



MAY 2017

LINKAGES Enhanced Peer Outreach Approach (EPOA)

IMPLEMENTATION GUIDE



USAID
FROM THE AMERICAN PEOPLE



LINKAGES
*Across the Continuum of HIV
Services for Key Populations*

fhi360
THE SCIENCE OF IMPROVING LIVES

ACKNOWLEDGMENTS

This guide draws on materials developed by FHI 360 for the enhanced peer outreach approach (EPOA) program in Thailand, the EPOA program in Vietnam, and similar programs in Botswana, Cameroon, Laos, Jamaica, Papua New Guinea, and Suriname. We acknowledge the work of those programs and appreciate the opportunity to share some of this material more widely.

This guide was drafted and edited by James Baer, and its development was supervised by Tiffany Lillie of FHI 360/LINKAGES. The input and comments of LINKAGES staff and consultants are gratefully acknowledged, with particular thanks to Matthew Avery, Daniel Levitt, and Virupax Ranebennur.

This document was made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The contents are the responsibility of the LINKAGES project and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government. LINKAGES, a five-year cooperative agreement (AID-OAA-A-14-00045), is the largest global project dedicated to key populations. LINKAGES is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill.



Contents

Introduction	3	3 Tracking and program monitoring	19
1 Essential components of the EPOA	5	3.1 Tracking outreach and referrals	19
1.1 The referral chain network and peer mobilizers	7	<i>Paper-based system</i>	19
<i>The role of peer mobilizers</i>	7	<i>Electronic system</i> <i>(the eCascade system)</i>	25
<i>How does the peer outreach worker</i> <i>manage PMs?</i>	10	3.2 Using data for supervision and program monitoring	26
1.2 Standardized approach to outreach	10	4 Tool: Illustrative activities checklist for planning and implementation of the EPOA	28
1.3 Performance-based incentives	11	5 Annexes	31
<i>More considerations for</i> <i>peer outreach workers</i>	13	1. Incentive scheme for peer outreach workers and PMs	31
<i>More considerations</i> <i>for peer mobilizers</i>	13	2. Commitment pledge	34
<i>Additional considerations</i>	15	3. Training outline	35
<i>Managing the confidentiality</i> <i>of HIV test results</i>	15	4. Message matrix	37
<i>Addressing concerns</i> <i>about potential misuse of</i> <i>performance-based incentives</i>	16	5. EPOA enrollment form for new KP members	40
2 Staffing and training for EPOA	17	6. Referral slip	44
Program management staff	17	7. Referral slip collection form	47
Facility-based staff	17	8. Service uptake aggregation form	48
Training peer outreach workers	18	9. Referral slip tracking log	49
<i>EPOA and community-led testing</i>	18	10. Incentives calculation worksheet	51
<i>EPOA and self-testing</i>	18		

Acronyms and abbreviations

ART	Antiretroviral therapy
CBS	Community-based supporter
EPOA	Enhanced peer outreach approach
HTS	HIV testing services
IEC	Information, education, and communication
KP	Key population
M&E	Monitoring and evaluation
PM	Peer mobilizer
STI	Sexually transmitted infection
UIC	Unique identifier code
USAID	United States Agency for International Development
USD	U.S. dollar



Introduction

Globally, HIV programs are paying increasing attention to the full cascade of services related to HIV prevention, diagnosis, care, treatment, and adherence. This technical shift is in response to UNAIDS' 90–90–90 goals.¹ The LINKAGES cascade (**Figure 1**) is an organizing framework for the LINKAGES project to improve HIV prevention, testing, treatment, and care for key populations (KPs) — sex workers, men who have sex with men, transgender people, and people who inject drugs — who bear a disproportionately high burden of HIV. LINKAGES advocates three community-led approaches to support KP members across the cascade:

- **Peer outreach** engages KP members regularly in activities for HIV prevention, testing, and related services. Peer outreach workers² focus particularly on KP members who frequent “hot spots” or visit drop-in centers, where they can be contacted regularly for one-on-one or group conversations and to receive prevention commodities such as condoms, lubricant, or sterile needles and syringes.
- **The enhanced peer outreach approach (EPOA)** complements peer outreach by engaging previously unidentified KP members for HIV prevention and testing — particularly those who are hard to reach and who may be at high risk of HIV, or HIV positive. The goal is to increase HIV testing yield, link HIV-positive KP members with treatment and care, and connect HIV-negative KP members with services that will help them remain HIV negative. The EPOA is led by peer outreach workers, who engage KP members to persuade

peers in their own social and sexual networks to be tested for HIV. It focuses on those who are not found at traditional hot spots, which is particularly important because technology changes the ways that some KP members contact and meet sexual partners.

- **Peer navigation** supports KP members who are living with HIV so that they enroll and remain in clinical care (especially antiretroviral therapy [ART]). Peer navigators are trained individuals who are usually living with HIV themselves and who are often KP members. (In some cases, peer outreach workers may fulfill the role of peer navigator.)

Most LINKAGES partners are already implementing peer outreach activities (or are beginning to do so), and some are piloting peer navigation. LINKAGES has developed materials to support peer outreach³ and is also developing a guide on peer navigation. This guide introduces the EPOA.

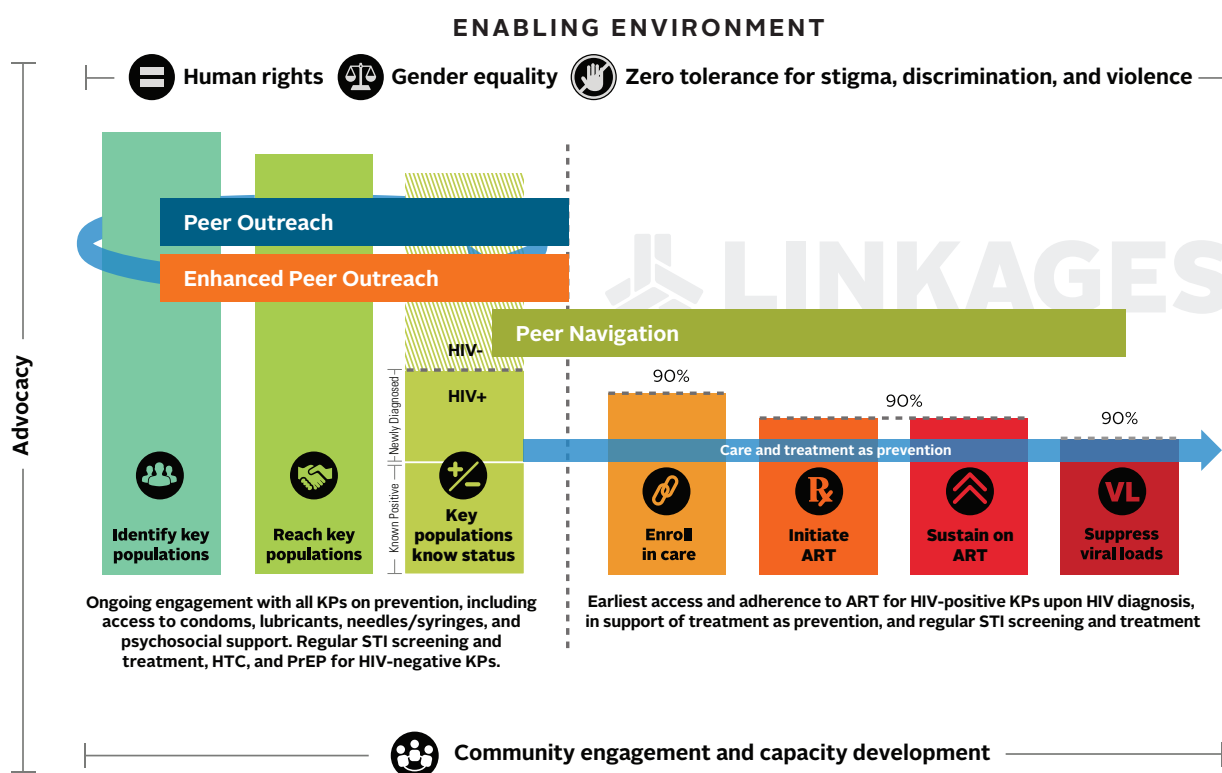
The EPOA is currently being piloted by LINKAGES partners in several countries in Asia, Africa, and the Eastern Caribbean. Experience so far shows that there is no “one-size-fits-all” approach to the EPOA. It is a model that requires adaptation to the local context, and because it is new, a period of adaptation may be needed as programs learn what works best for them. This guide describes the EPOA and its potential benefits, the essential components of the EPOA, and the steps involved in implementing it, including potential challenges. It includes a checklist for preparing to implement the EPOA (Section 4), and the annexes include examples of program tools and forms.

¹ By 2020, 90% of all people living with HIV will know their HIV status, 90% of people diagnosed with HIV infection will receive sustained ART, and 90% of people receiving ART will have viral suppression.

² In keeping with other LINKAGES documents, the term “peer outreach worker” is used for a KP member who is trained to do outreach to other KP members. Peer outreach workers may also be known as peer educators, peer leaders, or by other terms.

³ These include the Key Population Program Acceleration Guide and the Monitoring Guide and Toolkit.

FIGURE 1. The roles of peer outreach, the enhanced peer outreach approach, and peer navigation in the HIV cascade



Essential features of the EPOA

- ▶ The EPOA uses referral chain networks to reach KP members for HIV testing who may not be reached by normal peer outreach methods (see Section 1.1). It is implemented by trained peer outreach workers using a standardized approach (see Section 1.2) and by other KP members (peer mobilizers [PMs]) who require minimal orientation.
- ▶ The EPOA uses performance-based incentives to stimulate outreach to previously unreachable KP members (see Section 1.3).
- ▶ The EPOA complements targeted outreach done by peer outreach workers through mapping and microplanning, but it does not replace it. It can also be implemented in contexts where the traditional peer-led outreach has not yet been used.
- ▶ The EPOA can be done by current peer outreach workers, or by peer outreach workers who are specifically and newly trained to do it.
- ▶ Peer outreach, the EPOA, and peer navigation will work most effectively when carefully coordinated, but programs do not need to begin implementing all three simultaneously.

1 Essential components of the EPOA

Peer outreach, enhanced peer outreach, and peer navigation are closely related, and they complement one another (**Table 1**).

The EPOA does not replace peer outreach. It has been developed by USAID and FHI 360 to address the challenge of expanding outreach to KP members who are harder to reach and who may be at high risk of HIV, or who are more likely to be HIV positive.

The EPOA gives peer outreach workers an expanded role: they are trained to create and manage a **referral chain network** to extend coverage of interventions across the HIV cascade (**Figure 2**).

The referral chain network has a minimum of three levels:

1. **Peer outreach workers:** Under the EPOA, peer outreach workers, who are usually KP members themselves, are trained to engage new KP members for HIV testing

and to identify KP members — called PMs — who will offer referrals for HIV testing (or additional services) to KP members in their own social and sexual networks who have not previously been reached.

The EPOA may be most effective when implemented by experienced peer outreach workers. But in contexts where peer outreach has not yet been widely implemented, it can also be done by newly trained peer outreach workers. In some models, such as in Thailand, peer outreach workers implementing the EPOA are engaged by the program as full-time paid staff.

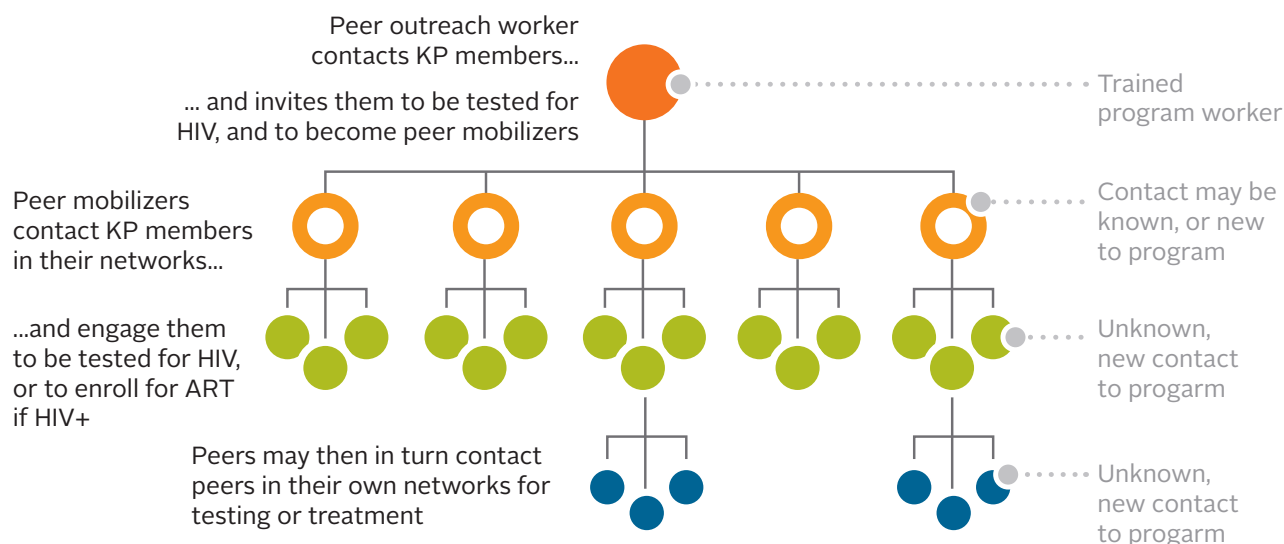
2. **PMs:** PMs are KP members who have undergone HIV testing (or are enrolled in ART if they are living with HIV), and who volunteer to pass referral slips for HIV testing to KP members (peers) in their social or sexual network. Those peers who test HIV negative can be connected with a peer outreach

TABLE 1. Roles for peer support across the HIV cascade

ACTIVITY	APPROACH	DONE BY	TRAINING REQUIRED?
Engaging KP members regularly in HIV prevention activities and referrals	Peer outreach	Peer outreach worker	Yes
Engaging new, hard-to-reach KP members for testing	Enhanced peer outreach	Peer outreach worker and PM	Peer outreach worker: Yes PM: No
Supporting KP members living with HIV in treatment and care	Peer navigation	Peer navigator*	Yes

* In some programs, a peer outreach worker may fulfill the role of peer navigator.

FIGURE 2. Expanding outreach through a referral chain



worker for regular HIV prevention services. Those who are living with HIV can be referred for treatment and care, with support from a peer navigator if this service is available and requested.

PMs generally have a short-term engagement with the program. They receive brief coaching from the peer outreach worker, who also oversees their activity, but they are not required to undergo training, and they have a simple, clearly defined role. This means they can act quickly and easily to bring new KP members into the program.

3. **Peers:** Peers are KP members referred by PMs to take an HIV test (if they have not been tested recently), or to go to an ART center (if they already know that they are HIV positive but have not started or remained on ART).

In some programs, the PM invites peers to

pass on referral slips to people in their own social or sexual networks. Thus, the peer becomes a PM. This extends the referral chain further, which helps the program engage even more hard-to-reach KP members for HIV testing. Some programs may find it appropriate to implement this additional level of peer mobilization once the EPOA is well established.

Although the EPOA should be adapted to the local context in each country, it will generally include most or all of the following components, in addition to the referral chain network. These components are described in detail in the sections that follow:

- **The referral chain network:** For more information, see Section 1.1.
- **A standardized approach to outreach:** Peer outreach workers follow a series of steps in the EPOA, using outreach forms and behavior change communication materials to determine

whether the individual is a KP member at high risk of HIV and whether he or she should be referred for HIV testing (or for ART if living with HIV and not currently enrolled). In countries where the EPOA has been piloted, programs have developed specific materials to guide the conversation. For more details, see Section 1.2.

- **Performance-based incentives:** Peer outreach workers receive a financial incentive to engage PMs who succeed in bringing new KP members to be tested for HIV. In addition, PMs themselves receive an incentive (monetary or in-kind) when the peers whom they contact complete a referral for an HIV test, or if a person known to be living with HIV completes a referral to an ART center. If any of those peers in turn become PMs, they also receive an incentive for completed HIV test referrals. For more details, see Section 1.3.
- **Rapid HIV testing in the field:** In some settings, rather than referring the KP member to a testing center, HIV tests are administered by trained, community-based lay health workers, or by peer outreach workers themselves, using either finger-prick or oral fluid testing kits. (In some settings, rapid HIV testing is also performed by peer navigators.) A KP member who receives a positive test result through community testing is usually referred to a central hospital or laboratory-based test center for a confirmatory test.
- **Referrals to ART and peer navigation:** For newly enrolled KP members who test HIV positive, referrals to treatment and care are essential. Where available, peer navigation is also offered to reduce loss to follow-up and to help people increase adherence and maintain a suppressed viral load.

1.1 The referral chain network and peer mobilizers

A referral chain begins with the peer outreach worker contacting other KP members at hot spots (whether small-scale or large-scale, public or private⁴). These may be high-risk individuals with whom the peer outreach worker is already in regular contact. Peer outreach workers also actively seek out KP members whom they have not contacted before in order to meet the health needs of others who may be vulnerable to HIV.

In addition to building rapport, doing a simple needs assessment (see Section 1.2), and offering behavior change communication, the peer outreach worker invites the KP member to be a PM — to reach other KP members in their social network who may not frequent those hot spots, and to encourage them to get tested. Thus, the EPOA uses the social networks of KP members to extend program coverage and to target hard-to-reach and highest-risk individuals who may be underserved by hot-spot-based outreach approaches.

The role of peer mobilizers

When KP members agree to become a PM, the peer outreach worker gives them several referral slips for HIV testing to pass on to friends. Referrals are generally made to a LINKAGES-supported testing and treatment site because it is easier to ensure that these services are KP-friendly and to provide follow-up support. The referral slip helps track peers through the process. The peer outreach worker explains to the PMs that they will receive a small financial incentive if an eligible peer completes an HIV test (**Table 2**, page 14). The peer outreach worker can help them identify the most likely referrals in their network — people they know best and who are most likely to be at high risk for HIV.

4 Examples of private hot spots are clubs, saunas, private parties, or virtual (internet) networks.

What makes an effective peer mobilizer?

No KP member is required to become a PM. It is not the goal of the EPOA to turn every contact into a PM, but all KP members who accept the invitation or who offer to be a PM can become one. Program experience to date suggests that only about a quarter of KP members accept the invitation to become a PM. There are several characteristics of effective PMs. They:

- Engage in behaviors that put them at high risk for HIV (they are more likely to be friends with others who are similarly at high risk)
- Have large social networks
- Are good communicators (they will be more successful at persuading their friends)

While all KP members who wish to become PMs can do so, peer outreach workers may choose to focus their support on those who have these characteristics. Unlike the peer outreach worker, the PM receives only brief coaching, rather than extensive training. So how successful can this approach be? It works because:

- The PM is not required to fulfill responsibilities that require special training, such as education and promoting behavior change.
- The PM's friends and contacts may be more likely to trust him or her than to trust an outreach worker whom they don't know.
- A PM who has already been tested for HIV or received other program services is in a good position to persuade friends to do the same.
- The PM receives a small incentive for successful referrals of peers for testing.

PMs may only volunteer with the program for a short time, and this is another reason not to commit time or money to train them. But even without training, they can successfully reach individuals in their social and sexual networks who might not otherwise be contacted by peer outreach workers, and connect them to program services. In addition, research shows that people who are living with HIV are more likely to have other HIV-positive individuals in their social and sexual networks, so PMs who are living with HIV may be able to link HIV-positive peers to care and treatment.

Each PM receives the same number of referral slips: the quantity is set by the program and may range from three to eight, to be adjusted if needed based on program experience. The PM is instructed to give referral slips only to eligible peers. An eligible peer:

- Is a member of a KP
- Has not been tested for HIV in the past three months (or according to the country's testing target for KPs, which could be every 6 months to year); or, if living with HIV, is not currently enrolled in ART

Note that requirements for training, level of effort on the project, and hiring criteria used in engaging a peer outreach worker differ from those of PMs:

- The peer outreach worker is trained to engage KP members in an in-depth conversation to build rapport and trust, and in this context, can ask them screening questions about risk behaviors to determine whether a referral for HIV testing is appropriate.
- The PM is not trained to have this kind of conversation, but instead uses the rapport that arises naturally from approaching people in their social or sexual networks, i.e., friends or acquaintances. Since the goal of the EPOA is to increase the number of hard-to-reach KP members receiving HIV tests, the PM does not ask their peers about risk behaviors but simply about whether they have been tested in the past three months.
- As the EPOA is implemented over time, analysis of program data will show the testing yield (proportion of peers testing positive for HIV). If the yield is low (i.e., if relatively few peers are at high risk of HIV), the program may consider requiring PMs to ask a simple screening question to identify peers with high-risk behaviors and focus on them for testing.

There are several ways in which the referral for HIV testing can be completed:

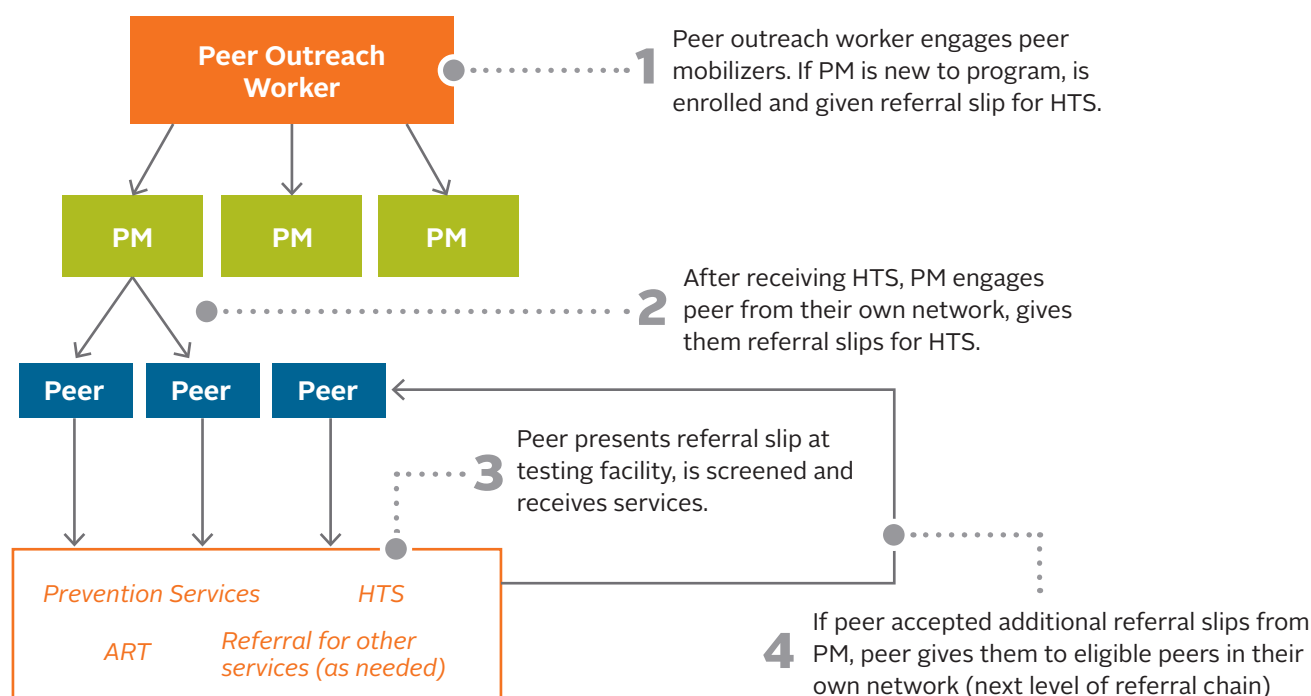
- In some models of the EPOA, peers go directly to an HIV testing center or ART center (usually one affiliated with the LINKAGES project) with the referral slip given to them by the PM. This has the advantage of being quick: peers may be able to receive the test very soon after the PM has spoken to them.
- In other programs, the PM first takes peers to the peer outreach worker, who conducts a more extensive needs assessment and does some behavior change communication, before accompanying peers to the testing center if requested. Although this adds a step to the process before peers receive the test, it has the advantage of introducing peers to the project (through the peer outreach worker) and

therefore increases the chance that peers will become engaged in the program's full range of prevention and support services.

- In programs that offer community-based testing, the peer outreach workers conduct the test themselves. If peers test HIV negative, they can be given further counseling about risk reduction and enrolled for regular contact by the program. If peers test HIV positive, they can be referred to a testing center for a confirmatory test, and be accompanied to the test if they wish.

Figure 3 shows how a peer outreach worker engages PMs, and how PMs engage their peers for HIV testing services (HTS) or other services related to violence and ART that the project wishes to support and strengthen through the social network model.

FIGURE 3. Activity flow for referrals to HTS, and other HIV services, by peer mobilizers





What is a realistic program goal for engaging peer mobilizers?

An example from Thailand

In June 2016, across four project sites in Thailand, 49 community-based supporters (peer outreach workers) engaged a total of 2,409 KP members using EPO. Of these, 689 (28%) agreed to be PMs, although only 137 (20% of the total PMs) completed at least one successful referral of a peer.

In total, therefore, just 6% of the 2,409 registered KP members became “productive” PMs. However, they engaged a total of 744 peers (an average of about five each; the performance of community-based supporters and PMs varied across the four sites). Thus, the referral network approach of EPO expanded the base of KP members tested for HIV from 2,409 to 3,153, an increase of 31%. Of these, 70 (9.4%) tested HIV positive.

How does the peer outreach worker manage PMs?

In places where the EPOA has been piloted, most peer outreach workers work with a group of four or five PMs at any one time. The peer outreach worker:

- Offers the PMs advice and support to successfully engage their peers for HIV testing
- Follows up to make sure they are reaching out to their peers
- Supplies them with more referral slips as needed

The length of time that a PM is active in the program will vary, but it is unlikely to be more than a few months. Program experience to date shows that PMs have varying success in persuading eligible peers to be tested for HIV. Some may not engage any peers; some may engage only one or two; and some may engage many, but eventually reach network saturation (i.e., run out of eligible contacts in their social network). For this reason, the peer outreach worker should try to engage new PMs on an ongoing basis to replace those who cycle out of the program.

Programs can use or adapt the materials that they have already developed for peer outreach.

However, in the EPOA, when peer outreach workers meet a new KP member (and potential PM), they go further than the tailored behavior change communication that is part of peer-led outreach and microplanning:

1.2 Standardized approach to outreach

Peer outreach methodologies, especially those using microplanning, follow a standardized approach that ensures that the same set of information is gathered by the peer outreach worker for each KP member. This helps ensure that all appropriate services — from prevention commodities to information to referrals — are offered to each KP member, and that no relevant services are omitted from one visit to the next.

The EPOA is no different in using a standardized approach. This includes confirming whether the individual is a KP member and whether they have engaged in activities that put them at high risk of HIV, and sharing appropriate behavior change communications and prevention commodities.

1. **After establishing a rapport, peer outreach workers ask KP members specifically about their HIV status**, and actively encourage KP members to get tested if they are unaware of their status. KP members are not **required** to answer questions about their HIV serostatus. In addition, peer outreach workers have the option not to ask the question if they feel the circumstances are not right; however, asking discreetly but directly about HIV status increases the chance of identifying HIV-positive individuals who may have been lost to follow-up and who may need assistance in enrolling in HIV treatment and care. If someone is living with HIV and not in treatment/care, the peer outreach worker can refer him or her to the appropriate services as well as link the person to a peer navigator for additional support if wanted.

- 2. Peer outreach workers give KP members a referral slip for HIV testing or other services. In the EPOA, peer outreach workers take a more active responsibility for encouraging KP members to follow through on the referral as soon as possible after the meeting.** They may offer to accompany KP members to the most convenient testing facility, perhaps immediately, or follow up by phone to see if the KP members have gone to be tested. In some programs, peer outreach workers offer on-the-spot oral fluid or finger-prick testing, which makes a referral unnecessary unless for confirmatory testing of a positive result.
- 3. Peer outreach workers enroll new KP members with a unique identifier code (UIC),** which they have been trained to generate. In many peer outreach programs, the UIC is assigned by a staff member (e.g., the data-entry or M&E officer) soon after a KP member has been enrolled. By contrast, giving the KP member a UIC on the spot facilitates access to HIV testing and ensures that the KP member can be tracked across the cascade of prevention, testing, treatment, and care services to help decrease the chances of that individual being lost to follow-up. (Note that when PMs—who are not trained—give a referral slip to a peer, they do not assign the peer a UIC; this is done either by the peer outreach worker [if the PM takes the peer to meet him or her before testing] or by the testing center when the peer hands in their referral slip.)
- 4. Peer outreach workers invite KP members to become PMs,** i.e., to take additional referral slips and pass them on to peers in their network who they believe are at high risk of HIV, or who are living with HIV but not enrolled in care and treatment. KP members are not required to become PMs, and eligibility for program services is not affected in any way if they decline to do so.

Peer outreach workers use a simple enrollment form to record details of their outreach, including basic KP member information, the responses to questions asked, services delivered, and referrals made (see Section 3.1). In some programs, data are instead recorded on a mobile-phone-based system (see Section 3.1). In either case, the use of a numerical tracking code or a QR (quick response) code (a unique image that is scanned by phone) links the referred KP member to the peer outreach worker. This enables the program to track the KP member across the cascade of prevention, testing, treatment, and care, and to credit the peer outreach worker with successful referrals and calculate their performance-based compensation.

1.3 Performance-based incentives

In the EPOA, peer outreach workers receive a stipend for their outreach work, which compensates them for lost income opportunities during the time they give to the program. (See the *LINKAGES Key Population Program Implementation Guide*, Element 4.3; SWIT p.60; MSMIT p.151–152). The outreach target of meeting 80% of the individuals they cover each month also remains (see the *Program Implementation Guide*, Element 4.1). However, the EPOA also includes a performance-based incentive that rewards peer outreach workers for engaging KP members to newly test for HIV, and to enroll or re-engage those who are living with HIV into care and treatment.

PMs, who are volunteers, also receive a small performance-based incentive to reward their successful efforts.

Incentive schemes must be designed to suit the context of each country's program, with the goal of increasing the number of KP members who are enrolled in the program's prevention, testing, treatment, and care services. There is room for a variety of approaches. Variables to consider when designing incentives include:

The EPOA in Southeast Asia: the “5 Ps” method

In Thailand, Laos, and Vietnam, peer outreach workers use a standardized set of outreach and behavior change communication tools that focus interpersonal communications on an individual KP member's specific risks and needs; gather the information necessary to link the KP member to relevant services, especially HIV testing; and invite him or her to participate as a PM. This methodology, referred to as the “5 Ps” — Peers and partners; Perform; Promote, Provide; Pass it on — shapes the outreach session.

Note that this approach differs in some respects from the EPOA as it is described in this guide. The “5 Ps” approach is presented here as an example of an enhance peer outreach model that was developed for a specific regional context.

- 1. Peers and partners:** Peer outreach workers focus their outreach on identified KP members (and their intimate partners). Initial questions are used to register new KP members in the program with a UIC (generated according to the program/national system), to record which KP they belong to, and to record their mobile phone number (if the individual has one and is willing to share it).
- 2. Perform:** Community-based supporters (CBSs) conduct a needs assessment for each person they meet. CBSs are trained to do this in a way that makes KP members feel comfortable about answering these questions. There is no fixed script, and CBSs can rephrase questions or change their order as appropriate. Three initial key questions are used with all KP members. These are pre-determined by the program according to the profile of the KP being reached and the program's priorities. Questions might be three of the following:
 - Do you know your HIV status?
 - Have you had sex without a condom in the past 3–6 months?
 - Have you exchanged sex for money or goods in the past 3–6 months?
 - Have you had anal sex without a condom in the past 3–6 months?
 - Have you injected drugs in the past 3–6 months?
 - Have you used recreational drugs in the past 3–6 months?

A set of simple follow-up questions enables CBSs to categorize the KP members as high or low priority for further engagement, such as:

- If you have had an HIV test, was it within the past 3–6 months and did you receive your results?
- If you are HIV positive, are you currently enrolled in care and treatment services?

- If you exchanged sex for money or goods, how many partners did you have in the past month?
- If you injected drugs, did you share needles?
- Have you experienced symptoms of a sexually transmitted infection (STI) in the past month?

It is important to limit questions only to those needed to identify the individual as a KP member and to determine their priority level.

High-priority KP members are those who require immediate referral to clinical services — HTS or ART (and, in some countries, STI testing and treatment). They are given a referral slip to take to the service center (see Section 3.1). KP members who know that they are HIV negative but who engage in high-risk behavior will be a high priority for continued outreach, to encourage healthy behaviors and regular HIV testing, pre-exposure prophylaxis (PrEP) where appropriate, etc. Outreach with low-priority KP members may be limited to less frequent face-to-face contact for education, and automated reminders (e.g., by SMS) for regular medical check-ups and HTS.

- 3. Promote:** CBSs offer support, motivation, and encouragement for KP members to engage in healthy behaviors (e.g., condom use, safe injection) and use appropriate services (HTS, ART adherence, STI testing and treatment). A message matrix provides a variety of approaches to communicating these messages according to KP members' individual circumstances (see [Annex 4](#)).
- 4. Provide:** CBSs provide appropriate communications materials, commodities as needed, and a referral slip for HTS or ARV (for high-priority KP members), including the name and address of the clinic to which KP members are being referred.
- 5. Pass it on:** CBSs invite KP members to become PMs, i.e., to take three additional referral slips and pass them on to peers in their network who they believe are at high risk of HIV, or who are living with HIV but not enrolled in care and treatment. CBSs explain to KP members the benefit of doing this for HIV prevention more generally, and the incentives available if referrals of eligible peers are completed, i.e., if the referred person completes an HIV test or is enrolled in ART (see Section 1.3). CBSs may also help PMs conduct basic contact mapping (network analysis) to identify the peers they are closest to and who are at highest risk of HIV.

- The **activity** for which an incentive is paid
- The **minimum threshold** of performance for which an incentive is paid (e.g., the peer outreach worker does not receive an incentive payment for the first five new KP members engaged, since this is considered a minimum requirement of their work)
- **Tiering** of incentive thresholds (e.g., a fixed payment is made for 5–9 new KP members engaged in testing, and an additional payment is made for 10–14 KP members)
- The **amount** of each incentive payment

Table 2 gives examples of incentive structures that have been tried (or are being piloted) by LINKAGES programs in three countries. These are provided as illustrations of possible models. The incentive structures in these countries are subject to change as programs assess their effectiveness and refine their outreach goals. For detailed description of the incentive scheme used by the enhance peer outreach program in Laos, see Annex 1.

More considerations for peer outreach workers

- In programs with established peer outreach, incentives should be paid on top of the agreed stipend that the peer outreach worker receives. It must be made clear that the incentives are paid for completed **new** referrals for testing, i.e., people in addition to the peer outreach worker's original "portfolio" of KP members. The minimum standards for outreach (80% of enrolled KP members reached each month) remain.
- The minimum threshold (refer to page 16 on minimum threshold, tiering, etc.) for engaging new KP members should be decided in consultation with peer outreach workers and based on the local context. In some programs the standard is the same across all implementing partners, but the consultation with peer outreach workers at the local level is

still important to ensure that the threshold is realistic and achievable.

- When considering the peer outreach workers' incentives, the total number of "KP members reached" includes those KP members directly contacted by the peer outreach worker **and** those reached by their PMs. This incentivizes the peer outreach worker to actively manage their PMs and encourage them to make referrals.
- When calculating the number of KP members successfully referred by a peer outreach worker each month, the program may use a rolling three-month average. This makes the incentive structure fairer for peer outreach workers, by taking into account factors such as a slow start while a peer outreach worker gets used to the EPOA; seasonal variation in the number of KP members in the locality; or poor weather that makes outreach difficult.
- If peer outreach workers refer fewer than the minimum required number of new KP members during the month, it is the responsibility of their supervisor to mentor and coach them to help them improve their performance. (See also the LINKAGES Key Population Program Implementation Guide, Element 4.3, Step 3, and SWIT p.58.)

More considerations for peer mobilizers

- Incentives are paid to PMs regardless of the outcome of the HIV test result. The PM is incentivized for successfully referring the peer to be tested, not for the identification of HIV-positive peers.
- Incentives for PMs may be a small amount of cash or a non-monetary incentive, such as mobile phone credit or food coupons. Incentive payments should be standardized across the program, wherever possible. Incentive payments are made to PMs by the implementing partner staff (not by the peer

TABLE 2. Incentive schemes for the EPOA in selected countries

Incentivizing outreach to high-risk KP members not currently connected with program services: monthly incentives for peer outreach workers		
LAOS (FULL-TIME)	CAMEROON (PART-TIME)	PAPUA NEW GUINEA
Base stipend: 150 USD	Base stipend: 50 USD*	In addition to incentives for supporting KP members to be tested for HIV, for KP members who test HIV positive, and for enrolling HIV-positive KP members at an HIV clinic, the enhanced peer outreach program in Papua New Guinea also offers peer outreach workers incentives for:
For each additional 5 new KP members reached and registered with a UIC, above a minimum threshold of 4 KP members per month ("reached" is defined by indicator KP_PREV)	For each additional 5 new KP members reached and registered with a UIC, above a minimum threshold of 5 KP members per month ("reached" is defined by indicator KP_PREV)	
<ul style="list-style-type: none"> • 5–9 new KP members: 20 USD • 10–14 new KP members: 50 USD • 15–19 new KP members: 90 USD • 20 or more new KP members: 140 USD 	<ul style="list-style-type: none"> • 6–9 new KP members: 9 USD • 10–14 new KP members: 17 USD • 15–19 new KP members: 20 USD • 20 or more new KP members: 25 USD 	
For each eligible KP member who receives an oral fluid HIV screening and the result (eligible means has not received an HIV test in the past three months): 5 USD	For each eligible KP member who receives an HIV test (eligible means has not received an HIV test in the past three months): 0.8 USD	<ul style="list-style-type: none"> • Successfully referring a new KP member to an STI clinic for an examination • Successfully referring a new KP member who is a victim of violence to counseling and care
For each reactive-screening KP member who receives a confirmatory test at the HIV testing center: 7 USD	*Stipend and incentive figures in this column are guidelines for implementing partners in the Cameroon program. The actual amounts offered may vary according to the context of the local site and the available budget.	
For each reactive-screening KP member who is confirmed HIV positive at the testing center: 5 USD		
For each new HIV-positive KP member successfully enrolled in pre-ART or ART: 5 USD		

Incentivizing outreach to high-risk KP members for ongoing prevention/treatment: quarterly incentives for peer outreach workers		
LAOS	CAMEROON	
For each HIV-negative KP member at high risk who returns for another HIV oral test within a period of at least 3 months: 5 USD	For each HIV-negative KP member at high risk who returns for another HIV test (rapid finger prick or blood draw) within a period of at least 3 months: 0.4 USD	
For each known HIV-positive KP member successfully re-enrolled in pre-ART or ART (re-enrolled means KP member was previously lost to follow-up for at least one year): 5 USD		

Incentivizing outreach to KP members not currently connected with program services: monthly incentives for PMs		
LAOS	CAMEROON	
Successfully refer an eligible peer to community-based supporter (peer outreach worker): 1.25 USD	Successfully refer an eligible peer to peer leader (peer outreach worker): 0.8 USD	
<ul style="list-style-type: none"> • "Successfully" is defined as a new peer reached (registered, UIC defined, and risk-reduction counseling and condoms and lubricant provided) 	<ul style="list-style-type: none"> • "Successfully" is defined as a new peer reached (registered, UIC defined, and risk-reduction counseling and condoms and lubricant provided) 	
If the referred peer consents to receive an HIV oral test (regardless of the result), the value of the incentive is doubled.	If the referred peer consents to receive an HIV test (regardless of the result), the value of the incentive is doubled.	

outreach worker managing the PM) to keep financial management of the program in-house. This means that the PM must go to the implementing partner's location to receive payment (unless the incentive is mobile phone credit, which can be uploaded to the PM's phone automatically).

- Programs can decide whether incentive payments to PMs are made immediately once the HIV testing referral is completed (which may incentivize the PM to encourage their contact to follow through with testing), or monthly (which may be simpler to administer). Many programs already implementing the EPOA collect referral slips from HTS facilities monthly. Note that if incentive payments are delayed for much more than a month, this may cause PMs to lose motivation.

Additional considerations

- The program can offer a fixed incentive for all referrals made, or it can implement variable incentives, e.g., incentives for those who go on to test HIV positive (as with the three countries listed above) or who are successfully enrolled (or re-enrolled) in ART (Laos and Papua New Guinea examples above), or those who are victims of violence (Papua New Guinea). A single, standardized incentive scheme is easier to manage, but variable incentives may promote the engagement of higher-risk KP members or specific subpopulations, according to the program's priorities.
- If peer outreach workers are funded by other (non-LINKAGES) programs, coordination with those funders may be needed to see whether all peer outreach workers can participate in the incentive scheme. If some are funded by LINKAGES, and some by another funder, it is probably inadvisable to offer incentives only to some peer outreach workers, as this is likely to demotivate those who are not offered incentives.
- Where community-based partners implementing the EPOA are integrated partially or fully into government-funded clinical service delivery systems, difficulties may arise if clinical staff see that peer outreach workers are receiving incentive payments. This is particularly true for peers who return for repeat testing or who are receiving ART, when the clinical staff are not entitled to such payments even though their work contributes to retaining the client in testing or treatment. This eventuality should be considered and planned for when establishing the EPOA.

Managing the confidentiality of HIV test results

When an incentive payment is made for a KP member who tests HIV positive, there may be concerns that the individual's confidentiality is breached by paying the peer outreach worker based on the positive test result. This concern is addressed in the following ways:

- The test result is not given to the peer outreach worker, but is communicated to the program by the HIV testing center.
- The peer outreach worker's incentive payment is not given immediately upon the test result being received, but rather monthly. Since the peer outreach worker will have referred at least six KP members for HIV testing in order to receive an incentive payment (if the minimum threshold for incentives is five referrals), this means that they will not know which of those six individuals tested HIV positive (except in the unlikely scenario in which all of them test HIV positive).
- Note that the PM does not receive an incentive for an HIV-positive test result, and thus will not know the test result of any friends or other contacts whom they refer for a test. PMs only receive an incentive for a completed referral.

In programs with community-led HIV testing (those where peer outreach workers conduct tests themselves), these confidentiality concerns do not

exist because it is the peer outreach worker who gives the result to the KP member. However, the incentive payment should only be assigned upon receipt of a confirmed test result from a testing facility, which gives the opportunity to link the HIV-positive individual into treatment and care.

Addressing concerns about potential misuse of performance-based incentives

There are two potential areas of concern for a program using performance-based incentives. Program managers should be aware of these and discuss them frankly with all relevant program staff, including peer outreach workers.

Potential coercion of KP members into being tested (so that the peer outreach worker/PM can receive an incentive payment). Although the peer outreach worker's role is to encourage newly registered KP members to take an HIV test if they have not done so in the past 3 months (or the interval determined by the national program, if different), KP members should never be pressured into undergoing a test if they do not wish to do so. Discussions and role-plays during training can help peer outreach workers understand the program's standards and what is considered unacceptable pressure or coercion. Each peer outreach worker should sign a commitment pledge that includes not coercing KP members into being tested, or into becoming a PM (see Annex 2).

Similarly, peer outreach workers should explain to their PMs that they must not coerce their peers into taking a referral slip for an HIV test. Programs should aim to set incentive payments at a level that will motivate PMs without tempting them to try to earn large sums through coercion.

The potential for coercion is much higher if there is a power differential between PMs and the KP members they are trying to engage. For example, a brothel owner or bar manager might have an extensive network of KP contacts, but they would probably be unsuitable as a PM because of the economic or physical control they may exercise over those individuals. For this reason, programs should set clear guidelines about the type of person who can be engaged as a PM.

Referrals of noneligible KP members to boost the peer outreach worker's numbers. It is possible that a peer outreach worker could refer low-priority KP members for HTS, i.e., those who have been tested recently, or whose risk assessment indicates that they are at low risk for HIV. Alternatively, a peer outreach worker could return to a previously tested but low-priority KP member after 3 months and refer them again for HTS, even though their risk profile has not changed. Once again, clear guidelines during training, ongoing supervision that reinforces an understanding of what constitutes an eligible KP member, and tracking of KP members who are given repeat referrals (through the M&E system) can help mitigate this risk.

Careful training and supervision, combined with strong M&E systems and oversight from program managers, will help avoid potential coercion or misuse of incentives. The program can also consider periodic interviews or surveys of enrolled KP members to determine whether any of them felt coerced into taking an HIV test by a peer outreach worker or PM, or whether they were asked to misrepresent their HIV risk status or the date of their last HIV test to be deemed eligible for new or repeat HIV testing.

2 Staffing and training for the EPOA

Staffing for the EPOA does not require changes in the number of staff, although it does involve some additional activities and specific training.

Program management staff

Program managers are responsible for ensuring that program staff and peer outreach workers understand the EPOA and that peer outreach workers are trained to implement it and are adequately supervised.

Outreach supervisors are responsible for providing supportive supervision to peer outreach workers and problem-solving with them. They should also ensure that peer outreach workers understand the tools for recording outreach and enrolling KP members, and that they are using the tools correctly as they do outreach and engage PMs. In some the EPOA programs, outreach supervisors also collect referral slips from HTS and ART facilities each month. See Section 3.1 for more details.

As with all peer outreach, M&E staff remain responsible for processing the data recorded by the peer outreach workers, whether in an electronic or paper-based system.

Facility-based staff

Partnerships between community- and facility-based implementers are an essential feature of the EPOA. All staff providing HTS or ART must be trained to understand the approach and especially

the referral system, so that they can process the referral correctly when a KP member comes to the center. Facility-based staff collect referral slips and record UICs. Correct processing of the referral — whether in an electronic or paper-based system — helps to ensure that the KP member is not re-registered (i.e., duplicate registration) if their registration has already been sent electronically by the peer outreach worker. It also helps the EPOA management personnel to correctly calculate performance-based incentives for the peer outreach worker or PM, and to monitor the impact of collective HIV response efforts.

Where HTS and ART services are delivered by the partner (such as a LINKAGES subpartner) that is implementing the EPOA, it will be relatively straightforward to integrate and coordinate the processing of referrals. When such services are provided by a different provider, such as a government or private clinic or health center, careful coordination and orientation of staff by the country program will be necessary. In particular, the program will have to ascertain whether the HTS center is willing (or legally able) to disclose HIV test results to the program so that it can follow up appropriately with the KP member. If a clinic cannot disclose data on individual KP members, there should at least be an agreement to share aggregate data (i.e., the percentage of KP members referred who tested HIV positive) so that the program can assess whether the EPOA is reaching KP groups with a high seroprevalence.

Training peer outreach workers

The training curricula that country programs have so far developed for the EPOA are intended for experienced peer outreach workers with existing knowledge of HIV prevention, care, and treatment and good interpersonal communications skills. Training encompasses three main areas:

- Introduction and objectives
- Overview of the HIV cascade, the EPOA, and peer outreach worker roles
- Standard operating procedures under the EPOA, including KP member registration, behavior change communication, the referral system, and performance-based incentives

For a sample training outline, see Annex 3.

The EPOA and community-led testing

In contexts where peer outreach workers or other KP community members have been trained to provide on-the-spot HTS through oral fluid or finger-prick testing, they can be trained in the EPOA and will provide the testing directly rather than making a referral to a center. This has the advantage of providing an immediate result for KP members, and anyone who tests HIV positive can be referred by the peer outreach worker to an ART center for confirmatory testing and, if the result is confirmed, enrollment in treatment and care.

The time between when a person gets HIV and when a test can accurately detect it is called the **window period**. It can take **3–12 weeks (21–84 days)** for an HIV-positive person's body to make enough antibodies for an antibody test to detect HIV infection. Approximately 97% of people will develop detectable antibodies during this window period.

The EPOA and self-testing

If KP members say they have recently (within the past 3 months) self-tested for HIV, then:

- If the test was positive, they should be advised to seek confirmatory results, in line with national testing guidelines.
- If the test was negative but taken during the window period for possible exposure, they should be advised to take another test.
- If the test was negative and not taken during the window period for a possible exposure, they should not be considered eligible for referral for testing.

3 Tracking and program monitoring

3.1 Tracking outreach and referrals

Outreach and referrals can be tracked using a paper-based or electronic system. Electronic systems offer several potential advantages: efficiency, ease of use, and more seamless tracking of contacts and referrals by linking the peer outreach worker's outreach records directly to those of referral facilities. However, there are important additional considerations:

- Electronic systems can be expensive to implement and to integrate with existing tracking systems. Electronic tracking systems require a separate set of resources and skills, and an implementing agency should make sure they have these (or are in a position to obtain them) before they implement an e-system.
- Electronic records may also be governed by local laws regarding the storage and transmitting of health information.
- Electronic systems are “seamless” only if they are used as intended. For instance, a real-time tracking system breaks down if the data are not entered and uploaded in real time.

A description of an electronic system is given later in this section. For many programs, a paper-based system may be more practical, at least in the initial stages of the EPOA.

Paper-based system

In a paper-based system, tracking takes place at two levels:

1. The peer outreach worker
2. Program M&E staff

Peer outreach workers use a simple form to record details of their outreach to a new KP member, and a referral slip to make a referral to HTS or ART (**Table 3**). These forms can be designed so that the referral slip is a tear-off part of the outreach form, making the paperwork as simple as possible to handle. The outreach form and the referral slip are described in more detail below.

Forms to track service delivery at the HTS center or clinic are already available in the **Monitoring Guide and Toolkit**. In addition, the implementing partner's M&E staff use several forms to support the EPOA, by tracking:

1. Which peer outreach workers are involved in enhance peer outreach
2. The identities of PMs, and which peer outreach worker manages them
3. The tracking numbers of the referral slips that are distributed to each PM
4. Which referrals for HTS or ART have been successfully completed
5. The amount of incentive payments due to each peer outreach worker and PM, and a record that these have been paid

If not all peer outreach workers are engaged in the EPOA, the register of peer outreach workers can easily be adapted to record those who are, or a separate register can be kept (item 1 on the list above). Items 2–4 can be tracked using the Referral Slip Tracking Log (see Annex 9). Other tools can be used by M&E and finance staff to aggregate program-wide information on the EPOA (i.e., to see how many new KP members have been reached across the program, and how many have completed referrals for HTS or re-enrollment in ART), and to calculate and track incentive payments to peer

outreach workers and PMs. Basic templates for these tools are provided in Annexes 7, 8, and 9. These should be adapted as needed, bearing in mind the procedures that countries may already have established for managing referrals and verifying service uptake. **Table 3** summarizes all the tools that are needed for basic tracking of the EPOA.

It is crucial that the KP program work with its M&E and finance staff to set up the necessary monitoring and financial systems before enhanced peer outreach is implemented, and train all staff who will implement these systems. This is just as important as the training of peer outreach workers and supervisors, because the success of the EPOA rests

partly on the accurate recording of referrals and the efficient disbursement of incentive payments.

Figure 4 shows the flow of activities, and the tools used to record and track them, when a new KP member is engaged as a PM.

The numbered paragraphs below refer to the numbered blue boxes in **Figure 4**.

1. Referring new KPs for HTS and engaging them as PMs: Peer outreach workers use the **EPOA enrollment form (Figure 5)** to record information based on their conversation with the new KP.

FIGURE 4. Tracking the activity flow for HTS referrals

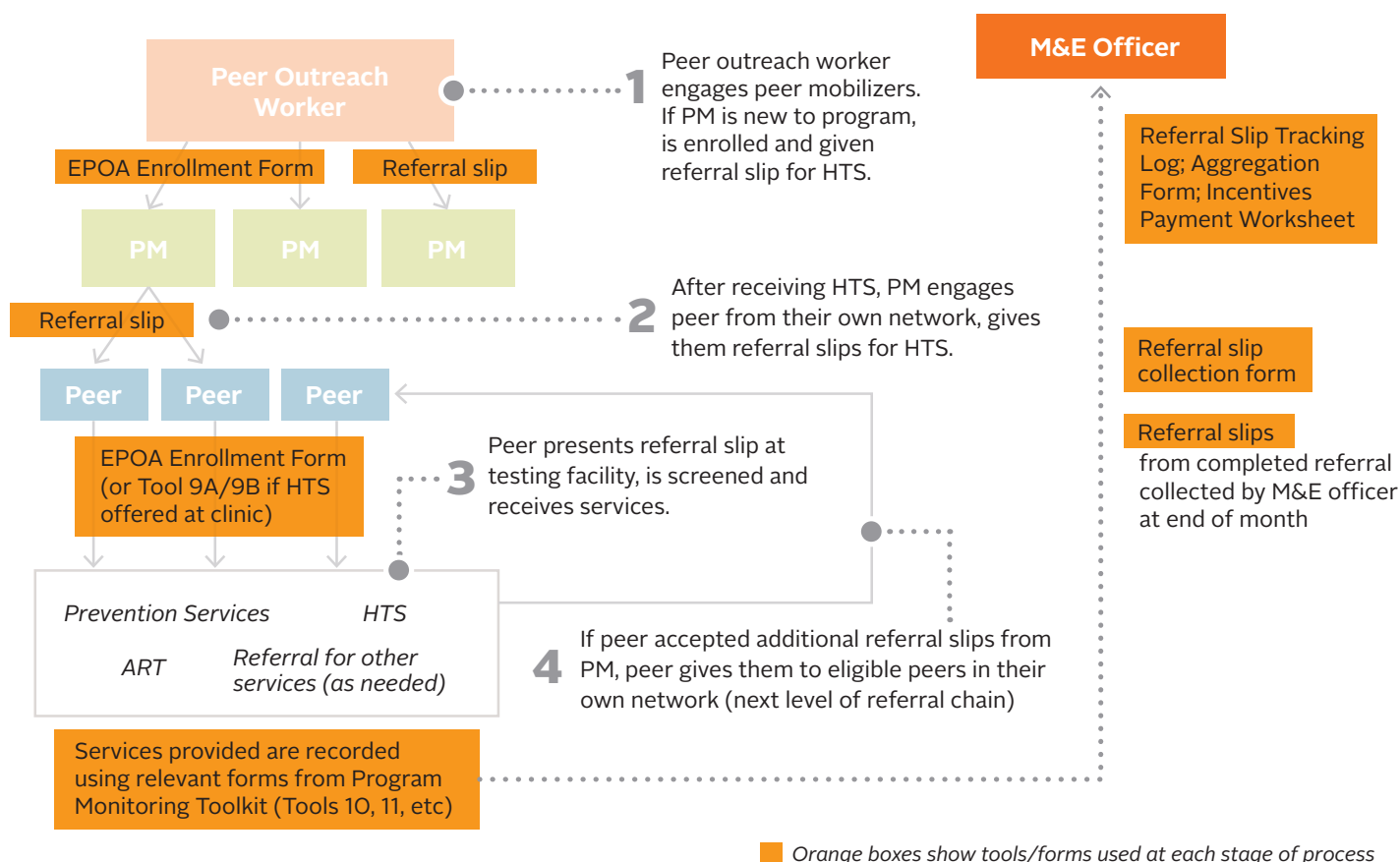


TABLE 3. Paper-based tools used to track the EPOA

ACTIVITY	DONE BY	TOOL AND SOURCE	REMARKS
Enrolling a new KP member for HIV testing (and as a PM)	Peer outreach worker	EPOA enrollment form (Figure 5)	Form can be modified to suit specifics of country program.
Enrolling a peer for HIV testing who has been referred by a PM			Form can be redesigned to be user-friendly for peer outreach worker, e.g., providing cues.
Referring a new peer for HTS	Peer outreach worker	Referral slip (Annex 6)	
Referring a new peer for HTS	PM	Referral slip (Annex 6)	
Registering/screening a peer at a testing facility	Testing facility staff	EPO enrollment form (Figure 5) • Used by HTS facility if new to program Clinic enrollment form (Program Monitoring Toolkit, Tool 9A/9B) • Used if HTS takes place at a clinic Clinic visit form (Program Monitoring Toolkit, Tool 10) KP PLHIV tracking sheet (Program Monitoring Toolkit, Tool 11)	Tools or forms that are required by country programs can be used in addition or instead.
Providing HTS and/or other services (at a clinic)			
Tracking referrals	Outreach supervisor Outreach supervisor Program M&E officer Program finance officer	Referral slip collection form (Annex 7) Service uptake aggregation form (Annex 8) Referral slip tracking log (Annex 9) Incentives Calculation Worksheet (Annex 10)	All these forms are completed monthly.

The initial information gathered and recorded through the conversation with individuals confirms:

- Whether they are a KP member (Step 1)
- Whether they are eligible for HIV testing (or ART), and whether they know their HIV status (Step 2)
- Whether they receive any prevention commodities or information, education, and communication (IEC) materials from the peer outreach worker (Step 3).

Peer outreach workers ask KP members if they wish to be referred for HTS (or ART), and then record any referral on the form (Step 4). They also record basic identifying information about the KP members (Step 5) including a UIC, which the peer outreach workers generate themselves according to the system used by the program. Programs should

consider carefully the potential advantages and disadvantages of recording a mobile phone number. It can make follow-up easier, and it is needed in programs where a PM is receiving phone credit as an incentive. However, in some countries, it is possible for the authorities to identify an individual based on their phone number, and this means the form could potentially reveal the KP member's HIV status. (A solution may be to omit the phone number here and for the peer outreach worker to record it at another time in a safe space like a drop-in center.) When making a referral, peer outreach workers also complete a paper referral slip (see Annex 6) that they give to KP members, with the address of the nearest two or three testing or treatment centers. Each referral slip should be pre-stamped with its own tracking number. If it is not possible to pre-stamp the numbers, they should be written in by hand by peer outreach workers upon receiving them from the program staff. Peer outreach workers

record the tracking number on the EPOA enrollment form (Step 4), so that the KP members' completed referral can be traced back to them, enabling the peer outreach worker to receive their incentive payment. Finally, the peer outreach workers invite the KP members to become PMs (Step 6).

Figure 5 shows the basic information that should be recorded during initial outreach with a KP member. However, programs may consider modifying this template to make it more appropriate for specific KPs, or to include additional information relevant to the local program, e.g. screening for TB or referrals for other services such as STI testing and treatment. However, the focus of initial outreach should remain on establishing rapport with KP members, encouraging them to get tested if they have not been tested recently and are at risk, and making a referral. Experience indicates that referrals for HTS are most successful in the EPOA if the initial encounter is streamlined and kept to basic information about testing and risk reduction.

Programs may also modify the form to make it more user-friendly for peer outreach workers, e.g., by adding cues to indicate which questions they should ask next based on a yes/no response to the previous question. This makes the form more of a job aid for a conversation, rather than a checklist for an interview. Annex 5 provides an example of a form that has been modified to request additional information and to be more user-friendly (and which also includes detachable referral slips).

Note that the EPOA enrollment form does not include all the information specified in the outreach enrollment form (Tool 6A) in the **LINKAGES Monitoring Guide and Toolkit**, such as more details about the KP member's sexual behavior. The peer outreach worker can ask for this information during a subsequent meeting as they gain the KP member's trust and confidence.

2. Engaging PMs: If KP members agree or ask to become a PM, peer outreach workers give them additional referral slips to pass on to eligible peers (KP members) in their network (Annex 6). Each referral slip is pre-stamped with a tracking number for the peer, and the tracking number of the PM who distributed it (or these numbers are written in by the peer outreach worker in advance). This enables the completed referrals to be traced back to the PM and to their peer outreach worker. Note that the enrollment form in Annex 5 contains a referral slip for the KP member and three more referral slips that the KP member who agrees to be a PM can provide to peers.

Peer outreach workers explain to PMs that they should only give the referral slip to an eligible peer — someone they know, who is a KP member. Peer outreach workers may also help them identify which people in their network are the best to approach, i.e., those who they know best who they also believe are at highest risk for HIV. (See the EPOA Training Curriculum, Activity 3.4, for more details.) Finally, peer outreach workers explain the incentive system and how the referral slip will enable the PMs' successful referrals to be tracked, so that they can receive the incentive to which they are entitled.

Peer outreach workers report to the M&E officer which tracking numbers (and associated referral slips) have been given to PMs, and the M&E officer records the PMs' UIC or name on the relevant page of the Referral slip tracking log (Annex 9).

In programs that decide to extend the referral chain by inviting peers to become PMs themselves, peer outreach workers will give PMs:

- Their own referral slip (if they have not recently been tested for HIV)
- Referral slips to give to peers (one slip per peer)
- Referral slips to give to peers to pass on to their

FIGURE 5. EPOA enrollment form template

Peer outreach worker name: _____ Implementing agency name: _____ Date of contact: _____							
STEP 1: SCREENING		YES	NO	STEP 4: REFERRAL		YES	NO
Has the person had sexual relationships in the past 3 months?		<input type="checkbox"/>	<input type="checkbox"/>	Person referred for HTS?		<input type="checkbox"/>	<input type="checkbox"/>
Was the sex in exchange for money or goods?		<input type="checkbox"/>	<input type="checkbox"/>	Person referred for ART?		<input type="checkbox"/>	<input type="checkbox"/>
Was the partner the same sex as the person?		<input type="checkbox"/>	<input type="checkbox"/>	PM Tracking Number (from referral slip): _____			
Has the person had more than one sexual partner during this period?		<input type="checkbox"/>	<input type="checkbox"/>	Was person referred/brought to you by PM?		<input type="checkbox"/>	<input type="checkbox"/>
Has the person injected drugs in the past 3 months?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, PM's name: _____ If yes, peer tracking number (from referral slip): _____			
STEP 2: HIV RISK ASSESSMENT		YES	NO	STEP 5: REGISTRATION			
Has the person been tested for HIV in the past 3 months?		<input type="checkbox"/>	<input type="checkbox"/>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other Age: _____			
Is the person willing to disclose his/her HIV status to you?		<input type="checkbox"/>	<input type="checkbox"/>	Mobile number: _____			
If yes, is the person HIV positive?		<input type="checkbox"/>	<input type="checkbox"/>	Has the member been contacted by someone from the HIV prevention program before?		YES	NO
If HIV positive, is the person currently enrolled at an HIV clinic?		<input type="checkbox"/>	<input type="checkbox"/>	UIC: _____		<input type="checkbox"/>	<input type="checkbox"/>
STEP 3: MATERIALS DISTRIBUTED			STEP 6: PEER MOBILIZER		YES	NO	
How many condoms provided?			Is the person willing to be a PM and pass on referral slips?		<input type="checkbox"/>	<input type="checkbox"/>	
How many packets of lubricant provided?							
How many sterile needles/syringes provided?			If yes, how many referral slips given?				
How many IEC materials distributed?							

own peers (three or more slips per peer – these should be of a different color than the other referral slips to avoid confusion)

One way to simplify tracking is to ensure that the tracking numbers on the referral slips distributed by the PM are related to the PM's own tracking number. For example, if the PM's referral slip (their PM tracking number) is numbered 100, the referral slips that PM 100 passes on to peers will be numbered 100-1, 100-2, 100-3, etc. And the referral slips that peer 100-1 passes on to peers in his or her network will be numbered 100-11, 100-12, 100-13, etc.

In programs where the PM refers a peer to the peer outreach worker prior to testing, the peer outreach worker records the PM's name and the PM tracking number on the EPOA enrollment form (Step 4), along with the peer tracking number (both numbers are on the peer's referral slip). It is important to record both numbers because this helps ensure that the peer outreach worker and the PM will receive any applicable incentive payment for a successfully completed referral. Recording this information also makes it possible to identify successful referral networks (those that lead to large numbers of referrals for testing and significant numbers of HIV-positive cases).

3. Completing the referral: Peers take their referral slip to the HTS facility or ART center and give it to the staff, who will conduct further screening as needed to confirm the peers' eligibility for HTS or ART. They may use the clinic enrollment form (Tool 9A/9B) from the **Program Monitoring Toolkit**. Since this form does not have a designated field for entering a peer's tracking number from the referral slip, the clinic should complete this piece of information on the EPOA enrollment form and attach it to the clinic enrollment form (or simply write the tracking number clearly on the clinic enrollment form).

Other services, such as family planning and STI screening, may also be offered as appropriate. Delivery of these services is noted on the appropriate forms from the **Program Monitoring Toolkit** (Tools 10 and 11).

4. Peer becoming a PM: If peers agree to engage others for HTS, they receive referral slips from the PM and simply pass these out to eligible KP members in their own social or sexual network. These peers in turn take their referral slip to the testing facility and are screened and provided with HTS or other services.

Tracking completed referrals: Each month, the implementing partner's outreach supervisor (or another staff member such as the M&E officer, but not a peer outreach worker) should visit the HTS and ART facilities to collect all the referral slips that have been received there (the green dashed line in **Figure 4**). The peer outreach worker should NOT collect the referral forms from the health facility because they could see the results of the HIV tests, which would be a breach of confidentiality. Once forms are collected by the M&E or other staff person, the collection of slips should be recorded carefully using a form such as the referral slip collection form (Annex 7). At the same time, the outreach supervisor uses the service uptake aggregation form (Annex 8) to record the total number of referrals at that facility that are linked to each peer outreach worker, and the outcomes of those referrals, i.e., how many of the people referred were tested for HIV, how many tested HIV positive, etc. (this information is provided by the facility medical staff).

The M&E officer receives the referral slips, the Referral Slip Collection Form, and the Service Uptake Aggregation Form, and uses the Referral Slip Tracking Log (Annex 9) to record each slip received, which links each completed referral to the peer outreach worker or PM who initiated the referral. This is essential in order to ensure that they will receive the correct incentive payment.

The finance officers complete the incentives calculation worksheet (Annex 10) to determine the payments that are due to peer outreach workers and PMs.

Electronic system (the eCascade system)

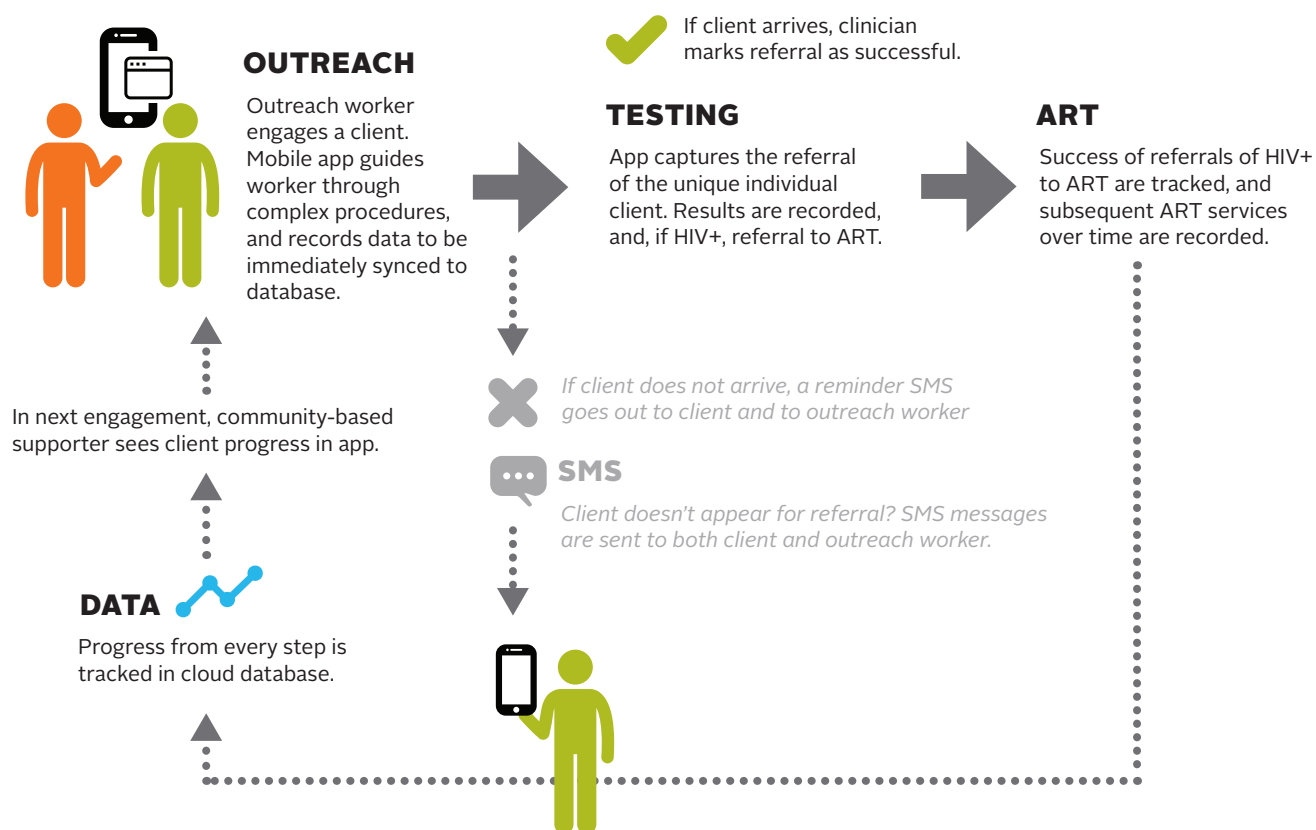
Developed for the enhance peer outreach program in Thailand, eCascade is a mobile-phone-based system that peer outreach workers can use to record all details of their outreach contacts, to register new KP members, and to make referrals for HTS or for ART enrollment. The eCascade system is used by HTS and ART centers as well, so referrals are automatically forwarded to these centers, and when the referral is completed, this fact is registered in the system (**Figure 6**). This system is described below as an example of how an electronic system can work.

Peer outreach workers use several forms that appear on their mobile phone in eCascade to record client information (including generating a UIC), services delivered, and referrals made. The referral system works much as in the paper-based system. One difference is that referral slips do not need

to be printed with individual serial numbers for tracking. Instead, the peer outreach worker attaches a sticker pre-printed with a unique QR code to the referral slip. This scannable code, separate from the UIC, links the referral slip to the KP member's registration.

Although the referral is sent electronically via eCascade, the paper referral slip is a second indication to the staff that KP members have been referred and are not walk-ins. It also helps clinic staff to match KP members to their electronic record upon their arrival. This saves time, prevents KP members from being registered again (potentially with a different UIC), and ensures that the completed referral is registered in the system so that peer outreach workers receive their incentive payment.

FIGURE 6. Use of the eCascade system for outreach and referrals





Note: outreach is not a survey!

Some programs may be tempted to use outreach screening as a survey or for research. However, the EPOA is not compatible with a research protocol, because peer outreach workers are trained not to ask questions in the same way or the same order with all KP members, but to adjust their questions to suit the context and to make KP members as comfortable as possible. This makes the outreach session and the information recorded on the form invalid as a rigorous survey instrument.

3.2 Using data for supervision and program monitoring

Weekly supervision with peer outreach workers has two purposes: first, to offer support and encouragement for their work, help solve practical problems, and discuss the peer outreach worker's own ideas for improving the EPOA; and second, to review the peer outreach workers' performance and that of their PMs. Relevant data for monitoring the performance of individual peer outreach workers includes:

- The number of KP members that peer outreach workers engaged, and where each of them is in the process of completing their referrals for testing, ART enrollment, violence prevention and response services, or STI
- The number of PMs newly engaged or continuing to be managed by peer outreach workers
- The number of new peers enrolled by the PMs, and where each of them is in the process of completing their referral

In programs that use eCascade or similar electronic data entry systems, reports can be generated electronically, but in paper-based systems peer outreach workers must bring along their own

outreach forms, like the supervision of peer-led outreach using microplanning. Whether the monitoring system is electronic or paper-based, it is possible to develop simple dashboards (Excel-based) that can show progress at the level of the peer outreach worker, and at the wider program level.

Important data points for program monitoring include numbers of:

- New KP members reached
- New KP members tested
- KP members testing HIV positive
- KP members enrolled on ART

These statistics should be disaggregated between peer outreach workers and PMs, if possible, to monitor the success of each in motivating HIV testing uptake, and to see whether there is a difference in the HIV yield (because it is assumed that the peers engaged by PMs will be those harder to reach with traditional outreach, and therefore may be more likely to be in high-risk networks). This helps to assess whether using PMs is contributing to achieving program goals.

Data from the outreach forms can be analyzed, as resources allow, for factors such as whether KP members were reached in the previous 12 months, whether they have previously been tested for HIV, and their condom and lubricant use at last sex, or injecting drug use. Again, disaggregating this information between peer outreach workers and PMs can give insight into the relative levels of risk within the referral networks.

Programs using e-data collection and with advanced technical capacity may wish to consider mapping referral networks to identify high-value PMs and social networks, to segment KP members to better understand high and low risk, and to assess the overall impact of referral chain networks.



Confidentiality and security of data

Every program should have a written policy on data confidentiality and security as it applies specifically to the EPOA. Enhanced peer outreach allows a program to track individual KP members from outreach through testing and (potentially) to HIV diagnosis, treatment, and care. This is necessary to ensure provision of services across the cascade, but it also implies that program staff may learn about the HIV status of individual KP members. Programs must consider carefully under what circumstances this information can and should be shared, and with whom, and how information on HIV serostatus gets

stored and secured.

For example, is it ever appropriate for peer outreach workers to know the HIV status of a person they have contacted, unless that person discloses it themselves? What procedures should be followed for offering peer navigation to a KP member who has tested HIV positive? Policies and procedures may vary depending on the way each program is implemented and its relationship with HIV testing centers, ART centers, etc. But the right of all KP members not to have their confidentiality breached must be understood and respected by program staff, peer outreach workers, and PMs.

4 Tool: Illustrative activities checklist for planning and implementing the EPOA

This tool is a checklist of the activities needed to plan and pilot the EPOA. You do not have to follow the steps below in precisely this sequence, and many will overlap.

NO.	MAIN ACTIVITY	NOTES/SUBACTIVITIES	PERSON RESPONSIBLE	DUE DATE	DONE? (Y/N)
1. INITIAL PROGRAM PLANNING AND BUDGETING					
1.1	Analyze current program and outreach data with program staff and peer outreach workers to identify coverage gaps and “leaks” in the HIV cascade, and decide on an appropriate model for the EPOA	Considerations may include: <ul style="list-style-type: none"> • Whether to target particular KPs or subgroups of KPs • Whether the EPOA is to be implemented by current peer outreach workers or by newly trained ones 			
1.2	Develop timeline for training, pilot, and wider roll-out	<ul style="list-style-type: none"> • Consult with partners to ensure that the timeline is feasible 			
1.3	Make initial plans for tracking system	<ul style="list-style-type: none"> • Paper-based or electronic? • Integration with existing systems, including UICs 			
1.4	Conduct working sessions with CBO partners on the proposed the EPOA pilot and associated costs, including the cost of multiple waves of incentives	Ensure that all agree on how long the pilot will run and how partner organizations can pause the process in order to examine and rectify implementation issues			
1.5	Develop incentive scheme for outreach workers and PMs	<ul style="list-style-type: none"> • Consult on a scheme with peer outreach workers • Review draft with partners and peer outreach workers, and finalize 			
1.6	Conduct budget conversations with LINKAGES leadership on the proposed costs, discuss potential scenarios/ limitations/challenges in implementing the EPOA, ensure sufficient funding, and agree on caps in timing/spending as necessary	<ul style="list-style-type: none"> • Develop budget based on estimated number of KP members referred for testing and engaged as PMs 			

NO.	MAIN ACTIVITY	NOTES/SUBACTIVITIES	PERSON RESPONSIBLE	DUE DATE	DONE? (Y/N)
2. DEVELOP SOPS AND ESTABLISH/CLARIFY REFERRAL NETWORK					
2.1	Develop KP member flow algorithm in schematic format	<ul style="list-style-type: none"> Algorithm should map the interactions of all key individuals, organizations, and forms along the services continuum (see Figures 3 and 4 above) Review with partners, including peer outreach workers 			
2.2	Meet with referral sites (program-run testing and treatment facilities)	<ul style="list-style-type: none"> Initial high-level meetings to introduce/discuss program and begin formalizing referral mechanisms Introduce draft KP member flow algorithms and revise as needed Discuss adopting UICs generated by peer outreach worker Develop agreements with referral sites as needed to formalize KP member flow and referrals/counter-referrals 			
2.3	Contact nonprogram facilities where HIV testing and treatment are offered to see if they are willing to participate	<ul style="list-style-type: none"> Considerations may include their willingness to participate in the tracking system (referral slips, adopting UIC codes), and their ability to share test result data with the program 			
2.4	Develop standard operating procedures (SOPs) for KP member flow, in conjunction with referral partners	<ul style="list-style-type: none"> SOPs describe each step along the way as KP members are reached in the field, referred to services, received and provided services at LINKAGES sites, referred/counter-referred to additional sites, and followed up by navigators/case management team members/outreach workers Issues to consider include: <ul style="list-style-type: none"> - KP confidentiality issues - Data security - Coordination of the EPOA with the introduction/roll-out of peer navigation 			
2.5	Develop SOPs for peer outreach workers	<ul style="list-style-type: none"> These should cover work planning, outreach methodology, referrals and follow-up, engaging and managing PMs, and incentive payments. 			
2.6	Develop outreach materials	<p>Adapt materials from LINKAGES EPOA Guide, or develop as needed:</p> <ul style="list-style-type: none"> Message matrix or other BCC materials Enrollment form Referral slips 			
2.7	Finalize SOPs and outreach materials	<p>Consult with referral sites and revise as necessary. In particular:</p> <ul style="list-style-type: none"> Discuss how referral slips will be processed Provide training for DIC staff in processing referrals 			

NO.	MAIN ACTIVITY	NOTES/SUBACTIVITIES	PERSON RESPONSIBLE	DUE DATE	DONE? (Y/N)
3. TRAINING					
3.1	Develop training for peer outreach workers	<ul style="list-style-type: none"> Review LINKAGES curriculum and adapt as needed 			
3.2	Train peer outreach workers and their supervisors	<ul style="list-style-type: none"> In contexts where peer-led outreach is being implemented for the first time, the EPOA can be integrated as part of the initial training of peer outreach workers 			
3.3	Develop SOPs for supervisors (or revise existing ones)				
4. TRACKING AND PROGRAM MONITORING					
4.1	Develop tracking tools/logs for KP members as they move through the services network	<ul style="list-style-type: none"> Adapt tools from LINKAGES EPOA Guide and LINKAGES Monitoring Guide and Toolkit 			
4.2	Develop SOPs for program monitoring	<ul style="list-style-type: none"> Clarify staff roles for inputting and reporting data 			
4.3	Develop data visualization tools (dashboards)	<ul style="list-style-type: none"> Ideally will be designed in advance, but should be revised as program is implemented to ensure they are useful 			
4.4	Conduct regular data feedback sessions to inform program revisions				
5. FINANCIAL TRACKING					
5.1	Develop/adapt payment disbursement and tracking system and forms	<ul style="list-style-type: none"> Assign responsibilities for compiling payment data for incentives, and disbursing payments 			
6. IMPLEMENTATION					
6.1	Begin implementation	<ul style="list-style-type: none"> A pilot phase of about three months is recommended, after which programs should review the SOPs and results in detail, to see whether adjustments need to be made to training, supervision, implementation methods, minimum standards (thresholds) for outreach, and incentives 			

5 Annexes

1. Incentive scheme for peer outreach workers and PMs

This is a draft performance-based incentive scheme from the Laos EPOA program, showing incentives for peer outreach workers (referred to as community-based supporters or CBSs) and PMs. It is provided here as an example only.

Performance-Based Scheme for Community-Based Supporter

Performance-based salary

- Achieve minimum operating standards (MOSs)
- MOS: Reached and tested with HIV oral test an average of five KP members/month over a period of 3 months
- If MOSs were not achieved during the first and the second month, the CBS will receive mentoring and coaching by the program manager, and a warning related to the limited performance and the danger of being dismissed for failure to meet targets
- If the MOSs were not achieved at the end of the third month, the CBS would be dismissed and a new one would be selected
- Must be recorded in CommCare [computerized data management system]
- Checked with indicators KP_PREV and HTC_TST
- Base salary: 150 USD

Bonuses

- **Bonus 1 (monthly):** Reached batch of MSM and transgender KP members
 - This bonus is based on number of new MSM/transgender individuals reached within one-month period
 - Reach fewer than five new MSM/transgender individuals: 0 USD (no bonus)
 - Reach five to nine new MSM/transgender individuals: 20 USD
 - Reach 10–14 new MSM/transgender individuals: 50 USD
 - Reach 15–19 new MSM/transgender individuals: 90 USD
 - Reach 20 or more new MSM/transgender individuals: 140 USD
 - The operational definition of “reached” is the one defined by USAID for the indicator KP_PREV
 - The wave should be completed for receiving the bonus; for instance, if the CBS reached seven new KP members, the bonus of the first wave will be attributed
 - For this bonus, only new reached MSM/transgender individuals will be considered (newly registered with UIC)
 - KP member must be recorded in CommCare by the CBS

- Bonus reported on Bonus Log Book for CBS
- Checked with indicators KP_PREV
- **Bonus 2 (monthly):** Provided HIV oral test (regardless of the result)
 - The CBS receives a 5 USD bonus for each KP member (MSM/transgender individuals only) who receives an HIV oral test and the result, whatever the result of the HIV test
 - For this bonus, the minimum period between two HIV oral tests with the same KP member should be 3 months. If more than one test is offered to the same KP member within a 3-month period, only one test will be considered for the purpose of calculating the bonus
 - KP member must be recorded in CommCare by the CBS
 - Bonus reported on Bonus Log Book for CBS
 - Checked with indicators KP_PREV and HTC_TST
- **Bonus 3 (monthly):** Successfully referred to ART center for confirmation of the HIV test (regardless of final HIV test result)
 - If a KP member (MSM/transgender individuals only) receives a “reactive” result for HIV oral test and receives a confirmation test (regardless of the result of the confirmation) at the ART center, then the CBS will receive a bonus of 7 USD
 - The results must be confirmed by a health care provider at ART site
 - The result of the confirmation test is not taken into consideration for calculating this bonus
 - KP member must be recorded in CommCare by the CBS and by a health care provider at ART site for the confirmation
- Bonus reported on Bonus Log Book for CBS
- Checked with indicator “Number of KP with a reactive oral HIV test (OraQuick) result successfully referred to ART center for confirmation”
- **Bonus 4 (monthly):** Identified newly diagnosed HIV positive
 - If a KP member (MSM/transgender individuals only) receives a “reactive” result for HIV oral test and s/he receives a positive confirmation test at the ART center, then the CBS will receive a bonus of 5 USD
 - The results must be confirmed by a health care provider at ART site
 - Only newly diagnosed HIV positive KPs will be considered for this bonus (verified with UIC number)
 - KP member must be recorded in CommCare by the CBS and by the health care provider at ART site for the confirmation
 - Bonus reported on Bonus Log Book for CBS
 - Checked with indicator HTC_TST (filtered by SDP—CBS— and result—positive)
- **Bonus 5 (monthly):** New HIV positive successfully enrolled in pre-ART or ART
 - If a KP member (MSM/transgender individuals only) confirmed HIV positive is enrolled in CST services (first visit) then the CBS will receive a bonus of 5 USD
 - The enrollment must be confirmed by a health care provider at ART site
 - Only newly enrolled HIV positive will be considered for this bonus
 - KP member must be recorded in CommCare by the CBS and by the health

- care provider at ART site to confirm the enrollment
- Bonus reported on Bonus Log Book for CBS
- Checked with indicator CARE_NEW
- **Bonus 6 (quarterly):** Known HIV-positive KP member successfully re-enrolled to pre-ART or ART
 - If a KP member (MSM/transgender individuals only) with a known HIV positive status is identified and re-enrolled in CST services (first visit) then the CBS will receive a bonus of 5 USD
 - Re-enrolled means that they were declared lost to follow-up from ART center for at least one year
 - The re-enrollment must be confirmed by health care provider at ART site
 - Only newly re-enrolled HIV positive will be considered for this bonus
 - KP member must be recorded in CommCare by the CBS and by the health care provider at ART site to confirm the enrollment
 - Bonus reported on Bonus Log Book for CBS
 - Checked with ART center (HIV Cam?)
- **Bonus 7 (quarterly):** frequent testers (at least 2 tests in past 4 quarters).
 - If an HIV-negative KP member comes back for another HIV oral test within a period of at least 3 months, then the CBS will receive 5 USD
 - For this bonus, the minimum period between two HIV oral tests with the same KP member should be 3 months. If more than one test is offered to the same KP member within a 3-month period, only one test will be considered

- If the last test of the period is positive, the test will be still included for the calculation of the bonus.
- Bonus will start coming up at end of the second quarter after the initiation of the project, if successful
- Bonus reported on Bonus Log Book for CBS
- Checked with indicator “Number of frequent testers KP”

Incentive-Based Scheme for PMs

The incentive-based scheme for PMs has two levels:

- Successfully refer an **eligible peer** to CBS: “successful” is defined as a new peer “reached” (registered into the CommCare system, UIC defined, and risk-reduction counseling and condoms and lubricant provided): a non-monetary incentive of a value of approximately **1.25 USD** will be given.
- If the referred peer consents to receive an HIV oral test (regardless of the result), then the value of the nonmonetary incentive would be at maximum **2.5 USD**.

Note: The performance-based scheme is subject to assessment at the end of the first and second quarters after implementation. CBSs must be clearly informed at the time they are contracted that this scheme may change.

2. Commitment pledge

LINKAGES ENHANCED PEER OUTREACH PROGRAM PEER OUTREACH WORKER'S COMMITMENT PLEDGE

My name is: _____

Having been trained on the enhanced peer outreach approach, I understand my roles and responsibilities and how I contribute toward the goal of reducing new HIV infections and caring for those who are living with HIV.

I commit that:

1. I will support people from KPs in reducing their HIV risk. I will respect their right to make their own decisions, and I will always keep their best interests in mind.
2. I will respect the individual's right to privacy, and I will protect and keep confidential their personal information, including their HIV status.
3. I will behave professionally and honestly with each person I work with.
4. I will not pressure or coerce anyone into taking an HIV test, and I will not pressure or coerce them into becoming a peer mobilizer.
5. I will fulfill my responsibilities as a peer outreach worker and complete all forms to the best of my ability.

Place _____ Date and Year _____

Signature _____



3. Training outline

DAY 1		
TIME	ACTIVITY	GOAL By the end of this activity, participants will (be able to)...
30 min	1.1 Introduction	<ul style="list-style-type: none"> • Participate and be heard • Learn more about one another • Contribute to an interactive learning environment
45 min	1.2 Training objectives	<ul style="list-style-type: none"> • Discuss their expectations of the training course • Review the training agenda and determine how it does and does not meet their expectations
15 min	1.3 Ground rules	<ul style="list-style-type: none"> • Create a list of ground rules on which all participants can agree • Contribute to creating a safe and comfortable learning environment
30 min	BREAK	
90 min	2.1 Introduction to the HIV cascade and LINKAGES	<ul style="list-style-type: none"> • Review key concepts related to the HIV cascade of services • Name key components of the HIV cascade • Identify causes of “leaks” and suggest strategies to prevent or repair them • Review latest LINKAGES project cascade data
60 min	LUNCH	
90 min	2.2 Overview of the EPOA	<ul style="list-style-type: none"> • Explain why an EPOA model is needed • Understand how a referral chain network works • Define the roles of peer outreach workers and PMs within the EPOA
30 min	BREAK	
60 min	3.1 Outreach: KP member screening and risk assessment	<ul style="list-style-type: none"> • Explain the importance of focusing outreach efforts on KPs • Understand the eligibility criteria for a referral for HIV testing • Understand the benefits and challenges of conducting a risk assessment for KP members
30 min	Day 1 Wrap-up	<ul style="list-style-type: none"> • Review key concepts from Day 1 • Address any outstanding issues in the “parking lot”

DAY 2		
TIME	ACTIVITY	GOAL By the end of this activity, participants will (be able to)...
30 min	Warm-up	<ul style="list-style-type: none"> Review key concepts from Day 1 Get energized for the day's activities
90 min	3.2 Outreach: Behavior change communication and risk reduction	<ul style="list-style-type: none"> Screen KP members for other health service and behavior change needs Determine topics for intervention Suggest information and/or behavior change messages
30 min	BREAK	
60 min	3.3 Outreach: Tracking KP members and making referrals	<ul style="list-style-type: none"> Process a referral for HIV services appropriately Explain the importance of UICs for tracking performance of the HIV cascade Generate a UIC according to the national guidelines
60 min	LUNCH	
45 min	3.4 Outreach: Peer mobilizers	<ul style="list-style-type: none"> Identify and engage PMs Help a PM complete a network map to identify peers to engage for testing
45 min	3.5 Outreach: Incentive scheme	<ul style="list-style-type: none"> Describe the systems of incentives for peer outreach workers and PMs who achieve program benchmarks
30 min	BREAK	
60 min	3.5 LINKAGES Jeopardy	<ul style="list-style-type: none"> Review key concepts from LINKAGES training up to this point Demonstrate an accurate understanding of the different fields in the Outreach Enrollment form
30 min	Day 2 Wrap-up	<ul style="list-style-type: none"> Review key concepts from Day 2 Address any outstanding issues in the "parking lot"

DAY 3		
TIME	ACTIVITY	GOAL By the end of this activity, participants will (be able to)...
30 min	Warm-up	<ul style="list-style-type: none"> Review key concepts from Day 1 Get energized for the day's activities
60 min	3.7 Outreach: Putting it all together (Round 1)	<ul style="list-style-type: none"> Demonstrate the entire EPOA process, from reaching a new KP member to enrolling and screening, to performing referral and managing a PM
30 min	BREAK	
60 min	3.7 Outreach: Putting it all together (Round 2)	<ul style="list-style-type: none"> Demonstrate the entire EPOA process, from reaching a new KP member to enrolling and screening, to performing referral and managing a PM
60 min	LUNCH	
60 min	3.7 Outreach: Putting it all together (Round 3)	<ul style="list-style-type: none"> Demonstrate the entire EPOA process, from reaching a new KP member to enrolling and screening, to making referrals and managing a PM
30 min	4.1 Wrap-up	<ul style="list-style-type: none"> Sign a personal Commitment Pledge Make a personal "I want" commitment Complete a training feedback form Receive a certificate of completion

4. Message matrix

This matrix provides sample messages to help peer outreach workers pursue a conversation with KP members on topics relevant to HIV testing, care, and treatment. Peer outreach workers should follow national or program guidelines on behavior change communication, and can choose messages appropriate to the situation of the individual they are talking to, and present them in their own words to develop a rapport and be persuasive.

Programs should develop a message matrix appropriate to their context, using this example as a starting point. Peer outreach workers and program managers should work collaboratively on this. This could also be done as part of the training on the EPOA for peer outreach workers (see Training Curriculum, Activity 3.2).

LINKAGES EPO Message Matrix		
PROMOTE	WHAT YOU NEED TO DO	WHAT YOU CAN SAY
HIV testing	<ul style="list-style-type: none"> Promote getting tested and the benefits of testing Identify location of nearest KP-friendly testing site (or alternative site based on KP member's preference) Provide KP member with a communication package 	<ul style="list-style-type: none"> Getting tested for HIV can be quick, confidential, and free or low cost. If you're negative, you'll feel better knowing it, and you can practice ways of staying negative. If you're positive, there are free medications you can take to live a long, healthy life and prevent transmission to others. The only way to get help is to get tested. There are many places you can get a confidential test. The closest one is at: _____
Condom use	<ul style="list-style-type: none"> Promote the benefits of using condoms correctly and regularly for anal/vaginal sex Promote use of water-based lube Provide KP member with a communication package Provide KP member with condoms and lubricants based on need 	<ul style="list-style-type: none"> Condoms protect you and your partner from HIV and other infections; try to use them every time you have vaginal/anal sex. If used correctly, they are nearly 100% effective. If you don't use condoms, you have a much higher risk of getting or transmitting an infection. You can use condoms for oral sex to increase protection. Dental dams can be used for oral-vaginal sex. Condoms can also protect you from getting pregnant. Make sure to use plenty of water-based lube, especially if you are having anal sex — it will feel better and keep the condom from breaking. Also, check the expiration date on the condoms and lube to be sure they haven't expired. Condoms also prevent more HIV from coming into your body. More HIV can be bad for your health and prevent your medications from working well. If you do not like to use condoms, consider exploring other types/brands. They come in various sizes, shapes, colors, and even flavors.

PROMOTE	WHAT YOU NEED TO DO	WHAT YOU CAN SAY
Sexual health checkup	<ul style="list-style-type: none"> Promote sexually-transmitted infection (STI) check-ups by a qualified provider every 3 months Encourage peers to demand full services Promote partner referral 	<ul style="list-style-type: none"> Many people can be infected by an STI but have no symptoms. Don't wait until you think something is wrong. Get a check-up every 3 months even if you look and feel fine. STIs can cause serious health problems and put you at greater risk for HIV. Most can be treated easily. It's important to see a doctor if you think you have an infection. Make sure you get a full check-up. Ask the doctor to check your throat, genitals, and anus, depending on the kind of sex you have. Encourage your partner to get checked out, too. If he or she is infected, then you may be infected again after you have been treated.
Enrollment in HIV care and treatment	<ul style="list-style-type: none"> Promote benefits of care/treatment enrollment and timely ART initiation Let KP member know there are people and services there to help him/her 	<ul style="list-style-type: none"> If you're HIV-positive, there is free medicine that can help you live a long, healthy life, including partnering and having children who are free of HIV. It's important to enroll in HIV care and treatment services. The doctors will do some tests to learn about your health status, treat any infections you may have, and prescribe medication to reduce the level of virus in your body. Starting treatment as soon as you can will help you live a healthier life, prevent others from being infected, and avoid infections and diseases caused by AIDS. There are programs working with clinicians at certain clinics/hospitals to make them friendly and supportive for MSM/FSWs/TG/PWID. I can tell you which ones those are. There are also free programs that provide clinical and social support, including healthy people living with HIV who can help you navigate and access the services you might need, and support you each step along the way. Would you like me to link you to a member of our team who can provide you with support? I can have someone call you, or provide you with a phone number.
ART adherence	<ul style="list-style-type: none"> Promote benefits of adhering to medication 	<ul style="list-style-type: none"> Adherence means taking your medications as prescribed by your doctors, getting regular examinations, and doing periodic tests to see if the treatment is working. Adherence helps you stop HIV from making copies of itself in your body. This allows your immune system to stay healthy and strong to fight against infections and diseases. When you adhere to your drug regimen, you can live a long, healthy life and prevent HIV from being transmitted to others. Failure to adhere to your treatment can result in new strains of HIV developing in your body, which may mean having to change treatments. It can also lead to treatment failure. If you have difficulties taking your medicine, have questions, miss an appointment, or are moving to a new place, it is important to talk with someone who can assist you (such as a nurse/doctor, navigator, adherence counselor, etc.). They will provide counseling and support so that you can manage the situation.

PROMOTE	WHAT YOU NEED TO DO	WHAT YOU CAN SAY
Family planning services	<ul style="list-style-type: none"> Encourage peers to make choices about pregnancy. 	<ul style="list-style-type: none"> Family planning can help you prevent getting pregnant when you don't want to have a baby. It can also help you choose when to have your next baby. There are many safe and effective methods to choose from. There are many places you can go to learn about and choose your method at low or no cost. There are short-acting methods, and long-acting methods that can prevent you from getting pregnant for many years. These can be reversed at any time. If you are HIV-positive and pregnant, or thinking of having children, you can take ART while pregnant which will help your baby not become infected by HIV in utero or during delivery. If you have had unprotected sex in the past 24–48 hours, there is a pill you can take to avoid getting pregnant, but you need to meet a clinician/pharmacist as soon as possible. Abortion should not be considered a family planning method. Choosing a safe method of preventing pregnancy will be healthier and safer for you. I can help you locate a clinician who can help you make the right choices for you.
TB screening	<p>Ask the four questions about TB symptoms—coughing, fever, night sweats, weight loss—and refer if the answer to ANY of them is “yes.”</p>	<ul style="list-style-type: none"> People living with HIV have a higher risk of contracting TB. TB is a serious disease, but it can be cured easily with medication. Any time you have cough, fever, sweats, or weight loss, it's time to get checked.
Violence prevention and response services	<ul style="list-style-type: none"> Explain what violence is and that it is unacceptable. Inform about the services offered in the service network, including counseling, referrals, and treatment if she/he has been sexually assaulted. Provide active referral to those services (offer to accompany). 	<ul style="list-style-type: none"> Violence can include physical, verbal, economic, and emotional abuse. It can be committed by sexual partners, family members, police, clients, strangers, and others. It includes situations where someone prevents you from using a condom, working, or moving to a new home. Violence is often common but it is not acceptable. No one deserves to experience violence. You have the right to be free from violence. If you are experiencing violence, there are free, confidential services that can help you. Would you like me to provide you with a phone number of someone who can help, or accompany you to a place where you can get support? You can also have someone meet you at a place of your choice. We can help ensure that the police help you if you want to file a complaint. There are people who can accompany you to make sure that your complaints are taken seriously and that you are treated respectfully.
Alcohol and drug use	<ul style="list-style-type: none"> Inform KP member that drug and alcohol use can increase their risk of transmission of HIV and other infections Provide referrals to substance use programs and/or counseling options 	<ul style="list-style-type: none"> Excessive use of drugs and alcohol can cloud your judgment and increase your risk of acquiring or transmitting HIV and/or other infections. It can also increase your risk of violence. There are programs that can provide you with support to help you reduce the harms of substance use no matter what your situation is, even if you are homeless. Some programs offer services separately for men, women, and transgender people. You may also have the option for residential or nonresidential treatment programs. Would you like me to provide you with a phone number of someone who can help, or accompany you to a site where you can get support?

5. EPOA enrollment form for new KP members

This enrollment form from the LINKAGES program in Trinidad has two sides, which are designed to be printed back-to-back. It shows how:

- An extended range of referrals is possible in the program, i.e., to STI, TB, and family planning services, as well as to services for violence prevention and response
- The form has been designed to cue the peer outreach worker about which question they should address next
- The form incorporates a referral slip for the KP member, and — if they agree to be a PM — three referral slips to give to their peers. These are torn off and given to the PM, while the peer outreach worker keeps the outreach enrollment form itself.



EPO Enrollment Form

Outreach Worker Name: _____ Date of contact: _____

Implementing Agency: _____

Consent for discussion?: ☐ YES ☐ NO

TIPS: Introduce yourself, the purpose of the conversation, and ensure confidentiality. Use the questions below as a guide. Adjust/skip questions as needed. Register the client's UIC and/or phone number if possible.

STEP 1. SCREENING

In the last six months has the client:

- | | | |
|--|----------------------------|----------------------------|
| ...had a sexual relationship? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| ...had sex in exchange for money or goods? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| ...engaged in sex with a same-sex partner?
(for transgender clients, with a client of the opposite sex) | <input type="checkbox"/> Y | <input type="checkbox"/> N |

STEP 2. ASSESSMENT

A. SEXUAL RISK

How often does the client use condoms when having sex with clients and/or regular sexual partners?

- ☐ Always [AFFIRM] ☐ Sometimes ☐ Never
[PROMOTE CONSISTENT CONDOM USE]

Has the client experienced any of the following symptoms within the past six months: discharge, painful urination, genital warts or sores?

- ☐ Y [PROMOTE STI SERVICES] ☐ N

B. HIV TESTING

Does the client know his/her HIV status?

- ☐ Y
☐ N [PROMOTE HIV TESTING; GO TO SUBSTANCE USE]

Does the client feel comfortable disclosing his/her HIV status?

- ☐ Y ☐ N [GO TO SUBSTANCE USE]

Is the client HIV positive?

- ☐ Y [GO TO HIV CARE] ☐ N

Has the client been tested for HIV within the last three/six months?

- ☐ Y [AFFIRM REGULAR TESTING]
☐ N [PROMOTE HIV TESTING; GO TO SUBSTANCE USE]

How many months ago was the last test?

- ☐ < 3 months ☐ 7–12 months
☐ 3–6 months ☐ > 12 months

C. HIV CARE

Is the client currently enrolled in and attending HIV care services regularly?

- ☐ Y [AFFIRM ADHERENCE]
☐ N [PROMOTE ENROLLMENT IN HIV CARE; GO TO SUBSTANCE USE]

D. SUBSTANCE USE

Has the client consumed alcohol, drugs, or other substances within the past six months?

- ☐ Y
☐ N [GO TO FAMILY PLANNING]

Which substances were used, and how often were they used?

Substances: _____

- ☐ Daily
☐ Weekly
☐ Monthly

E. FAMILY PLANNING

Is the client interested in family planning/reproductive health services?

- ☐ Y [REFER TO FP/RH SERVICES]
☐ N

F. TB

Is the client experiencing any of the following:

- ☐ Coughing ☐ Fever
☐ Night sweats ☐ Weight loss
[IF YES TO ANY REFER TO GP OR TB SERVICES]

G. VIOLENCE PREVENTION & RESPONSE

Has the client experienced violence of any kind?

- ☐ Y [COUNSEL AND REFER TO VPR SERVICES]
☐ N

H. PSYCHOSOCIAL/LEGAL SUPPORT

Would the client like psychosocial or legal support?

- ☐ Y [COUNSEL AND REFER TO APPROPRIATE SERVICES]
☐ N

STEP 3. REFERRAL

Client is **HIGH RISK/NEED** today; referred to:

- | | | | | |
|--|--|--------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> HIV testing (H) | <input type="checkbox"/> STI screening (S) | <input type="checkbox"/> ART/DIC (A) | <input type="checkbox"/> TB (T) | <input type="checkbox"/> VPR (V) |
| <input type="checkbox"/> Family planning (F) | <input type="checkbox"/> Psychosocial (P) | <input type="checkbox"/> Legal (L) | <input type="checkbox"/> Other (O) | |

Client is **LOW RISK/NEED** today; no referral needed

STEP 4. REGISTRATION

Program status: ☐ New client ☐ Existing client

Age: _____ Mobile #: _____

Gender: ☐ Male ☐ Female ☐ Trans ☐ Other _____

UIC: / / / /
F L Y Y M M D D

STEP 5. PEER MOBILIZATION

Does the client have one or more regular sexual partners? ☐ Y ☐ N [SKIP NEXT QUESTION]

Is the client willing to introduce his/her sexual partner(s) to the program?

☐ Y [RECORD PARTNER MOBILE # OR PROVIDE A CONTACT # TO CLIENT]

☐ N

Does the client wish to pass referral coupons on to peers?

☐ Y [PROVIDE COUPONS; EXPLAIN REWARDS]

☐ N [THANK CLIENT; COMPLETE STEP 6]

STEP 6. MATERIALS TRACKING

List the number/type of items provided:

☐ Condoms: (M)____(F)____ ☐ Packets of lubricant:_____ ☐ Peer coupons:_____

☐ IEC materials:

Type:_____ Number:_____

Type:_____ Number:_____

Type:_____ Number:_____

 **Call Me:**

 **Or, go here:**

Tel:

 **Call Me:**

 **Or, go here:**

Tel:

 **Call Me:**

 **Or, go here:**

Tel:

1

Referral Slip

Give to a service provider at:

Facility address:

CBO

Outreach Worker Name/Code

Referral for:

☐ H ☐ S

☐ A ☐ V

☐ T ☐ F

☐ P ☐ L

☐ O

Client UIC

 / / / /

Client Phone Number

2

Referral Slip

Pass it on to your friend!

CBO

Outreach Worker Name/Code

Original Client UIC or phone number

 / / / /

New Client UIC

 / / / /

F L Y Y M M D D

2

Referral Slip

Pass it on to your friend!

CBO

Outreach Worker Name/Code

Original Client UIC or phone number

 / / / /

New Client UIC

 / / / /

F L Y Y M M D D

2

Referral Slip

Pass it on to your friend!

CBO

Outreach Worker Name/Code

Original Client UIC or phone number

 / / / /

New Client UIC

 / / / /

F L Y Y M M D D

*Give this slip to a service provider
at the site to which you were
referred. Pass the others on to
your friends or partners in
order to earn extra bonuses!*

6. Referral slip

This is a basic template for referral slips. The information on the implementing partner (IP) shown between <these brackets> should be pre-printed on the slips. The PM tracking number and the peer tracking numbers can be pre-stamped on the slips, or they can be written in by hand before the referral slips are given to the peer outreach workers. (In the example below, a sample PM tracking number of 100 has been used.)

The left-hand slip (with the orange background) is completed by the peer outreach worker with the UIC of the KP member, and the peer outreach worker's own name. The peer outreach worker writes the address of the nearest two or three testing centers on the reverse side (unless the peer outreach worker is accompanying the KP member directly to the center).

The four right-hand slips (with the green background) are used if the KP member agrees to be a PM. When the PM engages a friend for HIV testing, they give one of the referral slips to the friend. They add the addresses of the nearest testing centers on the back of the slip. (If there is only one testing center in the locality, the address

can be pre-printed on the slip, or written in by the peer outreach worker before giving the slips to the PM.) The UIC number is not completed by the PM; when the peer is at the testing facility the staff will generate it (or look it up if the peer has previously been enrolled in the program).

If the KP member who receives the orange slip does not want to be a PM, the peer outreach worker simply tears off the green slips and returns these to the program's M&E officer, to ensure that the slips are not used by anyone not connected to the KP member (which would disrupt the tracking system).

The slips can be modified to suit the local program context. For example, a program may decide to give PMs fewer or more than four slips. If a program decides that the incentive given to PMs (or to peers who become PMs in turn) should be in the form of mobile phone credit, the form can be modified to include the individual's phone number.

For an example of referral slips integrated with the outreach enrollment form, see Annex 5.

Front side of referral slip

REFERRAL SLIP (Give to the clinic staff)	REFERRAL SLIP 1 (Pass it on to your friend)	REFERRAL SLIP 2 (Pass it on to your friend)	REFERRAL SLIP 3 (Pass it on to your friend)	REFERRAL SLIP 4 (Pass it on to your friend)
<Name of IP>	<Name of IP>	<Name of IP>	<Name of IP>	<Name of IP>
<District/Province>	<District/Province>	<District/Province>	<District/Province>	<District/Province>
(To be completed by peer outreach worker [POW])	(To be completed by peer outreach worker [POW])	(To be completed by peer outreach worker [POW])	(To be completed by peer outreach worker [POW])	(To be completed by peer outreach worker [POW])
UIC of person referred:	UIC of person referred:	UIC of person referred:	UIC of person referred:	UIC of person referred:
_____	_____	_____	_____	_____
Name of POW:	PM tracking number:	PM tracking number:	PM tracking number:	PM tracking number:
_____	100	100	100	100
PM tracking number:	Peer tracking number:	Peer tracking number:	Peer tracking number:	Peer tracking number:
100	100-1	100-2	100-3	100-4
<Contact details of IP>	<Contact details of IP>	<Contact details of IP>	<Contact details of IP>	<Contact details of IP>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Back side of referral slip

REFERRAL SLIP (Give to the clinic staff)	REFERRAL SLIP 1 (Pass it on to your friend)	REFERRAL SLIP 2 (Pass it on to your friend)	REFERRAL SLIP 3 (Pass it on to your friend)	REFERRAL SLIP 4 (Pass it on to your friend)
Address of centers for prevention and care services	Address of centers for prevention and care services	Address of centers for prevention and care services	Address of centers for prevention and care services	Address of centers for prevention and care services
Give this slip to the staff of the center when you arrive.	Give this slip to the staff of the center when you arrive.	Give this slip to the staff of the center when you arrive.	Give this slip to the staff of the center when you arrive.	Give this slip to the staff of the center when you arrive.
Address 1:	Address 1:	Address 1:	Address 1:	Address 1:
Address 2:	Address 2:	Address 2:	Address 2:	Address 2:
Address 3:	Address 3:	Address 3:	Address 3:	Address 3:

7. Referral slip collection form

Implementing partner: _____

Slip collector: _____

Signature: _____

[illegible]

8. Service uptake aggregation form

The outreach supervisor completes this form at the testing facility, together with a staff member who has access to the medical records. First the outreach supervisor sorts the referral slips by peer outreach worker, using either the name of the peer outreach worker on the orange slip, or the PM tracking number on the green slip (all identical PM tracking numbers are linked to the same peer outreach worker). The outreach supervisor then writes on the form the UIC from the referral slips. In the case of referrals by PMs, if the UIC has not been generated by the facility staff, the medical record number can be used instead.

Because of confidentiality concerns, the medical staff member may not be able to give the HIV test results for specific individuals; instead, they supply the total number of tests taken for the slips relating to each peer outreach worker, and the aggregate results of those tests. For example, if there are three slips relating to an individual peer outreach worker, the staff member may inform the outreach supervisor that all three KP members were tested for HIV, that two of them tested HIV positive, and that one of them enrolled in ART. The appropriate numbers are completed in the columns on the right-hand side of the form. This is repeated for each peer outreach worker's referral slips.

Referral slip tracking log

Facility name:

Facility address:

CSO Code:

Month (MM/YYYY):

Name of peer outreach worker	Client UIC and medical record number (record both per referral slip and designate whether slip is a referral from the peer outreach worker, or from the PM)								Total clients tested for HIV	Total new HIV positive cases	Total clients enrolled/re-engaged in care
	UIC:		UIC:		UIC:		UIC:				
	MR:		MR:		MR:		MR:				
	*P:	PM:	*P:	PM:	*P:	PM:	*P:	PM:			
	UIC:		UIC:		UIC:		UIC:				
	MR:		MR:		MR:		MR:				
	*P:	PM:	*P:	PM:	*P:	PM:	*P:	PM:			
	UIC:		UIC:		UIC:		UIC:				
	MR:		MR:		MR:		MR:				
	*P:	PM:	*P:	PM:	*P:	PM:	*P:	PM:			
	UIC:		UIC:		UIC:		UIC:				
	MR:		MR:		MR:		MR:				
	*P:	PM:	*P:	PM:	*P:	PM:	*P:	PM:			

Note: *Please mark with X the abbreviation that applies.

Verified and signed by service provider:

Date: _____ Month: _____ Year: _____

UIC=Unique ID Code

MR=Medical Record Number

P=Peer outreach worker

PM=Peer mobilizer

9. Referral slip tracking log

This log is completed by the implementing partner's M&E officer. It is used to track the referral slips given to peer outreach workers and record when those slips are received back from the HTS facility, indicating that a referral has been successfully completed.

At the time a peer outreach worker is given referral slips to use in outreach, a separate page of the log is completed for each slip. The M&E officer records the date and the peer outreach worker's name on each page, and the peer outreach worker signs the book to acknowledge receipt of each referral slip. A new PM tracking number (100 in the example below) is assigned for each referral slip, along with the associated peer tracking numbers (100-1, 100-2, etc. in the example below).

If the pages of the log have not been pre-printed with serialized numbers, these can be written in by the M&E officer. The M&E officer should check that these numbers match the ones written or printed on the referral slip. The PM's UIC or name can of course only be entered after the peer outreach worker has engaged them.

When referral slips are collected from the HTS facilities at the end of each month, the M&E officer matches the tracking numbers (either the PM tracking number for an orange slip, or a peer

tracking number for a green slip, using the model in Annex 6) and enters the date the slip was received on the appropriate line of the log, along with the UIC if desired. So, for example, the date of the orange slip with the PM tracking number 100 would be written on line 1, and the date of the green slip with the peer tracking number 100-3 would be written on line 4.

If a PM requests additional (green) referral slips to give to peers, a new page of the log should be completed. The PM's original tracking number will be retained and written down on the new log page, but new peer tracking numbers will be assigned, continuing sequentially from the first batch, e.g. 100-5, 100-6, 100-7, etc.

The log is designed to record referrals to the fourth level of the referral chain network, i.e., where peers engaged by PMs become PMs in turn (see **Figure 2** and the page following it). Where this level of referrals is not part of EPO, the tracking log can be simplified by deleting all the text in blue font in the example below (and therefore lines 5–16 also).

Implementing partner:

District/department:

Center:

Center code:

Peer outreach worker:

Date received referral slip:

Peer outreach worker signature:

PM Tracking Number: 100

Peer Mobilizer UIC/Name:

Slip No.	Date referral slip received from HIV testing facility*	UIC number (optional)	PM tracking number	Peer tracking number	Peer tracking number	Peer tracking number
Referral slip used by peer mobilizer to receive HIV test (2 nd level of referral chain)						
Referral slips distributed by peer mobilizer to peers (3 rd level of referral chain)						
1			100	100-1	100-2	100-3
Referral slips used by peers to receive HIV test (3 rd level of referral chain)						
Referral slips distributed by peers to peers in their own networks (4 th level of referral chain)						
2			100-1	100-11	100-12	100-13
3			100-2	100-21	100-22	100-23
4			100-3	100-31	100-32	100-33
Referral slips used by peers to receive HIV test (4 th level of referral chain)						
5			100-11			
6			100-12			
7			100-13			
8			100-21			
9			100-22			
10			100-23			
11			100-31			
12			100-32			
13			100-33			
14			100-41			
15			100-42			
16			100-43			

* or received from community-based HTS provider (e.g. peer outreach worker), where this service is offered.



10. Incentives calculation worksheet

This worksheet is based on the incentives designed for the enhanced peer outreach program in Cameroon (see **Table 2**). The figures in italic font are examples of the numbers that would be completed each month by the M&E officer, based on data from the peer outreach worker's outreach enrollment form (in the "Recorded" column) and from the service uptake aggregation form and the referral slip tracking log (in the "Verified" column). The figures not in bold font represent the amount of the peer outreach worker's stipend/salary and the incentive payments agreed by the program. The form can be created as an Excel spreadsheet, in which case formulas can be used to calculate the payments due automatically. A similar form can be used to calculate incentive payments for PMs.

Peer outreach worker's name:	MONTH 1 / YEAR				MONTH 2 / YEAR				MONTH 3 / YEAR			
	Recorded		Verified		Recorded		Verified		Recorded		Verified	
	Amount (\$)		Amount (\$)		Amount (\$)		Amount (\$)		Amount (\$)		Amount (\$)	
Base salary					50.00	50.00			50.00	50.00		
Incentive 1												
New KP members reached and enrolled	10	8	*			9.00	6	6	*		15	20.00
Incentive 2												
KP members completed referral for HIV test		6	0.80			4.80	5		0.80		12	9.60
Incentive 3												
Frequent Testers (Quarterly)	2	2	0.40			0.80	1	1	0.40		4	1.60
Total Incentives						14.60						31.20
Total Salary: Base salary + incentive						64.60						81.20
* 6-9 new KP members = \$9 / 10-14 = \$17 / 15-19 = \$20 / 20-25 = \$25												
Number of new KP members reached [Monthly - for information only]	8				6				15			
Minimum standard for outreach [Average over 3 months]					9.7							

