PROCESS MANUAL

Provision of HIV/STI/ Hepatitis Community Led Services to Key Populations in Sri Lanka

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Provision of HIV/STI/ Hepatitis Community Led Services to Key Populations in Sri Lanka

This is a process manual for NGO/CBO managers, Sexually Transmitted Infection clinic staff, and community-led Key Population intervention workers to ensure they run their operations according to an agreed-upon national standards.

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Editors

International Consultant:

Dr. Jan Willem de Lind van Wijngaarden

National Consultant:

Dr. Harischandra Yakandawala

Directors:

Dr. Vindya Kumarapeli – Director | NSACP

Peer Reviewed by:

Dr. Sathya Herath – National Programme Consultant | NSACP

Dr. Shyama Somawardhana – Consultant | Venereologist | Kegalle

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PART 1
Community-Led Programme Management

Introduction

Who is this manual intended for, and how should it be used?

This Process Manual is intended for NGO/CBO managers, Management assistants, Outreach Workers, Peer Educators, and National and district clinic staff members implementing Community-Led HIV services. The communities in focus are Men who have sex with Men (MSM), Transgender (TG), Female Sex Workers (FSW), and People Who Inject Drugs (PWID). It provides guidance on setting up and managing Community-Led HIV Services.

Sri Lanka's HIV epidemic and response

Since the beginning of the HIV epidemic, Sri Lanka has continued to maintain a low-level epidemic. The AIDS Epidemic Model estimated that 4,700 people were living with HIV by the end of the second quarter of 2024[1]. The estimated adult HIV prevalence is less than 0.1%. Almost three decades since the

[1] https://key population.aidscontrol.gov.lk/images/pdfs/hiv_data/quarter_report/HIV-AIDS_Quarterly_Report_-_2nd__Quarter_2024_v2_1.pdf

detection of the first HIV infection in Sri Lanka, as of June 2024, a cumulative total of 6,126 HIV infections have been reported to the National STD/AIDS Control Programme. Of them, 1,579 have died. The availability of ART provided free of charge in all STI clinics has encouraged more people to come forward for HIV testing. In 2023, a total of 694 new HIV cases were reported; in the first half of 2024, a total of 421 newly diagnosed cases were reported to the NAACP, indicative of a growing trend.

The 2018 IBBS survey revealed that the highest HIV prevalence was found among Men who have Sex with Men (1.5%), followed by Transgender women (1.4%). Prevalence was low among Female Sex Workers (0.1%), clients of sex workers (0.1%), and people who inject drugs (0%). These rates are higher than the reported data of previous years. An IBBS survey was planned for 2022 - 2024, which was implemented from 2025 onwards.

While Sri Lanka maintains a low HIV prevalence of less than 0.1%, between 2014 and 2018, there was a slight increase in Syphilis prevalence among Female Sex Workers (FSWs) in Colombo, rising from 1.6% in 2014/15 to 2.2% in 2018. The 2018 Integrated Biological and Behavioural Surveillance (IBBS) survey, covering five districts, revealed low HIV and STI

prevalence rates across key populations. However, the presence of risk behaviours, including inconsistent condom use and poor HIV health-seeking behaviour, coupled with limited coverage of HIV prevention programs, suggests a potential for future increases in HIV/ STI prevalence[2].

Sri Lanka has implemented a robust national response to HIV, led by the National STI/AIDS Control Programme (NSACP). The country has achieved universal testing coverage among pregnant women attending antenatal clinics, blood donors, and TB patients. Civil society organizations (NGOs and CBOs) have played a pivotal role in providing HIV/STI/Hepatitis prevention services[3]. However, according to data reported by Sri Lanka to UNAIDS in 2019 (using the 2018 IBBS results), coverage of these services was still very low: 12.7% for FSW, 27% for MSM, 2.7% for PWID and 38.5% for transgender women. A high percentage of these populations can be found in specific areas in a limited number of provinces, districts and municipalities (e.g.,

[2] HIV Sentinel Survey 2019. NASCP, 2019. Available from: https://key population.aidscontrol.gov.lk/images/publications/suvellance_reports/HIV-sentinel-surveillance_Annual_Report_2019.pdf

[3] David Lowe/SKPA/AFAO/FPA, Review of the Package of HIV Services for Key Populations in Sri Lanka. February 2020. Available from:

Colombo), which should make them easier to reach, but the overall coverage is still too low[4] to achieve the **95-95-95 targets** the MOH has committed to. Sri Lanka has successfully eliminated mother-to-child transmission of HIV and syphilis and has reported no transfusion-related HIV infections since 2000.

Challenges remain in reaching key populations with prevention and HIV/STI testing services. Factors such as program design, appropriate members as Key Population program staff, serving the young, recruiting the young, enthusiastic members to the team, and the hidden nature of key population groups, especially in the districts other than high burden districts, are some of the barriers to serving the key populations. Therefore, the community-led HIV/STI/ Hepatitis prevention services have evolved gradually since 2011. The NSACP partnered with the Global Fund to implement community-led services in Sri Lanka. This is when the NGO/ CBO was introduced to the HIV prevention services. The NSACP has been scaling up HIV/ STI/

[4] Readiness Assessment for transition and sustainability planning for Sri Lanka's AIDS Response. Transition Readiness Assessment report, 8 October 2020. Report prepared by UNAIDS. Available from: https://www.aidscontrol.gov.lk/images/Sri-Lanka-HIV-TRA-Report--FINAL-Oct-8-2020-3.pdf

Hepatitis community led services and services for Key Populations, including diversifying HIV testing modalities, making HIV testing more accessible, scaling up pre and post-exposure prophylaxis (PrEP/PEP) services across all STD clinics and in community set up, and community based hepatitis C testing and referral for treatment and harm reduction services within the community set up. These were possible through intensifying community-led outreach efforts, including virtual interventions, by the NGO/CBO contracted Key Population team.

Chapter 1:

Objectives of this process manual

1. To provide information on how to conduct community-led HIV/ STI/ Hepatitis community-led services
2. To provide information on operating the community center within the district by the NGO/CBO
3. To provide information on overseeing the community center by the STD clinics and by the NGO/CBO
4. To provide information on periodic supervision by STI clinics and NGO/CBO
5. To provide information to STI clinics and NGO/CBOS on continuous guidance/ continuous mentoring
6. To provide information on monitoring, evaluation, and prevention information management (PIM) system
7. To provide information on periodic reviews, meetings, and consultations to STD clinics and NGO/CBO
8. To provide information on internal training and continuous education to the contracted team
9. To guide the Community-Led Monitoring Mechanism

Planning the Community-Led Services

Selection of districts & Key Population Component,

Community-led services are planned based on the community's needs, the population size of each community, disease prevalence, and the feasibility of conducting interventions involving the communities.

District selection is based on the Quantitative & Qualitative factors such as

- Latest Population Size Estimation;
- HIV cases detected
- Number of PLHIV in the last 5 years
- STI cases detected
- Qualitative information of each district – hotels, hot spots, tourists, external migrants, tuition classes
- Population density
- Sentinel Surveillance Data
- IBBS survey findings

Contracting the Non- Government Organization (NGO)/ Community Based Organizations (CBO)

The NGO/CBO is contracted yearly through a formal selection procedure by calling for an expression of interest (EOI).

1. The EOI is published on the National STD/AIDS Control Program website & the Family Planning Association website.
2. Interested NGO/CBOS will respond to the EOI
3. The EOI will request details for the following

Selection of NGO/CBO

A suitable NGO/CBO will be contracted through a panel of members after the submitted documents, physical performance, financial and human resource performance, genuineness, and organization discipline are analyzed.

An agreement will be made with the NGO/CBO and the National STI/AIDS Control Program in partnership with the Regional Director of Health Services and district STI clinics.

Role of NGO/CBO

1. Maintaining a KP desk for the transitioned KP interventions in their office – peer diaries, stock balance, program action plan & monthly payment records
2. Make all documents available to any supervisory authority
3. Assist in recruiting the Management assistant, outreach worker, & Peer Educators
4. Initial training.
5. Processing salaries, incentives, and other payments, and relevant documents
6. Arrange monthly meetings and KP programme reviews, sensitize STD clinic staff when necessary, and hold advocacy meetings at the district level when required.
7. Facilitate any other activity requested by the STD clinic.
8. Recruiting peer–educators, field supervisors, and management assistants
9. Providing an uninterrupted sexual health service package through recruited KP communities (means of prevention, promotion of care-seeking behaviour & HIV testing)
10. M & E of the implementation of program

Operating a community centre within 5km of the primary district, a Sexually Transmitted Infection(STI) clinic

The contracted NGO/CBO, or if there is more than one NGO/CBO contracted in a district, must join in renting a suitable place to operate a community centre.

The necessary standards for the community centre are as follows.

1. This centre should be 5 km from the district STD clinic.
2. If more than one NGO/CBO is contracted in a district, one or more contracted NGO/CBOS should rent a joint community center, and a common center must be in place.
3. The contracting NGO/CBO must monitor and maintain the community center.
4. Monthly services provision data must be submitted to the district STD clinic each month, indicating this in the Prevention Information Management System (PIMS).
5. Services to be provided in the community center are education, condoms and lubricant provision, HIV/STI/ Hepatitis testing services, harm reduction services for drug use, PrEP and PEP provision, and direct observed treatment for Hepatitis C.

6. The Standard Operating Procedure for operating a Community Center for the key populations provides more details.

Contracting the community for the Key Population intervention

The key population groups must be hired according to the district's needs. The individuals will be selected per the said Terms of Reference (ToR); Each ToR can be referred to with each NGO/CBO agreement. The staff components are

a. An individual will coordinate the KP components
b. Individuals will plan, implement, and monitor the KP outreach
c. A team of community groups works in the field to identify, educate, and provide services within the communities.
d. The key population intervention team members are contracted

Prioritizing districts and Key Population components,

The districts are prioritized according to disease prevalence, Key population concentration, and other geographical parameters. Likewise, some districts are identified as high-burden districts for high disease prevalence and high key populations. Similarly, the prioritization alters with time and the feasibility of the program's gathering information.

1.2 Community-led HIV services complementing HIV clinical testing and treatment services

There must be a formalized understanding of each other's roles and responsibilities between Community-based HIV and clinical service providers. This Process Manual aims to help towards this goal.

Whereas clinical services are pivotal to providing life-saving treatment to people living with HIV and STI cases, there are key times and events when community-led HIV services can also be essential for the Key populations, as follows:

- To make Key population members aware of HIV/STI and enhance their understanding of ways to prevent infection, reducing misconceptions and fears;
- To link unreached Key population members to HIV counselling and testing services (either Government STI clinics or NGO/CSO-run services);
- To link HIV-hostile clients at high risk for HIV to PrEP/PEP services.

1.3 Ethical principles underpinning HIV work

1.3.1 Equality

HIV services, whether provided by NGOs/CBOs or Government facilities, are grounded in the fundamental belief that all human beings are equal regardless of gender, ethnicity, socio-economic status (class), family/cultural background, age, religion, personal beliefs, sexual orientation, gender identity, or gender expression. Everyone must be treated equally.

1.3.2 Acceptance and being non-judgmental

Community service providers and government HIV workers should never judge clients' identity, behaviour, or life choices; otherwise, these clients might be lost to the program forever. By

accepting clients without passing judgment and respecting them, in line with basic principles of public health, clients might eventually be supported to make better health choices.

1.Empathy

Empathy is like "walking a mile in the client's shoes," trying to understand the world from the client's perspective. Clients should be involved and considered equal partners in assessing and resolving their own healthcare and psycho-social needs. Empathy is also about having compassion, being client-centered, and respecting the client's right to choose, even if we may sometimes disagree with the client's choice(s).

1.3.4 Duty of Care

When encountering a serious issue that is beyond the direct scope of the program, HIV KP Outreach workers and Peer Educators have a 'duty of care' if the client's safety or the safety of others may potentially be compromised.

Some examples of serious issues that might indicate the urgent need for advice from others include:

- Statements by the client that indicate a risk of suicide or self-harm;

- Threats by a client to harm others;
- Suspicions of violence or abuse by or towards the client;
- Homelessness or acute poverty;
- Severe depression or other mental health issues.

In such cases, Outreach Workers/Peer Educators should always seek additional advice from outreach coordinators/ supervisors and clinical staff at the STI clinics and hospitals they work with. They can also seek support from the "Mithuru Piyasa" at some leading hospitals.

1.3.5 Informed consent

Clients' consent **must** be sought before engaging clients in any testing, outreach, or case management service. The 'client consent form' (Annex 1) is used with the client registration form (Annex 2) to obtain permission to use and store information the client will share with the program. Clients must be informed that all information they provide may be disclosed as aggregate or individual information without their identities being revealed and used in specific ways. Clients are given the option to refuse, at any time, any or all of the services provided, and this is explicitly

mentioned in the client consent form, thus ensuring that the consent to provide them with services is informed.

The only exception would be in cases where there is a ‘duty of care’ issue.

1.3.6 Privacy and Confidentiality

Clients' personal information, such as contact details, medical records, etc., MUST be held in the strictest confidence. HIV service staff need to respect confidentiality to keep their clients' trust; they cannot do their work without trust.

Confidentiality works on many different levels. When clients sign the consent form, reassurance is given that the program will always respect the client’s confidentiality so they can share their stories without fear of them becoming known to others. This trust and confidence is crucial for Outreach Workers/Peer Educators to support the client better, because an accurate understanding of the client's situation is only possible when the client is not afraid to be frank and straightforward.

Breaches of confidentiality, if they occur, should always be brought up, explained, and measures should be taken to avoid a repeat.

NEVER ignore a breach of confidentiality when it occurs! It is an opportunity to improve the service don't miss it.

Confidentiality is a skill that improves with practice and understanding of its importance. Key practices include:

- **Anonymity:** Respect a client's choice (and correct) to remain anonymous. Over time, trust may build and clients may tell you more about who they are.
- **No sharing personal details:** Never discuss clients' lives, even without using their names, as more information can quickly reveal their identity, especially in smaller communities. Staff must sign confidentiality agreements before their employment (Annex 3). Disclosure of a client's HIV/STI status without consent leads to immediate dismissal. In team meetings, anonymize any examples shared.

- **No gossip:** Gossip about clients or colleagues, including on social media, is strictly prohibited. Gossip is deadly poison for team-level confidentiality practices and clients' trust in the CSO/NGO providing Community-Led HIV services.
- **Discretion:** Acknowledge clients only in private. If you encounter a client in a public setting, interact only if the client initiates it. The client may not want to be identified as a key population member. Explain this policy during service initiation to avoid misunderstandings.
- **Secure records:** Use unique identifier codes instead of real names for client files. Store records in a locked cabinet and restrict access to relevant staff.
- **Private meeting venues:** Meet clients in uncrowded, discreet locations.

1.3.7 Professionalism: Remaining professional at all times

Outreach workers/Peer Educators must remain professional and avoid letting personal emotions, including romantic or sexual attraction, interfere with their role. They represent their organization, and professionalism is essential to maintaining its

reputation. If they cannot resist attraction toward a client, they should refer the client to a colleague.

1.3.8 Honesty and integrity

Honesty: Be straightforward with clients to build trust and encourage them to open up about personal issues.

Integrity: Act honourably and never engage in illegal activities, exploit clients, or seek personal gain. Due to legal implications, treat minors and differently abled individuals with care. Minors (under 18) need a guardian's consent letter for services. Refer them to the STI Clinic for further management.

1.3.9 Appropriateness

Provide information, support, and tools relevant to a client's situation and needs, ensuring content is accurate and easy to understand. Avoid giving incorrect information at all. It is better to admit this than provide misleading answers if unsure. Community service providers are not medical professionals and must not act as doctors, nutritionists, or mental health experts. Refer clients to qualified medical professionals when necessary and document this.

1.3.10 Responsibility and Accountability

Outreach workers and Peer Educators are responsible for their duties and must follow contract terms, avoiding conflicts of interest. Accountability includes measuring results, so monitoring and evaluation (M&E) are essential. Outreach workers and Peer Educators should maintain detailed records using monitoring tools to track work, monitor clients, and improve the program over time (See Annex 2, Annex 4, Annex 5, Annex 6); stocks should be well-managed (Annex 7) and programmatic results should be regularly shared with the team and with the NSACP and District STI/HIV Clinics.

1.4 Staff rights and responsibilities

1.4.1 Rights

The organization recruiting Outreach Workers or Peer Educators commits to:

- Ensure staff privacy and confidentiality.
- Treat all staff equally and respectfully.
- Provide orientation, training, and proper handovers for continuity.

- Offer support through supervision and regular team meetings.
- Keep staff informed about program updates and involve them in planning and evaluation.
- Clearly define roles with written job descriptions (see Annex 10 and Annex 11).
- Maintain a diverse, inclusive, and discrimination-free workplace.
- Address complaints promptly and respectfully.
- Communicate concerns about performance respectfully and allow a right of reply.
- Respect staff's personal space and time outside work hours.
- Fulfil legal obligations regarding salaries and benefits.

1.4.2 Responsibilities

Staff of Outreach/Peer Education programs must:

- Commit to their contracted service period.
- Attend supervision and team meetings.

- Perform duties and report as required.
- Abide by contracts and confidentiality agreements.
- Keep coordinators informed about client-related updates.
- Be reliable, honest, and considerate with all stakeholders.
- Update contact details when necessary.
- Be punctual and follow the manual's guidance for delivering services.
- Adhere to ethical practices to ensure services do not harm (see Section 2.3).

Ethical conduct is significant because professional conduct helps maintain a good reputation and service relationship with STI Clinics. Unethical conduct undermines the trust and respect needed to ensure that local service providers cooperate with the service.

The following behavioural rules are fundamental:

a. **No sex with outreach clients** under any circumstances.

b. **No breach of confidentiality** as detailed in the 'confidentiality and code of conduct agreement' (Annex 3).

c. **No gossiping** about clients or fellow team members during or after service provision.

d. **No drug taking or drinking alcohol** with clients under any circumstances.

e. **No financial transactions,** lending to or borrowing money from clients.

f. No **gifts or other tokens/services of significant value are accepted by clients**

g. **No engagement in illegal activity** during service provision or with clients during or after service provision.

Engaging in these behaviours should be met with the relevant disciplinary measure, with warnings issued in writing, and can result in dismissal, subject to due HR process.

Orientation must be undertaken at the start of a new staff member or volunteer's time with the service. In this orientation, the team coordinator should read the staff code of conduct (Annex 3). After reading each document, the coordinator should discuss it to ensure the staff fully understand all clauses and principles and allow for questions and concerns to be raised.

1.5 Reporting incidents: the process

Through the Community-Led Monitoring system, a question on the form that a client fills out to provide feedback on services received asks whether or not a serious incident occurred. If they mark yes and consent to follow-up, there is then a process where a trained focal point follows up to help resolve the issue. See Annex 9 for the form[5].

[5] Serious Incident Response and Reporting Protocol. Community-Led Monitoring for HIV services in Sri Lanka. Family Planning Association, Colombo, 2024.

Chapter 2:

Managing HIV/STI/Hepatitis Community-Led Services

2.1 Seven Elements for Enhanced HIV Outreach

Element 1: Providing a Comprehensive HIV Prevention Package

This element focuses on delivering HIV prevention education tailored to individuals based on their HIV status and ensuring the consistent availability of essential commodities such as condoms and lubricants, and promotion of PrEP/PEP. A key priority is meeting or exceeding distribution and education targets.

Element 2: HIV Case Detection Among Key Populations

This element aims to increase HIV screening uptake among key populations, confirm reactive test results, and ensure that newly diagnosed individuals initiate Antiretroviral Therapy (ART). Activities include training peer educators and outreach workers in motivating their clients to get tested, providing HIV screening tests, or referring to HIV testing facilities (including providing them with testing kits). A robust system for monitoring and reporting HIV testing data is needed to ensure the outreach effort

is effective in discovering previously undiagnosed HIV cases. This requires feedback from HIV testing sites to the Outreach team. The goal is to enhance case finding, improve linkage to care, and ensure individuals living with HIV know their status and access treatment promptly.

Element 3: Identifying New Places and Networks to Reach the Undiagnosed

This element emphasizes the continuous identification of new sites and networks where clients gather, prioritizing fieldwork in locations with higher rates of undiagnosed HIV. Field workers use mapping techniques and community engagement to identify these hotspots, intensify outreach efforts, and connect with individuals who traditional services may not have reached. Again, there is a need to provide feedback on recent testing results (at an aggregate level) from STI/HIV clinics to the outreach team so they can receive feedback on the effectiveness of their efforts or move on to new sites and networks.

Element 4: Exploring High-Risk Characteristics Through 'Random Walking'

'Random walking' is a method of identifying individuals outside traditional key population networks, often referred to as "outliers," who exhibit unique high-risk characteristics for HIV. This approach helps expand the program's reach by identifying and engaging populations that standard outreach methods might otherwise miss. It is part of Element 3 (continuously mapping and exploring new sites and networks).

Element 5: Leveraging New Technologies for Outreach and Coordination

This element promotes mobile (dating and other) apps, social media platforms, and bulk SMS messaging to improve HIV outreach and team coordination. These tools enhance the dissemination of information, enable better communication among team members, help promote HIV/STI testing services, and allow for more effective engagement with clients in accessible and innovative ways.

Element 6: HIV Case Management for Linkage to Care and Treatment

This element ensures that newly diagnosed individuals are linked to appropriate care and treatment services. It involves educating

and supporting ART initiation, encouraging treatment adherence, and assisting clients in navigating healthcare systems. Strong case management ensures better health outcomes for people living with HIV. At the current stage of the epidemic, Sri Lanka has elected not to have dedicated community-based HIV case managers; case management tasks are provided by qualified health personnel at STI/ART clinics, with back-up support from networks of people living with HIV.

Details of each element can be found in the technical guidance document 12.

2.2 Improving referral and linkages between HIV services at every step

To fix linkage losses at every step in the HIV cascade, from prevention to viral suppression, a strong spectrum-wide Linkages initiative, led by NSACP, is needed. This initiative will focus on reducing linkage losses at every step between prevention & screening, screening & repeat screening, screening & confirmation, confirmation & registration for care, registration & ART initiation, ART initiation & ART retention, ART initiation

& viral load testing, first & repeat viral load testing, and repeat viral load testing of failure cases.

This will include generation of due lists and defaulter lists at every step, monthly reconciliation meetings at every STI & HIV clinic with all the referral sites and testing sites, to identify clients who have become lost-to-follow-up, focus on six monthly repeat testing of hostile key population members, active involvement of key population networks & networks of people living with HIV to trace clients who have become lost-to-follow-up, provide reinforced adherence counselling, family support, all to bring them back into life-saving treatment and care services.

2.3 Definitions, functions, and structure of the outreach team

Outreach Workers versus Peer Educators

The geo-prioritization approach adopted by the Sri Lankan Ministry of Health stipulates that in certain districts, a more intensive approach for HIV prevention and case finding is applied than in others (see Section 1.1). This means in Colombo and Gampaha, full time Outreach workers operate, whereas in other districts there are full time Outreach Workers and Peer Educators who are Volunteers.

A second distinction of outreach work is that between Physical outreach and online/virtual outreach. However, the key roles and responsibilities of outreach workers and Peer Educators, as well as those operating Physical and those operating virtual/online, are the same: to educate / help key populations prevent HIV/STI infection, and to link them to HIV/STI Clinical services.

Key Roles and Responsibilities

The primary role of Outreach workers and Peer Educators is to reach individuals who have not been served by HIV services, particularly those who have never been tested for HIV/STI. (See the standardized job descriptions for outreach workers and peer educators in Annex 10.) Strategies to achieve this include:

- **Targeted Physical outreach** in locations where key populations gather.
- **Virtual/Online outreach** through social media, dating apps, and online platforms.

Outreach activities- HIV Prevention Package HPP focus on providing:

1. **Accurate information about HIV/STI transmission and prevention,**

2. **Distributing condoms and lubricants,**
3. **Promoting harm reduction and PrEP/PEP services,**
4. **Linking clients to key population-friendly health services.**

Outreach also aims to enhance client motivation and skills for behaviour change, such as adopting safer sex practices and adopting a habit of regular HIV/STI testing.

Physical outreach:

Physical outreach remains a cornerstone of Sri Lanka's HIV prevention efforts. Outreach workers and peer educators play a vital role in building trust, addressing individual needs, and overcoming barriers that may prevent individuals from accessing services. Key roles of Physical **Outreach Workers and Peer Educators** include (See Annex 10 and 11):

1. **Direct Engagement:**
    - **Identify and Reach Out**: Locate and approach individuals within key populations in places where they gather, such as community centers, hotspots, and social venues.

- **Build Trust and Rapport**: Establish meaningful connections by showing empathy, understanding, and respect for the clients' experiences and backgrounds.

2. **Provide Tailored HIV Prevention Education**

   - **Deliver Accurate Information**: Educate clients about HIV transmission, prevention methods, and the importance of regular testing.
   - **Distribute Prevention Commodities**: Provide condoms, lubricants, and informational materials to support safer behaviours or linkages to PrEP/PEP services.

3. **Facilitate Access to differentiated HIV Testing and Services**

   - **Offer On-the-Spot Testing**: When authorized and trained, conduct rapid HIV testing, ensuring confidentiality and informed consent.
   - **Refer to Health Services**: Guide clients to friendly healthcare facilities for testing, treatment, and other support services.

- **Follow-Up Support**: Encourage and assist clients in attending appointments and adhering to treatment plans if needed.

4. Registering and Tracking Clients

Outreach workers/Peer Educators ensure that every individual contacted through outreach is registered correctly. This includes:

- Using a **Unique Identification Code (UIC)** for clients to maintain confidentiality and streamline follow-up (using Client Registration Form, Annex 2).
- Recording details of services provided, such as education on STIs and HIV, referrals, or the delivery of commodities like condoms, lubricants, and HIV self-tests (Annex 4, 5, 6, 7).
- Document outreach activities in program monitoring systems like the Prevention Information Management System (PIMS).

Virtual outreach:

Virtual outreach is an essential tool to complement traditional physical HIV prevention efforts[9]. It helps reach individuals who may not access services due to barriers such as lack of awareness, confidentiality concerns, or low risk perception and lifestyle. Outreach workers and peer educators involved in virtual outreach aim to connect individuals to essential HIV prevention and testing services.

Key Roles of Virtual Outreach Workers

1. **Conduct Virtual Interventions**

   Virtual interventions refer to approaches that do not require Physical contact and can be internet-based or non-internet-based. Outreach workers and peer educators play a critical role in implementing these interventions by:

   - Identifying online spaces where key populations gather ("virtual hotspots") and conducting targeted outreach.
   - Engaging with individuals through social media, chat platforms, and messaging services to generate demand for HIV prevention and testing services.

- Guiding clients through the process of accessing services, from initial contact to booking appointments or receiving self-test kits.

2. Demand Generation

Outreach workers and peer educators create awareness and interest in HIV prevention and testing by:

- Developing and sharing straightforward, engaging social media content tailored to the needs and preferences of key populations.
- Using platforms such as **Know4Sure.lk** to disseminate information and connect with individuals.
- Testing and refining outreach strategies to improve effectiveness.

3. Registering and Tracking Clients

Outreach workers ensure that every individual contacted through virtual outreach is registered correctly. This includes:

- Using a **Unique Identification Code (UIC)** for clients to maintain confidentiality and streamline follow-up (using Client Registration Form, Annex 2).
- Recording details of services provided, such as education on STIs and HIV, referrals, or the delivery of commodities like condoms, lubricants, and HIV self-tests (Annex 4, 5, 6, 7).
- Document outreach activities in program monitoring systems like the Prevention Information Management System (PIMS).

4. Linking Clients to Services

The primary goal of virtual outreach is to transition clients from online engagement to accessing physical services. Outreach workers are responsible for:

- Referring clients to convenient service points, such as district clinics, physical outreach workers, or courier services for self-tests.
- Facilitating appointments through platforms like **Know4Sure.lk** and ensuring clients can easily access HIV testing and prevention services.

- Collaborating with clinic staff to track client visits and testing outcomes, ensuring a seamless linkage to care.

2.4 Effective recruitment of outreach workers and peer educators

The right mix of outreach workers and peer educators from different backgrounds and operating in different social and sexual networks is necessary. As a simple rule, the fewer outreach workers or peer educators who knew each other before they started working together, the better.

An outreach manager/coordinator should develop a recruitment plan based on the guidelines given by the NSACP, that ensures a proper mix of the outreach team, including the number of outreach workers'/peer educators needed. The outreach workers'/peer educators should reflect the desired age (preferably age 18 -35 years and active KP member), ethnicity, level of education, sexual orientation, gender identity, and in case of 'venue-based' outreach, for practical and logistical reasons their area of residence. There should also be agreement (or at least discussion) on how/where to recruit outreach worker's/peer educators to ensure a sufficiently diverse group.

Please do not rely solely on people who volunteer to be Peer Educators. They might not be representative of the target Key population and may not be able to commit consistently.

It is important to have a clear job description for outreach workers and peer educators. This description should be used in recruitment ads when new outreach positions become available; an example is given in Annex 10; see also a job description for Outreach Coordinators (Annex 11).

When the process of interviewing and selection starts, it is essential to have an agreed-upon list of selection criteria. Criteria can include:

- Availability to do outreach/peer education (including during late evenings and weekends)
- Age (18-35 Years old)
- Personal traits such as communication, leadership, team playing, and charisma.
- Social network or social media following/savviness
- Be an active KP community person
- Sexual orientation

- Gender identity
- Ethnicity
- Openness about sexual/gender identity (ability to conduct outreach in public spaces, or preference for online outreach)
- Level of education- Minimum 3 passes O/L examination
- Motivation (as apparent during the job interview)
- Acceptability by (particular segments of the) target audience; this means experience working in sex work for outreach with sex workers; experience having male-male sex for men who have sex with men, etc.)
- Previous working experience
- Having NVQ L 2,3 certificate depending on the requirement

Individual outreach workers'/peer educators will of course never meet all criteria: some will be more charismatic, others more organized, others more communicative than others; the idea is that people in the outreach team complement each other and share

their particular strengths with others, while learning from other team members' strengths.

If outreach workers and peer educators are recruited correctly, the group employed in an organization will be highly diverse. This will require careful people management. All outreach workers and peer educators will need to agree to a set of basic rules regarding being cordial and courteous, respectful of people of all backgrounds, prohibiting gossip, etc. (see Section 2.3).

2.5 Ensuring outreach workers and peer educators have the proper knowledge and skills

Outreach workers and/or peer educators under the Sri Lankan model must demonstrate high standards of knowledge and skills, ensuring that they are well-equipped to deliver HIV awareness and prevention education tailored to the individual needs of clients and effectively encourage them to access HIV, STI, and Hepatitis B and C testing services. After recruitment, all outreach workers and peer educators should receive comprehensive training and be assessed for their knowledge, attitudes, and communication skills using the evaluation tools provided in the Guide for Community Service Providers (also called Reference Manual).

Building Motivation and Addressing Barriers

Motivational interviewing is a critical skill for outreach workers and peer educators. This technique involves a structured yet empathetic conversation to help clients explore and resolve mixed feelings about behaviour change, whether related to testing, treatment adherence, or other risk reduction strategies. Outreach workers and peer educators should also be able to address complex issues, including:

- Alternative sexual risk reduction strategies (e.g., PrEP or behaviour modification).
- Managing substance use and its impact on HIV risk.
- Addressing stigma, discrimination, and gender-based violence related to sexual orientation, gender identity, or HIV status.
- Providing support for clients navigating sexual and gender identity issues.

Continuous Knowledge Development

To maintain high standards, outreach workers and peer educators should have access to updated scientific information on HIV prevention, care, and treatment. Regular knowledge checks, using

questions from the Guide/Reference Manual, should be integrated into weekly or biweekly team meetings. These sessions can be guided by a consultant venereologist, Doctor, STI clinic staff, or an experienced trainer or coach, and used to practice role-plays that simulate real-life outreach and counselling scenarios.

Effective Training Methods

Rather than full-day workshops, short, focused training sessions (2–3 hours) are recommended. These can be scheduled after team meetings or on weekends, ensuring they do not disrupt outreach schedules. Assigning homework, such as practicing new skills or discussing specific topics, allows participants to apply what they have learned and receive feedback during subsequent sessions.

Recommended Training Components for Outreach Workers and Peer Educators

1. **Basic Outreach Training (3–5 days):** This training covers HIV basics, prevention methods, and the roles and responsibilities outlined in this Process Manual. The Guide for Community Service Providers / Reference Manual should be the core text.

2. **Training on Ethics, Attitudes, and Norms (1–2 days):** This training focuses on desirable attributes and ethical principles and is offered in 3-hour weekly sessions if needed.
3. **HIV Counselling and Testing (3–5 days):** Includes pre- and post-test counselling techniques and practical training on the proper use of rapid testing kits.
4. **Motivational Interviewing (5 days):** This program provides outreach workers with communication tools to address complex client needs, delivered in short sessions over 12–13 days annually.
5. **Self-Study and Group Study:** Regularly scheduled group study sessions using the Guide/Reference Manual, integrated into weekly or biweekly team meetings.

By ensuring that outreach workers and peer educators have the necessary knowledge, skills, and tools, Sri Lanka's National HIV Program can enhance the quality and effectiveness of its outreach efforts, ultimately improving outcomes for key populations.

2.6 Organizing bi-weekly Outreach Meetings and Monthly Monitoring Meetings of key population CSP with clinical teams

Outreach workers and peer educators must learn from each other and work collaboratively. To support this, it is recommended that regular team meetings be held on a fixed day each week or fortnightly. These meetings allow team members to share updates, discuss challenges, and plan activities for the coming weeks.

Structure of (Bi-)Weekly Outreach Meetings

Meetings should follow a set agenda to ensure focus and productivity. An example agenda is provided in Annex 13.

Fostering Continuous Monitoring and Adaptation

Regular meetings help ensure the team remains alert, focused, and responsive to changing situations and needs. This aligns with the principle of *real-time monitoring*, where monitoring and evaluation are conducted continuously rather than only at predetermined project stages. This approach allows timely adjustments to outreach activities, targets, and strategies.

Ensuring Open Communication

In addition to team meetings, open communication channels

between outreach workers, peer educators, supervisors, and project managers are essential. Regular one-on-one supervision discussions (see Section 3.8 below), either in person or via platforms like Skype or WhatsApp, help provide personalized feedback and support.

Team Morale and Social Activities

Non-work-related social activities, such as team outings or gatherings, can significantly boost morale and strengthen team bonds. An annual retreat is recommended, which should include team-building exercises and provide a platform for reflecting on achievements and planning future activities.

Monthly Monitoring Meetings

Under the Peer-Led Model, implemented in the lower-priority districts, monthly cluster coordination meetings bring together clinic staff, peer educators, and key population representatives to ensure cohesive planning and implementation.

2.7 Logistical support for outreach workers and peer educators

Access to adequate resources is vital for the success of Physical and Virtual outreach efforts. Outreach workers and peer educators

have frequently highlighted the challenges caused by shortages of Information, Education, and Communication (IEC) materials and stock-outs of essential supplies like condoms, lubricants, and HIV testing kits. These shortages can severely hinder their ability to perform their roles effectively and, in turn, compromise the overall impact of HIV prevention programs.

The Importance of Consistent Resource Availability

IEC materials, such as brochures, posters, Video clips, and pamphlets (based on the Guide/Reference Manual), are crucial for delivering accurate information to clients. These materials not only reinforce verbal education but also provide clients with something tangible to refer back to, encouraging behaviour change and increasing awareness about services like HIV/STI testing and treatment. Without these resources, outreach workers rely solely on verbal communication, which clients may not always retain.

Condoms and lubricants are similarly indispensable. These commodities are prevention tools and symbols of trust and reliability between outreach workers and their clients. Offering these items reinforces the outreach worker's role as a practical support provider, helping build rapport with clients. Stock-outs of

condoms and lubricants can damage this trust and leave clients feeling unsupported, mainly when they are unable to afford or access these items through other means. See Annex 7.

HIV testing kits are another critical resource. Outreach workers rely on these kits to provide on-the-spot testing, which increases accessibility and reduces the likelihood of clients postponing or avoiding testing altogether. Shortages of testing kits reduce the number of clients who can be tested and create frustration among outreach workers, potentially leading to demotivation and reduced program efficiency.

Addressing Resource Challenges

To overcome these issues, outreach coordinators must prioritize consistently providing resources as a fundamental part of outreach planning. This includes:

- **Proactive Stock Management:** Coordinators should regularly monitor stock levels of IEC materials, condoms, lubricants, and testing kits. Advanced planning and coordination with suppliers can help prevent stock-outs.

- **Establishing Buffer Stocks:** Maintaining buffer stocks at the central and district levels can safeguard against unexpected resupply delays.
- **Strengthening Supply Chains:** Developing reliable supply chains and contingency plans can ensure the uninterrupted availability of resources, even in remote areas.
- **Transparent Communication:** Outreach workers should be encouraged to report shortages promptly, preferably before they occur. Supervisors can use these reports to address supply gaps and advocate for improved resource allocation.

Logistical Support and Planning

Transportation costs and logistical barriers, such as traveling to remote areas, can prevent outreach workers from engaging with vulnerable, unreached key populations. Allocating transportation budgets, ensuring timely supply delivery, and addressing logistical challenges are critical to ensuring outreach teams can operate without disruption.

Reliable resource provision enhances program impact and boosts the motivation and morale of outreach teams, ultimately strengthening the overall HIV response in Sri Lanka.

2.8 Supervising, mentoring, and monitoring outreach workers

Virtual/Online Outreach: Enhancing Reach and Documentation

Virtual/Online outreach is a relatively new approach in Sri Lanka's HIV KP Community-led program. Essential tools like the daily records and weekly report (Annex 5) can be used to profile clients contacted online. This ensures that the significant efforts spent reaching and chatting with potential clients are accurately reflected in outreach workers' and peer educators' daily reports, performance, and achievements.

When conducting online outreach, outreach workers and peer educators should document the social media ID used to communicate with clients and secure at least one additional contact method with the client, such as another social media profile or a phone number. Screenshots of conversations or inbox messages can prove online interactions, provided this is done carefully to maintain client confidentiality. Organizations should

identify practical documentation practices, not overburden workers, and protect client privacy.

Monitoring Quality and Performance

An outreach program is only as effective as the quality of services delivered by its workers. Key performance aspects include:

1. Success in identifying clients most at risk for HIV or in need of services.
2. Locations where clients are found.
3. The approach and tone used during client interactions.
4. The ability to listen to and respond to specific client needs.
5. Effectiveness in motivating clients to access testing and prevention services.

Strong supervision systems must focus on quantitative results (numbers reached) and the quality of outreach activities. Supervisors should avoid a top-down approach that induces fear of failure and instead adopt a coaching style. This builds trust, encourages workers to innovate, and ensures that constructive feedback is delivered nonjudgmentally.

Regular Team and One-on-One Meetings

Weekly or fortnightly outreach team meetings allow outreach workers and peer educators to discuss challenges, share solutions, and plan upcoming activities (see Annex 13 for a template agenda). These meetings can be complemented by one-on-one supervision sessions, where sensitive or private issues can be addressed. Such mentoring ensures personalized feedback and helps identify training needs.

Participatory Quality Monitoring

Quality monitoring should involve outreach workers and peer educators in evaluating their performance and identifying areas for improvement. Role-plays and discussions during team meetings or periodic workshops can improve skills and confidence. Supervisors should use the Reference Manual for regular knowledge updates and discussions on maintaining service quality.

Flexible Target-Setting

Numerical targets for outreach workers should be realistic and flexible, considering factors such as difficulty accessing specific populations. For example, reaching married middle- and upper-

class men who have sex with men may be more challenging than engaging with street-based populations and the distance to get new clients. Targets for new Outreach workers should also account for the time needed to build trust with key populations.

Reviewing Outreach Reports

Supervisors should review daily reports, weekly reports, and Monthly Reports accordingly to identify trends, unusual occurrences, or challenges. If an outreach worker misses targets repeatedly, supervisors should analyse the reasons, focusing on the quality of contacts rather than just numbers. For example, a worker referring fewer clients but successfully engaging high-risk networks may be achieving more significant impact than someone reaching more clients with low HIV risk.

Addressing Poor Performance or Ethical Breaches

Supervisors should issue warnings and set improvement goals if an outreach worker or peer educator consistently underperforms despite support and feedback. Continued poor results may necessitate termination of engagement after three written warnings. Immediate dismissal is warranted for breaches of

ethics, such as breaking confidentiality or engaging in inappropriate behaviour with clients.

Preventing Burnout Among Outreach Workers and Peer Educators

Outreach work can be emotionally taxing, especially when workers face challenges like high client volumes or personal stressors. Supervisors should actively watch for signs of burnout, which may include:

- **Exhaustion:** Fatigue, irritability, and reduced motivation.
- **Detachment:** Cynicism, apathy, or lack of job satisfaction.
- **Ineffectiveness:** Poor performance, missed deadlines, or reduced productivity.

Burnout can negatively impact both personal well-being and job effectiveness. Supervisors can implement strategies to prevent burnout, such as:

- Encouraging workers to take regular rest days to recuperate.
- Setting reasonable limits on working hours.

- Organizing team-building activities or retreats to strengthen morale.
- Providing training on self-care and stress management techniques.

Recognizing and addressing burnout early can help workers regain motivation and improve their overall performance.

PART 2

Outreach Worker/Peer Educator Process

Chapter 3:

HIV/STI outreach work in practice

This manual section provides information and resources needed for outreach workers and peer educators to deliver outreach in practice under Sri Lanka's HIV program for key populations.

3.1 The outreach worker/peer educator's 'toolkit'

Each outreach worker/peer educator must be equipped with the following:

1. A copy of the document "Guide for HIV/STI/Hepatitis C Community Service Providers in Sri Lanka" (referred to as the 'Reference Manual').
2. A certificate showing that the outreach worker/peer educator has passed at least 75% of the knowledge and attitudes exam questions based on the Reference Manual.
3. A photo-ID card issued by NSACP or the district STD/HIV clinic or their respective organizations that shows the outreach worker is 'official'; it can be used with suspected clients and law enforcement officers. (This ID can be used only for the Job)

4. A unique e-mail address or other social media ID for work-related purposes. The user names and passwords to these addresses must be shared with the outreach coordinator/supervisor when necessary.
5. A set of IEC materials about different topics, including the importance of HIV testing; Q&A about what happens after a person becomes positive; Q&A about condoms and lubricants; Q&A about PrEP; Q&A about PEP; Q&A about safer sex and a booklet with information and advice for people who have just turned HIV positive. The materials could be based on the different chapters of the Reference Manual, and should be made available both offline and online.
6. A rubber or plastic dildo that can be used to perform condom demonstrations.
7. For those who are trained and have passed the training, several rapid HIV test sets.
8. Condoms and water-based lubricants, to be handed out to clients.

9. A set of business cards/name cards that the outreach worker/peer educator can hand out to clients so they can get back in touch with them. Never use personal contact information; instead, use a work-specific phone number or social media ID accessible by the outreach coordinator/supervisor. The business card and all the information materials should link to the NGO website where the client can find additional information and, importantly, leave anonymous feedback on the quality of service received (CLM/PMIS).
10. A set of Client Informed Consent Form (Annex 1), Client Registration form (Annex 2), and Daily Recording Sheet (Annex 5) to document work done, in line with the requirements of the PMIS system.
11. A set of 'Client Cards' containing their UIC code will be issued to new clients.

3.2 The 'basic outreach package' that clients receive

For key population clients who receive physical outreach services, the seven main components of the outreach service they receive are:

- Condoms, at the very least, outreach workers need to talk to clients and inform them about the availability of textures of condoms in the private sector, so that they can try out which one suits them best. In principle, men who have sex with men and transgender women should be given 15 condoms and 15 lubricants per month, and people engaged in commercial sex work 30, unless they ask for more.
- An IEC material/brochure: Provide Leaflets/Brochures for the clients to get more information and to share with their partners.
- Contact details of the Outreach worker/Peer Educator (see above);
- Up-to-date information delivered orally / informally by the outreach worker, based on the questions, needs and level of knowledge and understanding of the client, about one or more of the following topics:
    - HIV, STIs and Hepatitis , what they are, how they are transmitted, how they are prevented and how they are

diagnosed and treated (including debunking local misconceptions);

- Information about safer sex, including the variety in lubricants and condoms kinds and sorts and the need to find the best fit, as well as the different risks for transmission between **oral, anal** receptive, anal incentive and **vaginal** sex and the possibility to reduce one's risk for infection even without using condoms by implementing strategies like zero-sorting, strategic positioning and negotiated safety that only work if one tests for HIV frequently;
- Information about the importance of regular testing for HIV, both for oneself as for one's sexual partners and for 'the community';
- Information about the importance of regular testing for STI and Hepatitis B and C, both for oneself as well as for one's sexual partners or injecting partners, and providing information on the options for testing.
- Information about the availability of free HIV treatment in case one tests positive, and the excellent

life expectancy people living with HIV have these days if they start treatment in time and are strictly adherent;

- Information about the availability of PrEP and PEP and, and how these methods work in terms of preventing HIV infection;
- Information about how alcohol, drugs and mental health issues can affect one's motivation and ability to have safer sex and ways to address this.

- Doing an HIV test. This can be done in three different ways:
  - A HIV screening test can be scheduled or performed on-the-spot or at a location of the client's choosing, in case the outreach worker/peer educator is certified and trained to do finger-prick rapid tests;
  - The client can be provided a test kit for HIV self-testing; try to first register them (if they are new clients) and generate a UIC code, and try to keep in touch with the client after the test is conducted.

- Assisted Self-Testing: If the client is unsure or cannot do it alone, assist the client in self-testing.
- Escorting to the NSACP or District STI clinic, an HIV testing center or other healthcare outlet for clients who need a test but who prefer to be tested by someone else than the outreach worker/peer educator or in case the outreach worker/peer educator is not trained to conduct HIV screening tests by themselves.
- Referral to a testing site – this is the least preferred option, but may be necessary if the client refuses or has no time to get tested immediately. The outreach worker/peer educator should ensure they maintain contact with the client.

- Only if the outreach worker does the screening test himself/herself (community-based testing). If the screening test turns out reactive, an accompanying referral to the STI/HIV clinic should be offered to the client to enable their access to confirmation testing, HIV treatment, and support services there. Note: Ideally,

before the test is done, the client should already have agreed to this procedure in case of a reactive test result.

- A 'client card' with their UIC code (which they should present at the following contact with the outreach worker/peer educator, or when they access an HIV service point.

Only part of the package can logically be provided for online outreach workers.

3.3 Reaching out to new clients

For physical outreach, having some form of identification as an outreach worker or peer educator can help when approaching strangers. It is often best to approach a client with small talk first.

Another strategy is to ask the owner or manager of a sex work venue or any bar, café, SPA, or other venue frequented by key population members to help introduce potential clients, or to ask existing or former clients to help organize events in these venues or to help facilitate so-called 'chain referrals'.

When operating online, it is much easier to approach strangers, which explains the enormous popularity of online dating applications.

A valuable and effective strategy is to promote HIV awareness during events/parties popular with key population members and provide HIV testing services on the spot. Such events can also expand the social network of the outreach/peer education team, with the ultimate goal of finding new clients.

If suitable, a private room can sometimes be hired at clubbing or other events for counselling and testing facilities to be set up there. Another option is to have a nearby mobile clinic where testing takes place. Its presence should ideally be announced to the event's patrons via the organizers every 30 minutes during the event.

Potential clients can be approached physically at cruising sites, sex work sites, spas, popular nightclubs, or hangout spots where key population members congregate. It would be strategic to identify local leaders in the networks there. Such network leaders are excellent candidates to be recruited as ‘community champions’ or peer mobilizers for reaching new clients (see next section).

Security is a concern when conducting physical outreach. Relevant law enforcement stakeholders and business owners

should be notified and in agreement with such outreach beforehand to avoid any legal complications.

Offering **condoms and lubricants** is also a good entry point for an education or information sharing session, or to invite people for testing.

Field-based outreach should be tailored to certain times of the day/week when it is busiest, for example, on Friday and Saturday nights, when entertainment, sex work, cruising establishments, and bars are busiest.

Outreach for MSM, of course, also happens online via **gay apps/gay social media** such as Blued and Grindr. Transgender women and women engaged in sex work use Facebook and other similar social media platforms as well, all these are essential tools to reach these key populations. Outreach workers can post or tweet information about services and availability of HIV screening or current HIV stats to generate discussion and possibly receive direct enquiries via private messages.

Many specific gay dating/info sharing **closed Facebook groups** or closed WhatsApp groups that target MSM, /gay/transgender women; these groups are mainly aimed at finding sexual partners.

The transgender community also has closed Facebook groups for networking and sharing information. Outreach workers can try to access these groups to contact its members individually or share information in the group. Discuss such groups with the 'administrator(s)' first; otherwise, the outreach worker could be blocked/removed.

When good quality services are provided and clients are satisfied, there is often **automatic follow-up** referral of friends and acquaintances of this client. Another strategy is to ask existing clients who were satisfied with the services received to refer friends or people at their workplace who have not been reached yet. In a way, such a client can be used as a "seed" to find untested/unreached friends and colleagues and refer them for follow-up.

3.4 Recruiting 'community champions'

If the number of newly-diagnosed HIV cases begins to drop after some time, this is usually an indication that the outreach/peer education team is reaching the limits of its current intervention reach-network.

A useful strategy to address this is to temporarily recruit popular people, such as a cricketer, an Actor, a Musician, who are

influential and have wide social networks or are popular social media influencers with huge online followings. Such leaders should be asked if they are willing to function as **'community champions' or mobilizers'** to support the program in allowing access to their social networks and/or followers for widening outreach. Community champions may be convinced to do this voluntarily, especially if an appeal is done on their importance in leadership and being an example for the rest of their group. Nonetheless, it is often necessary to provide tokens of appreciation for their collaboration. This could be an invitation as a guest of honour during World AIDS Day, AIDS Candlelight Memorial events, Red Ribbon awards, Pride events, beauty contests, etc. Certificates and awards can also be given for significant contributions, and in some cases, an MOU between the community champion and the implementing CSO might be helpful.

3.5 Tailored HIV/STI prevention strategies

HIV/STI prevention must address individual circumstances as knowledge and concern about HIV are often low among key populations. Outreach workers and peer educators should build

trust to offer client-specific options for reducing HIV/STI risk. These options are listed in the remainder of this section.

3.5.1 Condoms and Lubricants:

Condoms and lubricants remain essential for preventing HIV, STIs, and pregnancy. Outreach workers'/peer educators should educate clients on the availability of different condom types (textures, flavours) and lubricant options, emphasizing that only water-based lubricants are safe with latex condoms. Skills like proper application and storage help prevent condom breakage or slippage. Workers should also address "condom phobia" and advise practicing condom use privately to build confidence, especially for clients who claim inability to maintain an erection while using condoms.

3.5.2 PrEP, PEP:

- **PrEP (Pre-Exposure Prophylaxis)** is a medication taken by people who are HIV-negative to prevent HIV infection. It is highly effective when taken correctly and consistently. There are **two ways to take PrEP**:

- **Daily PrEP:** Involves taking one pill every day, regardless of sexual activity. This approach provides continuous protection and is recommended for people with frequent or unpredictable HIV exposure.
- **Event-Driven PrEP (ED-PrEP):** Also known as the "2-1-1 method," this involves taking pills around the time of potential exposure. It requires taking:
  - **2 pills** at least 2–24 hours before sex,
  - **1 pill** daily for the next two days after sex.

The choice between daily and event-driven PrEP depends on an individual's lifestyle, risk level, and personal preferences. Outreach workers should guide clients on the method most suitable for them[10]. It should be noted that for people engaging in vaginal sex and for transgender people who are on hormone replacement therapy, event-driven PrEP is not yet recommended by the WHO, due to

a lack of evidence on the efficacy of PrEP in these populations[6].

- **PEP**: A 30-day emergency treatment to prevent HIV after exposure (e.g., unprotected sex with an HIV-positive partner), effective if started within 72 hours. Free PEP is available for occupational exposure or rape and in a case of potential sexual exposure.

3.5.3 Non-Condom/PrEP Risk Reduction Strategies:

Even when no condoms are used, or if they are unavailable, individuals can reduce their risk for HIV infection by using the following (less effective) strategies:

- Switching to Safer Sex: Encouraging alternatives like oral sex or mutual masturbation instead of anal sex, this is very effective to reduce HIV risk.

[6] See https://key population.cdc.gov/hivnexus/hcp/prep/index.html and https://key population.who.int/news/item/26-07-2022-who-launched-new-implementation-guidance-for-simplified-and-differentiated-service-delivery-of-prep

- Treatment as Prevention (U=U): people living with HIV with undetectable viral loads (on ART for 12+ months) cannot transmit HIV.

3.5.4 Harm reduction

Harm reduction approaches have been proven to be able to address the HIV epidemic among the population of people who inject drugs. Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a range of strategies: from safer use, to managed use, to abstinence—strategies that can be applied depending on the needs and stage of recovery of people who use drugs. Two main strategies are currently in use:

1. The first is needle and syringe exchange programs (NSEP), which aim to reduce HIV transmission among groups of people who inject drugs by avoiding needle-sharing[7].

[7] See: DRAFT Standard Operating Procedure – Needle & Syringe Exchange Service (NSES) for People who Use Drugs in Sri Lanka. Unpublished (as of November 2024)

2. The second is methadone maintenance therapy (MMT), where clients switch from injecting using heroin, crystal methamphetamine or other substances to the controlled use of orally-administered methadone. The dosage of methadone is then gradually reduced over time, or is kept at a healthy level.

The following principles are considered central to harm reduction practice[8]:

i. It should be accepted that licit and illicit drug use is part of our world; HIV practitioners must choose to work to minimize its harmful effects rather than ignore or condemn it.

ii. Drug use must be understood as a complex, multi-faceted phenomenon that encompasses a continuum of behaviours from severe abuse to total abstinence; not all drug use is the same. It should be acknowledged that some ways of using drugs are safer than others.

[8] http://harmreduction.org/about-us/principles-of-harm-reduction/

iii. The success of interventions and policies should be measured by the improvement in the quality of individual and community life and well-being.

iv. Provision of services and resources to people who use drugs should be non-judgmental and non-coercive; this will ensure that people who use drugs and the communities in which they can be most effectively assisted to reduce harm involved in drug use.

v. People who use drugs and those with a history of drug use should be given an authentic voice in the creation and implementation of programs and policies designed to serve them.

vi. People who use drugs themselves are the primary agents of reducing the harms of their drug use; users should be empowered to share information and support each other in strategies which meet their actual conditions of use.

vii. The realities of poverty, class, ethnicity, religion, social isolation, past trauma, sexuality/gender-based discrimination and other social inequalities affect drug users' vulnerability to HIV and other drug-use-related

harms, and affect their capacity for effectively dealing with these challenges.

viii. While keeping an open mind is essential, policy makers and program implementers should not minimize or ignore the actual and tragic harm and danger associated with licit and illicit drug use.

Outreach workers and peer educators should study the relevant sections of the Guide/Reference Manual to familiarize themselves with basic information about harm reduction and other details.

3.7 Promoting HIV, STI, and Hepatitis B/C testing and treatment

Regular testing (every 3–6 months) for HIV/STIs is crucial for key populations to maintain good health and reduce onward transmission. Screening and treating STIs also lowers HIV risk. Pre- and post-test counselling are vital to prepare clients for results, prevent self-harm, and provide support. HIV testing is also needed for people interested in enrolling in PrEP services.

Volunteers from networks of people living with HIV (PLHIV) , who help provide case management services, can help ensure access to confirmation tests, ART, and support services, preventing loss to follow-up for key population members found with reactive HIV test results. This role is critical as some clients disengage after diagnosis, reappearing only in advanced stages of HIV. The Relevant HIV/STI clinic will coordinate with the relevant PLHIV organisation and link HIV positive cases for support.

Outreach workers and peer educators must address fears and misconceptions about testing, engage in discussions to understand client concerns, and support marginalized groups (e.g., migrants and minors). Adolescents (under 18) may face additional barriers like the requirement of parental consent.

Hepatitis B and C are severe liver infections, often asymptomatic for years. Hep B is preventable by vaccine; Hep C is curable with 12-week treatments (though availability is limited). Co-infection with HIV weakens the liver and complicates ART, making testing and treatment for Hep B/C essential.

3.6 Assisted or unassisted HIV screen testing

Outreach workers and peer educators have rapid HIV screen tests as part of their toolkit. These can be deployed in two ways: the client can get the test kit and do the test by themselves ('unassisted HIV self-screening'), OR the outreach worker or peer educator can perform the test for and with the client, and help the client interpret the result ('directly assisted HIV self-screening').

After providing information and doing pre-test counselling, HIV testing involves collecting the client's specimen, either oral fluid (for the **OraQuick test**) or blood (for the finger-prick test), using a rapid HIV test kit.

These approved tests detect antibodies to HIV-1 and HIV-2 and are designed for use by non-medical personnel, providing results within 20 minutes. Most HIV self-tests use second- or third-generation testing technology. These tests are highly accurate for detecting chronic (long-standing) HIV infections, but their ability to identify recent HIV infections varies; the window period (the period during which the test does not yet detect a recent HIV infection) is longer than for fourth-generation tests.

It is essential to explain to the client beforehand that a reactive result from this HIV self-test does not immediately confirm an HIV infection. This is why using the term 'positive test result' is not recommended for the screen test; please use the term 'reactive result' to avoid panic. All reactive results must be confirmed through further (blood) testing in the STD/HIV clinic, and the outreach worker/peer educator needs to bring the client to the clinic as soon as possible after obtaining a reactive test result. The client should also understand that a negative result does not entirely rule out HIV infection, especially if the test is taken shortly after a possible exposure to the virus.

Please refer to the NSACP HIV self-testing guidance[9] and HIV testing guidelines issued by NSACP[8] for further details.

3.7 Reporting achievements and evaluating client satisfaction

The following forms are used to monitor progress and record achievements of the program.

[9] Standard Operating Procedures for the Delivery of HIV Self-Testing Services in Sri Lanka. NSACP, 2022. Available from: https://key population.aidscontrol.gov.lk/images/publications/guidelines/HIV_self-testing_SoP.pdf

3.7.1 Client Registration Form / Client Informed Consent Forms

These forms are completed upon the start of outreach activities at field sites (Annex 1 and Annex 2). It includes the preparation of a Unique Identifier Code (UIC)[10] based on date of birth, initials, gender, risk category and district of birth.

3.7.2 Clinic Escort/Referral Form for HIV/STI Testing (Parts 1 and 2)

This form has two parts. Part 1 is filled out during outreach to document the referral or escort of a client to an STD/HIV clinic (Annex 4). The outreach worker or peer educators then hand this form over to the clinic staff, who retain it and complete Part 2. The completed form is submitted to a Management Assistant for data entry into PMIS for analysis.

3.7.3 Outreach Daily Record Form

This form is filled out daily by outreach workers and peer educators during their outreach activities, with one form completed per working day (Annex 5). After completion, it is

[10] Generating Unique Identifier Code, Standard Operating Procedures, NSACP (Unpublished).

handed over to the Coordinator, who then submits it to the Management Assistant for data entry.

3.7.4 Outreach Rapid HIV Test Result Form

This form (Annex 6) is completed by clinic staff to record the number of rapid HIV tests conducted each day and the test results. It also notes any referrals or escorts for HIV screening to an STD clinic.

3.7.5 Condom and Lubricant Stock Management Form

This monthly form is completed by the clinic's Management Assistant or the coordinator at a CSO/NGO to monitor and manage the inventory of condoms and lubricants available at the clinic's/CSO/NGO office (Annex 7).

3.7.6 Key Population Prevention Reporting Format

This reporting format (Annex 8) summarizes seven key indicators from the data collected across all forms. It is used to monitor and evaluate the HIV prevention program for key populations at each STI clinic and by the CSO/NGO, for discussion at the (bi-)weekly outreach meetings (CSO/NGOs, Annex 14) or the Monthly Coordination Meetings (STI/HIV clinics).

3.7.7 Program Information Management System reporting (PMIS)

The Program Information Management System (PIMS) is a software platform that monitors HIV prevention programs targeting key populations. It facilitates individual registration and tracking using a name-based Unique Identifier Code (UIC). This UIC ensures accurate identification, prevents duplicate entries across different outreach workers, and integrates data from both physical and virtual interventions. PIMS includes a feature that alerts users and monitoring and evaluation (M&E) officers to duplicate entries in real time based on the UIC.

PIMS is designed to capture comprehensive data on service provision and uptake, including the following:

- HIV Testing
- Condom and Lubricant Distribution
- Information, Education, and Communication (IEC) Events
- Virtual and Physical Outreach Coverage

The data collected generates detailed reports, enabling program performance monitoring and evidence-based decision-making to

enhance service delivery. PIMS also plays a key role in the **Performance-Based Incentive Scheme (PBIS)** by verifying target achievements for each intervention, ensuring transparency and accountability in incentive distribution to community health workers[6]. The ORWs and PEs should reach at least 50% of the monthly target to get the incentive.

While PIMS is a critical tool for monitoring and evaluating HIV prevention programs, it is still under development. Plans are underway to expand its functionality and improve user-friendliness, enhancing its impact on program management and service delivery.

3.7.8 Community-Led Monitoring

Community-Led Monitoring (CLM) is a participatory strategy involving key community members in monitoring HIV/STI programs. A standard set of indicators is monitored **(Availability, Accessibility, Acceptability, Quality (AAAQ)) as well as Satisfaction and prevalence of Serious Incidents** (see below)[5]. While relatively new in Sri Lanka, CLM is quickly gaining momentum as an approach to enhance the effectiveness, accountability, and responsiveness of HIV programs.

How CLM Works in Sri Lanka:

- **Training and Data Collection**: Community members are trained to collect data on the availability, accessibility, and quality of HIV services. This includes metrics such as clinic wait times, stock availability of condoms and lubricants, and healthcare workers' attitudes toward key populations.
- **Experiential Data Gathering**: Community members also gather information on the lived experiences of key populations with HIV services. This encompasses issues like stigma and discrimination, barriers to accessing services, and the quality of care received.
- **Advocacy for Improvement**: The data collected is used to advocate for better HIV services. Community members present their findings to government officials, healthcare providers, and other key stakeholders to drive changes in service delivery.
- **Accountability of Service Providers**: CLM serves as a mechanism to hold service providers accountable for their

quality of care. By highlighting gaps and challenges in service delivery, CLM can help ensure improvements.

Benefits of CLM include:

- **Enhanced Data Quality**: Community members, with their deep understanding of local contexts, are often better positioned to collect accurate and nuanced data on the experiences of key populations compared to external researchers. Their ability to build trust within their communities also enhances data reliability.
- **Increased Accountability**: By involving community members in the monitoring process, service providers are more likely to address the needs and concerns of key populations, fostering greater accountability.
- **Empowerment of Key Populations**: CLM empowers key populations to take an active role in their health by increasing their awareness of available services and enabling them to advocate effectively for their needs.
- **Improved Program Effectiveness**: By identifying gaps and problems in service delivery, CLM helps improve the overall effectiveness of HIV programs. Programs that are

closely monitored and informed by community insights are more likely to achieve their intended outcomes.

In summary, CLM is a transformative approach that improves the quality of HIV services and empowers key populations to play a central role in shaping the health programs that serve them. As it gains traction in Sri Lanka, CLM is poised to become a cornerstone of the country's efforts to enhance HIV service delivery and equity.

Serious incident reporting

If an incident occurs, please follow the steps outlined in Section 2.5 and use the incident report format in Annex 9.

Annexes

Annex 1: Client informed consent form

To provide you with HIV outreach services, I need to ask for your permission to collect, store, and use some information about you. The HIV outreach team keeps files on each client it supports. These files are kept in a locked storage cabinet in our office. Personal and contact information on clients is not released to others without your permission. If we report on you as part of a progress report to the government or donor organizations, no names, addresses, or information that could identify you is provided.

	Yes	No
Do you agree?	☐	☐

I have:

	Yes	No
a. Been informed about why and how information is kept about me	☐	☐
b. Participated in determining the support that will be provided to me	☐	☐
c. Been informed where and how this information will be stored	☐	☐

Sometimes, it can be helpful to coordinate your support with other services such as other NGO/CSOs, STD/HIV clinics, or welfare agencies. After discussion with your outreach worker, you can nominate here the agencies that you agree we can talk to on your behalf:

a. _____

b. _____

c. _____

d. _____

e. _____

Signed: _____
Date: ____/____/____
(Client's Signature)

Name: _____
Outreach worker
(Client's Name)

Annex 2: Client Registration form/UIC generation form

STD-KP/M&E/1/2020

Client Registration Form

STD Clinic	
Date	
Peer Meeting Point	
Peer Educator Name	

new client ☐ loss of card/ change of UIC

										UIC ☐

If change of UIC, old UIC (if known)

(1st letter of client's first name, 1st letter of client's second name, client's month of birth (2 digits), client's date of birth (2 digits), 2-digit code for client's district of birth, one letter for sex at birth (M/F)

1. Core Information:

Primary KP: (indicate: PWID, sex worker, MSM, beach boy, transgender)

Secondary KP/Overlapping risk (probe): (indicate: PWID, sex worker, MSM, beach boy, transgender)

Client contact phone (optional): _____

2. Health information (optional):

Has been tested for	*Ever (Y/N/ not known)*	*Over the past six mo (Y/N/ not known)*	*Knows, negative*	*Knows, positive*	*Status not known*	*Is receiving HIV treatment since which year*
HIV						
TB						
Hep B						
Hep C						
STI (any)						

3. Risky behavioral practices (optional):

Question:	**Y/N**
1. Had more than one sexual partner over the past year Y/N, if yes:	
a. Used a condom during last sexual intercourse?	
b. Had a commercial sexual partner over the past year (offered sexual services in exchange for money or other benefits)?	
2. Injected drugs during the past year Y/N, if yes:	
a. Used a clean syringe during the last injection?	

4. Other information

4.1 Year of birth (mandatory field)

4.2 Transgender? Y/N (mandatory field)

4.3 Marital status (optional) **1.** Single **2.** Married **3.** Living together **4.** Divorced **5.** Separated **6.** widowed

Peer Educator _____

Field Supervisor / Management Assistant

_____

Annex 3: Clinic Escort/Referral Form

STD-KP/M&E/2.1/2020

Clinic Escort / Referral for HIV/STI Testing-Part 1

Serial No._____

(Version 10.1.2020)

Part 1 (to be completed by PE)

UIC

Referred by:	
Peer Educator Name	
Date of referral	
Project name	
Peer Educator phone number	
Referred to:	
STD Clinic	
Clinic address phone number	
Peer Educator signature	

Annex 4: Clinic Escort / Referral for HIV/STI Testing- Part 2

STD-KP/M&E/2.2/2020

Part2 (to be completed by STD clinic)

Serial No.____

UIC | | | | | | | | | |

(verified by STD clinic staff with NIC)

PH Number / STD file number: _____

Service provided and result	**Date**	**Doctor's name**	**Doctor's signature**	
HIV screening test Yes ☐ No ☐				
HIV screening test result Positive ☐ Negative ☐ Indeterminate ☐				
The client received the result. Yes ☐ No ☐				
Confirmed HIV test result				

Positive ☐ Negative ☐ Indeterminate ☐			
STI screening test result: 1 – Syphilis Positive ☐ Negative ☐ 2 – Gonorrhoea Positive ☐ Negative ☐ 3 – chlamydia Positive ☐ Negative ☐ 4 – hepatitis B Positive ☐ Negative ☐ 5 – hepatitis C Positive ☐ Negative ☐			
STI Treatment/referral: 1 – Syphilis treatment ☐ 2 – Gonorrhoea treatment ☐ 3 – Chlamydia treatment ☐ 4 – Hepatitis B referral for treatment ☐ 5 – Hepatitis C referral for treatment ☐			

Annex 5: Outreach Daily Record Form

STD-KP/M&E/6/2020

KP Prevention Reporting Format

(Version 10.1.2020)

(The table below should be completed separately for each KP)

Name of the KP community: _____

Reporting Period :_____

#	Indicator	Target	Result
1	Number of KP (MSM / PWID / SW / BB / TG) reached with HIV prevention programs - defined package of services that includes: 1) IEC/BCC; 2) condom promotion and distribution; and 3) information on and/or referral to HIV testing/STI diagnosis and treatment		
2	Number of KP (MSM / PWID / SW / BB / TG) that have received an HIV test during the reporting period and know their results[1]		
3	Number of KP (MSM / PWID / SW / BB / TG) who were referred / escorted to STD clinic for HIV / STI screening		
4	Number of KP (MSM / PWID / SW / BB / TG) who attended the STD clinic out of those who were referred / escorted to STD clinic for HIV / STI screening		

5	Number of KP (MSM / PWID / SW / BB / TG) who had an HIV- positive rapid test result in outreach		
6	Number of KP (MSM / PWID / SW / BB / TG) who had an HIV- positive screening test result in STD clinic		
7	Number of KP (MSM / PWID / SW / BB / TG) who had confirmed HIV-positive test result		

Field Supervisor / Management Assistant : _____

Signature of Venereologists/MOIC : _____

Annex 6: Outreach Rapid HIV Test Result Form

STD-KP/M&E/4/2020

Outreach Rapid HIV Test Result Form

(To be completed by clinic staff)

STD Clinic	
Date	
Project	
Name of clinic staff	
Designation of clinic staff	

#	UIC	Rapid test result			Escort /referral for HIV screening to STD clinic (Y/N)
		positive	negative	Indeterminate	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Signature of Venereologists/ MOIC _____

Annex 7: Daily Record Form of PE (for Peer-led Outreach model)

STD-KP/M&E/3.1/2020

STD Clinic	
Date	
Project Name e.g. GF,	
Peer Educator Name	

	UIC	Behaviour Change Information (Y/N)	IEC materials (Y/N)	Condom promotion (Y/N)	Condom distribution (number)	Lubricant distribution (number)	Pre-test information (Y/N)	Rapid HIV test (Y/N)	Blood sample collected for HIV test at STD clinic (Y/N)	Escort /referral for HIV / STI screening to STD clinic (Y/N)
1.										
2.										
3.										
4.										
5.										
6.										
Peer meeting place and other details										

Peer Educator _____

Field Supervisor / Management Assistant _____

Annex 8 :Daily Record Form of PE (for Case Finding outreach model)

STD-KP/M&E/3.2/2020

STD Clinic	
Date	
Project name	
Peer Educator Name	

	UIC	Behaviour Change Information (Y/N)	IEC materials (Y/N)	Condom promotion (Y/N)	Condom distribution (number)	Lubricant distribution (number)	Pre-test information (Y/N)	Rapid HIV test (Y/N)	Rapid test result (positive / negative / indeterminate)	Escort /referral for HIV / STI screening to STD clinic (Y/N)
1										
2										
3										
4										

5										
6										
7										
8										
Peer meeting place and other details										

Peer Educator _____

Field Supervisor / Management Assistant_____

Annex 9: Condom/Lubricant Stock Management Form

STD-KP/M&E/5.1/2020

Condom Stock Management Form **(Version 10.1.2020)**

(Completed by Management Assistant)

STD Clinic	
Data of the month	
Name of Management Assistant	

	Date	Balance at the start of the period	Number received by MA	Number issued to PE	PE name	Balance at the end of the period
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

MA signature: _____

Date of completion: ----------

Annex 10: Lubricant Stock Management Form

(Version 10.1.2020)

STD-KP/M&E/5.2/2020

(To be completed by Management Assistant)

STD Clinic	
Data of the month	
Name of Management Assistant	

	Date	Balance at the start of the period	Number received by MA	Number issued to PE	PE name	Balance at the end of the period
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

MA's signature :_____

Date of completion:_____

Annex 11. Key Population Prevention Report

(by Manager/coordinator)

KP Prevention Reporting Format (Version 10.1.2020)

(The table below should be completed separately for each KP) Name of the KP community: Reporting Period:

#Indicator Target Result

1 Number of KP (MSM / PWID / SW / BB / TG) reached with HIV prevention programs - defined package of services that includes:

1) IEC/BCC; 2) condom promotion and distribution; and 3) information on and/or referral to HIV testing/STI diagnosis and treatment

2 Number of KP (MSM / PWID / SW / BB / TG) that have received an HIV test during the reporting period and know their results

3 Number of KP (MSM / PWID / SW / BB / TG) who were referred / escorted to STD clinic for HIV / STI screening

4 Number of KP (MSM / PWID / SW / BB / TG) who attended the STD clinic out of those who were referred/escorted to STD clinic for HIV / STI screening

5 Number of KP (MSM / PWID / SW / BB / TG) who had an HIV-positive rapid test result in outreach

6 Number of KP (MSM / PWID / SW / BB / TG) who had an HIV-positive screening test result in STD clinic

7 Number of KP (MSM / PWID / SW / BB / TG) who had confirmed HIV-positive test result

Field Supervisor / Management Assistant:

Signature of Venereologists/MOIC:

Incident report

Annex 12 Staff confidentiality & code of conduct agreement

1. Parties to the Agreement:

a. _____
____ (hereinafter known as the Employee),

b. _____
___ (hereinafter known as the employer).

This agreement is for the Employee's employment as _____(job title) ---------- for_____(program name) _____ (hereinafter known as the HIV Outreach Program)

I. Confidentiality (non-disclosure)

1. The Employee understands and accepts that during employment, they will be privy to confidential and

personal information about clients and the program as a whole.

2. In the context of the HIV Outreach Program, the confidential and personal information of a client is defined as:

Any personal, medical, and psycho-social support information of a client found in client records filed by the Employer and all other client records in clinics and other service providers under the HIV Outreach Program.

This includes but is not limited to:

a. Medical conditions and treatments;

b. Relations with family members;

c. Sexual relations, HIV status of individuals, and engagement in sex work or drug use by individuals;

d. Names and addresses of people living with HIV;

e. Other personal and sensitive information;

f. Other records of volunteer workers, staff, and clients

3. In the context of the HIV Outreach program, confidential and personal information of the program covers all records of the internal matters of the HIV Outreach Program

This includes but is not limited to:

a. Records, documentation, and reports;

b. Minutes and notes of team meetings, discussions and sharing;

c. Personnel records and details of the Program as well as other employees or volunteers or volunteers of the Employer

4. The Employee must never reveal the confidential and personal information as detailed in items 2 and 3 above or **at any time** to:

a. Other Clients

b. Any non-employee of the Employer

c. Any employee of the Employer that are not directly involved with the HIV Outreach program

d. Family members (including spouses)

e. Friends and acquaintances

f. Any other parties not explicitly outlined above

5. The Employee must take all necessary reasonable steps to ensure that confidential and personal information, as detailed in items 2 and 3 above, is not discussed in areas where it might be overheard by parties listed in item 4 above.

6. The Employee must not expose confidential and personal information, as detailed in items 2 and 3, on any form of online media or other digital platforms that can be read by parties listed in item 4 above.

7. Any unauthorized disclosure of confidential and personal information, as detailed in items 2 and 3 by the Employee, will be subject to disciplinary action up to and including termination from employment by the Employer and/or potential

civil or criminal proceedings under Sri Lankan law, as applicable.

8. The Employee accepts that clients can, at his or her disposal, pursue any legal action(s) deemed necessary and appropriate if he or she rightly feels that the Employee has wrongfully disclosed his or her confidential and personal information, as detailed in item 2.

    a. If the Employee's breach of confidentiality could render the Employee liable for damages, the Employer is not obligated to indemnify the Employee.

    b. If the Employee's breach of confidentiality could render the Employer liable for damages, the Employer may, in turn, hold the Employee liable.

9. The Employee further understands that this obligation not to disclose confidential and personal information, as detailed in items 2 and 3,

applies after the Employee ceases to be an employee.

II. Code of Conduct

10. In addition to confidentiality as detailed in Part II of this agreement, the Employee also must abide by the following ethical code of conduct under all circumstances both during and after service provision:

    a. Not to breach the terms and conditions of the contract of employment

    b. No discrimination or verbal or physical bullying of clients or staff of the Employer

    c. No romantic or sexual relationships of any kind with clients

    d. No consumption of any illegal substances, drug taking, or drinking alcohol with clients

e. No financial transactions such as lending to or borrowing money from clients or our partners. Do not accept cash or solicit gifts from clients or our partners.

f. No engagement in any form of illegal activity of any kind with clients

g. No inappropriate use of the case management program's facilities and resources (including staff) for personal gain.

h. No conflict of interest between your private interests and the HIV Outreach program

11. Any breach of the ethical code of conduct as listed in item 10 above by the Employee will be subject to disciplinary action by the Employer up to and including termination from employment and/or potential civil or criminal proceedings under Sri Lankan law, as applicable.

12. The Employee is to be aware that clients can, at his or her disposal, pursue any legal action(s) deemed necessary and appropriate if he or she rightly feels that the Employee has breached any ethical code of conduct.

    a. If an employee's breach of the ethical code of conduct could render the Employee liable for damages, the Employer is not obligated to indemnify the Employee.

    b. If the employee's breach of the ethical code of conduct could render the Employer liable for damages, the Employer may, in turn, hold the Employee liable.

III. Declaration

As the Employee, I hereby declare that.

1. I have received a copy of, read, understood, and agreed to uphold this confidentiality and code of conduct agreement.

2. I understand that in my daily job duties, any breach of confidentiality and/or breach of ethical code of conduct, as stipulated in this agreement, could result in

    1. disciplinary action up to and including termination and/or potential civil or criminal proceedings under Sri Lankan law as applicable.

    2. Liability for damages that I will not be indemnified for

    3. Liability for damages by the Employer that I may be held liable for.

3. I understand that I am to report immediately to the management of the Employer any breaches of confidentiality and/or breach of ethical code of conduct as stipulated in this agreement

4. By signing this agreement, I hereby undertake to uphold this agreement, which will be kept in my personnel file.

Signed this _____ day of _____, in the year_____.

The Employee (Full name & signature):

Representative of the Employer (Full name, title and signature)

Witness (Full name & signature):

Annex 13: Job description for MA and Outreach Workers

Post of Management Assistant MA

District Sexually Transmitted Diseases (STD) Clinic

The Management Assistants will be recruited to the District STD clinics to assist with special interventions to prevent and control HIV and sexually transmitted infections. They will be placed in each district STD clinic under the supervision of a consultant or medical officer in charge of that clinic.

DUTIES AND RESPONSIBILITIES:

Generally, this particular position has to work with a team of field supervisors (FS) /outreach workers (ORW) and peer educators (PE) in each district. Hence, the individual has to be able to play a key role as a team player or leader.

The responsibilities are as follows.

1. To understand the overall district-specific Key Population (KP) intervention project assigned to each STD clinic.

2. To understand and study all relevant documents related to these KP interventions.

3. Prepare an action plan and prepare documents to facilitate the KP interventions in the local setting, as per the district's needs.

4. To be able to manage the targets to be implemented in each quarter and as a whole for the year

5. Close coordination and monitoring of the FS and PE are needed to work smoothly and reach the KP targets.

6. Maintain all documents (programmatic and administrative) up to date and follow the instructions given thoroughly to facilitate programmatic performance and payments, including monthly salaries.

7. Maintain a data sheet in a computer that can generate data as and when needed.

8. Coordinate and arrange outreach activities, programs, monthly review meetings, and any special activities.

9. Coordinate with NGO/CBO in administrative and technical capacity to smoothly run the program.

10. Ensure all activities follow the supervisors' technical guidelines and instructions.

11. Handle official communications under your capacity by informing the supervisor; emails, emails, fax ext.

12. Ensure safe storage of project documentation and maintain confidentiality.

13. Perform other duties that may be assigned.

REQUIRED EDUCATION QUALIFICATIONS, EXPERIENCE, SKILLS & COMPETENCIES:

1. Should have passed the General Certificate of Education (Ordinary Level) examination in six (06) subjects in one sitting with credit passes in Sinhala/Tamil/English Language, Mathematics and two other subjects and a pass in all subjects at the General Certificate of Education (Advance Level) Examination (other than the standard general paper) at one sitting (a pass in 3 subjects under the old syllabus at one sitting would be sufficient).

2. Should have a minimum of one year of hands-on experience in a similar capacity at Government /foreign-funded projects or Corporate Sector organisations.

3. Strong computer skills in statistical software, spreadsheets, word processing, presentations, the Internet, and email software are necessary.

4.Demonstrated communication skills (written and oral) and manageable proficiency in English, along with fluency in Sinhala and/or Tamil, are required.

5. Be results-oriented and able to meet strict timelines for outputs.

6. Be able and willing to travel within the district for outreach activities, central-level training, and meetings outside the district.

7. Be self-motivated, versatile, and adaptable to different cultures and people.

8. A high degree of personal discipline, honesty, and integrity is necessary.

9. Capability to work independently and to work under pressure.

10. Maintaining confidentiality of information and exercising discretion in dealing with confidential or sensitive matters is a prerequisite.

11. Outstanding team player who can adapt to the organization's environment and is interested in growing with the organization.

GENERAL CONDITIONS:

1. May need to travel to project implementation sites throughout the district.

2. Age should be below 35 years as of ……., however, a suitable younger candidate will be given priority

3. Recruitment will be on a contract basis.

4. The contract will be a maximum of one year.

5. The salary is as per the agreement made by the National STD/AIDS Control Programme. It will be paid through the contracted NGO/CBO for this intervention.

6. The employer's contribution to EPF is 12%, and the ETF contribution is 3% of the salary. The employee's contribution to EPF is 8% of the salary.

7. The selected applicant should be able to take up the assignment as soon as possible, as per the instructions by the contracting NGO/CBO.

8. Only short-listed candidates will be called for an interview.

Assigned By	**Accepted By**
Name	Name
Designation	Designation
Signature	Signature
Date	Date

Approval …….. Approved by

Consultant/ MO-In Charge

District STD Clinic (Name of the clinic) ----------

…….. Counter-signed Executive Director

NGO/CBO (Name) ----------

Post of Outreach Worker

District Sexually Transmitted Diseases (STD) Clinic

The Outreach Worker will be recruited to the District STD clinics to assist in special interventions to prevent, & control HIV and sexually transmitted infections. They will be appointed to each district STD clinic under the supervision of a consultant or medical officer in charge of each clinic.

Generally, this position works with a team of Management Assistants (MA) and peer educators (PE) in each district. Hence, the individual has to be able to play a key role as a team player.

DUTIES AND RESPONSIBILITIES:

1. Mapping service area with Peer Educators and Peers

2. Conduct a stakeholder analysis for the identification of areas hot spots with the Peer Educators for service provision

3. Training Peer Educators/ getting them for training to increase knowledge and skills over time

4. Support Peer Educators in completing the Client Registration Form, Peer Educator Calendar, Diary and Referral Slips

5. Establish the requirement from the stakeholders for program success and sustainability

6. Ensure Peer Educators and Peers have a sense of ownership in the peer education programs through early involvement and ongoing consultation

7. Conduct bi-monthly pocket meetings with PE and his/her peers and share the minutes of SID clinics and NGO/CBO

8. Develop complementary interventions to educate and support behaviour change in Peer Educators and Peers

9. Maintain good relations with STD Clinic and other officials

10. Follow up on testing with Peers and organize mobile clinic testing

11. Continuously improve the knowledge and attitude of Peer Educators

12. Conduct regular field visits and verify Peers

13. Subject to knowing the status of a Peer, providing home-based care, support and follow-up, etc.

14.Ensure timely submission of the required forms to the management assistant

15.Support Management Assistant to maintain all programmatic and administrative documents (training attendance sheet, training completion report, stock registry, condom distribution list)

16.Perform other duties that may be assigned.

REQUIRED EDUCATION QUALIFICATIONS, EXPERIENCE, SKILLS & COMPETENCIES:

12. Should have passed the General Certificate of Education (Ordinary Level) examination in six (06) subjects in one sitting.

13. Working knowledge of computer skills.

14. Demonstrated communication skills (written and oral), fluency in Sinhala and/or Tamil, and an understanding level of proficiency in English are required.

15. Have an understanding and knowledge about the project

16. Be results-oriented and able to meet strict timelines for outputs

17. Be able and willing to travel and work within and outside the district, even in remote areas in challenging circumstances

18. Be self-motivated, supportive, versatile, and adaptable to different cultures and people

19. A high degree of personal discipline, honesty, and integrity is necessary.

20. Capability to work independently and to work under pressure

21. Maintaining confidentiality of information and exercising discretion in dealing with confidential or sensitive matters is a prerequisite.

22. Outstanding team player who can adapt to the organization's environment and is interested in growing with the organization.

GENERAL CONDITIONS:

9. Required to travel to project implementation sites all over the district.

10. Flexible working hours depending on the Peer Educators

11. The age should be below 35 as of …….... However, a suitable younger person will be given priority.

12. Recruitment will be on a contract basis.

13. The contract will be for a maximum of one year.

14. Salary is as per the agreement made by the National STD/AIDS Control Program

15. The employer's contribution to EPF is 12%, and the ETF contribution is 3% of the salary. The employee's contribution to EPF is 8% of the salary.

16. Selected applicants should be able to take up the assignment within the earliest possible maximum of one month.

17. Only short-listed candidates will be called for an interview.

Assigned By	Accepted By
Name	Name
Designation	Designation

Signature Signature

Date Date

Approval

……..

Approved by

Consultant/ MO-In Charge

District STD Clinic (Name of the clinic) ----------

…….. Counter-signed Executive Director

NGO/CBO (Name) ----------

Post of Peer Educator

District Sexually Transmitted Diseases (STD) Clinic

The Peer Educators will increase their network and involvement with peers at the grassroots level to work more closely with STD clinics across the districts to increase peer knowledge and understanding of the NAACP approach, communication, methodology, and intervention strategy. They will lead in inspiring a positive transformation of mindsets, attitudes, and behaviors within themselves and their local community through non-formal values—and skills-based education.

He/she will work under the supervision of the consultant/ MOIC of the district STD clinic.

DUTIES AND RESPONSIBILITIES:

1. Assist in developing a clear action plan to roll out peer education in the respective districts and communities.
2. Identify peers in the district
3. Train and support Peers to effect change at the individual, group, or societal level
4. Provide education on HIV/STD Condom use and distribute condoms
5. Escort Peers to STD Clinics
6. Facilitating HIV education programmes
7. Help in HIV testing
8. Support information gathering and record-keeping purposes
9. Support the district and national events and campaigns by NSACP

10. Support existing work by NSACP and create new ideas to promote peer education
11. Perform other duties that may be assigned.

REQUIRED EDUCATION QUALIFICATIONS, EXPERIENCE, SKILLS & COMPETENCIES:

23. Basic knowledge of Sexual Reproductive Health and Rights
24. Strong commitment to inner change and the development of skills to promote harmony and positive attitudes within communities
25. Demonstrated communication skills (written and oral), fluency in Sinhala and/or Tamil, and understanding-level proficiency in English are required.
26. Be results-oriented and able to meet timelines for outputs
27. Be able and willing to travel and work in remote areas in challenging circumstances
28. Be self-motivated, supportive, versatile, and adaptable to different cultures and people
29. A high degree of personal discipline, honesty, and integrity are a must.
30. Capability to work independently and to work under pressure
31. Maintaining confidentiality of information and exercise discretion in dealing with confidential or sensitive matters in pre-requisite.

32. Outstanding team player with the ability to adapt to the organization's environment and has an interest in growing with the organization.

GENERAL CONDITIONS:

18. Required to travel to project implementation sites all over the district.
19. Flexible working hours
20. Recruitment will be on a contract basis.
21. The contract will be for a maximum of one year when a monthly allowance of Rs. ……. will be paid without EPF and ETF.
22. Selected applicants should be able to take up the assignment within a reasonable period, maximum, within one month.
23. Only short-listed candidates will be called for an interview.

Assigned by	Accepted By
Name	Name
Designation	Designation
Signature	Signature
Date	Date

Approval

…….. Approved by

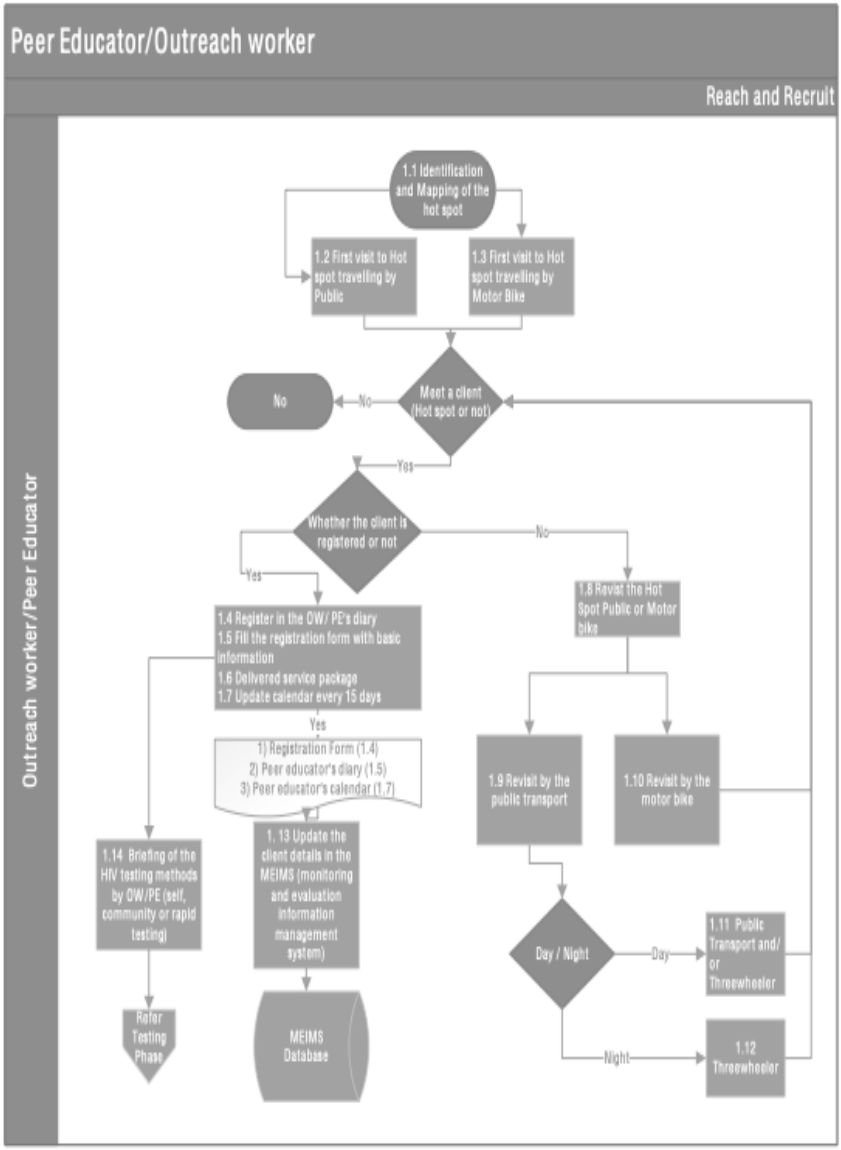
Consultant/ MO-In Charge

District STD Clinic (Name of the clinic) ----------

…….. Counter-signed Executive Director

NGO/CBO (Name) ----------

Annex 14: Flow chart of Peer Educator and Outreach Worker Tasks



Annex 15 : (Bi-)Weekly Outreach Meeting Agenda

- **Updates from the Manager/Director/Supervisor/Coordinator:**
  Report on recent meetings with STD/HIV clinic team, health department staff or other key stakeholders, so that outreach workers and peer educators are informed about program developments.

- **Weekly Report Discussion:**
  The Outreach Coordinator presents the consolidated (bi)weekly report based on individual reports, followed by a group discussion of key results:
  1. Number of new and repeat clients reached with the outreach package.
  2. Number of clients tested for HIV (new and repeat) through outreach or at facilities, and their results.
  3. Challenges faced in linking clients to HIV testing and treatment services, and follow-up actions.
  4. Updates on quality of outreach services based on feedback or evaluations.
  5. Inventory review: Check stocks of condoms, lubricants, HIV test kits, IEC materials, etc.

- **Problem-Solving and Updates:**
  Group discussion to share experiences, such as:
  1. Difficult clients and strategies to address their needs.
  2. New trends, meeting places, or online platforms being used by key populations.

3. Updates to the HIV Hotspots Map if new locations are identified.

- **Planning for the Upcoming Week:**
    1. Are there upcoming events or opportunities to reach new clients?
    2. Are there areas with low case detection rates that should be deprioritized?
    3. Are there areas with high numbers of new HIV cases where efforts should be intensified?
    4. Review and adjust weekly targets as needed, taking into account the difficulty of reaching certain networks.
- **Refresher Training:**
  Short training sessions based on one or more chapters from the Reference Manual to reinforce skills and knowledge.
- **Team Building and Sharing:**
  Discuss ways to enhance teamwork, share issues faced in the field, and identify strategies to work better as a group. Celebrate achievements to boost morale.
- **Other Business:**
  Any additional issues brought up by outreach workers and peer educators.