

PEER LED OUTREACH AT SCALE: A Guide to Implementation



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PEER LED OUTREACH AT SCALE:

A Guide to Implementation

Based on the Experience of Avahan, the India AIDS Initiative
of the Bill & Melinda Gates Foundation



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INTRODUCTION

Peer led outreach is an approach to providing large-scale HIV prevention services to populations most at risk of infection (high-risk groups). These groups are often difficult to reach due to their poor socioeconomic status, low level of education, and social marginalization. However, trained high-risk individuals can reach their peers effectively using mapping and micro-planning tools to plan and track service delivery at the individual level. These tools position high-risk individuals as leaders and managers of service provision.

The tools described in this guide have been developed as part of Avahan, the India AIDS Initiative of the Bill & Melinda Gates Foundation. In four southern and two northeastern states of India where there is a high prevalence of HIV infection, Avahan's 168 local partner NGOs (overseen in each state by a lead implementing partner) provide HIV prevention outreach to high-risk groups.* The program has expanded rapidly to cover approximately 221,000 female sex workers, 81,000 high-risk men who have sex with men and transgenders, and 18,000 injecting drug users.**

This guide is a distillation of the methods used by Avahan to implement peer led outreach with high-risk groups. It defines the roles and responsibilities of peer outreach workers, outlines peer training requirements, describes how mapping and micro-planning tools work, and explains the organizational infrastructure used by Avahan to manage and scale up peer led outreach. Avahan has developed approaches and tools that vary significantly according to diverse community contexts and programming needs, and the examples in this guide reflect the variations and lessons learned.

Avahan's publication, *Managing HIV Prevention from the Ground Up: Peer Led Outreach at Scale in India* (2009), describes the broader context of the Avahan initiative, the history of Avahan's development and implementation of peer led outreach, and results and lessons learned from the program. The document is available at www.gatesfoundation.org/avahan.



* Because the structure and terminology of HIV prevention programs in other countries may differ from Avahan's, this guide henceforth uses the term "regional or statewide partner" to refer to what Avahan calls its lead implementing partners, and "local NGO" or "NGO" to refer to the local partner NGOs in each town that perform direct outreach.

** Definitions of many terms used in this guide can be found in the glossary.

PEER LED OUTREACH

What is a peer outreach worker?

A peer outreach worker (or peer) is a member of a high-risk group recruited and trained by an NGO to provide HIV prevention outreach to other members of the same group.* Each peer usually works in a small locality, making systematic and regular contact—both one-to-one and in groups—with an average of 50 high-risk individuals (depending on the setting, the number may range from 35 to 85). She** provides them with a "package" of outreach services that typically includes information and counseling about HIV prevention; distribution of condoms or clean needles and syringes; and referrals to other available services such as STI clinics, HIV counseling and testing centers, oral substitution therapy for injecting drug users, and drop-in centers established by the HIV program.***

Peers work primarily among their social network (i.e., among high-risk individuals whom they know and with whom contact is frequent, natural, and informal). They also actively plan and conduct outreach with newcomers to their outreach area.

Peers plan, analyze, and monitor their work using the methodologies of mapping and micro-planning. These are explained in detail in the section, "The Components of Peer Led Outreach," page 14. Although peers are supervised by staff members of the local NGO, micro-planning enables them to manage their own work and to lead outreach. They use the data that they themselves have recorded to set outreach priorities and develop strategies to address the risk and vulnerability factors faced by each of the individuals in their caseload.



* In this guide, the terms "peer outreach worker" and "peer" are used interchangeably.

** While peers may be female, male, or transgendered, the majority of Avahan peers are female, and for simplicity they are referred to in this guide using feminine pronouns.

*** Drop-in centers are described in the glossary.

Why is peer led outreach important for HIV prevention?

By connecting with hard-to-reach groups on the ground, peer outreach workers can improve uptake of clinical and social support services and are thus a critical resource for providing effective HIV prevention programs at scale. Peers are able to identify and understand the factors that put community members at risk for HIV and STIs, and they have the access and influence that make behavior change possible. Developing the capacity of high-risk individuals to serve as peers creates a number of benefits for an HIV prevention program:

- **Breadth of outreach:** It enables outreach to diverse communities of high-risk individuals in varied geographic areas.
- **Access:** It strengthens outreach to communities that are unlikely to seek services on their own, due to poor self-esteem, stigma, or marginalization. In addition, as peers take on aspects of outreach that were previously the responsibility of NGO staff, they become the face of the program to the community that is served.
- **Management:** It makes the best use of peers' credibility and insider knowledge and their understanding of risk. This is most effective when combined with training and tools that enable peers to collect and analyze data, and then use the information to manage their own work.
- **Sustainability:** It helps to enhance leadership among high-risk individuals, strengthens community ownership of programs, and fosters problem-solving within high-risk communities. Peers may begin by doing outreach within their community and progress to supervise other peers, become full-time staff members of the NGO that is coordinating the intervention, or lead other community actions beyond the program.
- **Empowerment:** It gives high-risk individuals the skills and impetus to participate in more general advocacy on issues of importance to their communities, such as access to health and educational services, and freedom from discrimination and violence.

THE ROLE OF PEERS AND PREPARING THEM FOR THE JOB

What do peers do?

A basic scope of work or job description should be developed for peer outreach workers. Job descriptions are similar for peers working with female sex workers, high-risk men who have sex with men and transgenders, and injecting drug users, with some variations for each group, and include the following components.

Mapping

- Once population size estimations have been conducted to establish the total denominator of high-risk individuals (the number that the program will aim to serve through outreach and services), peers regularly conduct two kinds of additional local mapping exercises, which keep outreach up to date and ensure complete coverage. A hotspot map visually represents the locations of high-risk individuals within the peer's assigned area. Social network mapping shows the connections between peers and other high-risk individuals within a hotspot, allowing peers to be assigned non-overlapping groups for outreach. (See the section, "Mapping," on page 15 for more detail.)

Outreach

- Perform weekly outreach to an average of 50 high-risk individuals, spending an average of four hours a day, six days a week on outreach (depending on the geographic area, and the typology of the high-risk group, a peer's outreach group may range in size from 35 to 85 individuals).
- Conduct face-to-face discussions with her outreach group, primarily one-on-one but sometimes also in small groups.
- Provide information and services according to the minimum package established by the program. (See the detailed description in the section, "Outreach Activities," on page 14.)

Micro-planning

- Assess risk and vulnerability factors and outreach needs for each high-risk individual in her caseload, and prioritize outreach accordingly.
- Record details of outreach with each high-risk individual on a daily or weekly tracking sheet.
- Transfer monitoring information on each high-risk individual to a monthly tracking sheet (with assistance from NGO staff where literacy is an issue).
- Participate in weekly meetings with other peers and NGO staff to review records, assess progress, and prioritize the work for the following week.

How to select peers

Potential peers can be identified from the outset of program planning. The NGO engages high-risk individuals from the local community to conduct initial population size estimates. During the course of these exercises, the high-risk

individuals can also help identify potential peers to participate further in the program. Good potential peers are those who:

- Demonstrate a serious commitment to the population size estimation process
- Reflect the typologies and age groups of high-risk individuals revealed by the exercises
- Are knowledgeable about a hotspot within the NGO's service area and acquainted with a significant number of the high-risk individuals who live or work there
- Are well recognized and respected by other members of their high-risk group
- Are open-minded and willing to learn
- Demonstrate initiative
- Are willing to work regular hours for the program on an ongoing basis (with a fixed honorarium)
- Are willing to commit to the program goals, and to model behaviors such as condom usage and clinic attendance
- Are at least 18 years old

Training peers

Training content

While training for peer outreach workers may vary from region to region—and even between local NGOs—each curriculum typically contains the following elements:

Program overview

- Goals and objectives of the HIV prevention program
- Goals and objectives of peer led outreach
- Role and responsibilities of peers
- Code of conduct (this can be developed or reviewed with peers at initial training sessions; see page 13 for more details)

Mapping

- Hotspot and social network mapping is integrated into the training as a participatory exercise that builds rapport among peers and NGO staff, strengthens peers' understanding of the program, and prepares them for outreach work.

Outreach skills

- Interpersonal communication skills
- Condom negotiation skills
- How to identify and describe symptoms, disease processes, and treatment of STIs, HIV, and AIDS
- How to give a condom demonstration
- How to make referrals to the clinic
- How to build a sense of community and support in high-risk groups

Micro-planning

- The use of specific planning and record-keeping tools to plan, prioritize, and analyze outreach (when training is conducted for the first time, micro-planning tools can be designed with peer input)
- Understanding risk and vulnerability, and applying knowledge of vulnerability factors to understand a person's risk profile

Advanced training

As the program develops, additional training may cover topics such as:

- Advanced communication and counseling skills
- Dealing with stigma and discrimination
- Building self-esteem
- Community mobilization
- Establishment and organizational development of community-based organizations (CBOs)
- Empowerment through knowledge of the law and legal rights
- Violence and crisis intervention
- Care and support for people living with HIV and AIDS
- Other health issues related to the intervention (e.g., tuberculosis screening and treatment, syphilis screening and treatment, oral substitution therapy)

Curriculum design

Avahan partners have developed their own detailed curricula for training peers. (Two examples of a curriculum outline are given in the Appendix.) The regional or statewide partner responsible for the peer led outreach program should ensure that any curriculum and materials used are compatible with the scope of the program.

Once the program becomes established, trained peers can be involved in refining the curriculum. Trainers may solicit peer trainees' feedback at the end of each training session and consult experienced peers to identify any gaps in the training based on their work in the field.

A participatory training methodology will build knowledge and skills, and foster relationships between the NGO staff and the peers. The curriculum design should also take into account the social and educational profile of the peers and staff to be trained:

- Peers may have little or no formal education.
- Peers may have low literacy or be illiterate.
- Peers may be unaccustomed to formal training or methods such as small group work.
- Peers and NGO staff may not be accustomed to participating actively, giving input, or sharing their opinions.
- NGO staff may have prejudices about high-risk groups' lifestyles and behaviors which need to be addressed.

Organization of the training

Providing peer training jointly to peers and the staff of the local NGO helps them to build rapport and confidence, develop an understanding of their respective roles, and collaborate in the development of management tools such as a code of conduct, indicators for measuring peer performance, and micro-planning forms.

Training may be provided by the regional or statewide partner, with follow-up provided by the local NGOs. This helps to ensure a uniform standard and quality of training and set standards for participatory work between peers and NGO staff. An alternative model is for NGOs to provide the training themselves, which is a less expensive approach. In this case it is important to have a staff member of the regional or statewide partner facilitate in order to maintain consistency.

This first training group is often relatively large, and it may therefore prove more efficient and cost-effective to organize a collective training using regional or state resources. The initial training may be held at the offices or drop-in center of one local NGO, with subsequent training rotating among other NGOs.

As the program develops and is scaled up, a regional- or state-level training organization may conduct a training of trainers for staff from each local NGO, as well as for peers who have demonstrated an aptitude for leadership and training. As a second tier of trainers, these staff and peers can then conduct further peer training for local NGOs. If the number of incoming peers at each NGO is insufficient to warrant training at each location, regional training is preferable.

Code of conduct

Each local NGO should establish a code of conduct for peers in consultation with them. This can be done through group discussion during the initial training of peers, in which peers are shown model codes and/or invited to suggest components of the code, with facilitation and support from trainers. Once established, the code of conduct should be discussed as part of further peer trainings so that all peers understand each element and are committed to upholding it.

Sample Code of Conduct for Peer Outreach Workers

- I maintain the confidentiality of the individuals I serve.
- I work for the agreed number of hours per day for the program.
- I do not entertain customers while working for the program.
- I am not intoxicated or under the influence of drugs while working for the program, and I do not carry any alcohol or drugs with me while working for the program.
- I do not get involved in fights because of drunkenness or drugs at any time, whether working for the program or not.
- I respect the opinions of others and abide by program decisions.
- I try hard to understand others and be friendly with them.
- I am open to learning new things and sharing what I have learned with others.

Remuneration

Remuneration of peers within a national HIV program may be subject to the law or regulations of the country or state in which an HIV prevention program is operating, but international norms suggest compensation is appropriate. In India, Avahan peers are not formal employees of the NGO with which they work, but they receive an honorarium in recognition of the fact that the time they give to their work as peers means a loss of income from their regular work. The honorarium also serves as a kind of positive acknowledgment of peers' work and helps to retain them in the program.

Ideally, the state or regional government and any donors should agree on a standard honorarium covering the largest geographic area possible, prior to launching peer led outreach. It can become problematic if programs operating in the same area offer differing amounts. Avahan established pay at the general levels set by state governments for similar work, currently in a range equivalent to US \$20-\$30 per month.

THE COMPONENTS OF PEER LED OUTREACH

Peer led outreach relies on two methodologies: mapping and micro-planning. Mapping precedes outreach activities and identifies and defines the people to be reached locally by each peer. Micro-planning is the main tool peers use to organize outreach. It allows peers to refine and strengthen their outreach using a visual chart to record and easily analyze data on the high-risk individuals they have contacted and the specific needs of each one. These two methodologies are described in detail following the outline of outreach activities.

Outreach activities

Each peer delivers a standardized service package, which ensures a minimum level of outreach and allows comparison of data across the program. The essential elements of the package are delivered through a weekly one-to-one meeting with each high-risk individual. This discussion may take place at the hotspot, at another location preferred by the high-risk individual, or at the program's drop-in center. It takes the form of an informal conversation, but the peer systematically incorporates some or all of the following components:

- Referring and/or accompanying high-risk individual to clinic for regular quarterly check-up and STI services, and to drop-in center for social support and further information
- Distributing condoms (free or socially marketed)
- Demonstrating correct condom use

During each outreach visit, a set of standard indicators is recorded for each contact:

- Health care service utilization (i.e., clinic visits, hospital visits)
- Condom use (number of condoms requested)
- STI symptoms
- Client load (reported number of sex worker's clients per week)

As the program matures, the service package may be expanded to include:

- Risk counseling (does the number of condoms distributed adequately cover the needs of the individual; is the individual exhibiting STI symptoms in need of treatment; are there any particular risks or vulnerabilities that need to be addressed?)
- Meeting with regular partners of high-risk individuals
- Group communication session (e.g., on communication with partners, or safer sex negotiation skills)
- Screening for TB symptoms
- Ensuring regularly scheduled treatment is obtained (e.g., for TB or reactive syphilis serology)
- Encouraging membership in community groups for social support and community empowerment

Indicators may be expanded in more mature interventions to track new sex workers in the area and ensure they are contacted shortly after arrival. Additionally, more in-depth information about the risk and vulnerability of peers' outreach groups may be captured by including:

- Experience of violence (reported violence from regular partner, pimps, police, and local thugs)
- Alcohol or substance abuse (this may be reported by the individual or by other colleagues)

In order to build trust and facilitate communication regarding the HIV program and the needs of the high-risk community, peers may also hold informal meetings with stakeholders in the community such as brothel owners, pimps, and madams.

Mapping

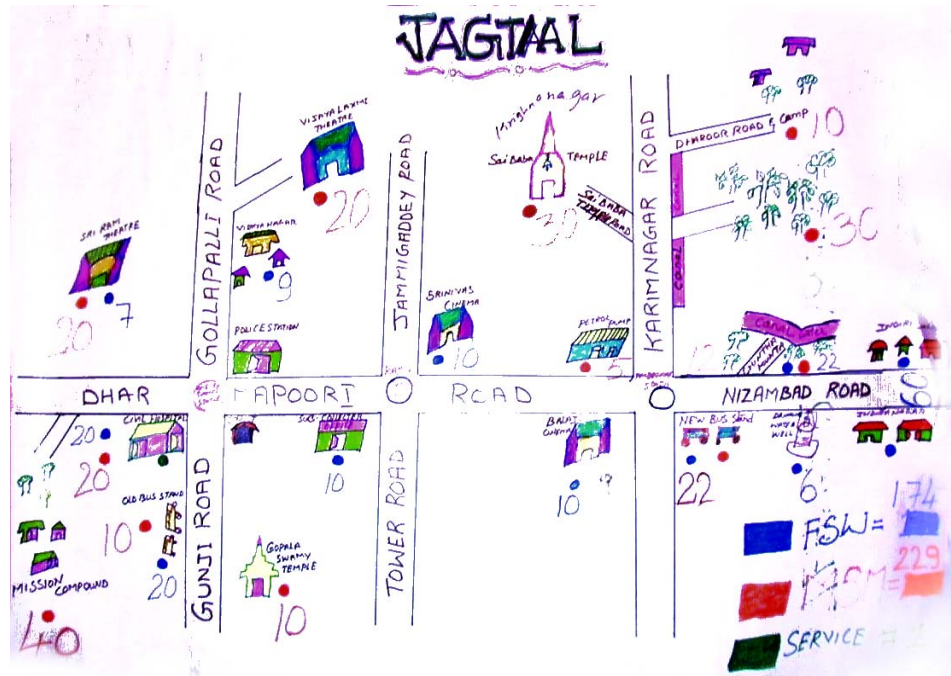
Mapping takes place in two stages: hotspot mapping and social network mapping. Peer and NGO staff outreach workers, supported by a facilitator, first map the hotspots where they will work. A hotspot map is a simple pictorial representation of an area where there is a concentration of high-risk behavior. It includes streets, buildings, major features such as railways, bus, and train stations, cinemas, police stations, and locations where condoms are available (Figure 1). The peer also identifies the location and number of high-risk individuals within the hotspot. Removable stickers to represent high-risk individuals are useful, as they can be moved or removed to update the maps, and may be color-coded for typology (e.g., brothel-based sex worker, street-based sex worker).

In the second stage, peers create maps of their social networks within their beat. These non-topographical maps list the names of their friends and acquaintances in the high-risk communities, and use symbols or colors to mark their typologies and baseline risk characteristics (e.g., number of clients per month), and the connections between them (Figure 2). Examined together, hotspot and social network maps provide a visual representation of the total high-risk population across several locations. They enable outreach supervisors and peers to assign outreach groups to peers at the sites where they know the most people, ensuring that each high-risk individual is covered through outreach and there is no overlap in coverage.

Peers revise hotspot and social network maps on a regular basis (usually every six months) to track changes, such as new high-risk individuals who should be assigned to a peer for initial outreach, others who have left the area, and peers' own expanding social networks. More frequent revisions may be needed when there is high mobility among high-risk individuals.

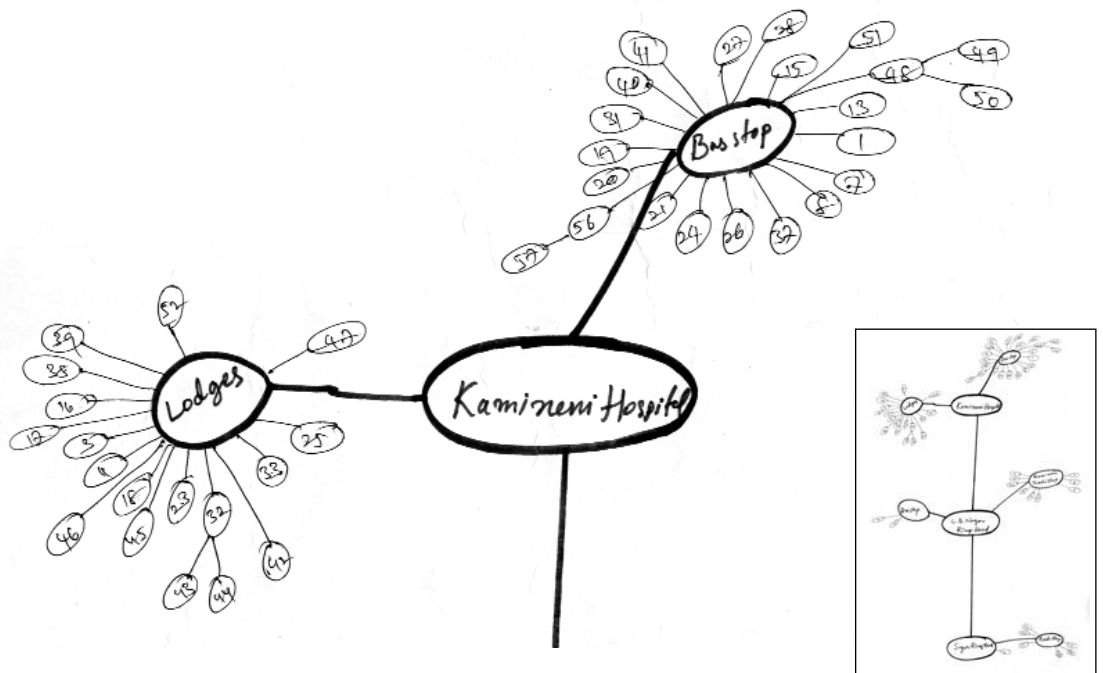


Figure 1: Hotspot Map



Source: Alliance for AIDS Action Project, International HIV/AIDS Alliance

Figure 2: Social Network Map



Source: Alliance for AIDS Action Project, International HIV/AIDS Alliance

Micro-planning

Micro-planning enables peers to record individualized data about the people with whom they do outreach, so that they can analyze their work and plan their future outreach. The peers use daily, weekly, and monthly tracking tools, which can be developed with their participation at the district or regional level, and field tested at the local level. In some instances each local NGO may develop its own tracking tools to take into account local preferences and needs, but the data points gathered must correlate with any data standards established by the program at the regional or state level.

Several examples of tracking tools are shown below to demonstrate how micro-planning works. The examples highlight different aspects of the micro-planning methodology, showing:

- How these tools may be designed and formatted to capture information so they can be easily used by low-literate or illiterate peers (Figures 3-6)
- How assessment of risk factors can be incorporated into outreach prioritization (Figures 7-8)
- How planning and the results of outreach can be "scored" for the purpose of analysis (Figures 8-9)


Figure 3: Daily Tracking Form

Source: Aastha Project, Family Health International

Symbols and pictures are used to define the types of outreach being performed, so that low-literate or illiterate peers may use the form.

- The red circles are crossed through by the peer to indicate a new contact (a high-risk individual who has not previously been profiled by the program). Blue circles indicate that a service has been provided to a repeat contact (i.e., to an already profiled high-risk individual). It is particularly important to track this information where high-risk populations are highly mobile and individuals are frequently entering or leaving the program.
- Since names are not recorded directly on the tracking sheet, the peer meets with her supervisor at least every two days in order to identify the contacts while they are still fresh in her mind, and the information is transferred to the monthly tracking form (Figure 4), where names (or pseudonyms) are included.

Figure 4: Monthly Tracking Form

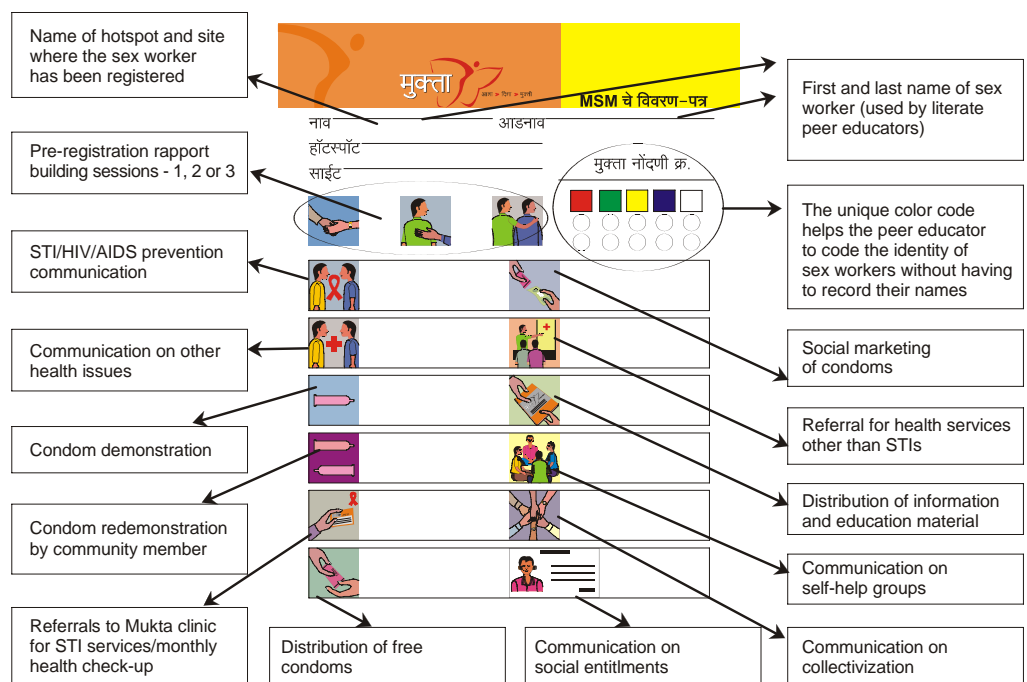


Individual Tracking Sheet for KP																
Name of CRW		Sangeeta	Name of Peer		Manisha		Month - Mar-09									
ID No.	Area	Nickname	Contact	1-1 Sessions	1-G Sessions	Visited clinic for health services	Visited Camp for health services	Received condoms				Attended Aastha Gat Meeting	Any incidences faced			
								Week 1	Week 2	Week 3	Week 4		Arrest	Harrasment	Other Emerger	
2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	
100122	Ratan Medical Gali	Rupa	8, 15, 29	5 th , 28 th				10		15						
100001	Shop	Sharmila	17 th , 27 th		23 rd	27 th		5	10			23 rd				
100002	Shop	Simran		15 th			17 th					23 rd				
100003	Shop	Priya		10 th	28 nd							21 st		21 st		
100004	Shop	Shobha	21 st , 30 th		7 th			40	30	20		01 st				
100005	Shop	Vishaka		24 th			17 th					3				
100006	Near Kirana Shop	Pooja	22 nd		21 st					4						
100007	Near Tee Hotel	Rama		5 th				5								
100008	In Dhabba	Dhabba	11 th		7 th			0				01 st				

Source: Aastha Project, Family Health International

The form records the names of each of the high-risk individuals assigned to a peer. (The initials "KP" stand for Key Population, a term used by the Aastha Project, which means the same as high-risk individual.) Completing this form requires a degree of literacy, and NGO staff can help the peer transfer data from her daily records to it.

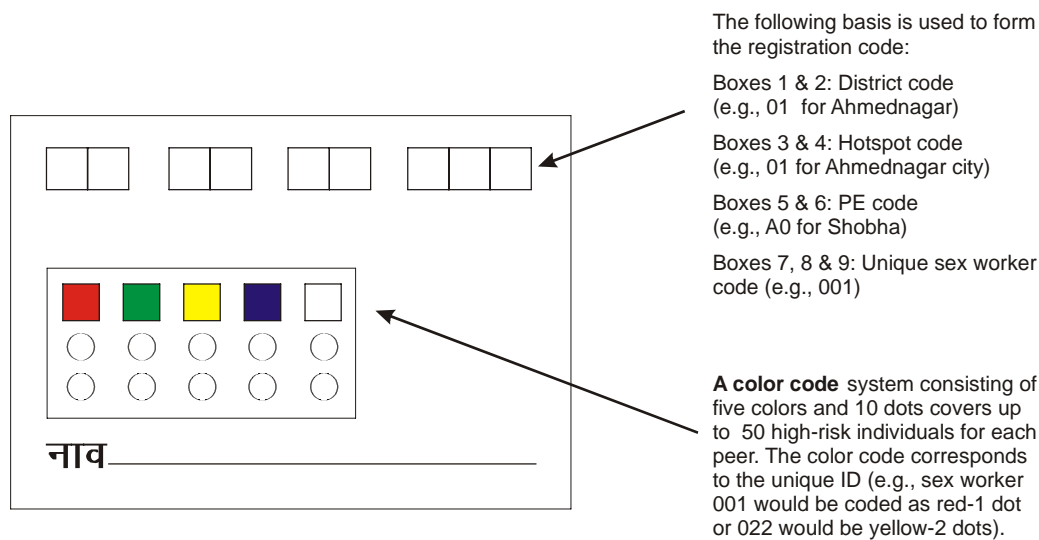
Figure 5: Daily Tracking Form



Source: Mukta Project, Pathfinder International

In most states Avahan has developed a palm-sized flipbook, small enough for a peer to slip inside her clothes, with a page for each one-to-one interaction with a sex worker. Each page of the flipbook has space to identify the sex worker, and to note the type of interaction (e.g., an initial rapport-building encounter), topics covered in the discussion, and any actions taken (e.g., distribution of free or socially marketed condoms, referral for health services). The symbols for each of these elements remind the peer of what should be included in the outreach session. Each high-risk individual is identified using a unique identifier code to ensure confidentiality (Figure 6).

Figure 6: Sex Worker Registration Code



Source: Mukta Project, Pathfinder International

A monthly tracking form contains information on all the peer's contacts on a single sheet (Figure 7). As with the flipbook, the sex workers are identified by codes and symbols to maintain confidentiality. The peer completes the form by using stickers to identify which of four services in the minimum package were delivered during a given week: a meeting with the sex worker; handing out a referral coupon to a clinic to encourage health check-ups; handing out condoms (free or socially marketed); or a visit to the clinic by the sex worker that has been verified by the peer.

The monthly tracking form also contains symbols representing eight risk and vulnerability factors that are understood to most directly impact high-risk individuals' ability to access HIV services (these are the blue boxes which are enlarged at the top of the form). These eight factors are:

1. No condom use
2. Lack of financial resources
3. Substance abuse
4. Regular partner*
5. High client load
6. Non-utilization of health care services
7. Brothel owner's pressure or harassment
8. Exposure to violence (including domestic violence)

* Condom use with regular partners is invariably lower and more difficult to negotiate. Limited research by Avahan has also found that regular partners are associated with increased levels of debt on the part of sex workers, and thus greater risk-taking.

Figure 7: Monthly Tracking Form

The form is a grid with 50 rows (25 in each column) and 10 columns. The top row is a header with the following text: 'नियोजन मार्गदर्शिका' (Employment Guide), 'मुक्ता' (Mukta), 'मार्च ०९' (March 09), and 'मार्च ०९' (March 09). Below the header, the columns are: 'क्र.' (Serial Number), 'नाव' (Name), 'चिन्ह' (Symbol), 'संसर्गाचा योग्य आकलनाची शक्ती' (Ability to assess contact), 'पहिला आठवडा' (First Week), 'दुसरा आठवडा' (Second Week), 'तिसरा आठवडा' (Third Week), and 'चौथा आठवडा' (Fourth Week). Each row contains a serial number, a name, a symbol, a grid of icons representing risk and vulnerability factors, and four empty cells for weekly tracking. A 'priority box' with colored dots is located at the top left of each row.

Source: Mukta Project, Pathfinder International

The relevant factors for each sex worker are identified by the peer in conversations with the sex worker. Those that do not pertain to the individual are covered up on the form with a white sticker. The remaining factors are thus easy to distinguish, and the peer discusses them at her weekly meeting with her supervisor. As the risk and vulnerability factors for the sex worker change, stickers can be removed or added to change her profile.

There is also a "priority box" on the form for each sex worker, which can be marked with a colored dot to identify individuals who require special attention from the peer (e.g., the peer has been unable to contact them, they have not visited a health clinic, or they possess a particular combination of risk and vulnerability factors).

Figure 8: Weekly Outreach Prioritization Form Using Risk Factor Analysis

S. No.	Indicator	Details	Score	Final Score
1	Age of the high-risk individual as in mapping (fixed score for a quarter)	≤ 25 yrs	5	
		26-40 yrs	3	
		≥ 41 yrs	1	
2	Number of clients per week (fixed score for a quarter and calculated through mapping)	46 and above	4	
		31-45	3	
		16-30	2	
		0-15	1	
3	Percent of condom usage for encounters with clients (fixed score for a quarter and calculated through mapping)	< 50%	5	
		50%-90%	3	
		> 90%	0	
4.	High-risk individual ever visited program clinic (fixed score for a quarter and calculated through social needs analysis)	Never visited	3	
		Visited	0	
5.	Harassment in past 1 week (variable score every week and calculated in community guide [peer] review meetings)	Police	"1" if Yes & "0" if No	
		Goonda [Gang Member]		
		Client Temporary		
		Husband / Lover		
6.	Did peer meet the high-risk individual in last 10 days? (variable score every week and calculated in community guide review meetings)	Not met	3	
		Met	0	
7.	High-risk individual having any STI symptom in last 1 month (variable score every week and calculated in peer outreach worker review meetings)	"Yes" & not visited	3	
		"Yes" & visited clinic for that symptom	1	
		No	0	
8.	Due date for clinic visit given by doctor/counselor (variable score every week and calculated in peer outreach worker review meetings)	Yes	1	
		No	0	

S. No.	Item	Total Score	Source of Score	Results
1	Scoring for deciding risk of a sex worker	10-14	Cumulative final scores of indicators 1-3 above	Red
		6-9		Blue
		2-5		Green
2.	Prioritizing outreach for a sex worker by a peer	18-28	Cumulative final scores of indicators 1-8 above	Top Priority
		9-17		Medium Priority
		2-8		Low Priority

Source: Swagati Project, Hindustan Latex Family Planning Promotion Trust

The form shown in Figure 8 quantifies the analysis a peer does in her head, assigning a numerical score to each sex worker to evaluate risk factors (such as age, condom usage, number of clients per week) as well as the services delivered by the peer in the previous week to 10 days. Further factors include whether the sex worker has STI symptoms and whether she has an appointment for a clinic visit. This risk prioritization is done weekly by the peer with her supervisor, and the peer uses it to plan outreach for the following week. The discussion with the supervisor has a larger goal than simply generating a score: it cross-checks the qualitative analysis that the peer uses to guide her work and offers an opportunity for the peer to receive valuable coaching from her supervisor.

Figure 9: Monthly Site Tracking Form

Peer Educator Zone wise performance of Aastha Minimum Package (AMP) Score																
Location of Intervention	ORW Responsible	Peer Educators Responsible	Place of Intervention	No. of Key Population handled	Services			Provided Condoms				AMP Score	Maximum AMP score	% Achievement to Max AMP score	% KPs attended clinic	% KPs Provided Condom
					Provided One-One Session	Provided Clinic Services	Attended Aastha Gat Meeting	Once in a Month	Twice in a Month	Thrice in a Month	Four Times in a Month					
P.M.G.P Colony	Poonam Rangasibi	Lata	P.M.G.P. Colony	50	34	19	19	15	10	5	3	88	200	44%	38%	66%
		Naseem	P.M.G.P. Colony	50	38	21	12	12	6	2	2	81	200	40%	42%	44%
		Laxmi	Shatabdi Nagar	85	29	42	11	20	14	8	4	104	340	31%	49%	54%
P.M.G.P Colony	Naseem	Laila	Naik Nagar	50	28	25	7	27	15	6	2	81	200	40%	50%	100%
		Shamshad	Prem Nagar	47	30	25	7	32	6	4	1	77	188	41%	53%	91%
		Shamshad Nabi	Shatabdi Nagar	50	26	18	9	22	16	8	4	77	200	38%	36%	100%
		Ameena	Discovery Bar	30	18	14	0	8	4	2	1	39	120	32%	47%	50%
		Anita Mishra	Raj palace	13	8	7	0	4	2	2	3	22	52	41%	54%	85%

Source: Aastha Project, Family Health International

This management form tracks overall delivery of services at each site in the Aastha Project. A score is assigned to each hotspot within a program site, based on the number of services delivered by each peer during the month as part of the "Aastha Minimum Package" (AMP):

- One-to-one session - 1 point
- Visited clinic for any service - 1 point
- Attended Aastha gat (community group) meeting - 1 point
- Received condoms - 0.25 points for each condom provided (e.g., if 12 condoms are given once a month and 6 condoms twice a month, this is a total of 24 condoms, which scores 6 points)

The percentage of the maximum possible AMP score, and the percentage of female sex workers who attended a clinic, are color-coded (red, orange, or green) to indicate the priority for follow-up.

Whenever results are quantified in this way, their analysis must take into account any factors at the site that may be impacting uptake of services, such as structural obstacles (e.g., brothel keeper does not allow sex workers to access clinic) or a lack of demand for services. This is where the peer's perspective from the field is crucial. In the Aastha Project, the score sheet is reviewed in a monthly meeting of peers and outreach workers along with the program coordinator and a monitoring and evaluation officer. By focusing on brainstorming solutions, this review becomes a positive experience for peers, which reinforces their leadership roles in management and analysis of outreach.

MANAGING AND SCALING UP A PEER LED OUTREACH PROGRAM

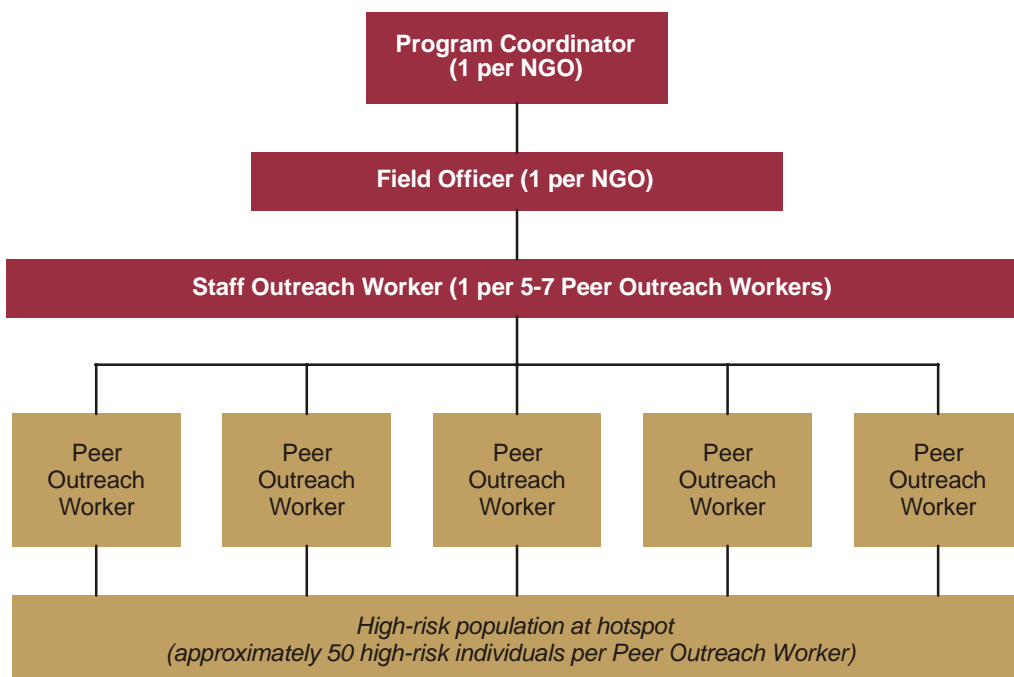
Successful implementation of peer led outreach within an HIV prevention intervention requires careful management of peers within the structure of the local NGO. From the start, peer management and the structural design of the program must take into account plans for program growth, so that the intervention can be scaled up without losing quality.

Successful peer management entails a clear supervisory structure; the acknowledgment of peers' work; giving peers opportunities to progress to positions of greater responsibility within the organization; and recruiting new peers to replace those who move up or move on. Program scale-up is most successful when it is done in phases; data collection systems are established for monitoring and evaluation; and clear but flexible program standards are set from the beginning.

Oversight of peer outreach at the local NGO level

In Avahan's model, each local NGO has a program coordinator with overall financial and hiring authority, and a field officer who runs the program day-to-day. Staff outreach workers coordinate and supervise the work of the peer outreach workers (Figure 10).

Figure 10: Organizational Structure of Peer Led Outreach within the Context of the Local NGO



Program Coordinator

The program coordinator has overall managerial responsibility for implementation of the NGO's program, including work planning, budgeting, and reporting of data to the state or regional program.

Field Officer

The field officer is usually an NGO staff member who manages the staff outreach workers, oversees registration of new members of the program, and prepares monitoring reports for the regional or statewide partner. The field officer also works to establish rapport with stakeholders in the community, such as madams of brothels, owners of establishments where sex workers operate, and the police.

Staff Outreach Worker

The staff outreach worker oversees the work of 5-7 peers, meeting with each at least once a week to help them complete and review their micro-planning forms and plan their forthcoming work. Staff outreach workers also organize capacity-building activities for peers. They are themselves trained by the regional- or state-level organization as well as in-house by the NGO.

Overall program structure at the local NGO level

In the initial stages of the program, peer outreach activities are integral to condom distribution and clinic attendance. As the program matures, outreach can also become integral to a broader program structure, which may include:

- Social support services (provided through drop-in centers and through site-level community groups)
- Advocacy work (led by community members with support from NGO staff and peers)

Given that peer led outreach is concerned not just with service delivery but also with strengthening the leadership of high-risk individuals, they will over time naturally support this broader mandate to demand access to services and hold systems accountable for effective HIV prevention services.

Acknowledging peers' work

There are simple but effective ways to recognize and appreciate peers for their work. These enhance peers' personal satisfaction and motivation and encourage them to remain in the program:

- Publicly recognizing peers at community events
- Offering small gifts that are work-related (e.g., pens or a bag to carry educational materials)
- Giving badges with the program logo to outstanding peers
- Giving an award to high-performing peers

Peer progression

As peers develop experience and skills, they can be given opportunities to progress to new levels of responsibility and oversight in the program. Within the local NGO, peer progression may occur on a continuum from peer to staff outreach worker, field officer, and program coordinator. Peers may also be invited to serve on committees that oversee different aspects of the program (e.g., management, advisory, and advocacy committees).

Peer progression offers several benefits:

- It enables the program to grow to meet increasing demand for services.



- It allows new peers from the community to take an active role in the program, thus preventing burn-out.
- It provides opportunities for peers to develop leadership skills.
- It prevents peers from becoming entrenched or complacent in their positions.
- It generates greater community ownership of the peer outreach program.

The regional or statewide partner overseeing the local NGOs in a given area can develop clear criteria for eligibility and the process for peer progression. Where possible, selection should be made democratically by a committee convened by each NGO for the purpose. Members can be selected to represent the needs of various communities (by geography and typology) as well as various stakeholders. It is important that the majority of the selection committee be high-risk individuals, and that most of these be non-peers (i.e., people who receive outreach and services). A workable membership mix is:

- 40 percent high-risk individuals (not peers)
- 20 percent peers
- 40 percent NGO staff

This committee can also be responsible for dismissing underperforming peers who have not improved under supervision, and for selecting new peers as the program expands.

Selecting new peers for program growth

Over time, additional peers will be needed in order to cope with the program's expansion, to replace peers who have progressed to other positions, and to deal with the turnover caused by peers who are unable to continue their participation for any other reasons.

There are numerous approaches that can be used to recruit additional peers:

- Request recommendations from past or current peers and from high-risk communities.
- Recruit new peers with different social networks, to expand coverage as much as possible (peers may nominate only friends from the same sites where they operate).
- Look for people with characteristics similar to successful peers already selected.
- Ensure that the selection criteria are clear when recruiting, in order to maintain the community's trust.

Phased scale-up of program

Implementation of peer led outreach as part of an HIV prevention intervention is most effective when it is done in phases, since it is generally not feasible to attain complete and in-depth coverage immediately. Phased scale-up allows time to build the capacities of the local NGOs and make adjustments based on circumstances in the field. It also allows for management and training focus on fundamentals and the introduction of more sophisticated components of outreach as staff and peers gain skills and confidence. The phases can be summarized as follows:

Start-up

- Contracting state lead partners and local implementing NGOs
- Recruiting and training high-risk individuals in mapping, in order to estimate size of high-risk population for programming
- Establishing the peer outreach network:
 - Setting standards for peer outreach (e.g., appropriate peer ratio, selection criteria, and norms for hiring peers)
 - Defining denominators for each of the peers and introducing tools for planning outreach
 - Recruiting peers based on detailed social network mapping
 - Training initial peers on outreach planning
 - Setting standards for peer performance and beginning outreach

Expanded Roll-out of Services

Improving outreach and service delivery

- Introduction of micro-planning to enable peers to analyze gaps in service delivery and prioritize outreach
- Redefinition of role of the peer from educator to case manager for HIV prevention
- Project monitoring (focused on the number of condoms distributed and clinic visits by individual) is supplemented by field visits to assess the quality of peer interaction with community members, so that the relative impact of interactions and "opportunity gaps" in service levels can be understood

Refinement of Scope

Building peer capacity to become opinion leaders and change norms of behavior in the community

- Peer outreach expanding from risk reduction focus to address underlying vulnerability. High-risk individuals are linked not just to services but to crisis response systems, local advocacy efforts, and community groups.
- Peers from different geographic areas network to learn from one another across districts and states.
- Peers are increasingly community leaders who set norms for health-seeking behavior and role models as responsible program partners—they practice safe sex, go to the clinic, and take initiative to tackle community priorities.

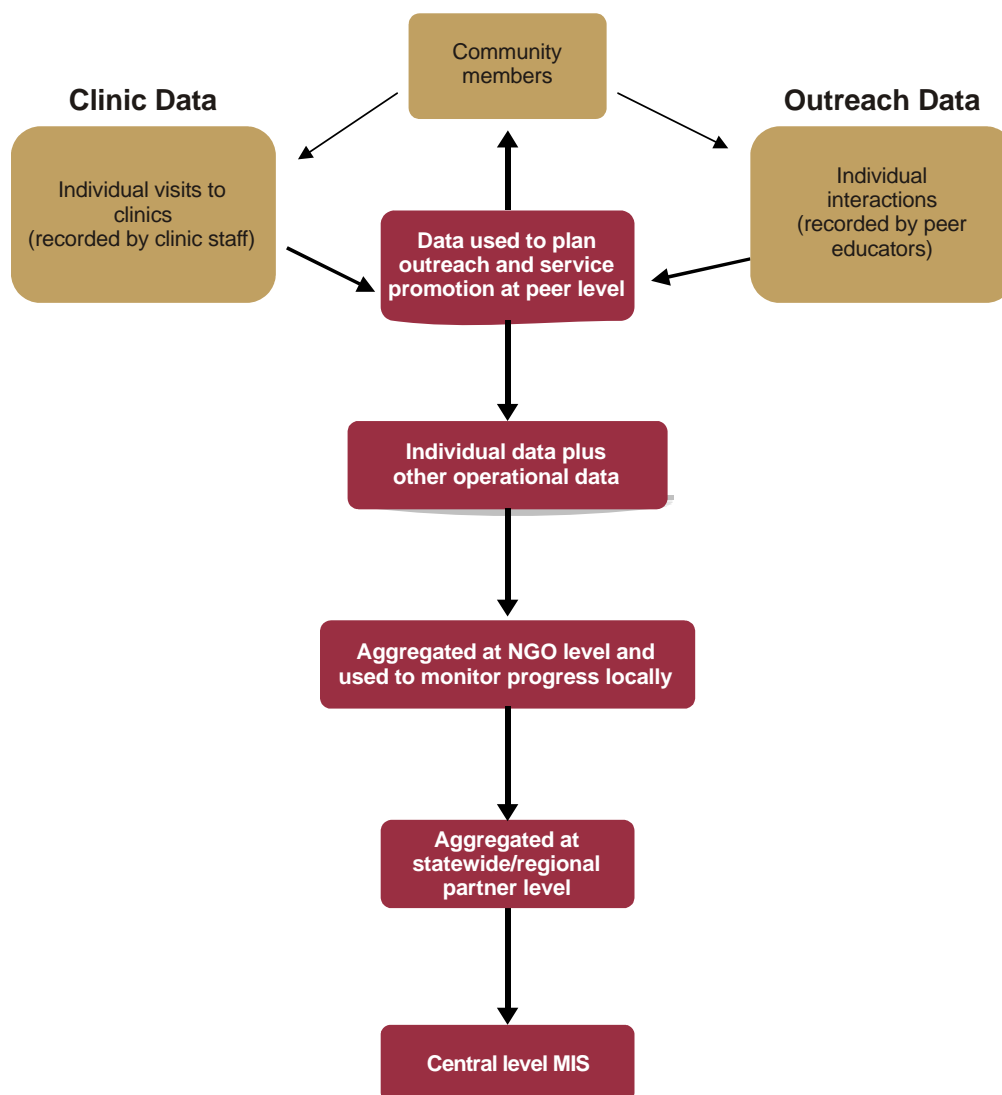
Data management

Effective collection and management of data by peers is a critical component of micro-planning, but their data should also be aggregated by the local NGO in order to provide a picture of overall coverage and to examine any quality issues in outreach. Records of visits to clinics and to drop-in centers complement this picture.

These data are in turn consolidated at the regional or state level (or higher in a national program) to monitor overall coverage and quality of outreach. Standardized indicators are developed by the regional or statewide partner, and a designated staff member of the local NGO gathers and reports the relevant data on a monthly basis. The early development of a flexible computerized management information system (CMIS) is essential to this process.

Comparing effectiveness of outreach across different geographic areas makes it possible to promote best practices and adjust program priorities, resources, and structures where needed. Figure 11 shows how routine data monitoring is used within the Avahan program.

Figure 11: Avahan Routine Monitoring Data Flow



Regional or statewide standards for scale-up

It is best that peer led outreach be locally led and resourced to be sustainable and relevant, yet it also requires some central coordination to maximize its effectiveness. Avahan has found that program implementation standards must be defined early on, so that even where the program may be narrowly focused on basic risk indicators and peers may not initially have a strong leadership role, there is scope for local leadership to develop.

Standards that are broad and flexible will allow for local innovation, for example in terms of the micro-planning forms, and will need to change as the program matures. Ideally such standards will be introduced in ways that encourage and permit local NGOs to add specificity and detail through consultation with peers. The standards for social network mapping and micro-planning in the following table are based on Avahan's Common Minimum Program, which specifies operational and managerial standards and indicators.

Social Network Mapping

Goal

To establish a clear understanding among peers of the group of high-risk individuals to be covered by each peer in outreach.

Benchmarks

- a. NGO maintains an updated peer log distilling information from periodically updated social network maps and listing the current outreach group that each peer is responsible for and her outreach area.
- b. Each peer can easily locate and describe her map, demonstrate where different groups of community members are located, and locate trouble spots and safe spots where group discussions can be held.
- c. The social network maps are updated on an ongoing basis (e.g., semi-annually) showing new members, discontinuation of high-risk individuals, or members leaving for a known period of time (e.g., to visit their family home).

Performance Boosters

- Exchange visits, in which a small group of peers from a strong district are brought to a weaker one to train both the NGO staff and peers, can reinforce standards, generate peer leadership, and strengthen NGO support of peers.

Micro-Planning

Goal

To enable peers to actively analyze risk and vulnerability and prioritize outreach based on individual service and support requirements.

Benchmarks

- a. Peers can describe how to use visual forms and suggest accurate ways to counsel individuals facing particular risks.
- b. Peers collect a standard set of information about individuals in their outreach group using forms on which they enter one week's worth of data.
- c. Peers keep the weekly tracking sheets with them; the names of the individuals they cover are represented by symbols or other codes that cannot be deciphered by outsiders.

- d. A weekly meeting is held with all peers and staff outreach workers to review visual forms and ensure they are updated and filled in correctly and to problem-solve major obstacles in coverage.
- e. Clear criteria for identifying the highest-priority individuals are understood by the majority of peers, and there is an environment in which peers mentor one another to build their understanding.
- f. Peers help to determine what additional or different information is important to track over time, as the program evolves.
- g. During the week, staff outreach workers check in with peers during their rounds at the hotspot to coach them about meeting their weekly goals and to help surmount obstacles in outreach with stakeholders and the peer.
- h. Monthly records are kept to track each individual covered by the NGO. These offer a profile of each individual, their needs, and type of service received over a period of time, and highlight particular risks.
- i. Peers can recall and describe the risk and vulnerability characteristics of each high-risk individual in their outreach group.
- j. Peers have a clear understanding of factors that increase risk and vulnerability (e.g., high client volume and low condom use; exposed to violence or coercion; serious financial instability, etc.).
- k. Peers can identify which high-risk individuals in their outreach group should receive greater attention, more effort for service delivery, or program engagement based on their risk and vulnerability profile.
- l. Peers continuously assess the risk and vulnerability of the high-risk individuals in their outreach group to detect changes that may alter the way they prioritize individuals for outreach or service delivery.

Performance Boosters

- Initially peers should be consulted in the development of tracking forms, the symbols used on them, and techniques for filling them in.
- Incentives can be put in place to ensure peers train and mentor other peers.
- A coaching relationship is best established between staff outreach workers and peers during meetings and when solving problems in the field.
- Peers encouraged to develop a performance metric and to participate in the performance reviews of other peers may feel greater ownership of the program.
- Peers should be offered semi-annual training opportunities, and act as trainers as their skills develop.
- Recognition should be given to peers who have been particularly successful on a monthly basis (e.g., for those who had the most contacts, demonstrated leadership with stakeholders).

APPENDIX

SAMPLE OUTLINES FOR PEER TRAINING

Example I

Family Health International's Aastha Project (in Mumbai and Thane districts of Maharashtra state) developed the following outline for its four-day basic peer training. (This should be considered illustrative rather than prescriptive.)

Part I: I am a peer

1. Introduction and warm-up activity
2. Ground rules and expectations
3. Understanding the program
 - 3.1 The program goal
 - 3.2 Planned activities to reach the goal
4. Being a Peer
 - 4.1 What is my "job"?
 - 4.2 Why am I important in this program?
 - 4.3 What else do I need to know about being a peer? (e.g., code of conduct)

Part II: Peer communication skills

5. What communication skills do I need?
6. Confidentiality
7. Who do I work with?
8. Starting a conversation
9. What is a behavior change communication session?

Part III: Key messages

10. How our health affects our looks and earnings
11. Our bodies: inside and out, using body aprons (Note: Body aprons depict the internal organs of the body in an anatomically correct position when worn)

Part IV: Knowing about STIs

12. What are sexually transmitted infections (STIs)?
13. Getting the right treatment
14. What are the long-term effects of untreated STIs?
15. Explaining STIs that show no symptoms

16. Visiting the clinic
17. Making a clinic referral

Part V: What we need to know about condoms

18. Condoms and lubrication - teaching correct use
19. Condom negotiation

Example 2

The peer training program organized by the Karnataka Health Promotion Trust's Sankalp Project focuses on outreach to sex workers. Following an introduction to the basic program components, the peer outreach workers participate in exercises in which they use their own experiences, together with data from each hotspot gathered during site assessments, to analyze needs and plan their outreach. The process is divided into two courses: the first precedes outreach work, and the second is used to refine outreach work once peers have gained some experience.

COURSE 1

Process 1: Spot analysis

Helps participants compile and analyze information about sex work (e.g., volume, locations, time of day) for each hotspot in their respective program areas.

Process 2: Contact mapping

Helps participants map and define the contacts they have with female sex workers in each hotspot and plan for outreach based on these contacts.

Process 3: Networks

Helps participants understand geographic and social networks of female sex workers and advantages and disadvantages associated with both.

Process 4: Opportunity gaps analysis

Helps participants understand gaps in coverage in each hotspot, reasons for these, and ways to overcome them.

COURSE 2

Process 5: Participatory site load mapping

Helps participants understand the gap between estimates of female sex workers, the number of unique contacts, and the number of regular contacts by studying the client load in a day, a week, and a month at different sites.

Process 6: Seasonality diagramming

Helps participants understand peaks and troughs of sex work at a given place in a year and their impact on outreach planning.

Process 7: Force field analysis

Helps participants understand the reasons for gaps in their contacts and determine how to reduce the gaps.

Process 8: Preference ranking

Identifies the reasons for gaps in regular contact and clinic attendance and prioritizes these.

Process 9: Condom accessibility and availability mapping

Maps condom availability points to ensure easy access to condoms for female sex workers.

Process 10: Peer maps

Helps participants understand the nature of outreach done by peer outreach workers with female sex workers.

Process 11: Sex work typology-wise outreach planning

Helps participants understand the link between types of sex work and outreach.

GLOSSARY

Community ownership means that the community has control over the activities the program undertakes, and significant understanding of, and influence over, service delivery. Community-owned programs have significant leadership, initiative, and oversight by communities, and accountability systems are in place to ensure that the program's interests do not supersede those of the community, and that adequate representation of the community is established.

Drop-in centers were established early on in the Avahan initiative to provide a safe space for high-risk groups to come together. The centers are often basically equipped but clean rooms that accommodate 50-150 people, with cushions and mattresses on the floor, bathing facilities, and a mirror. They are often housed next door to the program-managed medical clinic. With no similar refuge available, drop-in centers have become the hub of community life, each serving from 5 to 11 contact points or hotspots where high-risk groups solicit and practice sex.

High-risk groups are female sex workers, high-risk men who have sex with men, transgenders, and injecting drug users.

High-risk men who have sex with men are self-identified men who have sex with men to whom Avahan provides services. This group of men is not representative of all men who have sex with men in India. In the settings where Avahan works they are at high risk on account of their large number of sex partners and the fact that a disproportionate percentage sells sex or practices anal receptive sex.

Micro-planning is the methodology used by peers in their outreach for recording and analyzing risk and vulnerability during outreach. Peers use a visual tool to collect data which they use to directly plan outreach based on the individual needs of the population they are serving.

Peer outreach workers (peers) are representative members of a community who serve as a link between the program and the community. They manage the program on the ground through outreach and serve a population with whom they have a similar occupational, behavioral, social, or environmental experience and among whom they are trusted and a role model. Peers work with 35-85 members of their community to influence attitudes and provide support to change risky behaviors.

Staff outreach workers (outreach workers) are experienced peers or professionally trained social workers employed by an implementing NGO to supervise between five and seven peers each. An NGO typically has 5-10 outreach workers on staff.

Typology of sex workers refers to the different locations where they solicit sex, such as on the street, in a brothel, at home, in a hostel, or in some other location.

Vulnerability refers to the circumstances which impact an individual's or a high-risk group's control over acquiring HIV. Vulnerability for a sex worker or a man who has sex with men is linked to abuse, violence, and social stigma, and impacts her/his power in sexual encounters.

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- Our focus is clear—and limited—and prioritizes some of the most neglected issues.
- We identify a specific point of intervention and apply our efforts against a theory of change.
- We take risks, make big bets, and move with urgency. We are in it for the long haul.
- We advocate—vigorously but responsibly—in our areas of focus.
- We must be humble and mindful in our actions and words. We seek and heed the counsel of outside voices.
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- Delivering results with the resources we have been given is of the utmost importance—and we seek and share information about those results.
- We demand ethical behavior of ourselves.
- We treat each other as valued colleagues.
- Meeting our mission—to increase opportunity and equity for those most in need—requires great stewardship of the money we have available.
- We leave room for growth and change.

The Avahan India AIDS Initiative, funded by the Bill & Melinda Gates Foundation and managed by an in-country foundation team, is a large and ambitious HIV prevention program. Avahan's ten-year charter has three distinct elements. The first is to build and operate a scaled HIV prevention program, with saturated coverage for populations most at risk in the six states which account for the bulk of HIV infections in India. The second is to transfer the program to the Government of India and other implementers in the country; and the third is to encourage the replication of best practices by fostering and disseminating lessons learned from the program.

Now in its sixth year of operation, Avahan reaches more than 220,000 female sex workers, 80,000 men who have sex with men and transgenders, 18,000 injecting drug users, and about 5 million men at risk.

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