	2	
5.7 IEC materials were displayed appropriately	O	NA	0	1	2	
5.8 Clients are greeted warmly followed by a good morning/afternoon or Namaste or in local custom (see strategic goal# 1 of BISHWAS manual)	SI/O	NA	0	1	2	
5.9 Monthly DIC activity plan is prepared and displayed	SI/O	NA	0	1	2	

Indicators						
(see strategic goal # 2 of BISHWAS manual)						
5.10 The DIC is equipped with the minimum set up criteria and requirements (see strategic goal#3 of BISHWAS manual)	MI/SI/O	NA	0	1	2	
5.11 Information provided on the scope of the services provided is accurate, clear, concise and up-to-date (see strategic goal#5 of BISHWAS manual)	SI/O	NA	0	1	2	
5.12 Clients are dealt with promptly and fairly through suitable queuing arrangements	SI/O	NA	0	1	2	
5.13 Waiting clients are acknowledged while still giving priority to the client being dealt with	SI/O	NA	0	1	2	
5.14 Staff personalizes their dealings with the client by introducing themselves and by using (if appropriate) the client's name	SI/O	NA	0	1	2	
5.15 Staff is tidy and are dressed appropriately	O	NA	0	1	2	
5.16 Staff is genuinely friendly and courteous when providing services	SI/O	NA	0	1	2	
5.17 Attentive interest is shown by asking questions and listening to the answers (Don't be too attentive or pushy though, as clients may get annoyed)	SI/O	NA	0	1	2	
5.18 Staff is fully knowledgeable about all services available	SI	NA	0	1	2	
5.19 Clinet interactions end by saying good bye and asking them to visit again	SI/O	NA	0	1	2	
5.20 Daily DIC log sheet and other recording and reporting formats are up to date	SI/O	NA	0	1	2	
5.21 Unnecessary, irrelevant or information which is already in the records were not asked for (except for verification purposes)	SI/O	NA	0	1	2	
5.22 When using records, ensure the client that all information remains confidential	SI	NA	0	1	2	
5.23 Simple, understandable language with no technical jargon, codes or abbreviations is used	SI/O	NA	0	1	2	
5.24 The client is treated with genuine empathy, courtesy, patience, honesty and fairness at all times	SI/O	NA	0	1	2	
5.25 When faced with a complaint from a client, staff listens in order to understand the issue and to resolve—staff does not jump to conclusions or become defensive	SI/O	NA	0	1	2	
5.26 Input/feedback is obtained from beneficiary groups periodically to ensure that services are accessible and acceptable. This type of input /feedback is used to improve the services. Suggestion box is kept to collect suggestions/feedback	MI/SI/O	NA	0	1	2	

Indicators						
5.27 DIC operator explained the meaning of 5 petals of BISHWAS logo (Reliable, Dependable, Friendly, Secure and Comfortable) to highlight the quality of services available from DIC/IHS site	SI/O	NA	0	1	2	
5.28 DIC log sheet, summary sheet and other records were stored in a secure filing cabinet and only specifically designated staff have access to this During hours of operation, files are not left in areas where clients and non-authorized staff members can readily access them	SI/O	NA	0	1	2	
6 Referral Relationships						
6.1. The organization associates with a range of supportive networks or complementary partner organizations	MI/SI	NA	0	1	2	
6.2. The partner organizations provide useful complementary services to target groups	MI/SI	NA	0	1	2	
6.3. Referral systems with service delivery networks are operational and the target groups use them	MI/SI	NA	0	1	2	
6.4. The organization can provide recent examples of target group experiences with referral partners	MI/SI	NA	0	1	2	
6.5. The organization can provide examples of assisting target group members access services from referral partners or intervening based on negative feedback	MI/SI	NA	0	1	2	
6.6. Information covering referral services is available for clients	MI/SI	NA	0	1	2	
6.7. Referral forms for relevant services are available and used	MI/SI/O	NA	0	1	2	
6.8. Clients are actively encouraged to use available prevention, care and support services	O	NA	0	1	2	
6.9. The organization is actively working with referral partners to improve services for target groups	MI/SI	NA	0	1	2	
6.10. The organization accepts and incorporates external feedback and responds to urgent issues or requests identified by stakeholders	MI/SI	NA	0	1	2	
6.11. The organization allocates time to important networking and partnering activities	MI/SI	NA	0	1	2	
6.12. Partnerships and networks effectively reduce overlap of services	MI/SI	NA	0	1	2	
6.13. The organization actively follows up experiences of individuals with referral partners	MI/SI	NA	0	1	2	

TOTAL SCORE:	/117			

Note: MI= Management Interview
SI= Staff Interview
O= Observation
EI= Exit Interview
NA=Not Applicable

0= No
1= Yes Partially
2= Yes

Annex 23: Supervision Issues and Action Matrix

Name of IA:
Name of Project:
Name of OE/CM: Working Area:
Issue and Action Matrix:

SN	Date of Supervision Visit	Supervised by	Issues	Action	Support (What/whom)	Deadline	Status

Annex 23 A: Daily Diary

District: **Unit:** **Working area:** **Year: 2010/2011 (please put tick marks in the appropriate year)**

SN	Date	Name of the place visited	Name of the person visited	Address (only if it is a newly identified MARP)	MARP (please put √ mark)		Code #	Age (only if it is a newly identified MARP)	Type of visit (please put √ mark)		Condom distribution (number)	Education given on (please put √ mark)				Time spent in educating (in minute)	Referral (please put √ mark)				If new, was s/he contacted before (please put √ mark)
					New	Old			One-on-one	In group		HIV	STI	Condom	Others		STI	VCT	Care / support	Other	
Important activities of the day (explain in brief if above mentioned activities does not cover your work on the day):																					
Supervisor's comment (If checked):																					

Annex 23 B: Daily Log Sheet for CM/OE Outreach Activities

Name of Organization:

Name of Staff: **Month:** **Year:**

Type of Staff: CM/OE (Circle one)

Working Area: **Target Group Code:**

S.N	Date	Contacts		# Condom distributed	Referral				Remarks
		One-on-one	Group		STI	VCT	CST	Other	
	Total								

Note: Please use one form per TG

Annex 23 C: Prevention Project Indicator Form (PIF)

Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS (ASHA)
Managed By Family Health International / Nepal
Project Indicator Form (PIF)
HIV Prevention

Implementing Agency:
District:
Month: **Year:**
Program Technical Area: Prevention
FCO Number:

S/N	Indicators	Target Groups																				Total by this month			
		Clients of FSWs							IDUs		Migrants		Spouse of		PLHA		MSMs	Transgender	Others					
		FSWs	TW	Rickshaw Pullers	Uniform Services	Labors	Others	Total	Male	Female	Male	Female	Male	Female	Male	Female			Male	Female	Male	Female	Other	Total
1	Number of new people contacted in HIV/AIDS prevention							0													0	0	0	0
2	Number of individuals reached with peer or outreach							0													0	0	0	0
3	Number of CM/PE contacts for one-on-one education for HIV/AIDS prevention							0													0	0	0	0
4	Number of OE contacts for one-on-one education for HIV/AIDS prevention							0													0	0	0	0
5	Number of group contacts (CM/PE and OE)							0													0	0	0	0
6	Number of community events																							
7	Number of people reached in community events							0													0	0	0	0
8	Number of STI referrals made							0													0	0	0	0
9	Number of VCT referrals made							0													0	0	0	0
10	Number of CST referrals made							0													0	0	0	0
11	Number of other referrals made							0													0	0	0	0
12	Number of condoms distributed							0													0	0	0	0
13	Number of individuals visiting outreach centers							0													0	0	0	0
14	Number of visits in the outreach centers							0													0	0	0	0
15	Number of members participated in RLGs							0													0	0	0	0
16	Number of new members joined RLGs							0													0	0	0	0
17	Number of Radio broadcasts																							
18	Remarks:																							

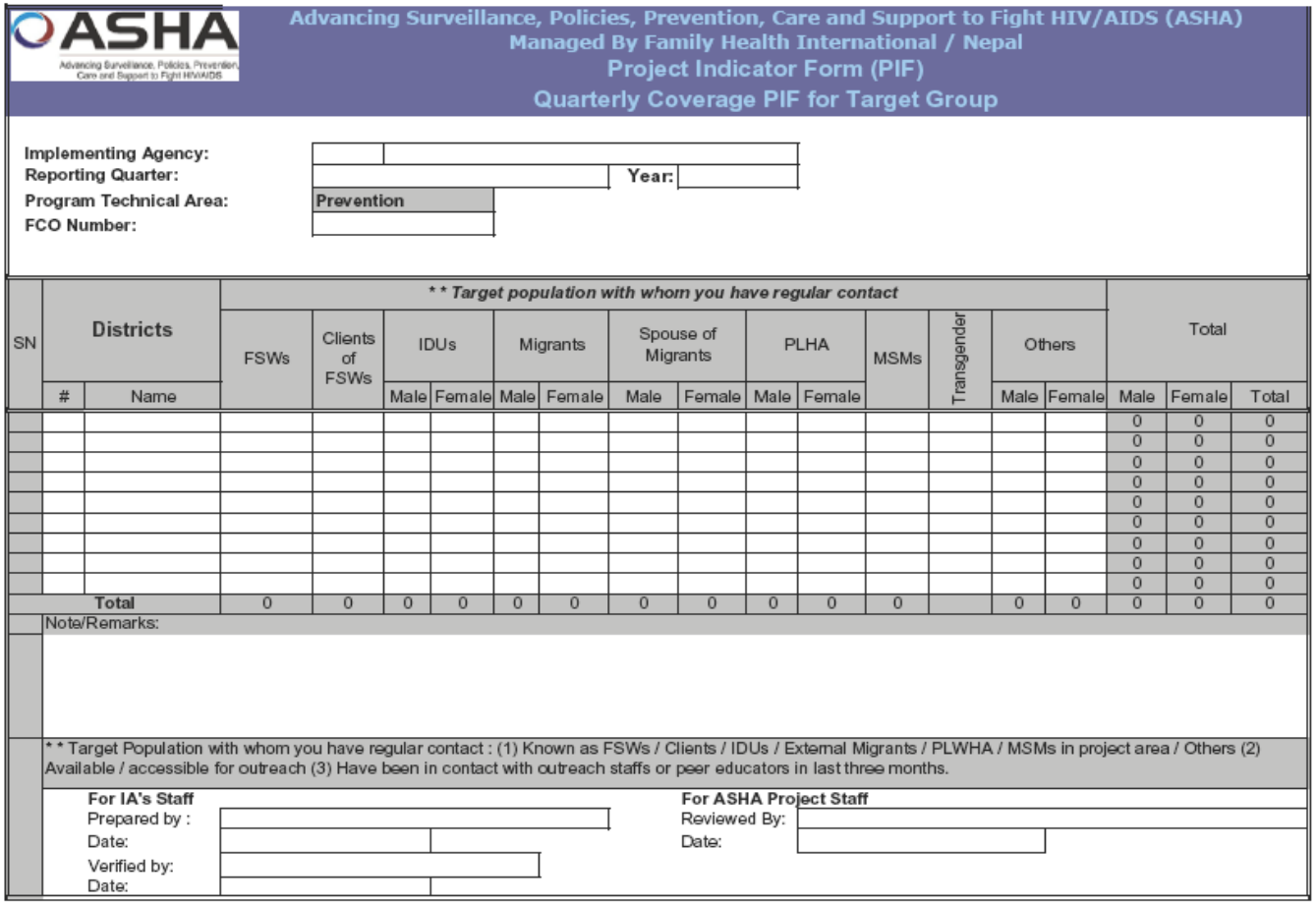
For IA's Staff only

Prepared by :
Date:
Verified by:
Date:

For ASHA Staff only

Reviewed By:
Date:

Annex 23 D: Quarterly Coverage PIF



Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS (ASHA)
Managed By Family Health International / Nepal
Project Indicator Form (PIF)
Quarterly Coverage PIF for Target Group

Implementing Agency:
Reporting Quarter: **Year:**
Program Technical Area: Prevention
FCO Number:

SN	Districts		** Target population with whom you have regular contact														Total		
	#	Name	FSWs	Clients of FSWs	IDUs		Migrants		Spouse of Migrants		PLHA		MSMs	Transgender	Others		Male	Female	Total
					Male	Female	Male	Female	Male	Female	Male	Female			Male	Female			
																	0	0	0
																	0	0	0
																	0	0	0
																	0	0	0
																	0	0	0
																	0	0	0
																	0	0	0
																	0	0	0
																	0	0	0
	Total		0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0

Note/Remarks:

** Target Population with whom you have regular contact : (1) Known as FSWs / Clients / IDUs / External Migrants / PLWHA / MSMs in project area / Others (2) Available / accessible for outreach (3) Have been in contact with outreach staffs or peer educators in last three months.

For IA's Staff
Prepared by :
Date:
Verified by:
Date:

For ASHA Project Staff
Reviewed By:
Date:

ASHA Project
Family Health International (FHI)
Nepal Country Office
PO Box: 8803, Kathmandu
Tel: 01-4437171, Fax: 01-4417475
Email: fhinepal@fhi.org.np
Website: www.fhi.org

Family Health International

AMDA-Nepal