MEETING TARGETS AND MAINTAINING EPIDEMIC CONTROL (EPIC) PROJECT

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Community-Led Monitoring Technical Guide

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EpiC Meeting Targets and Maintaining Epidemic Control

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EpiC is a global cooperative agreement dedicated to achieving and maintaining HIV epidemic control. It is led by FHI 360 with core partners Right to Care, Palladium International, Population Services International (PSI), and Gobee Group. For more information about EpiC, including the areas in which we offer technical assistance, click here.

Contents

Purpose

This guide supports the implementation of EpiC's comprehensive community-led monitoring (CLM) system, comprised of four components: LINK, Community Scorecard (CSC), Adverse Event Prevention, Monitoring, Investigation, and Response (AEPMIR), and Implementer Security. The guide provides steps and tools for implementation, outlines attributes of each component, and illustrates how the components come together to function as a single monitoring system. Each component can also be implemented on its own. Per the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan (COP) 2021 guidance, CLM systems are a critical aspect of the PEPFAR programs. All PEPFAR programs are required to develop, support, and fund a CLM system in close collaboration with independent civil society organizations (CSOs) and host country governments. The AEPMIR component helps address some of the PEPFAR requirements for programs implementing index testing.

Introduction

CLM is a system that empowers program beneficiaries, CSOs, and networks to routinely monitor accessibility and quality of HIV services and client satisfaction. As a solution-oriented system, CLM is designed to use this feedback to inform changes and monitor improvements needed to ensure clients—especially members of key populations (KPs), priority populations (PPs), and people living with HIV (PLHIV)—receive optimal client-centered HIV care and services and response to individual concerns they raise if immediate support is required or desired. **The main objective of the EpiC CLM system is to empower local communities to monitor and improve the quality of HIV services through the collection and presentation of information.** This includes providing feedback on services, proposing and negotiating solutions with health providers and other decision-makers, and monitoring progress toward addressing specific issues.

Key elements of the CLM system include:

- Clients, health care providers, and implementers are able to comfortably report feedback, complaints, or issues through a variety of channels
- Quantitative and qualitative data and observations on HIV service experiences are systematically collected from clients, health care providers, and implementers
- Safe and ethical provision of HIV services is monitored and ensured by a team of stakeholders including the clients themselves
- Client complaints, adverse events, and security incidents receive rapid response

The four components complement each other to provide a comprehensive view into the HIV service experience. They provide multiple channels and mechanisms for reporting sensitive

issues, and data is triangulated to minimize lack of reporting of adverse events and other service quality issues. In addition, while client focused, the CLM process engages other stakeholders, allowing for various perspectives. Discussions to generate changes in service provision occur primarily at the unit level, but also have the potential to promote changes in the wider health structure. The four components are:

- **LINK**: This component collects individual feedback and reports from clients accessing HIV services through brief surveys that measure satisfaction with HIV services, key factors impacting satisfaction, and open-ended feedback, which may include adverse event reporting. Frequently monitored, issues reported through LINK can be responded to quickly and on an ongoing basis.
- **Community Scorecard** (CSC): This component gathers collective inputs and recommendations from clients of HIV services through group discussions. The group discussions allow for in-depth exploration of issues and solutions. CSCs are complemented by key informant interviews with service providers and local health administrators that allow further exploration of any service issues.
- **Adverse Event Prevention, Monitoring, Investigation, and Response** (AEPMIR): This component collects individual reports of adverse events and incidents of violence from clients accessing HIV services. To reinforce this reporting system, trainings are included for service providers on how to prevent adverse events, create an environment where clients feel comfortable reporting adverse events, and respond to adverse events when they are reported.
- **Implementer Security**: This component collects individual reports of adverse events and violence from staff at facilities or sites including clinical implementing partners and service providers for the purpose of monitoring their own security. They may sometimes themselves be PLHIV or members of a KP or PP. This reporting system is complemented by tools and trainings to help providers and implementers improve their security.

Gathered from these four components, feedback is triangulated and discussed among stakeholders to identify persistent challenges and issues related to the HIV services so targeted actions for improvements can be made. The information also sheds light on and addresses common issues that clients face across all HIV care and challenges that service providers face in its provision. EpiC's CLM also helps address PEPFAR's minimum standards for safe and ethical index testing, including adherence to the five Cs (Consent, Confidentiality, Counseling, Correct, and Connection), inclusion of intimate partner violence (IPV) risk assessment and response, monitoring adverse events, and training and supervising providers on the rights of clients, informed consent, and ethics. The CLM system does not generate research but is a mechanism to create accountability by empowering communities to collect, present, and monitor information on HIV service quality.

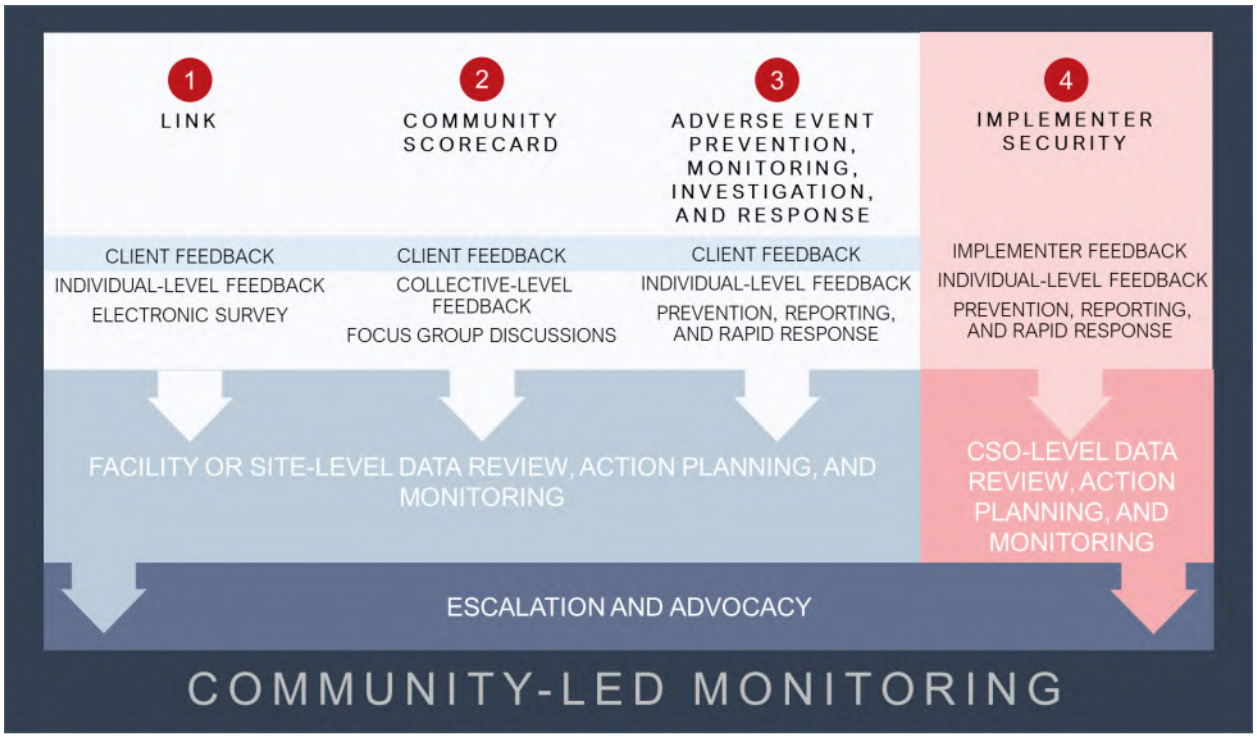
How it works together

The four components—LINK, CSC, AEPMIR, and Implementer Security—work together to gather feedback on experiences in HIV service provision for quality improvement and to reduce barriers for accessing care. While each component can be implemented independently to collect and monitor feedback and reports of adverse events, implementing the four together allows for comprehensive monitoring of service quality. Each component has its own unique data collection mechanism allowing clients and service providers to share in whatever way they feel most comfortable. The design allows for a variety of inputs from clients. All inputs are reviewed together in one joint action planning meeting for a comprehensive review of health facility or site service quality.

While each component of the CLM system can be implemented independently to collect and monitor feedback and reports of adverse events, implementing the four together allows for comprehensive monitoring of service quality.

While data from LINK and AEPMIR are collected and reviewed weekly and daily, respectively, to respond quickly to complaints and reports of adverse events, the CSCs are collected less often but allow for more in-depth discussions of any issue. Data from LINK and AEPMIR may be incorporated in the CSC to further understand each issue raised through individual client feedback. Implementer Security functions in parallel with the other components. But unlike the others, it is focused on prevention, monitoring, and response to adverse events experienced by service providers and other implementers, who are sometimes members of the community themselves. Implementer Security has its own data collection and reporting system, as well as an action planning and monitoring process at the CSO level. All the data, feedback, and reports gathered through the four components are reviewed together on a monthly or quarterly basis to inform combined action planning and monitoring at the facility or site level. Each program can decide whether to review all Implementer Security reports or limit the reviewed data to those that pertain only to the specific facility or site being reviewed during the CLM joint action planning meeting. Some security reports that are not directly related to the health facility or site may still be beneficial to review with the CLM team, including a local health administrator. Figure 1 illustrates how the four components create a single community-led monitoring system.

Figure 1. Community-Led Monitoring Framework



Case study: How data collected through the components can be triangulated and used to improve services

Larry is HIV positive. When visiting the clinic for routine services, a health care worker, Arvin, tells Larry that if he does not provide a list of his partners for index testing services, he will not receive further care. Reluctantly, Larry provides his boyfriend's name. Larry then receives a link to a client survey, LINK, on his mobile phone and decides to make a complaint that he was forced to provide his partner's name. He chooses to provide his contact information for further support, which LINK notes will be provided within one week (a telephone number for more urgent support is also provided, but Larry does not feel the need to speak to someone immediately). The client complaint coordinator at the international nongovernmental organization (INGO) in charge of the HIV program reviews all complaints submitted via LINK on a weekly basis. Larry's complaint is read by Olivia, and his complaint is documented in the Client Complaint Tracker. Olivia contacts Larry to let Larry know that his complaint has been received, to further understand what happened at the health facility, and to ask whether Larry needs any support.

Through their conversation, Olivia recognizes that Larry may benefit from services for those who have experienced abuse, including adverse events related to index testing. Olivia knows that there is a site manager at the facility Larry attended, Monica, who has been trained in first-line support (LIVES—listen, inquire, validate, enhance safety and support) and who helps link survivors of abuse to services. Monica is also in charge of documenting and investigating adverse events.

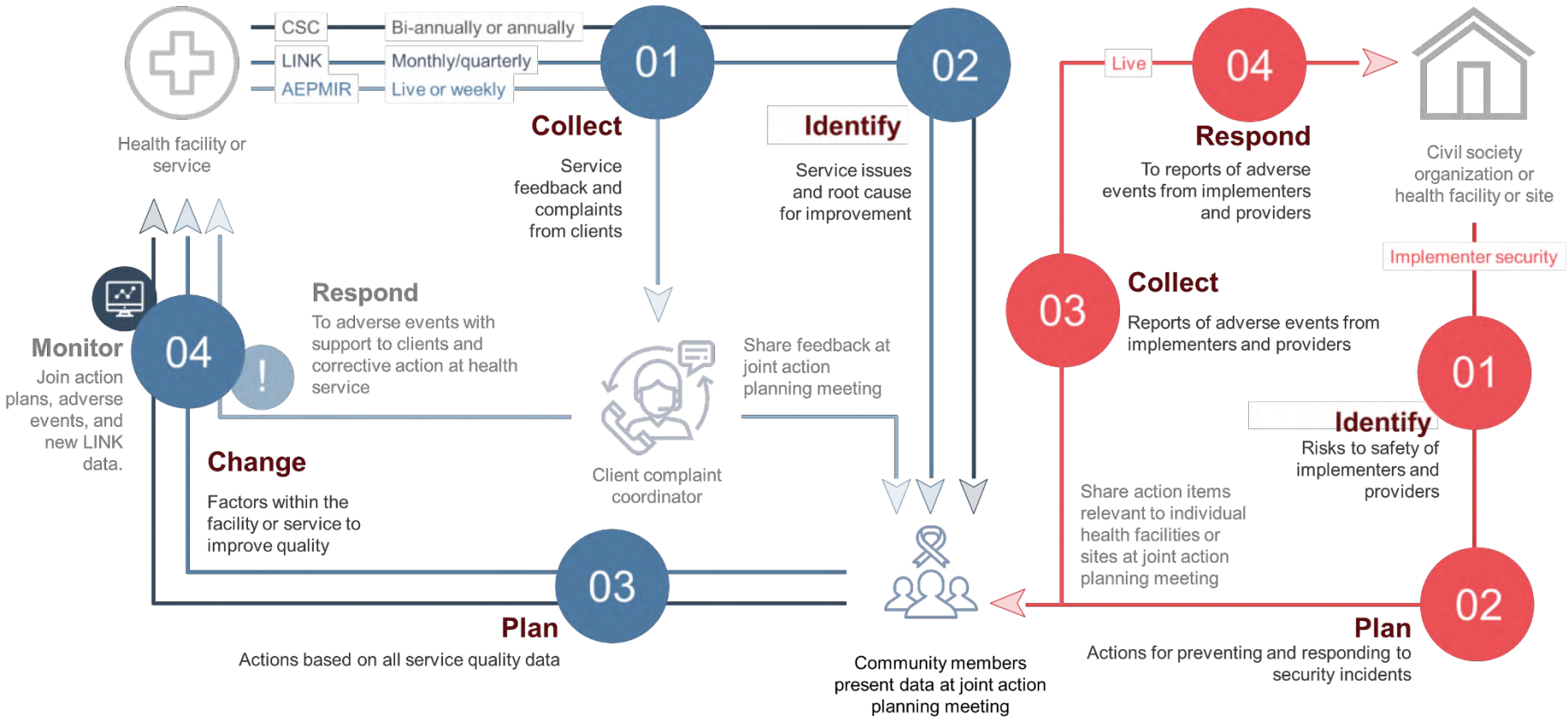
Olivia tells Larry there are services available to people who have experiences like his and offers to contact Monica. Larry accepts. Monica connects to Larry, explains the services available, and links him to the services he requests, including speaking to a counselor about his anxiety about his partner learning his status. Monica also records the complaint on the Beneficiary Abuse Disclosure and Response Form,* along with the services that she provides to Larry. As Monica is the site manager, she also investigates the event by reviewing the documented information from the visit and speaking with Arvin (she does not disclose Larry's name during the investigation). The site manager then records the findings in the investigation portion of the Beneficiary Abuse Disclosure and Response Form.* Given the nature of the offense, the site manager recommends that Arvin not be allowed to provide index testing services or any other direct services to clients until he is re-trained. The health facility's management agrees, and Arvin is suspended from all duties until a refresher training can be conducted.

The information from LINK is then used to adjust the CSC. Additional probing questions are asked about the quality of index testing at the facility to a focus group of men who have sex with men (MSM). The focus group reveals that forced naming of partners is common and that health providers do not even explain why they are asking for the names in all cases. The following week, the facility-level monthly joint action planning meeting is held where members of the community, health facility staff, representatives from the local government, and other stakeholders convened to review health facility service quality data to develop and implement an action plan for quality improvement. During this meeting, community participants present the CSC results, and the LINK data is also reviewed. From LINK, they find that, aside from Arvin's case, there have been several other anonymous complaints made by clients about the ethical provision of index testing via LINK and the complaint box. From the CSC, they are able to deduce more details and see that providers are not explaining the purpose of index testing or why they are asking for the names of the clients' partners. The clients are not told that providing names is optional, but are instead told they must provide names and must name all partners.

The group decides that a refresher training on the ethical provision of index testing is needed for all the service providers, not only Arvin. The health facility management is tasked with organizing this training for all providers. Representatives of the community who attended the joint action planning meeting are tasked with communicating with the community that their concerns were discussed and that plans for actions to improve the services are in process. They also encourage the community to come forward to the Community Advisory Board (CAB) or submit complaints at the facility if similar behavior occurs in the future. Noting that the ethical provision of index testing is an area of focus for this health facility, the CSC is updated to include additional questions to help home in on the issue and monitor long-term progress in this area.

* In Annex E of the Standard Operating Procedure for Adverse Event Monitoring, Investigation, and Response in the Context of Index Testing found on this webpage.

Figure 2. Community-Led Monitoring Process



Implementing the Components of Community-Led Monitoring

LINK

TOOLS

LINK Technical Guide

- Standard LINK Service Feedback Form*
- All-Facility Client Feedback Report (Quarterly)*
- Facility-Specific Client Feedback Report (Quarterly)*
- Client Complaint Tracker*
- Action Planning Form*

* *Included as annex in the LINK Technical Guide*

LINK is the first component of the CLM system. LINK is an electronic system for collecting and analyzing client feedback on HIV services. This client feedback approach should be implemented regularly and throughout the lifespan of an HIV program and is not done as a research project (for instance, LINK would not be implemented only once or pre- and post-intervention). Clients are offered to provide their feedback via the survey each time they access services. The survey can be completed a number of ways including field- or clinic-based tablets operated by clinic staff or community outreach workers. Clients may also be followed up remotely after service access by a case manager who takes them through the survey by phone or sends it directly to the client's phone by SMS with a link to the survey. LINK survey data collection can be automated if HIV programs use it with the FHI 360 Online Reservation and Case Management App (ORA). ORA allows clients to book appointments for HIV services on their phone, and the system automatically send the client an SMS with link to the survey after their appointment time. The survey can be administered via online tools such as Survey Monkey or QuestionPro, or off-line data capture tools such as Open Data Kit (ODK). The tool and implementation method may also be adapted to allow health providers to share their perspectives, which may affect client experience.

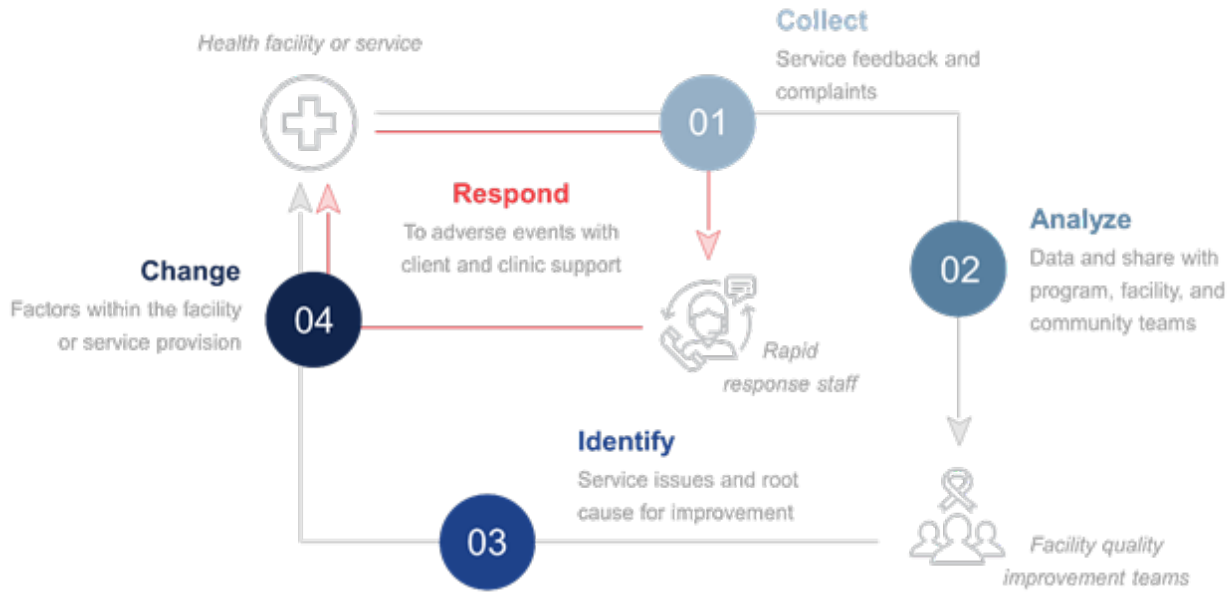
The standard LINK survey format is short and administered to identify barriers to care, initiate feedback loops between clients and providers, and generate easily understandable and actionable data. LINK was specifically designed to ensure that PLHIV and others who are disproportionately affected by the HIV epidemic, including KPs and PPs, can confidentially provide candid feedback about the quality of HIV services and their experiences with health care providers. The LINK survey allows clients to express their satisfaction by ranking the service using the Net Promoter Score (NPS) framework based on their likeliness to recommend the service to others, followed by identifying one driving factor that impacted their NPS score (such as location, privacy, and friendliness). This is followed by open feedback questions and an optional client complaint form to provide additional detail on negative experiences related to their HIV service access.

Adverse events reported through LINK are reviewed by the client complaint coordinator and are quickly reported to the site manager of the AEPMIR system at the respective health facility or site for response by trained personnel.

LINK eliminates paper forms and can be linked to automated data analysis tools (such as those in Survey Monkey and QuestionPro) or synced to a more powerful data analysis tool such as Power BI. Using these electronic and online tools may greatly reduce the time between data collection and use. Programs use the collected client feedback to quickly identify factors contributing to low and high ratings and consider client open feedback to identify the root cause of positive and negative experiences. Rapid response teams receive client complaints and respond with corrective actions for service providers. Rapid response teams include a field-based client complaint coordinator (someone who views and reports new client complaints weekly) as well as program and community staff trained to respond to violence and adverse events.

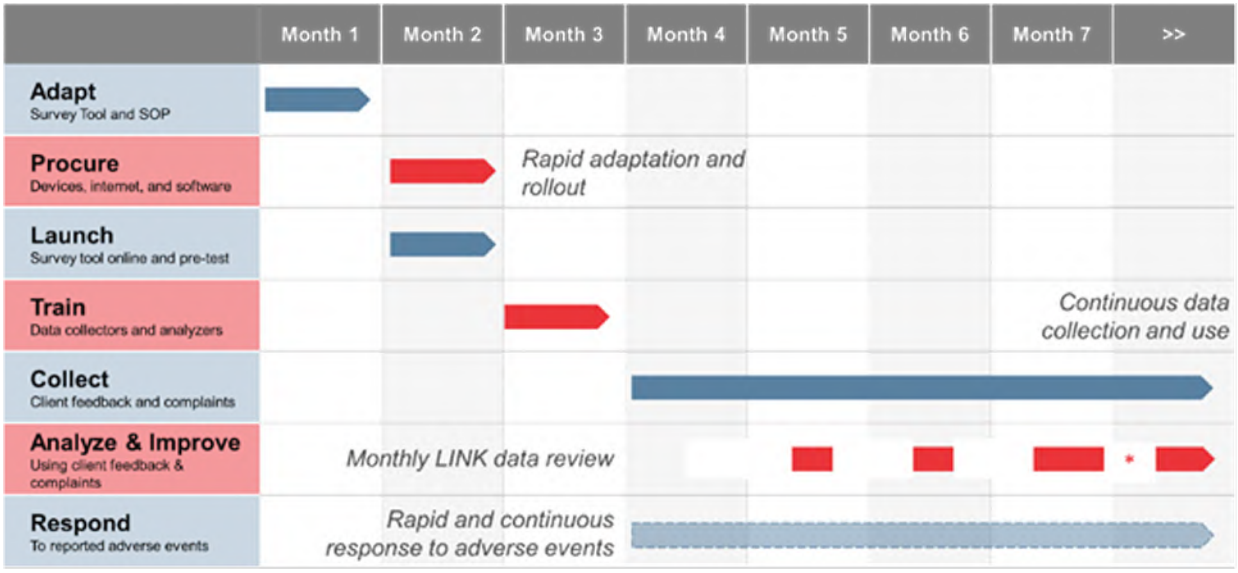
Client feedback collected on LINK is analyzed and shared with others involved in quality improvement efforts including government or community stakeholders (to guide community score card teams).

Figure 3. LINK Process



Steps for implementation

Figure 4. LINK Timeline



Step 1. Adapt LINK to context

Step 2. Procure technology and devices

Step 3. Launch LINK tools

Step 4. Train staff and users

Step 5. Start routine data collection using LINK

Step 6. Analyze and use LINK data

Detailed steps for implementing LINK and analyzing LINK data can be found in the LINK Technical Guide.

Adapt LINK to context

Prior to implementation, a situational assessment of existing community monitoring and feedback systems is conducted to understand how LINK can be integrated into the established system. HIV programs consult relevant stakeholders and key informants to determine their needs and objectives for monitoring client satisfaction. Some programs may decide to provide an option for health workers to use a similar survey to provide their feedback and perspectives on metrics that may affect client experience as well. The rollout and data collection plan for LINK, as well as the questionnaire **Standard LINK Service Feedback Form (Annex 1 of LINK Technical Guide)**, is then adapted, and stakeholders continue to be engaged throughout the process to gain consensus on the LINK plan and revise as necessary. A LINK stakeholder committee, consisting of service providers, local health administrators, community members, and CSO staff trained on LINK, should then be established to review and respond to LINK data as reports come in. These teams can be

newly convened (which may require additional funding for support participation), or LINK data can be provided to existing stakeholder engagement and service quality mechanisms at the facility, site, community, and program level.

Procure devices and launch survey online

LINK can be used on any device with access to the internet including smartphones and tablets. It can also be administered in different ways depending on the program's needs, including in the community by community workers, in the health facility or site by facility staff or the client, or self-administered anywhere by clients' choice by sending a link to the survey directly to their mobile phones. Depending on the method of administration chosen, as well as context in which the program plans to implement LINK, the team should consider the number and types of devices that should be purchased to support data collection. Once the devices and any software subscriptions needed are purchased, the devices are then formatted for the project (branding, setting up login details, downloading apps). Survey Monkey, or any other online survey service, should be used to create the online link to the adapted LINK questionnaire. The online surveys should then be pretested and revised as necessary before full rollout.

Train staff and users and start routine data collection using LINK

Program staff are then trained on how to use Survey Monkey or other programs to view and analyze data. Training documents are developed for data collectors, and the training is conducted with facility or site management, community representatives, and data collectors. Detailed instructions on how to develop the data visualization on Survey Money can be found at the end of the **All-Facility Client Feedback Report (Annex 2 of LINK Technical Guide)** tool and the **Facility-Specific Client Feedback Report (Annex 3 of LINK Technical Guide)** tool.

Staff supporting LINK data collection are then provided with the procured devices and internet connection. An electronic client database, or online reservation and case management app (ORA), can be programmed to automatically send clients a link to provide feedback by SMS or they can track when someone on the program team has offered the feedback survey to clients. As a standard, all clients may be offered to provide their feedback on LINK, but this can be reduced to every other client or every third client to reduce SMS sending costs or to conserve the time of clinic or community implementers of the LINK survey.

Analyze and use LINK data

HIV programs using LINK have access to two kinds of data from the questionnaire that should be used regularly for quality improvement: (1) routine client satisfaction and (2) client complaints. Routine client satisfaction data is reviewed

When implemented independently, LINK data is reviewed monthly or quarterly to inform facility-level action planning and progress monitoring by facility or site quality improvement teams. When implemented as part of the CLM system, the facility or site quality improvement teams are combined with the joint action planning team and additional stakeholders. Data from the other components is reviewed.

monthly or quarterly to inform regular program and facility-level quality improvement activities, such as the joint action planning meeting as part of the CLM.

The HIV program develops a facility-level LINK data dashboard to routinely display data and develop presentations, including the **All-Facility Client Feedback Report (Annex 2 of LINK Technical Guide)**. As a standard, facility-level analyses should only be produced if there are more than 20 surveys completed for the period (month or quarter), however programs may increase this threshold to limit the number of facilities or sites to be given an analysis. Additionally, facilities or sites may address a low response rate by offering the survey to more clients or offering clients who complete a survey entry to a lucky draw for a small prize (such as airtime). The data analyzed and presented in a dashboard is shared with various quality improvement channels, including implementing partners and health facility or site management as a part of monthly discussions about the quality of HIV services and the provision of stigma-free care. This monthly data is used by the health facility's quality improvement team to develop an action plan using the **Action Planning Form (Annex 5 of LINK Technical Guide)**.

> Inclusion of an additional column in the action planning form to identify root causes is recommended if your program is implementing only LINK. When using this template as part of CLM, it is recommended to use this template as is. However, this template should be adapted in whatever way is most beneficial to your program.

Responding to client complaints

Client complaints are reviewed more frequently, at least weekly, to ensure timely support services are provided and to address facility-level misconduct and prevent future complaints and negative experiences. The **Client Complaint Tracker (Annex 4 of LINK Technical Guide)** is used to review and respond to any new client complaints and track responses. Adverse events or violence experienced by clients should be immediately communicated to staff who can respond to the client with first-line response and referral for post-violence services. Staff members who will be responsible for first-line response and referral should be identified prior to launching LINK.

> If AEPMIR is also implemented in the facility or site, adverse events should be reported to the site manager for timely appropriate response.

All complaints submitted to LINK are entered in the **Client Complaint Tracker (Annex 4 of LINK Technical Guide)** by the client complaint coordinator, who may or may not be the same person who offers first-line support. The tracker can be viewed by authorized HIV program team members using a secure document-sharing system such as Google docs, Microsoft One Drive, or SharePoint. The HIV program can transparently track all complaints and how each was addressed, but does not include client identifying information (such as email addresses or phone numbers that clients may voluntarily provide within the complaint form so they can receive direct support related to their complaint).

All complaints are reviewed for validity by the client complaint coordinator. Valid complaints are those that identify a problem related to the HIV program and can be addressed at the national, district, or facility level. For instance, many clients complete the complaint form by mistake or use it to describe a positive experience or something unrelated to their HIV service access; those would be considered invalid. For all valid complaints with client contact information, the program staff member contacts the client to inform them that their complaint has been received and ask for further details to help complete the story of what happened. The details provided by the client, the specific responses taken by the facility or site, and the status of each complaint (closed: no further action required, or open: action left to be taken) should be updated on the client complaint tracker. All surveys include a note to the clients that if they submit a complaint anonymously, program staff will not be able to follow up with them, but will keep their complaints on record.

If a complaint mentions violence and includes client contact information, regardless of whether the violence is related to the HIV program, the staff member must offer to connect the client to a provider who has been trained to provide first-line support and refer for other post-violence services. If the client agrees, the complaint is sent to the appropriate facility or site response teams or directly to facility or site management who then reaches out to the client. When information on violence-related complaints is recorded, special care should be taken to ensure that no identifying information is included.

Clients who provided their contact information on their complaint form are then informed of how their complaint was addressed. If a valid complaint is reported anonymously and information provided in the complaint is not sufficient to respond properly, the client complaint coordinator still includes the valid complaint in the client complaint tracker. If the complaint is about violence, regardless of its relationship to the HIV program, it must be reported to the AEPMIR process.

If AEPMIR is implemented at a health facility or site and a team trained in AEPMIR exists at the health facility or site, then adverse event complaints reported through LINK should be immediately communicated to the trained site manager with their contact information to be responded to via the AEPMIR response system. When cases are transferred from LINK to AEPMIR, the LINK client complaint coordinator should ensure completeness of this transfer and report it back on the LINK client complaint tracker.

LINK in Malawi

Malawi was the first country to implement LINK, beginning in early 2017. More than 1,600 surveys have been administered by implementing partner (IP) organizations that run a variety of programs to support men who have sex with men, female sex workers, and transgender people. The outreach workers who are employed by these partner organizations are responsible for administering LINK surveys on smartphones as part of their regular duties when conducting outreach activities in communities. By administering the surveys, they now engage clients in discussions they never had before. Because of LINK, they talk with clients about the quality of HIV services they are receiving from health care providers and about which facilities discriminate against stigmatized populations—and which do not. They get to know more about their clients' unique experiences navigating the health care system. Even before the LINK survey data are analyzed, the outreach workers use their knowledge of client experiences to refer clients to facilities that are friendlier to stigmatized populations and guide them away from facilities that discriminate.

LINK in Nepal

In Nepal, clients who book an appointment on the ORA platform, merosathi.net, are sent an SMS to their mobile phones after their appointment with a link to open the survey and provide feedback. Posters displayed on health facility walls have a QR code for clients to access the survey. Additionally, the survey is promoted through online outreach workers, community-based supporters, and drop-in centers (DICs) where clients may provide feedback. An orientation was conducted for IP staff and networks of PLHIV on the LINK survey for sensitization and demand creation. In addition to program facilities, LINK is also implemented for government antiretroviral therapy (ART) facilities. The Nepal team found that the main factor promoting access to care among clients was staff friendliness while the most cited detractor for accessing services was privacy. Between July and September of 2020, five negative experiences were recorded regarding index testing at government ART sites that are not PEPFAR index testing sites. Two people said they were forced to disclose personal information, one reported having been asked for sensitive information, one felt stigmatized by providers, and one complained of rudeness from the provider. Because none of the clients wanted to provide the name of the personnel concerned, the program decided to address the incidents through continued education for ART sites' staff.

COMMUNITY SCORECARDS

TOOLS

- Annex B. Community Scorecard Standard Operating Procedures
- Annex B1. Suggested focus group stratifications*
- Annex B2. Example community scorecard focus group facilitation guide*
- Annex B3. Key informant interview guide*
- Annex B4. Implementation plan template*
- Annex B5. Action plan form*
- Community Scorecard Group Facilitator and Key Informant Interviewer Training (see slide presentation on this webpage)

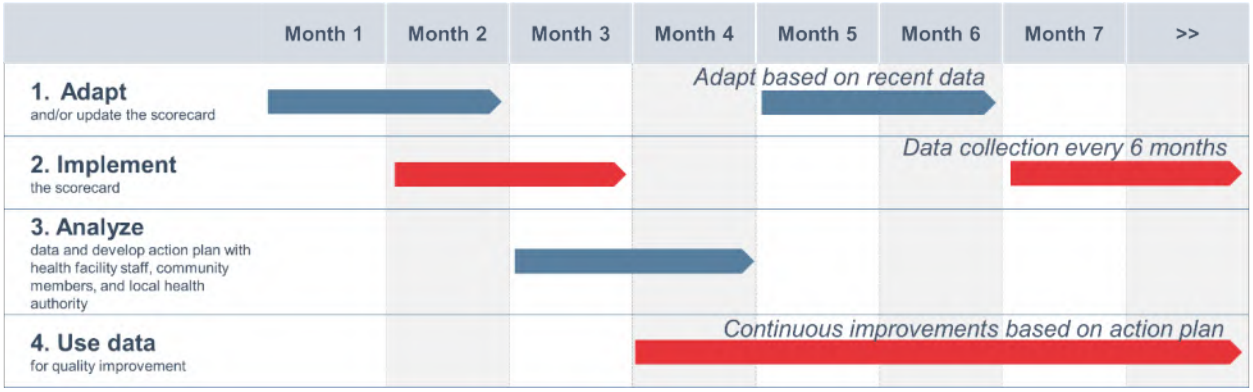
* *Included as annex in the community scorecard standard operating procedures*

The Community Scorecard (CSC) process is the second component of the CLM system. The CSC is a participatory, quality improvement tool routinely used for assessing, planning, monitoring, and evaluating HIV and other health services. The CSC is used by both community members, including CSOs and advocates, and health care providers to obtain community feedback on services and/or to take a deeper dive into issues reported through individual client feedback. Unlike individual client feedback that is focused on individual experience and may have limited depth or explanation of root causes of service quality issues, the CSC process uses the collective community feedback and experience to further understand the reported challenges and issues, and is focused on monitoring at the local administration and facility or site levels. As such, the questions included in the scorecards can be adjusted based on a review of individual client feedback and designed to gain greater insight into the indicated challenges.

Relying on information generated by the scoring, focus group discussions (FGDs), and key informant interviews (KIIs), the CSC process depends heavily on the participation of community members in the assessment of service quality. CSC data is reviewed along with any other data on facility or site service quality in an action planning meeting where community members, health facility and site staff, and local health administrators come together to discuss actionable steps toward service quality improvements. The community can engage with health facility or site providers in a formal setting and deliberately and positively encourage service quality, efficiency, and accountability. Stakeholder groups engage in participatory dialogue that is action based and accountability focused. As part of the CLM, this meeting is replaced by the joint action planning meeting incorporating data from all other components.

Steps for implementation

Figure 5. Timeline of CSC Process Implementation



Step 1. Adapt/update the scorecard

Step 2. Implement the scorecard

Step 3. Analyze data and develop an action plan

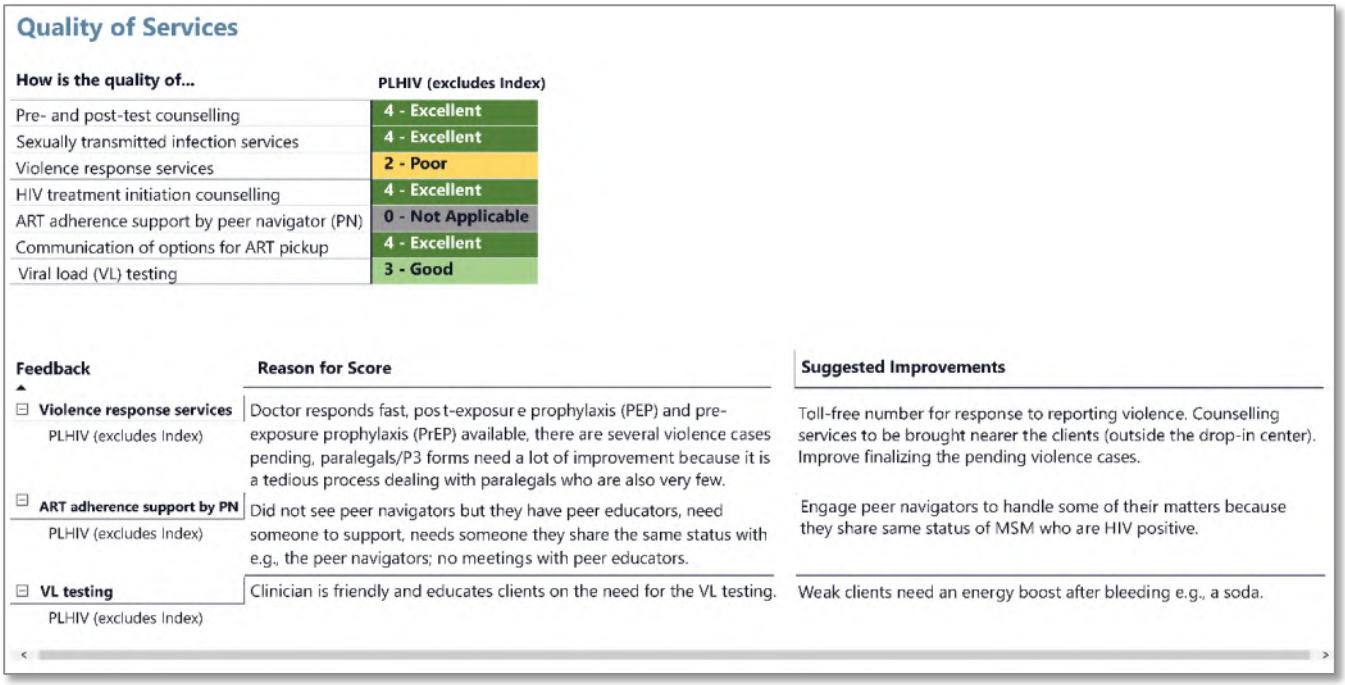
Step 4. Use data for quality improvement and advocacy

Detailed steps for implementing the CSC process are included in **Annex B. Community Scorecard Standard Operating Procedures.**

Adapt and/or update the scorecard

The CSC tool, which is also a FGD guide, is used to gather feedback from the clients of HIV services. **The CSC Focus Group Discussion Guide (Annex B2)** should be adapted to the country context as well as to the target population (e.g., KPs, PPs, PLHIV, non-PLHIV, etc.) from whom programs plan to receive in-depth feedback. The **suggested stratification of FGDs** by target groups and HIV serostatus is in **Annex B1.** The **Key Informant Interview (KII) Guide (Annex B3)** is used for interviewing health service providers and/or local health administrators on their perspectives on challenges with service provision. This tool should also be adapted to the context of the country and the health facility or site with which interviews will be conducted. The **Implementation Plan Template (Annex B4)** can be used to help organize and plan for the various discussions and interviews. An online data entry form, such as Open Data Kit, for the CSC tool should be developed so the data collected can be imported into an online dashboard for ease of visualization and review. Data visualization on the dashboard should be customized to the program's needs.

Figure 6. Example of CSC Data Visualization from CSC Dashboard



Implement the scorecard

Once the scorecards have been adapted, CSC facilitators should be selected. CSC facilitators should ideally be representatives of the community who will participate in the group discussion. For example, if the individuals participating are FSWs, the facilitator should also be an FSW. The CSC facilitators should be oriented and trained on how to conduct group discussions. The **Community Scorecard Group Facilitator and Key Informant Interviewer Training** (found on this webpage) can be used for this training.

Participants for the CSC FGDs are community members who have received services from the health facility or site that is being monitored, and have been recruited from community groups (e.g., citizen groups, support groups, etc.) for voluntarily participation. The KIIs are conducted with voluntary participation from service providers, facility or site mangers, and local health administrators of the health facility or site that is being monitored. CSO staff or members of other community groups collect the data and, therefore, are trained by the HIV program on FGD facilitation and KII procedure. Based on the number of FGDs and interviews planned, the number of CSO staff to be trained will be determined and then trained. The CSC process should ideally be conducted routinely every six months.

Figure 7. Participants to Recruit

FGDs with service beneficiaries	KIIs with service providers	KIIs with health representatives/ administrators
~10 beneficiaries of respective health facility or site per group	1 service provider AND/OR 1 facility or site manager (1–2 people per facility or site)	1 local health administrator per health facility or site

Analyze data and develop an action plan

Once the FGDs and KIIs are completed, an action planning meeting under CLM is convened to review the collected data and facilitate a discussion with the community representatives who were participants in the FGDs, health facility or site managers, and local health administrators. Prior to this meeting, CSO and/or HIV program staff help community representatives prepare by summarizing for them the key issues and suggestions for improvement raised during the FGDs and strengthening their negotiation skills. Any apparent disagreements between the FGD and KII findings are addressed during the action planning meeting, and support is provided to community representative on how to lead these discussions.

During the action planning meeting, data from the CSC process, as well as any other data on facility or site service quality, such as LINK, are reviewed. Based on the discussion, participants collaboratively develop an action plan with top priorities listed. Responsibility for carrying out the plan will be determined by the specific issues and actions. As part of the CLM system, this meeting is replaced with the joint action planning meeting and data from all other implemented components are presented and reviewed.

Use data for quality improvement and advocacy

Actions agreed upon during the meeting should be integrated into the annual health facility, site, or government plan as well as CSO plans to promote awareness about how the community can take part to improve their welfare at the health facilities or sites. A social contract may be signed between the community and the relevant authorities to ensure implementation. Issues that are beyond the scope of the health facility or site should be escalated to CSOs, community-led forums, or technical working groups (TWGs) to address the issue or advocate for change on a higher level. CSO staff leading the CSC process should use the issues raised during the action planning discussion to update the CSC for the next round of data collection. Either monthly or quarterly, action planning meeting participants should convene to monitor progress, review data, and update the plan. As part of the CLM system, these same steps are taken using the outcomes of the joint action plan meeting.

Community Scorecards in Malawi

In Malawi, the CSC tools were adapted using feedback from suggestion boxes and LINK. Due to COVID-19, FGD facilitation training of staff from two partner CSOs was conducted online with representatives from two public health facilities working with FSWs and one from a facility working with MSM. Participants for FGDs were selected by partner CSO staff, and groups were stratified into PLHIV-only, people with unknown or negative HIV status, and those of any HIV status based on their health registers. Participants included FSWs, MSM, and transgender people. Nine focus groups with six health facilities and three drop-in centers (from different districts) were conducted. KIIs were conducted with three health service managers: two from a facility that provides services to FSWs and one from a facility providing services to MSM. FGDs and KIIs were conducted by CSO staff.

Prior to conducting the interface meeting, the EpiC Malawi team met with CSO staff and community representatives to assist with organizing and preparing data. Data, collected using paper-based forms, was loaded into an online collection tool to be consolidated into a dashboard for visualization. Community representatives, health facility staff, and CSO staff attended the meeting. The group of FSWs, MSM, and transgender people elected by the community included beneficiaries, peer educators, and peer navigators. Action plans based on identified gaps and challenges were developed, and each stakeholder was tasked with an action item.

The Mlomba Health Center in Machinga district serves FSWs. Among the various criteria assessed, the center received one of the lowest scores for “access to HIV treatment services.” In the FGD, clients expressed that it is not necessarily an issue of access but rather confidentiality. To practice social distancing due to COVID-19, clients are asked to wait outside for their appointments, and their names are called out when their turn comes. Because the ART clinic is next to the outpatient department, people waiting in the outpatient line could hear the names and know they are on ARVs. During the action planning meeting, health facility staff explained that the location of the ART clinic is an infrastructure issue that would be challenging to address. However, the interface meeting participants agreed that clients could be provided with a number to be called for their turn. This action item was assigned to the facility in-charge; the clients’ names are no longer called out loud.

Likangala Health Center in Zomba district, which also serves FSWs, found that some challenges do not have easy fixes or are beyond the scope of the facility. The interface meeting included the facility in-charge, health care providers, ART coordinator and laboratory personnel from the DHO, laboratory technician, health facility staff, community representatives, and project staff. The only item for which the facility received a “poor” rating was “access to services.” The greatest challenge was access to viral load testing, rated “very poor.” Clients indicated that turnaround time for results is very long, and sometimes samples go missing and they never receive results. To address this issue, an

action item was negotiated for the facility in-charge to keep a record of all samples collected and cross-check with the list of people who received results to track results not yet returned. Another action item was to sensitize clients to continuously request their results if they have not been received. The health facility staff said the turnaround time was beyond their control as tests are conducted at one central laboratory used by several facilities, and the issue should be escalated up. The issue was conveyed to DHO staff present at the interface meeting who then agreed to brief the district health officer responsible for Zomba. Another challenge was wait time for services, which was addressed by extending open hours. However, it was noted that this issue stems from shortage of staff, which will need to be addressed over the long-term.

Most issues related to violence did not receive major attention during the FGD. Access to violence response services and quality of violence testing assessment for “intimate partner violence” section received an overall score of “good.” However, “explaining why the health care workers were asking about IPV” received a “poor” rating and was discussed by interface meeting participants. To address the issue, the drop-in center (DIC) manager arranged an orientation on adverse event prevention, monitoring, investigation, and response for the health care workers under the AEPMIR component. During the discussions on violence, FSWs also mentioned violence committed by uniformed officers and, in response, the DIC manager organized a sensitization training with the Malawi Defense Force.

The EpiC Malawi team found that the meetings provided an opportunity for KP members to express common concerns and for service providers to respond. They also helped strengthen the relationship between the teams from public facilities and DICs as they worked together to understand and solve issues. All action items implemented will be monitored for completion and effectiveness in making the intended improvements. An assessment of facilities will be conducted again in six months to understand how these action items have improved services from clients’ perspectives.

ADVERSE EVENT PREVENTION, MONITORING, INVESTIGATION, AND RESPONSE

Definitions

Adverse event: Any incident that results in harm to the client or others because of their participation in HIV services.

Harm: Any intended or unintended cause of physical, economic, emotional, or psychosocial injury or hurt from one person to another, a person to themselves, or an institution to a person, occurring before, during, or after HIV services.

Adverse event related to index testing: Any incident that results in harm to the client or others as a result of their participation in index testing services.

Illustrative severe adverse events include:

1. Threats of physical, sexual, or emotional harm to the index client, their partner(s), or family members, or to the index testing provider
2. Occurrences of physical, sexual, or emotional harm to the index client, their sexual or drug-injecting partner(s), or family members, or the index testing provider
3. Threats or occurrences of economic harm (e.g., loss of employment or income) to the index client, their partner(s), or family members
4. Withholding HIV treatment or other services from the person offered index testing, their partners, or family members
5. Forced or unauthorized disclosure of client's or contact's name or personal information
6. Abandonment or forced removal of children less than 19 years old from the home

Illustrative serious adverse events include:

1. Contacting partners without obtaining consent for participation in index testing and/or for notifying partners
2. Stigma perpetrated by health site staff (e.g., intentionally prolonging clients' wait times, discriminatory behavior) or criminalization (e.g., sharing personal information with the criminal justice system about a KP member and/or person living with HIV who is seeking care)

While intimate partner violence (IPV) and other forms of violence may be adverse events (i.e., they can occur because of one's participation in HIV services), they may also occur for other reasons. Having a robust adverse event prevention and response (AEPR) system in place allows facilities or sites to respond to IPV and other forms of violence, regardless of their cause, appropriately. No one who experiences violence should be denied services because the violence was not caused by participation in an HIV program.

Source: U.S. President's Plan for AIDS Relief. Guidance for implementing safe and ethical index testing services. Washington (DC): PEPFAR: 2020. Available from: https://www.pepfarsolutions.org/resourcesandtools-2/2020/7/10/pepfar-guidance-on-implementing-safe-and-ethical-index-testing-services?rq=index%20testing.

The Adverse Event Prevention, Monitoring, Investigation, and Response (AEPMIR) process is the third component of the CLM system. It includes:

- Setting up systems to monitor, investigate, and respond to adverse events, including by revising program policies or re-training staff
- Training providers to identify IPV or other forms of violence experienced by clients, including as part of index testing
- Training providers to educate KP members and other clients on adverse events and their rights, including their rights as patients
- Training providers to respond appropriately when adverse events are disclosed, including when violence is disclosed and requires first-line support

The AEPMIR reporting system provides opportunities for disclosure and encourages clients to report any experiences of harm. Ensure the system has the capacity to respond quickly and appropriately based on reports and to monitor improvements in a facility or site's ability to prevent and respond to adverse events experienced by clients. When reports of an adverse event are made directly to a provider, the provider immediately offers support, such as LIVES. Non-anonymous reports through LINK or comment boxes are also responded to immediately. Embedding responses to adverse events within community monitoring systems gives individuals another incentive to report the harms they experienced and allows time-sensitive services, such as post-exposure prophylaxis and emergency contraception, to be delivered effectively.

TOOLS

Standard Operating Procedure for Adverse Event Monitoring, Investigation, and Response in the Context of Index Testing (found on this webpage)

- Content Recommendations for SOPs Describing Clinical Violence Response Services*
- Index Testing Script*
- Adverse Event Report Form for Index Testing Services*
- Adverse Event Investigation Form*
- Beneficiary Abuse Disclosure and Response Form and Instructions*
- Patient Rights Poster*
- Customer Complaint Form*
- Implementer Security Incident Log*
- Index Testing Register (from the PEPFAR Index and Partner Notification Testing Toolkit)

Standard Operating Procedure for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing (found on this webpage)

- Content Recommendations for SOPs Describing Clinical Violence Response Services**
- Steps for Establishing and Maintaining a Referral Network**
- Referral Network Template**
- Referral Letter Template**
- Safe Storage of Information**
- IPV Routine Enquiry Questions for Key Populations**
- Job Aid for IPV Screening and Response as Part of Index Testing**
- Index Testing Script**
- Identifying, preventing, and responding to violence in HIV programs serving key populations: Building health care workers' capacity to offer safe and ethical index testing training slides and facilitator's handbook (found on this webpage)

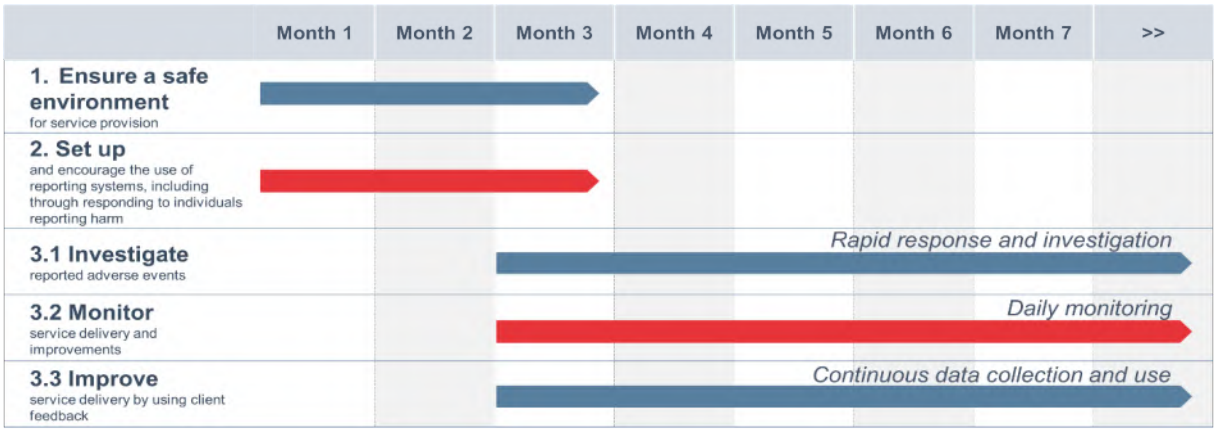
* *Included as annex in the Standard Operating Procedure for Adverse Event Monitoring, Investigation, and Response in the Context of Index Testing*

** *Included as annex in the Standard Operating Procedure for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing*

Training providers on how to identify and avoid adverse events, particularly those related to IPV, also prevents harm by instructing providers to discourage index testing when the partner is violent. Finally, the AEPMIR process also provides training specifically on the necessary processes and documentation required for implementing index testing ethically. Adverse events reported through LINK, anonymous or not, should also be connected to the AEPMIR process.

Steps for implementation

Figure 8. Adverse Event Prevention, Monitoring, Investigation, and Response Timeline



Step 1. Ensuring a safe environment for service provision

Step 2. Set up and encourage the use of reporting systems, including through responding to individuals reporting harm

Step 3. Investigate, monitor, and improve

For detailed steps for implementing the AEPMIR process, see the **Standard Operating Procedure for Adverse Event Monitoring, Investigation, and Response in the Context of Index Testing** (referred to as AE SOP hereafter) and the **Standard Operating Procedure for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing** (referred to as IPV SOP hereafter) found on this webpage.

While these two tools are specific to index testing, they can be adapted to include other HIV services. Similar steps should be followed for all HIV services provided at the facility or site.

The two SOPs were originally developed as a response to troubling reports of adverse events, including incidents of IPV specifically related to index testing. While especially important to facilities' or sites' efforts to provide ethical index testing, these SOPs can be adapted for additional HIV services to ensure our programs are proactively preventing, monitoring, investigating, and responding to adverse events. Notably, the distribution of self-testing to partners and pre-exposure prophylaxis (PrEP) initiation both require IPV identification and response (as covered in the IPV-focused SOP). All services benefit from adverse event monitoring and response plans.

Ensuring a safe environment for service provision

A safe environment includes both the health facility or site staff and the infrastructure and systems in place. Trained HIV program staff train health care workers on and receive capacity building for providing index testing and other HIV services in a safe and ethical manner. Health care workers are trained on: how to create systems at the facility or site that allow IPV assessment to be conducted (as shown in Figure 9), how to conduct an IPV risk assessment; how to provide first-line support if violence is disclosed including skills to provide psychological first aid, discuss safety, and refer effectively (active referral); how to use documentation forms and procedures when adverse events are reported (including IPV related to index testing); and how to follow up with a client to determine if they have experienced an adverse event following participation in index testing or other HIV services. The **Identifying, preventing, and responding to violence in HIV programs serving key populations: Building health care workers' capacity to offer safe and ethical index testing** training slides for health care workers (found on this webpage) cover these topics and can be adapted and used.

Figure 9. Minimum Requirements for Asking about Violence

Health facilities should ensure that various protocols and systems are also in place that create an environment where clients feel safe and know their rights. Health facilities or sites assess crisis response and community support systems that may already exist. Ways to engage these systems are then strategized to develop effective referral systems that connect clients to further appropriate services when adverse events are reported (i.e., medical, legal, social, psychosocial, shelters). Where no existing violence response services are available, or may

not be sufficient, programs may consider hiring individuals who can provide counseling and other services. To conduct IPV screenings, private spaces where clients feel safe to talk in confidence are also necessary. Posters and materials are used to notify clients of their rights to quality services. These communication materials, at minimum, convey the voluntary nature of all HIV services, the client's rights to confidentiality, and the various ways to file a complaint anonymously. An example **Patient Rights Poster** from PEPFAR is provided in **Annex F** of the **Standard Operating Procedure for Adverse Event Monitoring, Investigation, and Response in the Context of Index Testing** (found on this webpage), which may be adapted for each health facility or site.

Set up and encourage the use of reporting systems, including through responding to individuals reporting harm

An effective reporting system must be in place to ensure effective monitoring. To encourage clients to report adverse events, multiple pathways should be available (e.g., hotlines, comment boxes, LINK) for them to choose the one with which they feel most comfortable. The **Customer Complaint Form for HIV Services (Annex G of the AE SOP)** can be adapted. Community Advisory Boards (CABs), made up of community leaders and PLHIV, are recommended to act as a liaison between the facility or site and the community as another way complaints can be communicated with the health facility or site staff if clients do not feel comfortable making complaints alone. Similarly, the CSC process is another means for adverse events to be reported. Members of the CAB should also attend the joint action planning meeting as part of the CLM or CSC in addition to providers who are trained to ask about violence and adverse events.

Appropriate and timely responses to these reports are necessary to demonstrate to clients that their well-being is important and that actions are being taken to prevent such events from occurring in the future. Health facilities or sites adapt processes and forms to document and investigate the adverse events reported. Individuals who report non-anonymously are linked to support per client request. The health facility or site adapts an **Adverse Event Report Form for Index Testing Services (Annex C of the AE SOP)** for staff members to record reported adverse events, including in services beyond index testing, and what has been done in response to meet the client's needs.

If an adverse event is submitted anonymously via other mechanisms, the site

As noted in the Site Improvement through Monitoring System (SIMS) 4.1, it is a requirement for sites to have the following in place:

- Index testing training and supportive supervision
- Monitoring adverse events from index testing
- Secure handling and storage of index testing data
- Intimate partner violence risk assessment and support

Implementing AEPMIR addresses all of these SIMS requirements.

manager must enter this information into the Adverse Event Report Form. All reporting mechanisms should be monitored by the site manager. If the complaint is not submitted directly to a provider but provides contact information, the site manager should offer support to the person who experienced the adverse event or offer to connect them to an appropriate provider, such as someone who has been trained in first-line support.

Investigate, monitor, and improve

Facilities and sites also identify a site manager who will investigate all the serious and severe adverse events, identify follow-up steps and actions to prevent similar adverse events, and document the steps taken during the investigation using the **Adverse Event Investigation Form (Annex D of the AE SOP).** In the case of IPV caused by participation in index testing, the site manager investigates to ensure that IPV risk assessment occurred appropriately during index testing. The **Standard Operating Procedure for Adverse Event Monitoring, Investigation, and Response in the Context of Index Testing** (found on this webpage) can be adapted for each health facility or site. Adverse events reported through any of the channels provided, whether directly to a provider or through other pathways, are documented in the **Adverse Event Report Form** mentioned above**.** The provider who receives the report notifies the facility or site manager immediately and provides the facility or site manager with the documentation of the adverse event. The facility or site manager investigates any adverse event within two to four business days of receiving the report and fills out the **Adverse Event Investigation Form**. In cases where the adverse event is IPV, the investigation should focus on whether procedures were followed regarding the IPV assessment, provision of psychological first aid, and appropriate referrals. The facility or site manager completes the investigation and notifies the stakeholders (i.e., implementing agency, implementing partner, Ministry of Health) within four days of receiving the report.

The investigation identifies what caused the adverse event, if not IPV, and what should be done to remediate. A remediation plan is developed to address adverse events, and stakeholders discuss the plan and report it back to the CAB, or other community-led mechanism, to ensure they agree with the actions planned. The site manager is then responsible for ensuring the corrective actions are taken at the facility or site.

If an adverse event occurs due to a trained provider's failure to abide by the minimum standards for index testing or any other HIV services, the provider must immediately stop offering services until remedial actions, such as further provider training, occur.

When conducted ethically, index testing has potential benefits for epidemic control and for the index client. However, if index testing is provided without following the necessary steps to protect the client and the client's partners, it may lead to harm. The following steps should be followed by health care workers when they offer index testing. They are part of safe and ethical index testing. They are illustrated in **Job Aid for IPV Screening and Response as Part of Index Testing (Annex G of the IPV SOP)**.

When introducing index testing, the provider will ensure that the client understands that index testing is voluntary and will ask for the client's consent before soliciting partners' names using **Index Testing Script (Annex B of the AE SOP)**. Consent or reasons for nonparticipation should be captured by the provider conducting index testing in the **index testing register**.

If the client consents to index testing, the provider should conduct a risk assessment for IPV with each named partner using **IPV Routine Enquiry Questions for Key Populations (Annex F of the IPV SOP)**. If violence is disclosed, first-line support must be provided, and the health care worker should recommend that the client not initiate index testing. If the client wishes to initiate index testing and the provider believes it can be done safely, the provider should help the client choose a method of index testing that does not require disclosure following **Standard Operating Procedure for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing** (found on this webpage).

The provider should routinely follow up with index clients to ask if they experienced any adverse event due to index testing during the client's first two to three clinic appointments OR through follow-up (e.g., via phone) four to six weeks following testing of the client's contact(s) OR as long as contacts are being actively traced. Follow **Standard Operating Procedure for Adverse Event Monitoring, Investigation, and Response in the Context of Index Testing** (found on this webpage) for documentation and investigation.

IMPLEMENTER SECURITY

TOOLS

- Annex C. Threat and Vulnerability Assessment Tool
- On webpage: Ensuring Compliance with the EpiC Data Safety and Security Checklist
- Annex D. Survey Instructions Tool
- Strengthening the Security of HIV Service Implementers Working with Key Populations training slides and facilitator's handbook (found on this webpage)
- Annex E. Implementer Security Plan
- Annex F. Implementer Security Action Plan Template
- Annex G. Security Protocol Template
- Annex H. Security Incident Report

Implementer Security is the fourth and last component of the CLM system. The specific harms caused to organizations led by and/or serving members of KPs, PPs, and/or PLHIV—who are acknowledged as vital to effective HIV programming—are widely recognized. Security refers to the absence of intentional harm, such as attacks on a CSO, and is distinct from safety, which is broader and can relate to issues such as appropriate personal protective equipment (PPE) and adequate disposal of medical wastes. Ensuring the security of service providers, both the physical security of the buildings and the security of outreach staff when working in the community, lays the foundation for high quality services and promotes improvement. Many groups have found effective ways to mitigate the impacts of security concerns and/or respond effectively in the face of violence, but a greater and more systematic investment is needed to identify and address security in almost every context where HIV programming for KPs, PPs, and PLHIV occurs. To ensure the safety of service providers, the Implementer Security component provides strategies to prevent security incidents experienced by them as well as methods for monitoring and responding to these incidents to continuously improve their security. Improvement in security is necessary for improvement in client services. For example, if peer teams are prevented from conducting outreach because they risk arrest for carrying condoms and lubricant, fewer services are accessible to potential program beneficiaries.

Definition
Security: The state of being free from risks or harm that come from intentional violence.

For further information on overarching recommendations to address security challenges and support on how program implementers, especially those working in direct service delivery, can more effectively address security challenges within their HIV programs, please see the full security toolkit here. While developed for the MENA region, it provides important information and self-assessment tools for any HIV program operating in a hostile environment, such as nations where KPs are criminalized.

For details about the security of information collected as part of project monitoring and evaluation, please see **Ensuring Compliance with the EpiC Data Safety and Security Checklist** (found on this webpage).

Steps for implementing security plans at each CSO

The security toolkit recommends that organizations plan in advance to prevent and mitigate the harm that can be caused by intentional attacks on organizations offering HIV services to KPs. Developing a security plan can be accomplished via the following steps.

Develop a security management team

Implementer Security is managed on the CSO level, though it can be facilitated by international nongovernmental organizations (INGOs) and donors partnering with local implementing organizations. As a first step, each CSO should identify one security focal point individual who is tasked by the HIV program with coordinating the organizational response and sensitizing and updating colleagues on internal security policies. This person should review the full security toolkit. This focal point then organizes the development of a security management team (SMT) consisting of:

- One person from senior management (or an individual with decision-making power)
- One or two staff members from different levels in the organization who can speak to different types of security challenges (e.g., a member of an outreach team and a project manager)
- One person with information technology expertise if digital security will be discussed
- Focal point individual

The SMT designs and operationalizes Implementer Security activities in response to identified gaps. The size and composition of this team will vary depending on the size of the organization. Duties of the SMT include completing the security checklist (more below) and making strategic decisions about, developing procedures for, and coordinating the implementation of security policies. The checklist topics include safe physical and online outreach, functional and institutionalized security protocols including for emergencies, and data safety and safe communication.

A representative of the SMT, preferably the focal point, is also part of the CLM joint action planning meeting. This person is responsible for communicating to the rest of the CLM joint action team regarding the CSO-level Implementer Security action plan and keeping them up-to-date on security incidents affecting the CSO. Any action items or concerns that pertain directly to the health facility or site and its staff working in the community are reiterated at the joint action planning meeting. Local health administrators are part of the joint action team and, therefore, any issues that cannot be fully addressed at the CSO level can be escalated.

SMT is a CSO-level team while CLM joint action planning team is a health facility or site-level team. If a CSO oversees multiple health facilities or sites, the focal point attends the CLM joint action planning for each facility or site. CSOs may also decide to assign a security focal point at each health facility/site, but there must be at least one security focal point at the CSO level.

Assess threats, vulnerabilities, and capacity

The SMT is responsible for assessing the CSOs' current security situation. The existing security-related strengths and gaps of the CSO are assessed using a **checklist of security strategies**. The checklist is divided into eight sections, each includes instructions on who must complete it. The checklists are completed on the CSO level, and section D is completed by the drop-in centers and clinics operated by the CSOs. The SMT should reference Tool 2 in the security toolkit for further guidance on how to complete this survey.

After assessing their current security gaps and needs, the CSO's SMT is ready to attend a security training. During the training, they will be exposed to tools to prioritize their risks, identify threats, and develop security plans. All steps are described in detail in the training, **Strengthening the Security of HIV Service Implementers Working with Key Populations** (found on this webpage). If no facility or site-led security training is possible, the SMT members should review the training materials to understand the various tools at their disposal, all of which are listed in the facilitator's guide.

Prioritize risks and develop a security plan and action plan

At the end of the training, the SMT will develop an **Implementer Security Plan (Annex E)** for the top security risks identified. While identifying the top three risks is recommended, each CSO should decide based on need. The threats, vulnerabilities, and CSO vulnerabilities and capacities associated with each of the risks are documented in the security plan. Actions required to decrease vulnerability and increase capacity related to the top security risks are then identified. Once the security plans for all prioritized security risks are developed, the SMT reviews the required capacities and prioritizes those that can be completed quickly and/or with limited funding. Actions that can be taken immediately include beginning to document security incidents to establish patterns, password protecting all computers and hard drives, developing systems to track outreach workers' movements, and providing airtime to staff while they conduct outreach. Longer-term actions are those that require more funding, such as physical security (bars and locks) or changing an office's location to a more secure site, or those that entail staff training on new topics, such as first aid.

The security plan is a long-term solution. As a short-term solution, the SMT develops a security protocol to establish the steps to take now when large-scale security incidents occur. **Security Protocol Template (Annex G)** can be adapted. The protocol defines the levels of security concerns so incidents can be quickly categorized. For each level, specific actions are to be taken by the staff and programs established as to how the premises should be handled (i.e., contracting a security guard, pre-vetting visitors, etc.).

The security focal point is then responsible for communicating the action plan and the protocol to all CSO staff as well as implementing partner staff, including the staff of clinics and drop-in centers operated by the CSO. In the event of an incident, all CSO and implementing partner staff follow this protocol. The SMT is responsible for ensuring all staff and implementing partners are aware of the protocol.

Document, report, and monitor security incidents

Along with the security action plan and protocol, all CSO and implementing partner staff must be made aware that any security incident they face as a result of their service provision must be reported to the security focal point. The contact information of this security focal point should be shared with all staff. If there are security focal points at each health facility or site, staff should be made aware of both the facility or site-level focal point person and the CSO-level focal point person and how to contact them. The security focal point is responsible for keeping the **Security Incident Report (Annex H)** where all reported incidents are documented. At regular CSO and facility or site-level meetings, time should be provided for staff to describe any threats to their own security. These should be documented by the security focal person.

Whenever an event occurs that requires a response (e.g., an injury, mental health impact, theft, or assault of a staff person), a system of support should be made available to the person reporting the event. This should include mental health support, physical health support, and legal/psychosocial support as needed. Strengthening these support systems can occur under work to prevent and respond to adverse events: the same systems that benefit clients can benefit providers (though, ideally, providers will be offered off-site mental health support as well as the support of someone else on staff). In addition, it is best practice to offer insurance to CSO staff so that costs of treatment can be defrayed.

Various ways of reporting incidents to the security focal point should be made available, including an anonymous option. One option would be for providers to fill out **complaint forms (Annex G in AE SOP,** found on this webpage**)**, found in each facility or site. These complaint forms are reviewed by the site manager at each facility or site, who is then responsible for reporting the incident to the security focal point.

When the incident is reported, the security focal point should document whether the incident was index testing related or not. While all incidents are documented, those related to index testing must be reported as part of adverse events related to index testing.

Data use for quality improvement

If implementing just one of the CLM components, it is recommended to follow the action planning and monitoring system described under the respective sections. When electing to implement two or more of the facility or site-level monitoring components, it is recommended to adapt the larger CLM joint action planning and monitoring process to encourage the comprehensive review of all available feedback from clients to inform decisions.

While each of the components has its own integrated action planning and routine monitoring process, when implemented as part of the larger CLM system, each of these action planning and monitoring processes are combined into one large joint action planning meeting. Data and feedback collected through LINK, AEPMIR, CSC, and Implementer Security components will be used to inform the joint action planning and monitoring held at the facility or site level. The purpose of the joint action planning meeting is to invite various stakeholders, including health facility or site management, service providers, community representatives, local health administrators, and the CAB and DIC committee members where they exist to come together to review the feedback from clients collected through the various channels, identify key issues or challenges clients face when accessing services, discuss how these challenges can be addressed by the various stakeholders, and together develop **one joint action plan (Annex B5)** for improving the quality and accessibility of the services provided at the facility or site. CAB members may also help escalate issues that are beyond the control of the joint action planning team. Similar to the CSC process, emphasis should be placed on improving services together with contributions from all stakeholders and ensuing that each stakeholder is held accountable for the necessary changes. As much as possible, the same members who attend the first joint action planning and monitoring meeting should attend the subsequent monthly follow-up meetings.

In preparation for the monthly/quarterly joint action planning meeting, the CSO staff should compile the dashboards, reports, client feedback, and other data collected through, but not limited to, the four components to share with all stakeholders. As much as possible, joint action planning meetings should be led by the community representatives with support from CSO staff. Prior to the meeting, CSO staff should work to build the capacity of community representatives on negotiation skills and to share the data and their concerns. CSO staff can help facilitate the meeting.

In addition to the compiled client feedback and data, the quality of the process in collecting this data should also be reviewed. For example, if many clients are opting to stay anonymous when reporting adverse events, not allowing for further provision of support to the client, stakeholders may decide to brainstorm ideas on how to encourage clients to provide contact information so the program can better support the client. One action item may be for the community representatives to communicate with their peers about the benefits of sharing

their contact information through LINK. It is also important to monitor the response times for adverse events reported through LINK, AEPMIR, and Implementer Security, and the actions taken in response to the adverse events. The client complaints tracker, Adverse Event Report, and Adverse Event Investigation Report can be reviewed to see how many reports of adverse events were reported and how many were addressed in a timely manner to monitor the effectiveness of the systems in place. **Table 1** provides a list of tools from each component that should be reviewed during the action planning meeting.

Table 1. Data to be summarized and presented at the joint action planning meeting

- LINK dashboard (client feedback)
- Client complaints tracker
- Facility client feedback analysis tool
- Adverse event reporting tool
- Adverse event investigation tool
- Community Scorecard dashboard
- Summaries of KIIs
- Any other data on client feedback about health services provided at the specific facility or site

The action planning tool from the CSC process (Annex B5) should be used to develop the joint action planning meeting action plan. The same steps outlined in the CSC process for using data for quality improvement advocacy should be followed. Either monthly or quarterly, the joint action plan team should meet to review the plan, monitor progress, review the most recent data to highlight new issues that come up, assess whether the changes made based on the action plan have been effective in resolving issues identified, and incorporate new items into the plan to address new issues.

Representatives from stakeholders and stakeholder groups in Table 2 should be included in the CLM joint action planning meeting.

Table 2. Roles and responsibilities

Role	Definition
LINK	
Rapid response team	Consists of a field-based client complaint coordinator and program staff trained to respond to violence and adverse events on the HIV program level. Receives client complaints and responds with corrective actions for service providers.
Client complaint coordinator	HIV program staff part of the rapid response team. Reviews complaints reported via LINK and flags those that are adverse events at least weekly.
LINK stakeholder committee	Consists of service providers, local health administrators, community members, and CSO staff trained on LINK. Group of stakeholders engaged throughout the LINK process to gain consensus on the LINK plan and to review and respond to LINK data as reports come in.
Quality improvement team	An existing team at a health facility or site tasked with reviewing clinical performance of the facility or site. This is not a team established as part of LINK or CLM. However, if such a team already exists, it should be engaged as part of LINK and/or CLM.
Community Scorecards	
CSC group facilitators	Facilitate CSC with key groups of beneficiaries (key populations, priority populations, PLHIV).
Key informant interviewers	Conduct KIIs with health providers, health facility or site managers and/or local health administrators.
Community representatives from group discussions	Review and analyze results of group discussions and present findings and proposed solutions at joint action planning meeting.
Adverse Event Prevention, Monitoring, Investigation, and Response	
Site Manager	A trained health facility or site staff member responsible for receiving reports of adverse events from providers or clients and investigating incidents to understand why they happened.
Community Advisory Board	Consists of community leaders and PLHIV. Responsible for liaising between the facility or site and the community as another way complaints can be communicated with the health facility or site staff.
Trained team of health facility or site staff	Responsible for reviewing the findings of the investigation conducted by the site manager to develop a remediation plan.

Role	Definition
Implementer Security	
CSO security management team	Consists of one person from senior management (or an individual with decision-making power), one or two staff members from different levels in the organization, one person with information technology expertise if digital security will be discussed, and the security focal point. Responsible for implementing implementer security activities in response to identified gaps, completing the safety and security survey, and making strategic decisions about, developing procedures for, and coordinating the implementation of safety and security policies.
Security focal point	Trained CSO staff person responsible for organizing and participating in the security management team and communicating to staff and partners regarding the security plans and protocol.
All components	
Joint action planning team	Consists of health facility or site management, service providers, community representatives, local health administrators, and stakeholders mentioned above. Responsible for meeting monthly or quarterly to review data from the four components, discussing areas in need of improvement, and developing an action plan.

Annexes

ANNEX A. LIST OF CLM TOOLS AND DESCRIPTIONS

CLM TOOLS	DESCRIPTION
LINK	
LINK Technical Guidance	Guidance with detailed steps for implementing LINK and analyzing LINK data
Standard LINK Service Feedback Form	LINK survey tool that can be adapted and used
All-Facility Client Feedback Report	Analysis page developed monthly or quarterly to compare results across all facilities or sites
Facility-Specific Client Feedback Report	Analysis page developed quarterly to review volume of LINK client data and analyze results for one facility or site with over 20 surveys
Client Complaint Tracker	Tracker used to respond to any new client complaints and track responses
Action Planning Form	Form used to develop a facility or site quality improvement plan and monitor progress
Community Scorecard	
CSC Standard Operating Procedures	SOP with detailed steps for implementing the CSC process
Suggested focus group stratifications	Outline of potential ways to stratify CSC focus groups
Example CSC focus group facilitation guide	CSC focus group guide to be adapted and used
Key informant interview guide	Key informant interview guide to be adapted and used
Implementation plan template	Template used to help plan and schedule all focus group discussions and key informant interviews
Action plan form	Form used to develop facility or site-level quality improvement plan during the action planning meeting and monitor progress
Community Scorecard Group Facilitator and Key Informant Interviewer Training	Slides used to train focus group facilitators and key informant interview interviewers
Adverse Event Prevention, Monitoring, Investigation, and Response	
Standard Operating Procedure for Adverse Event Monitoring, Investigation and Response in the Context of Index Testing	SOP with detailed procedures to prevent adverse events, encourage reporting of adverse events when they happen, respond to adverse events, and investigate and report up adverse events
Content Recommendations for SOPs Describing Clinical Violence Response Services	Guidance for health facility or site managers to develop an SOP for clinical violence response services
Index Testing Script	Script used by health care providers when offering index testing services and asking for consent
Adverse Event Report Form	Form used to record and track all reported adverse events
Adverse Event Investigation Form	Form used to document investigation status and results of all reported adverse events
Beneficiary Abuse Disclosure and Response Form	Form used to record and track all reported adverse events and document investigation status and results (can be used in place of both the adverse event report and investigation forms)
Detailed instructions to complete Beneficiary Abuse Disclosure and Response Form	Detailed steps for completing the Beneficiary Abuse Disclosure and Response Form

CLM TOOLS	DESCRIPTION
Patient Rights Poster	Poster that can be adapted to be placed on health facility or site walls to inform clients of their rights as patients
Customer Complaint Form	Form used to collect complaints from clients from various channels
Index Testing Register	Register used to document index testing consent and IPV risk assessment results
Standard Operating Procedure for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing	SOP with detailed steps for inquiring index testing clients about experience of IPV and providing support, referrals, and follow-up to those who disclose
Steps for Establishing and Maintaining a Referral Network	Detailed steps and recommendations for how to develop and maintain a referral network to support clients who disclose violence
Referral Network Template	Form used to develop and document details and contact information of services and providers in the referral network
Referral Letter Template	Letter template used by health providers when referring clients to services in the referral network for clients to take with them to provide necessary information to the referral services
Safe Storage of Information	Checklist used to ensure patient records are securely stored
IPV Routine Enquiry Questions for Key Populations	Guidance and questions that can be asked to routinely enquire about IPV to key populations
Job Aids for IPV Screening and Response as Part of Index Testing	Graphic outlining steps and decision points when screening for IPV and responding to disclosed violence
Identifying, preventing, and responding to violence in HIV programs serving key populations: Building health care workers' capacity to offer safe and ethical index testing training slides and facilitator's handbook	Slides used to train health care workers and service providers on identification, prevention, and response to disclosed violence
Implementer Security	
Threat and vulnerability assessment tool	Self-assessment tool used by implementers and service providers to understand their security threats and vulnerabilities
Checklist of security strategies	Checklist used by implementers and service providers to assess the security of their facility, site, staff, and data
Survey instructions tool	Instructions on how to complete the checklist of security strategies
Strengthening the Security of HIV Service Implementers Working with Key Populations training slides and facilitator's handbook	Slides used to train implementers and services providers on how to assess, prevent, monitor, and respond to any security incidents
Implementer Security plan	Tool used to organize and summarize security assessment findings to understand next steps
Implementer security action plan template	Form used to develop a security improvement action plan and monitor progress
Security protocol	Example protocol for implementers to follow in case of a security incident that should be adapted
Implementer security incident log	Form to record reported security incidents and program response to the incident

ANNEX B. COMMUNITY SCORECARD STANDARD OPERATING PROCEDURES

Community Scorecard Standard Operating Procedures

1.0 About CSC

The Community Scorecard (CSC) process is the second component of the Community-Led Monitoring System. In addition to the individual client feedback system, LINK, the CSC will be used to further understand reported issues and develop action plans for improvement. However, the CSC can be conducted on its own without LINK. The CSC is a participatory, quality improvement (QI) tool routinely used for assessing, planning, monitoring, and evaluating HIV and other health services. The CSC is used by both community members, including civil society organizations and advocates, and health care providers to facilitate collective agreement and action with the goal of improving service delivery. It allows a community to engage with health facility or site providers in a formal setting and deliberately and positively encourage service quality, efficiency, and accountability. This is achieved by providing space for these two groups to participant in dialogue that is action based and accountability focused.

The CSC process is used to help community members and health facility or site and/or government partners take a deeper dive into individual client feedback on HIV services provided by health units collected through, but not limited to, LINK. Unlike individual client feedback that is focused on individual experience and may have limited depth or explanation of root causes of service quality issues, the CSC process uses collective community feedback and is focused on monitoring at the local administration and facility or site levels. Relying on the information generated by the scoring, focus group discussions (FGDs) and key informant interviews (KIIs), the CSC process depends heavily on the participation of community members in the assessment of service quality and performance and negotiating the findings with service providers. The CSC process can also include the acknowledgment and resolution of security challenges faced by facility or site and community-based service providers (some of whom will also be community members). This can be accomplished through the inclusion of implementer security log reviews as part of the information reviewed during the interface meeting.

2.0 Purpose

This Community Scorecard process is designed to:

1. Provide an opportunity for community members to help monitor HIV services supported by EpiC or LINKAGES
2. Provide an avenue for a deeper understanding of any issues reported through the LINK individual client feedback system and those recorded in implementer security logs
3. Provide the basis for development of joint community/provider/local government administrator action plans to address any issues identified

3.0 Stakeholders

The following stakeholders should be engaged prior to implementing the CSC:

- **Community members** who receive care from participating health facilities or sites (e.g., members of key populations, people living with HIV, adolescent girls and young women (AGYW), other representatives of groups from whom specific feedback is desired)
- **Community leaders** who influence community members to use services by generating demand for services, linking individuals to the services, providing the services, or all three (i.e., CSO partners). Community leaders may also be community members.
- **Staff of facilities or sites providing HIV services** whose services are being scored (i.e., chief health officers, HTS/ART providers, health unit/DIC focal points)
- **Policymakers** who can take action based on the scorecard process (i.e., district health officials, health administrators)

4.0 Data Collection Methods

Data collection methods include:

- **Focus group discussions (FGDs)** with community members who have received services from the health unit, facility, or site
- **Key informant interviews (KIIs)** with health care providers and local health officials/administrators

5.0 The CSC Tools

- **Community Scorecard (CSC) Tool** (See **Annex B2**): The scorecard is a set of questions that can be scored and monitored. These questions will be used to assess performance, measure progress, and inform action items. Each question is given one collective score by the FGD participants through their discussion. FGD participants are health facility or site clients. FGDs will be conducted by CSO staff or affiliates who are ideally members of the community with which they conduct the FGD.
- **Key Informant Interview (KII) Guide** (See **Annex B3**): This guide will be used to interview health service providers, health facility or site managers, and/or local health authorities to gain their understanding of how well their facilities or sites are providing various services and where they see need for improvement. KIIs will be conducted by CSO staff or affiliates who are ideally members of the target community.
- **Implementation Plan** (See **Annex B4**): This tool will help organize and carry out the various types of FGDs and KIIs.
- **Action Plan Guide** (See **Annex B5**): This tool will be used during the interface meeting to facilitate action plan development and implementation after all data are collected.

Considerations for implementing CSC while adhering to COVID-19 infection control procedures:

- Any activities conducted should follow local COVID-19 guidelines and regulations.
- All meetings, interviews, and focus group discussions can be done virtually.
- If you decide to hold in-person activities:
  - Make sure to observe social distancing and provide protective equipment such as masks and hand sanitizers to all who are attending.
  - For focus group discussions, you may decrease the number of people included in each of the discussions to observe social distancing.
  - Preferably, all in-person activities should be conducted outside or in areas with enough ventilation but ensuring social distancing is still maintained.

6.0 Implementing the CSC Tools

Table 1. Timeline of CSC process implementation

	Month				
Activity	**1**	**2**	**3**	**4**	**5**
6.1 Develop the scorecard	X	X			
6.2 Implement the scorecard		X	X		
6.3 Analyze data and develop action plan			X	X	
6.4 Use data for QI				X	X

6.1 DEVELOP THE SCORECARD.

NOTE: Involve community partners in at least one step of the scorecard development process.

6.1.1 Adapt tools to country level

CSC tool/FGD guide:

1. Identify the target population(s) (i.e., FSWs, MSM, AGYW, and/or general populations). Focus groups (FGs) should be as homogenous as possible and stratified by population type.
2. Decide whether to conduct FGDs with PLHIV and people who are HIV negative/unknown status together or separately (i.e., you may consider having some FGDs together and others separately, having FGDs only with PLHIV, etc.) Suggested stratification of FGs by target groups and HIV serostatus are available in **Annex B1.**
3. Choose the appropriate type(s) of scorecards to adapt from the following: **(1)** for FGs with PLHIV and HIV-negative individuals or individuals of unknown status combined in one group, **(2)** for FGs of HIV-negative individuals or individuals of unknown status only, and/or **(3)** for FGs with PLHIV only.

NOTE: The score scale can be adapted as well, but this is not necessary.

CSC tool/FGD guide and KII guide:

4. Determine the final list of questions to be asked. Consider factors including but not limited to:
   - Number of questions to include
   - Wording of questions

CSC tool/FGD guide online data entry form:

5. Develop the data entry form on an online survey platform, such as Open Data Kit, so data can be entered via a web link or on an Android-based tablet.
6. Fully test the data entry form for accuracy.
7. Link data entry forms to a data visualization platform, such as Power BI, to automate data display. Consider how you want to display your data and customize. Data display of scores across time may be considered after the second round of assessment.

Figure 1 and Figure 2. Examples of scorecard data display

Results Overview - Areas for Improvement

Question	Score	Reason for Score	Suggested Improvements
6. Dans quelle mesure pouvez-vous accéder facilement aux produits de prévention tels que les préservatifs et les lubrifiants ?	1 - Very Poor	Il faut se déplacer et souvent on donne un paquet pour trois personnes	Revoir les quantités qui sont minimes.
6. Dans quelle mesure pouvez-vous accéder facilement aux produits de prévention tels que les préservatifs et les lubrifiants ?	1 - Very Poor	Il y a fréquemment des ruptures de stocks	Ameliorer le service avec un bon suivi qui se fera avec le concours d'un comité de gestion unissant la structure et les usagers.
7. Dans quelle mesure pouvez-vous accéder facilement aux services d'infection sexuellement transmissible (IST) ?	2 - Poor	Il y a assez de difficulté dans l'offre qui est minime.	Il faut revoir les quantités qui ne sont pas suffisantes et qui
4. Quelle			
4. Quelle			
3. Dans q lubrifiant			
3. Dans q lubrifiant			

Results Overview - Highest Scoring Areas

Value	Score
2. How convenient is the location of this clinic?	4 - Excellent
4. How easily can you access prevention commodities such as condoms and lubricant?	4 - Excellent
5. How easily can you access sexually transmitted infection (STI) services?	4 - Excellent
6. How easily can you access violence response services (such as post-exposure prophylaxis, crisis response teams, or a trained counselor)?	4 - Excellent
7. How effectively are you navigated/linked to the site/facility when reached in the community?	4 - Excellent
8. How easily can people living with HIV (PLHIV) access HIV treatment services?	4 - Excellent
9. How easily can PLHIV access viral load testing?	4 - Excellent
2. How is the quality of HIV service provision?	4 - Excellent
3. How is the quality of STI services (counselling and management or signs and symptoms)?	4 - Excellent
4. How is the quality of violence response services?	4 - Excellent
6. How is the quality of anti-retroviral therapy (ART) adherence counselling by health facility providers?	4 - Excellent
7. How is the quality of ART support for adherence by peer navigators?	4 - Excellent
8. How effective are providers at communicating options for how/where you can pick up ART (multi-month dispensing [MMD], community ART options, pharmacy pick up, etc.)	4 - Excellent
9. How is the quality of viral load testing?	4 - Excellent
5. How available is ART (HIV treatment medicines) for PLHIV? Are there any anti-retroviral (ARV) stock outs?	4 - Excellent
6. How available is MMD 3-6 months?	4 - Excellent
7. How available is viral load testing?	4 - Excellent
1. How available are HIV test kits?	4 - Excellent
4. How available are supplies of condoms and lubricants when you need them?	4 - Excellent
1. How well do facilities keep services confidential and private?	4 - Excellent
2. How well do community services keep services confidential and private?	4 - Excellent

6.1.2 Adapt CSC to facility or site level through data review

1. Review facility or site-level data/information and include questions that may provide a deeper look at the issues being identified. Data/information to review may include but is not limited to:
   - LINK data
   - Aggregate statistics regarding the number of adverse events attributable to index testing and the percentage of those events that were resolved
   - Implementer security logs to identify challenges faced by implementers themselves
   - Key issues from facility or site suggestion boxes

NOTE: At this stage, questions should be defined/validated by the community and other previously selected indicators, such as from LINK. Ideally, having LINK data before conducting CSCs is best, but it can be done without having implemented LINK as well.

6.1.3 Complete the implementation plan

1. Complete the FGD portion of the Implementation Plan Template with decisions made in 6.1.1.
2. Using the KII portion of the Implementation Plan Template, identify all the key informants to be contacted and recruited and finalize the Implementation Plan.

6.2 IMPLEMENT THE SCORECARD.

NOTE: Steps 6.2–6.4 should ideally be conducted routinely as this is a continuous process for monitoring. Every 6 months is recommended.

6.2.1 Participant recruitment

1. Reach out to community groups (e.g., citizen groups, support groups, etc.) to request voluntary participation in FGDs from people who have received services from the health facility or site.
2. Reach out to the service providers, facility or site managers, and local health officials/administrators from respective health facilities or sites identified on the Implementation Plan to request voluntary participation in KIIs.

NOTE: It may be easier to gather information on each participants' availability during the next month to facilitate scheduling.

Table 2. Participants to recruit

FGDs with service beneficiaries	KIIs with service providers	KIIs with health representatives/administrators
~10 beneficiaries of respective health facilities or sites per group	1 service provider **AND/OR** 1 facility or site manager (1–2 people per facility/sites)	1 local health official per health facility or site

6.2.2 Train staff and facilitators

1. Determine the number of CSO staff to recruit and train based on the number of FGDs and interviews to be conducted, and recruit.

NOTE: The facilitators of the FGDs should be members of the respective communities (e.g., the facilitator of an MSM PLHIV focus group should ideally be facilitated by an MSM PLHIV).

2. Coordinate and schedule date for the facilitators to be trained
3. Conduct the training(s) on the scheduled day(s) and ensure that all facilitators have been trained (can be done online)
4. If time and budget allow, conduct a pilot of the CSC tool with one to two focus groups and adjust the tools as necessary

NOTE: If using tablets for data collection during the FGDs, have a notetaker as well as a facilitator to allow the facilitator to focus on the participants and not be distracted by manipulating the tablets. This is the same if conducting them online. A simple tablet training should also be provided. If you are unable to have a notetaker at each FGD, consider using paper-based tools for data collection. Voice recorder may be considered, but verbal consent must be obtained. Data can be entered into the data entry form after the FGDs.

6.2.3 Conduct FGDs and KIIs

1. Coordinate and schedule date/time/setting of each FGD and KII (these can be done online).
2. Print necessary materials for the FGD and KIIs including but not limited to:
   - Adapted tools for each group/individual (for FGDs and KIIs if the tools are paper based)
   - Graphic with the Scoring Definitions (for FGDs)
   - “Four Approaches to Index Testing” handout from the index testing section (for FGDs that will have questions about index testing)
   - Participant register (for FGDs)
3. If using tablets, confirm that the tablets are fully charged.
4. Conduct FGD with each group and KIIs with key local officials/health administrators.

NOTE: Ensure confidentiality and verbal consent from each participant before starting any focus group or interview. In FGDs, go around to each participant to confirm consent from each individual. Incentives/refreshments may be considered.

NOTE: If a service beneficiary is also a service provider, clarify at the start of the FGD that everyone should reflect on their experience as a beneficiary rather than a provider. When interviewing a service provider who is also a beneficiary, clarify at the start of the interview to reflect on their experience as a service provider.

NOTE: In FGDs, 'Reasons for Score' should be added where anything needs to be qualified and must be added for any rating of 'Very Poor'.

5. Facilitate each focus group to elect one to two representatives who will represent the community at the interface meeting with health service providers and local government health officials.
   - Communicate to all FGD participants the next steps in this process (purpose of the interface meeting, responsibilities of the representatives, expected outcomes of the interface meeting, etc.).
   - Ideally, the same representatives will participate in subsequent focus groups and interface meetings so take this into consideration when making the selection.
6. Immediately after FGDs, enter FGD scorecard data into the country-specific data entry forms using a tablet or computer.
7. Immediately after KIIs, take additional notes and summarize key points from the interviews.

NOTE: At this stage, all CSCs should have been entered into the online form. Once online forms are submitted, they are automatically pulled into the Power BI dashboard for easy review.

6.3 ANALYZE AND REVIEW DATA.

6.3.1 Conduct interface meeting with community representatives, health facility or site staff, and local government.

NOTE: This interface meeting is not limited to the CSC tools. Data from LINK and adverse event reporting and response are also reviewed.

NOTE: Ideally, one interface meeting should be conducted with representatives from all focus groups. However, we recommend receiving feedback from communities on the structure. For example: Is it acceptable to convene representatives from all the various focus group populations considering possible stigma? If not, consider convening separate meetings.

1. Coordinate date/time/setting of the meeting and communicate to the key informants interviewed and the elected community members from the focus groups.

2. Prepare materials needed for the interface meeting including but not limited to:
   - Flipcharts
   - Markers
   - Dashboard of all CSCs
   - Summary of KIIs
   - LINK analysis data and client feedback data
   - Implementer security logs
   - Action plan form
3. Support elected community members to prepare for the interface meeting:
   - Identify issues and concerns raised by the community during the FGD
   - Identify suggestions for improvements proposed by the community during the FGD
   - Strengthen negotiation skills of elected community members
   - Develop a simple plan to agree on who will present and discuss what will be shown
4. Conduct the interface meeting with elected community members, health care providers, and local health officials to review the scores and concerns and propose solutions.
5. Use the action plan form to help reach consensus on priority actions with local solutions. Additional strategies for effective action planning include:
   - Make all actions “S.M.A.R.T.” (specific, measurable, attainable, relevant, and timebound).
   - Limit action items to approximately five top priority ones that can be achieved in the next quarter.
   - Ensure responsibility for each action item is distributed evenly among members.

6.4 USE DATA FOR QUALITY IMPROVEMENT AND ADVOCACY.

6.4.1 Institutionalize action and plans.

1. Integrate the agreed actions into annual health unit/government plans and CSO plans to promote awareness on areas where KP members need to take part to improve their welfare at the health facilities or sites.
2. If feasible, incorporate a public event (virtual if COVID-19 does not allow for group events/meetings) where service providers and other relevant authorities sign a ‘social contract’ with the commitments derived from the interface meeting.

NOTE: This public event should be done as appropriate. It may not be necessary to do this after every round.

6.4.2 Tracking and advocacy

1. Support community members and providers to regularly (monthly/quarterly) monitor the priority issues in the health unit/government annual plans and the data from LINK and adverse event reporting and response.
    - This may mean reconvening the attendees of the interface meeting before the next round of FGDs and KIIs (e.g., conduct the CSCs every six months and convene the interface meeting every three months).
2. Support CSOs to strengthen mechanisms to escalate issues whose solutions require action beyond the scope of the health unit via KP-led CSOs, national KP forum, and KP TWGs that can work with authorities to address issues at site, district, regional, and national levels and advocate as appropriate.

Annex B1: Suggested Focus Group stratifications

Participants for each group should be as homogeneous as possible. For example, key population (KP) types should not be mixed in the same group. There are different options for organizing focus groups, depending on whether you want to hold separate focus groups with PLHIV and individuals who are HIV negative or have unknown status. *When choosing separate focus groups for PLHIV, careful consideration should be given to ensure confidentiality and consent from PLHIV participants before participation in any focus group.* One option is to use existing PLHIV support groups.

Option 1: PLHIV and those who are HIV negative or of unknown HIV status are combined in one group. Suggested groups are as follows:

- KP programs:
  - Female sex workers (FSWs) who have received services at the site or health facility in question
  - Men who have sex with men (MSM) who have received services at the site or health facility in question
  - Transgender people who have received services at the site or health facility in question
  - People who inject drugs (PWID) who have received services at the site or health facility in question
- Non-KP specific groups:
  - Men living with HIV who have received services at the site or health facility in question
  - Women living with HIV who have received services at the site or health facility in question
  - Youth living with HIV who have received services at the site or health facility in question
  - Priority populations (PPs)/adolescent girls and young women (AGYW) who have received services at the site or health facility in question.

Option 2: KP, AGYW, and PP programs may also consider conducting separate group discussions with KP/AGYW/PP who are PLHIV and KP/AGYW/PP who are HIV negative or of unknown HIV status. If you choose this option, the composition of the focus groups could be as follows:

- KP programs:
  - FSWs who are HIV negative or of unknown status and have received services at the site or health facility in question
  - MSM who are HIV negative or of unknown status who have received services at the site or health facility in question

  - Transgender people who are HIV negative or of unknown status who have received services at the site or health facility in question
  - PWID who are HIV negative or of unknown status who have received services at the site or health facility in question
  - FSWs living with HIV who have received services at the site or health facility in question
  - MSM living with HIV who have received services at the site or health facility in question
  - Transgender people living with HIV who have received services at the site or health facility in question
  - PWID living with HIV who have received services at the site or health facility in question

- AGYW/PP specific groups:
  - AGYW who are HIV negative or of unknown status who have received services at the site or health facility in question
  - PP members who are HIV negative or of unknown status who have received services at the site or health facility in question
  - AGYW living with HIV who have received services at the site or health facility in question
  - PP members or AGYW who are HIV negative or of unknown HIV status who have received services at the site or health facility in question.

Note: *Given the length of the PLHIV and index testing scorecards, you may also decide to have separate PLHIV groups—one that focuses solely on the index testing questions and one that focuses on all other questions. For example, if you work with MSM and FSWs, you may decide to have the following group discussions:*

- Non-PLHIV Community Scorecard:
  - MSM who are HIV negative or of unknown status
  - FSWs who are HIV negative or of unknown status
- PLHIV Community Scorecard without the index testing questions:
  - MSM living with HIV
  - FSWs living with HIV
- Community Scorecard with index testing questions only:
  - MSM living with HIV
  - FSWs living with HV

Annex B2: Example Community Scorecard/Focus Group Facilitation Guide

Example Community Scorecard

Date:	_____ MM/DD/YYYY
Name of Site or Health Facility serving the community: *(Note that site can include community-based or mobile services.)*	_____
Type of Site: *(KP drop-in center, project-run community clinic, government clinic, private health facility, mobile services)*	_____
HIV services offered at the site or facility: *Circle all that apply.*	HIV treatment services, HIV testing, STI services, PrEP, condoms/lubricant, family planning, TB screening/treatment, community mobilization/recreation
Name/Type of Community:	_____
District:	_____
Name of Person Completing Scorecard:	_____

Interviewer Reads: *Thank you for participating in our community discussion. Today, we would like to get your feedback on the HIV services offered at* [NAME OF SITE/HEALTH FACILITY].

I am now going to ask you a series of questions to see how well the site or facility is doing at offering HIV services. Please note that your feedback may be combined with the feedback from others and shared with the site or facility. They will not be given your names and will not know who said what. Therefore, we ask that you provide your honest feedback so we can be sure HIV services remain safe and meet the needs of people like you.

For each question, please tell me if the service provided "does not exist," or is "very poor", "poor", "good", or "excellent". You can refer to this chart with different emojis to help you remember the possible scores.

Scoring Definition

Not applicable	Needs Urgent Remediation	Needs Improvement	Meets Expectations	Surpasses Expectations
0	1	2	3	4
Not Available or Does Not Exist	Very poor	Poor	Good	Excellent
				

You can use your own experience as well as what other people have told you about their experience at this health facility or site when answering the questions. If you are sharing another person's experience, please do not name that person.

Please also tell me a reason for your score and any suggestions for improvement you may have.

You can refuse to answer or simply say "I don't know" to any question.

You will need to agree as a group on a score to record in our scorecard. However, if someone feels strongly that the score decided on by the group does not represent their experience, this perspective can still be captured in the comments.

Are there any questions before we begin?

Annex B2.1 Group Discussion Guide—combined PLHIV and non-PLHIV (Option 1)

Instructions: Ask your community group each question. Allow them to discuss and then decide together on a score using the scale above. If the indicator is not relevant, write 0 (zero).

Discussion Questions		Score (0-4)	Reason for Score	Suggestion for Improvement
A	**Access to Services**			
1	How convenient are times of site/facility hours?			
2	How convenient are times of mobile services?			
3	How convenient is the location of the site/facility?			
4	How convenient are locations of mobile services if offered by the site/facility?			
5	How easily can you access HIV services (pre-exposure prophylaxis [PrEP], HIV testing, HIV treatment, viral load testing)?			
6	How easily can you access prevention commodities such as condoms and lubricant?			
7	How easily can you access sexually transmitted infection (STI) services?			
8	How easily can you access violence response services (such as post-exposure prophylaxis, crisis response teams, or a trained counselor)?			
9	How effectively are you navigated/linked to the site/facility when reached in the community?			
10	How easily can people living with HIV (PLHIV) access HIV treatment services?			
11	How easily can PLHIV access viral load testing?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
B	**Quality of Health Center Services**			
1	How beneficial is pre- and post-test counseling for HIV testing?			
2	How is the quality of HIV service provision?			
3	How is the quality of STI services (counseling and management or signs and symptoms)?			
4	How is the quality of violence response services?			
5	How is the quality of HIV treatment initiation counseling?			
6	How is the quality of antiretroviral therapy (ART) adherence counseling by health facility/site providers?			
7	How is the quality of ART support for adherence by peer navigators?			
8	How effective are providers at communicating options for how/where you can pick up ART (multi-month dispensing [MMD], community ART options, pharmacy pickup, etc.)			
9	How is the quality of viral load testing?			
C	**HIV and AIDS Commodities Availability and Accessibility.** ***We are now going to discuss the availability of certain commodities.***			
1	How available are HIV test kits?			
2	How available are PrEP medications when you need them?			
3	How available are supplies of condoms and lubricants when you need them?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
4	How available are needles and syringes when you need them?			
5	How available is ART (HIV treatment medicines) for PLHIV? Are there any antiretroviral (ARV) stock-outs?			
6	How available is MMD 3-6 months?			
7	How available is viral load testing?			
8	How is the site/facility at returning viral load test results to the patient?			
D	**Stigma and Discrimination**			
1	How well do sites/facilities keep services confidential and private?			
2	How well do mobile services keep services confidential and private?			
3	How well does the site provide information or post copies of the Patients' Rights Charter where clients can see them? For example, on the notice board, in the waiting areas, in the consultation and treatment rooms, in the pharmacy or ART pickup, etc. This charter explains the rights you have as a patient at this health facility. This includes the right to make a complaint if you feel your rights have not been respected.			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
E	**Health Care Worker (HCW) Attitudes toward Key and Priority Populations/PLHIV**			
1	How respectful are HCWs toward female sex workers?			
2	How respectful are HCWs toward men who have sex with men?			
3	How respectful are HCWs toward people who inject drugs?			
4	How respectful are HCWs toward transgender people?			
5	How respectful are HCWs toward adolescent girls and young women?			
6	How respectful are HCWs toward PLHIV?			
F	**Counseling on Index Testing**			

Instructions: *We are now going to talk about index testing. As a reminder, index testing services are offered to people living with HIV to help them get their sexual partner(s) and biological child(ren) tested for HIV. This can include persons who have been newly diagnosed as HIV positive as well as those on ART who have a high viral load and/or are co-infected with TB. Anyone can refuse to participate in index testing if they do not believe it is right for them or they fear harm from their partners from their participation.*

There are four approaches to index testing services: (1) the person living with HIV (also known as the index client) tells their partner about their HIV status and encourages their partner to come to the facility for an HIV test (passive referral); (2) the counselor sits with the index client and his or her partner and supports the client to tell their partner about their HIV status and then offers the partner an HIV test (dual referral); (3) the counselor calls or visits the partner and directly offers them an HIV test without revealing the name of the index client (provider referral); and (4) the counselor gives the index client 14 days to tell their partner about his or her HIV status. If the client is unable to bring the partner in for testing after these 14 days, the counselor contacts the partner directly (contract referral).

Please tell me how well the counselors did at providing the following information or services during the counseling session on index testing:

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
1	Greeting you and making you feel comfortable?			
2	Offering index testing services in a private room where other people could not see you or overhear what you were saying?			
3	Explaining the importance of getting partner(s) and child(ren) tested for HIV?			
4	Explaining what index testing services are and why the clinic is offering these services to PLHIV?			
6	Describing the four approaches to index testing (e.g., client referral, dual referral, partner notification, and contract referral), including the risk and benefits of each approach?			
7	Describing that partner notification can be done anonymously? This means that the index client does not have to tell the partner about his or her HIV status. Instead, the provider offers the partner an HIV test, without revealing the name of the index client to the partner.			
8	Describing other options for index testing, such as anonymous referral of sexual OR SOCIAL contacts (Risk Network Referral).			
G	**Voluntariness and Informed Consent**			
1	Explaining that index testing services are voluntary? This means that you have the right to say no to sharing the names of your partner(s) and child(ren) if you do not want to provide this information.			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
2	Asking your consent to participate in index testing services before asking you to list the names of your partner(s) and child(ren)? This could be written or verbal consent.			
3	Asking your permission to contact your partner(s) and offer them HIV testing services if you chose provider notification or contract referral?			
4	Allowing you to say no to index testing services without any threat to your ongoing care at the facility (e.g., withholding ART unless you gave the names of your partners)?			
H	**Confidentiality**			
1	Explaining how the facility will protect the confidentiality of the information you provide including the names and contact information of your partner(s) and child(ren)?			
2	Explaining that your partner(s)' name and contact information may be shared with another organization that offers HIV testing in the community (if you chose provider notification or contract referral)?			
I	**Assessment for Intimate Partner Violence and other Adverse Events**			
1	Explaining the reason that they wished to ask you about violence or abuse committed by named partners?			
2	Asking whether each partner you named had ever harmed you physically, sexually, emotionally, or economically?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
3	[If violence was disclosed], reviewing the different approaches for getting your partner tested for HIV in a way that keeps you safe. This includes not notifying your partner if your safety is in doubt.			
4	[If violence was disclosed], listening empathetically to you?			
5	[If violence was disclosed], explaining what services are available in the community to help individuals experiencing violence in their relationships?			
6	[If violence was disclosed], offering to call referral services to let them know that you were coming or to accompany you to those services?			
7	[If violence was disclosed], keeping your information confidential unless you consented to share with other providers?			
Index Testing Follow-Up **Instructions:** *Now, we are going to talk about the first visit to the health facility/site **AFTER** one has received index testing services. How well did counselors do at providing the following information or services:*				
1	Asking whether you experienced any harm from your partner, health care provider, or anyone else during or as a result of receiving index testing services at the facility? This includes physical, emotional, sexual, or economic harm.			
2	[If yes], explaining what services are available to help you address the harm you experienced and linking you to those services according to your preferences?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
3	[If the issue was not intimate partner violence but was another adverse event] Explain the steps that would be taken to prevent the same issue from occurring again in the future?			
J	**Site/Facility Level Service Delivery of HIV Services, including Index Testing**			
Instructions: *Please tell me how well the health facility/site provides the following services related to index testing:*				
1	Providing LINK survey, a drop box, hotline, or other (non-LINK) website to allow ART clients to make anonymous or confidential complaints about index testing and other HIV services?			
2	Using a community representative or advisory board as another option for ART clients to make complaints about index testing and other HIV services at the facility? This allows ART clients to make complaints to the community representative who then reports it to the health facility/site on the client's behalf.			
3	Following up with clients who make complaints to understand the situation and see how the complaint can be resolved?			

Please summarize the Key Issues identified for the elected community members to share with the facility or site providers/managers:

Issue **Suggestions for improvement**

Annex B2.2 Group Discussion Guide—non-PLHIV only (Option 2A)

Instructions: Ask your community group each question. Allow them to discuss and then decide together on a score using the scale above. If the indicator is not relevant, write 0 (zero).

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
A	**Access to Services**			
1	How convenient are times of site/facility hours?			
2	How convenient are times of mobile services?			
3	How convenient is the location of the site/facility?			
4	How convenient are locations of mobile services if offered by the site/facility?			
5	How easily can you access HIV services (pre-exposure prophylaxis [PrEP], HIV testing, HIV treatment, viral load testing)?			
6	How easily can you access prevention commodities such as condoms and lubricant?			
7	How easily can you access sexually transmitted infection (STI) services?			
8	How easily can you access violence response services (such as post-exposure prophylaxis, crisis response teams, or a trained counselor)?			
9	How effectively are you navigated/linked to the site/facility when reached in the community?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
B	**Quality of Health Center Services**			
1	How beneficial is pre- and post-test counseling for HIV testing?			
2	How is the quality of HIV service provision?			
3	How is the quality of STI services (counseling and management or signs and symptoms)?			
4	How is the quality of violence response services?			
C	**HIV and AIDS Commodities Availability**			
1	How available are HIV test kits?			
2	How available are PrEP medications when you need them?			
3	How available are condoms and lubricant when you need them?			
4	How available are needles and syringes when you need them?			
D	**Stigma and Discrimination**			
1	How well do sites/facilities keep services confidential and private?			
2	How well do mobile services keep services confidential and private?			
3	How well does the site provide information or post copies of the Patients' Rights Charter where clients can see them? For example, on the notice board, in the waiting areas, in the consultation and treatment rooms, in the pharmacy or ART pickup, etc. This			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
	charter explains the rights you have as a patient at this health facility. This includes the right to make a complaint if you feel your rights have not been respected.			
E	**Health Care Worker (HCW) Attitudes toward Key and Priority Populations/PLHIV**			
1	How respectful are HCWs toward female sex workers?			
2	How respectful are HCWs toward men who have sex with men?			
3	How respectful are HCWs toward people who inject drugs?			
4	How respectful are HCWs toward transgender people?			
5	How respectful are HCWs toward adolescent girls and young women?			
6	How respectful are HCWs toward people living with HIV?			

Please summarize the Key Issues identified for the elected community members to share with the facility or site providers/managers:

Issue **Suggestions for improvement**

Annex B2.3 Group Discussion Guide for PLHIV only (Option 2B)

Instructions: Ask your community group each question. Allow them to discuss and then decide together on a score using the scale above. If the indicator is not relevant, write 0 (zero).

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
A	**Access to Services**			
1	How convenient are times of site/facility hours?			
2	How convenient are times of mobile services?			
3	How convenient are locations of site/facility hours?			
4	How convenient are locations of mobile services if offered by the site/facility?			
5	How easily can you access HIV services (pre-exposure prophylaxis [PrEP], HIV testing, HIV treatment, viral load testing?			
6	How easily can you access prevention commodities such as condoms and lubricant?			
7	How easily can you access sexually transmitted infection (STI) services?			
8	How easily can you access violence response services (such as post-exposure prophylaxis, crisis response teams, or a trained counselor)?			
9	How effectively are people living with HIV (PLHIV) reached in the community navigated in the site/facility?			
10	How easily can PLHIV access HIV treatment services?			
11	How easily can PLHIV access viral load testing?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
B	**Quality of Health Center Services**			
1	How is the quality of pre- and post-test counseling for HIV testing?			
2	How is the quality of STI services (counseling and management or signs and symptoms)?			
3	How is the quality of violence response services?			
4	How is the quality of HIV treatment initiation counseling?			
5	How is the quality of antiretroviral therapy (ART) adherence counseling by health facility/site providers?			
6	How is the quality of ART support for adherence by peer navigators?			
7	How effective are providers at communicating options for how/where you can pick up ART (multi-month dispensing [MMD], community ART options, pharmacy pickup, etc.)			
8	How is the quality of viral load testing?			
C	**HIV and AIDS Commodities Availability and Accessibility** ***We are now going to discuss the availability of certain commodities.***			
1	How available is ART (HIV treatment medicines) for PLHIV? Are there any antiretroviral (ARV) stock-outs?			
2	How available is MMD 3-6 months?			
3	How available is viral load testing?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
4	How is the site/facility at returning viral load test results to the patient?			
5	How available are condoms and lubricant when you need them?			
6	How available are needles and syringes when you need them?			
D	**Stigma and Discrimination**			
1	How well do sites/facilities keep services confidential and private?			
2	How well do mobile services keep services confidential and private?			
3	How well does the site provide information or post copies of the Patients' Rights Charter where clients can see them? For example, on the notice board, in the waiting areas, in the consultation and treatment rooms, in the pharmacy or ART pickup, etc. This charter explains the rights you have as a patient at this health facility. This includes the right to make a complaint if you feel your rights have not been respected.			
E	**Health Care Worker (HCW) Attitudes toward Key and Priority Populations/PLHIV**			
1	How respectful are HCWs toward female sex workers?			
2	How respectful are HCWs toward men who have sex with men?			
3	How respectful are HCWs toward people who inject drugs?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
4	How respectful are HCWs toward transgender people?			
5	How respectful are HCWs toward adolescent girls and young women?			
6	How respectful are HCWs toward PLHIV?			
F	**Counseling on Index Testing**			
Instructions: *We are now going to talk about index testing. As a reminder, index testing services are offered to people living with HIV to help them get their sexual partner(s) and biological child(ren) tested for HIV. This can include persons who have been newly diagnosed as HIV positive as well as those on ART who have a high viral load and/or are co-infected with TB. Anyone can refuse to participate in index testing if they do not believe it is right for them or they fear harm from their partners from their participation.* *There are four approaches to index testing services: (1) the person living with HIV (also known as the index client) tells their partner about their HIV and encourages their partner to come to the facility for an HIV test (passive referral); (2) the counselor sits with the index client and his or her partner and supports the client to tell their partner about their HIV and then offers the partner an HIV test (dual referral); (3) the counselor calls or visits the partner and directly offers them an HIV test without revealing the name of the index client (provider referral); and (4) the counselor gives the index client 14 days to tell their partner about his or her HIV. If the client is unable to bring the partner in for testing after these 14 days, the counselor contacts the partner directly (contract referral).* *Please tell me how well the counselors did at providing the following information or services during the counseling session on index testing:*			
1	Greeting you and making you feel comfortable?			
2	Offering index testing services in a private room where other people could not overhear what you were saying?			
3	Explaining the importance of getting partner(s) and child(ren) tested for HIV?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
4	Explaining what index testing services are and why the clinic is offering these services to PLHIV?			
5	Describing the four approaches to index testing (e.g., client referral, dual referral, partner notification, and contract referral), including the risk and benefits of each approach?			
6	Describing that partner notification can be done anonymously? This means that the index client does not have to tell the partner about his or her HIV status. Instead, the provider offers the partner an HIV test, without revealing the name of the index client to the partner.			
7	Describing other options for index testing, such as anonymous referral of sexual OR SOCIAL contacts (Risk Network Referral).			
G	**Voluntariness and Informed Consent**			
1	Explaining that index testing services are voluntary? This means that you have the right to say no to sharing the names of your partner(s)and child(ren) if you do not want to provide this information.			
2	Asking your consent to participate in index testing services before asking you to list the names of your partner(s) and child(ren)? This could be written or verbal consent.			
3	Asking your permission to contact your partner(s) and offer them HIV testing services if you chose provider notification or contract referral?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
4	Allowing you to say no to index testing services without any threat to your ongoing care at the facility (e.g., withholding ART unless you gave the names of your partners)?			
H	**Confidentiality**			
1	Explaining how the facility will protect the confidentiality of the information you provide including the names and contact information of your partner(s) and child(ren)?			
2	Explaining that your partner(s)' name and contact information may be shared with another organization that offers HIV testing in the community (if you chose provider notification or contract referral)?			
I	**Assessment for Intimate Partner Violence and other Adverse Events**			
1	Explaining the reason that they wished to ask you about violence or abuse committed by named partners?			
2	Asking whether each partner you named had ever harmed you physically, sexually, emotionally, or economically?			
3	[If violence was disclosed], reviewing the different approaches for getting your partner tested for HIV in a way that keeps you safe. This includes not notifying your partner if your safety is in doubt.			
4	[If violence was disclosed], listening empathetically to you?			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
5	[If violence was disclosed], explaining what services are available in the community to help individuals experiencing violence in their relationships?			
6	[If violence was disclosed], offering to call referral services to let them know that you were coming or to accompany you to those services?			
7	[If violence was disclosed], keeping your information confidential unless you consented to share with other providers?			
Index Testing Follow-Up **Instructions:** *Now, we are going to talk about the first visit to the health facility/site **AFTER** one has received index testing services. How well do counselors do at providing the following information or services:*				
1	Asking whether you experienced any harm from your partner, health care provider, or anyone else during or as a result of receiving index testing services at the facility? This includes physical, emotional, sexual, or economic harm.			
2	[If yes], explaining what services are available to help you address the harm you experienced and linking you to those services according to your preferences?			
3	[If the issue was not intimate partner violence but was another adverse event] Explain the steps that would be taken to prevent the same issue would not occur again in the future			

	Discussion Questions	Score (0-4)	Reason for Score	Suggestion for Improvement
J	**Site/Facility Level Service Delivery of Index Testing**			
Instructions: *Please tell me how well the health facility/site provides the following services related to index testing:*				
1	Providing LINK survey, a drop box, hotline, or other (non-LINK) website to allow ART clients to make anonymous or confidential complaints about index testing and other HIV services?			
2	Using a community representative or advisory board as another option for ART clients to make complaints about index testing and other HIV services at the facility? This allows ART clients to make complaints to the community representative who then reports it to the health facility/site on the client's behalf.			
3	Following up with clients who make complaints to understand the situation and see how the complaint can be resolved?			

Please summarize the Key Issues identified for the elected community members to share with the facility/site providers/managers:

Issue **Suggestions for improvement**

Annex B3: Example Key Informant Interview Guide

Interview Guide for Key Informants: health care workers, health facility or site managers, local health administrators

Before starting the interview, read or share the following information with the interviewee: *Thank you very much for agreeing to this interview. We are gathering information from service users, service providers, and health administrators in order to improve HIV services. The purpose of this interview is to better understand HIV and HIV-related service provision, particularly from the health provider and health administrator level. This is your opportunity to call attention to what is working well so that it can be replicated and expanded. It is also your opportunity to note where improvements are needed so that these can be addressed in future trainings and program activities.*

Your answers will be used to inform a discussion with HIV service users and health facility or site staff and local health administrators. While some of the content of your answers may be shared, we will not share your name in relation to any of the information provided in this interview. You may skip any questions that you do not want to answer.

The interview will take about 45 minutes. Do you have any questions before we begin?

Example Interview Guide for Key Informants

Date:	_____ MM/DD/YYYY
Name of Site or Health facility where interviewee works: *(or is attached to, in case of health administrator)*	_____
Type of Site: *(KP drop-in center, project-run community clinic, government clinic, private health facility, mobile services).*	_____
Services offered at the site/facility. *Circle all that apply.*	HIV treatment services, HIV testing, STI services, PrEP, condoms/lubricant, family planning, TB screening/treatment, community mobilization/recreation, violence response services, PEP Other (specify): _____
Name of Community:	_____
District:	_____
Name of Interviewer:	_____

1. What is your position/role at or in relation to ***[NAME OF SITE/HEALTH FACILITY]*** health facility or site?

2. How long have you worked with/at ***[NAME OF SITE/HEALTH FACILITY]*** health facility or site?

3. Which of the following populations receives services at this health facility/site? ***[Add choices based on your project's target group if needed]***
    a. Female sex workers (FSWs)
    b. Men who have sex with men (MSM)
    c. Transgender people (transgender)
    d. People who inject drugs (PWID)
    e. Adolescent girls and young women (AGYW)
    f. People living with HIV (PLHIV)

4. What challenges does this site face in providing services to:
   [Select only the relevant population(s) based on the answer to Question 3.]
   [**FSW/MSM/Transgender/PWID/AGYW/PLHIV]**?

5. Has your facility/site experienced stock-outs of any of the following:
    a. HIV test kits
    b. Condoms/lubricant
    c. ART
    d. STI drugs

   5a. If yes, how often do stock-outs of HIV test kits occur?

   5b. If yes, how often do stock-outs of condoms/lubricant occur?

   5c. If yes, how often do stock-outs of ART occur?

   5d. If yes, how often do stock-outs of STI drugs occur?

6. Is your health facility/site successfully encouraging ***[Select only the relevant population(s) based on the answer to Question 3]***

   [**FSW/MSM/Transgender/PWID/AGYW]** to get tested for HIV?
    a. If yes, please describe what makes the facility/site successful.
    b. If no, please describe why the facility/site is not successful.

7. What one change would improve HIV testing uptake among ***[Select only the relevant population(s) based on the answer to Question 3]***

   [**FSW/MSM/Transgender/PWID/AGYW]**? Why?

8. What one change would improve HIV treatment uptake among ***[Select only the relevant population(s) based on the answer to Question 3]***

   [**FSW/MSM/Transgender/PWID/AGYW]**? Why?

9. How is the site/facility at returning VL test results to the patient?

10. Beyond health, what kinds of support does your site offer to *[Select only the relevant population(s) based on the answer to Question 3]* **[FSW/MSM/Transgender/PWID/AGYW/PLHIV]** when he/she receives an HIV test result?

11. What kind of support does this site need to improve HIV and HIV-related services for *[Select only the relevant population(s) based on the answer to Question 3]* **[FSW/MSM/Transgender/PWID/AGYW/PLHIV]**?

Questions 12–14 are for health facility/site managers/staff only. For local health administrators, skip to question 16.

12. How does the facility/site maintain confidentiality? What are the challenges and gaps in terms of maintaining confidentiality?

13. Does the facility/site have a private space (where no one can see or hear the client) to provide all forms of HIV testing, including index testing? If yes, please describe.

14. Is Index testing offered to all PLHIV? Please explain your answer.

15. Are PLHIV able to opt out of index testing? If yes, please describe.

16. What happens in situations in which PLHIV are not opting out of index testing, but are just not comfortable listing or naming their partners/contacts?

17. How is the anonymity of sexual partners listed during index testing maintained?

18. On a scale of 1–5 with 5 being 'great' and one being 'poor', how respectful are health care workers toward *[Select only the relevant population(s) based on the answer to Question 3]* **[FSW/MSM/Transgender/PWID/AGYW/PLHIV]?** Could you please describe some examples of behaviors by health care workers you have seen that made you give that score?

19. Have health care workers at your health facility/site been trained in gender-based violence, human rights, or stigma or discrimination? Have they had any key population sensitivity training?
    a. [If yes] Please describe for each one.

20. Are there any other things about providing HIV and HIV-related services to ***[****Select only the relevant population(s) based on the answer to Question 3****]*** [**FSW/MSM/Transgender/PWID/AGYW/PLHIV]** that you would like me to know?

21. Do you have any questions for me?

Annex B4: Implementation Plan Template

Focus Group Discussions

No.	Health facility/ unit	Partner/ Program	FGD type	Proposed dates	Comments	Responsible person
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Key Informant Interviews

No.	Health facility/unit	Service Provider	Health facility/ site manager	Health official	Confirmed?	Date proposed	Responsible person
1	*Name of facility*	*Name of service provider from the facility to interview*	*Name of facility manager from the facility to interview*	*Name of health official of the facility to interview*			
2							
3							
4							
5							
6							
7							
8							
9							
10							

Annex B5: Action Plan Form

Action Planning Form

Date: _____

Name of Site/Health Facility: _____

Type of Site (circle one): *KP drop-in center* *Project-run community clinic* *Government clinic*
Private health facility *Mobile services* *Other:* _____

No.	Challenge/Gap	Actions to be taken to address the issue	Lead person responsible	Timeline/ due date	Supervisor	Status
1						
2						
3						
4						
5						

Note: *This same tool should be used for CLM action planning.*

For programs using LINK without Community Scorecard, consider adding a column to the action plan above to note the root cause of problems identified in the facility, which can help determine solutions.

ANNEX C. THREAT AND VULNERABILITY ASSESSMENT TOOL

Questions to assess the danger of a threat.

1. What are the facts surrounding the threat?
2. Is there a series of threats that became more systematic or frequent over time?
3. Who is the person who is making the threats?
4. What is the objective of the threat?
5. Do you think the threat is serious?

What does an attacker need to be successful?

- Access: To you physically or electronically
- Resources: Anything that can be used to carry out the attack – information on the victim location, weaknesses, weapon, transport, money
- Impunity: A lack of consequences for the attacker, legal and/or social
- Motive: A reason to cause harm

ANNEX D. SURVEY INSTRUCTIONS TOOL

Completing the Survey

Key workers involved in completing the survey and implementing activities in response to identified gaps are the members of a safety and security management team. If no such team exists, the first step in this process is to form one (see box **Safety and Security Management Team**).

Safety and Security Management Team

MEMBERS

The size and composition of this team will vary depending on the size of your organization. Each organization should identify a **safety and security focal point individual**—someone who coordinates the organizational response, who has been trained in safety and security, and who sensitizes and updates colleagues on internal safety and security policies. Ideally, the safety and security management team should include:

- Safety and security focal point
- One person from senior management (or an individual with decision-making power)
- One or two staff members from different levels in the organization
- Someone with information technology expertise if digital security will be discussed

RESPONSIBILITIES

Beyond the completion of the survey, the duties of the safety and security management team should include making strategic decisions about, developing procedures for, and coordinating the implementation of safety and security policies.

Once the team is formed, you should collectively agree on when you will use the survey. The survey may be used regularly as part of routine safety and security planning in your organization or program. For example, you could review the survey every six months at a meeting of the safety and security management team. It may also be used when a specific safety and security incident occurs or begins to happen more frequently to help you systematically think about options for mitigating future harms.

Whenever the survey is used, it should be completed in a safe and private space where it is possible to speak openly. Because Tool 2 is designed to inform policies and procedures governing activities wherever program design, implementation, and monitoring occurs, the safety and security team should visit those sites or speak to representatives from those sites to better understand the unique challenges and needs in different settings.

When completing the survey, refer to each section heading to determine what type of organization should complete this portion. For example, some sections should be filled out by

lead agencies (such as principal recipients of The Global Fund) as well as organizations who are implementing activities (such as Global Fund subrecipients). Others, such as section D, which covers safety at physical locations, should only be completed by those who implement activities directly but should be done individually for each site instead of at an organizational level. This is further discussed in the box **How can collaborating organizations and regional networks work together to meaningfully complete the survey?**

How can collaborating organizations and regional networks work together to meaningfully complete the survey?
The rationale for having different organizations complete different sections of the survey is that not all strategy types are relevant to each organization, and organizations working together can complement one another. Especially in the context of an umbrella organization and several implementing partners all working on the same objectives, the way an organization completes the survey may be dependent on their collaborators' approaches to security. For example, if a lead organization has asked all implementing partners to direct journalists' questions to the Ministry of Health, then each implementing partner will simply mark questions such as "Does the organization have a designated member for talking to the media?" with "not applicable" because they do not need to have someone designated to speak to the media based on the approach used by the lead organization. Regional networks may be unsure which components of the survey to complete. Central leadership of such regional networks will likely benefit from completing the sections indicated as for "the organization leading the project" while their member agencies may wish to fill out the components indicated as for "individual organizations implementing activities." They can then look at their collective results to determine where the network would like to focus their energies to fill gaps as well as share good practices across organizations.

For all those completing the various sections of the survey, please read each question in Column B. If the question requires further clarification, refer to Column C where clarification is offered. After each question put a "1" under either yes, no, somewhat, or not applicable to indicate the response that best aligns with your organization's reality.

- **Yes:** This answer indicates that the organization routinely implements this strategy. For example, under question 1. "Does the organization take actions to be visible to the public, portraying a positive image?" if the organization has a continued campaign to be visible in a positive way, they would put a 1 under "yes."
- **No:** This answer indicates that the organization has never engaged in this strategy and does not currently implement it. For example, under question 1. "Does the organization take actions to be visible to the public, portraying a positive image?" if the organization has never conducted activities to have positive public visibility, they would put a 1 under "no."
- **Somewhat:** This answer indicates that the organization has used this strategy in the past but is not currently using the strategy, or that the strategy is only partially employed. For example, under question 1. "Does the organization take actions to be

visible to the public, portraying a positive image?" if the organization only does public activities in some of the districts where it implements or previously had a publicity campaign that is no longer operational, they would put a 1 under "somewhat."

- **Not applicable:** This answer indicates that this strategy is not relevant or useful to the organization. For example, under question 1. "Does the organization take actions to be visible to the public, portraying a positive image?" some organizations do not wish to be visible in any way because they feel that visibility may result in harm. In this case, avoiding public visibility is a well-thought-out choice and they would choose "not applicable" because this strategy is not useful to them. Activities that are irrelevant, such as questions on outreach for an organization that only delivers services at a clinic, would also be marked as "not applicable."

In the column following the yes/no/somewhat/not applicable responses there is room for the person(s) completing the survey to explain their answer under "notes." See **Notes** for more.

Notes

While it is not required that an organization fill out the "notes" column after each question, filling it out will help make decisions on next steps, particularly if you select "somewhat" as a response and wish to provide details explaining your choice.

Interpreting Scores

Each "yes" answer awards a full point to the organization, "somewhat" awards a half point, "no" awards zero points. An answer of "not applicable" does not affect the score positively or negatively. Beyond each lettered section, A–G, there are cross-cutting scores for Emergency Preparedness, Digital Safety, and COVID-19. When you fill out the survey, consider that this tool is designed for your own personal use and your scores will only be shared if you choose to make them available to others. See the box **Getting the Most Out of the Survey** for additional information.

Your scores are presented as a graph on the second tab of the Excel document, "Responses Graph."

Getting the Most Out of the Survey

This survey is designed to be useful to implementers. If a strategy is not useful or relevant to your organization, marking it as "not applicable" will not impact your score and will allow you to focus only on those strategies that you think would be beneficial to employ. What you mark as "no" or "somewhat" is also not a reflection of a failure. Many of these important components of security have not been contemplated or funded in HIV programs. You can use low scores (which will result from selecting "no" and "somewhat") to work with your funder and organization to highlight areas for growth while high scores may indicate that your organization could provide technical assistance or guidance to others embarking in this new area.

ANNEX E. IMPLEMENTER SECURITY PLAN

Risk (of something):			
Threats	**Vulnerabilities**	**Existing capacity**	**Required capacity**

ANNEX F. IMPLEMENTER SECURITY ACTION PLAN TEMPLATE

Top 10 Required Capacities to be Pursued		Requires additional monetary resources? (Y/N)	Time capacity will be fully implemented	Main person(s) responsible
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

ANNEX G. EXAMPLE SECURITY PROTOCOL

Security Protocol (adapt to your program)

- Security plans take time to implement. Determine steps to take now to deal with issues when they occur. The solution to short-term needs is a security protocol.
- First, determine the levels—green (normal), amber or orange (indications that an attack could be carried out), red (extreme likelihood of attack)—and then think about what to do as it relates to: staff, programs, and premises.

Here is a sample security protocol.

	Staff	Programs	Premises
Green	No restriction	No restriction	Normal security procedures
Amber	1. Staff deemed most at risk (defined/determined in advance) do not come to work or do not work in public spaces. 2. Reminder sent out to all staff on who they should inform in case of emergency. 3. Alert trusted neighbors and allies of the situation ("Hey, we think it's OK, but let us know if you see something strange."). 4. Alert organizational lawyers.	1. Extremely sensitive activities or those occurring in hostile environments (determined in advance) are put on hold. 2. Non-sensitive activities continue as normal. 3. Alert donors. 4. Alert beneficiaries to the situation and ensure they follow any required security measures (e.g., we will no longer host large events until further notice).	1. Contract a short-term security guard for surveillance during office hours. 2. Visitors must be pre-vetted to access office premises (no unannounced visitors). 3. Staff are reminded to check that no sensitive information is easily accessible (digital and physical). 4. Move contingency funds so that they can be easily accessed (maybe on ATM cards, maybe within Western Union).
Red	1. Staff deemed "most at risk" will temporarily re-locate (with staff and re-location sites defined in advance). 2. Other staff do not come to the office. 3. Organizational allies are informed and mobilized. 4. Organizational lawyers are alerted.	1. Temporarily suspend all project activities. 2. Inform organizational donors that projects have been suspended. 3. Communicate suspensions to beneficiaries.	1. Lock the office (determine staff responsible for locking office in advance). 2. Contract security guard for surveillance during and after office hours. 3. No visitors allowed on premises

ANNEX H. SECURITY INCIDENT REPORT

Security Incident Log			
	Question	**How to Answer**	**Response**
1	Security incident number	Begin with number 1 and continue; the numbering allows security incidents to be linked to one another (see question #14)	
2	Date of incident	Type as YEAR-MONTH-DAY (e.g., 2019-02-17 for February 17, 2019) in order to organize this security event log by date	
3	Time of incident	Specific time of day (if known), or more general (morning, afternoon, evening, night)	
4	Perpetrator	If known and safe to list, or use a more general term such as “law enforcement officer”	
5	Affected organization	Name of HIV program implementing partner (i.e., community-based organization’s name)	
6	Target	Specific person or type of staff, physical space (e.g., name of a specific hot spot), website, database, etc. Do not name individuals here unless you have their permission to do so.	
7	Where incident occurred	Physical address, online, by phone, etc.	
8	Believed motivation of aggressor (if known)	For example: intimidation, to stop programming, to deflect attention from other local issues	
9	Description of security incident	For example: Facebook posts on project page said “paste specific message here;” or peer educators were arrested without charge when distributing condoms to a group of MSM during a mobile HIV testing event	
10	Programmatic consequences of security incident	For example: implementing partner will conduct only online outreach until physical outreach is considered safe to conduct	
11	Description of actions taken to respond to security incident	For example: on YEAR-MONTH-DAY implementing partner targeted in Facebook post decided that it is not safe to conduct outreach activities for a two-week period and implementing partner filed a complaint with the police.	

Security Incident Log

	Question	How to Answer	Response
		On YEAR-MONTH-DAY local Ministry of Health officials held a meeting with power holders and local law enforcement; they discussed threats to the implementing partner and created a WhatsApp group that can be used to notify and activate allies immediately as needed. Please include dates of actions taken (and continue to update this row as actions are taken).	
12	Was the security incident related to index testing?	Select one: Yes or No or Unsure	
13	Was the security incident related to COVID-19?	Select one: Yes or No or Unsure	
14	Which other security incidents is this related to? (if any)	Note whether this incident was related to other security incidents by listing other security incident numbers here.	
15	Incident resolution (if any)	For example: on YEAR-MONTH-DAY peer educators were released from state custody and provided with mental health support.	