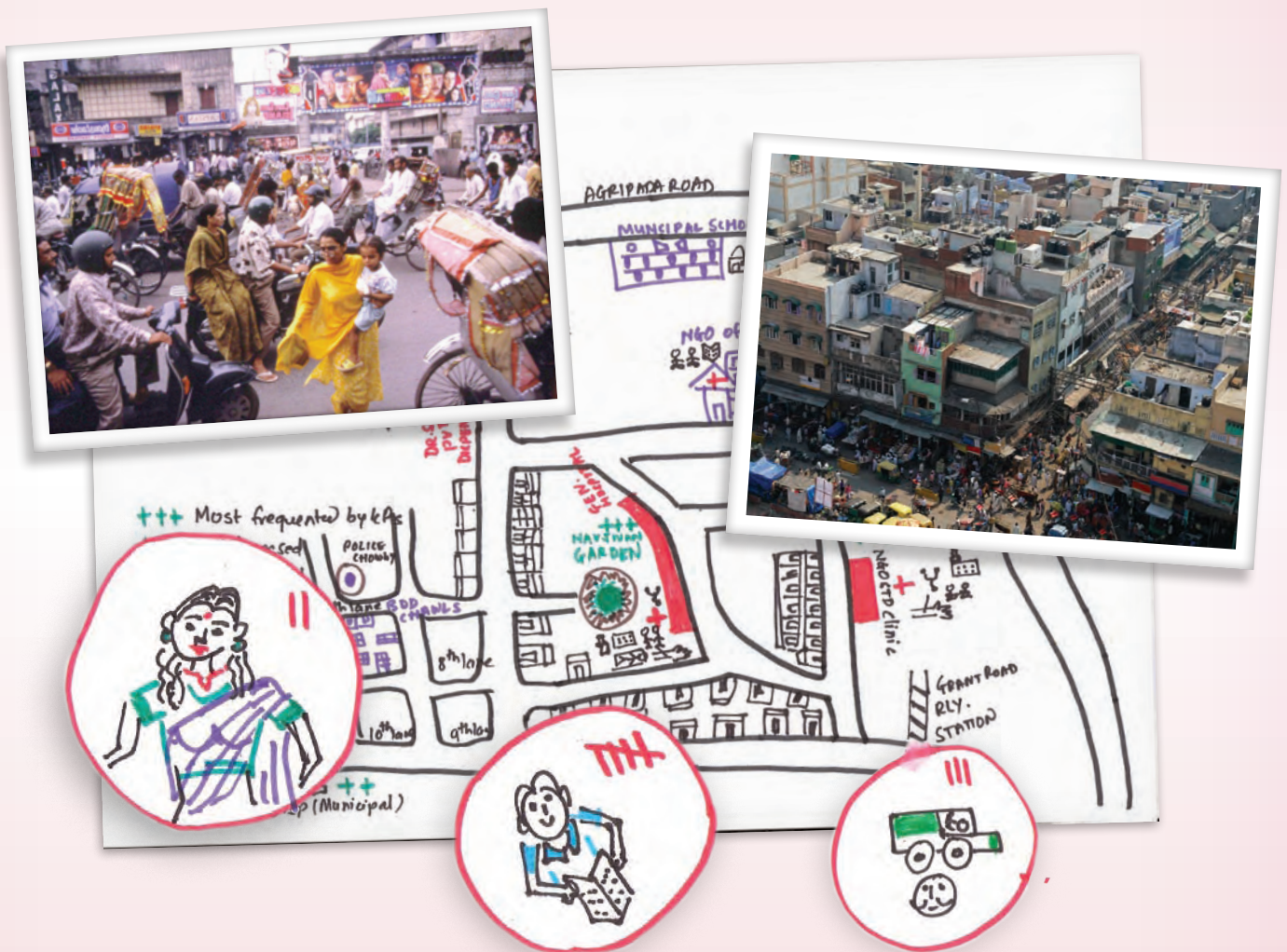


# Participatory Site Assessment

*A guide to generating information to design community-based  
interventions for HIV prevention in India*



PATH is an international, nonprofit organisation that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public- and private-sector partners, we help provide appropriate health technologies and vital strategies that change the way people think and act.  
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## Acronyms

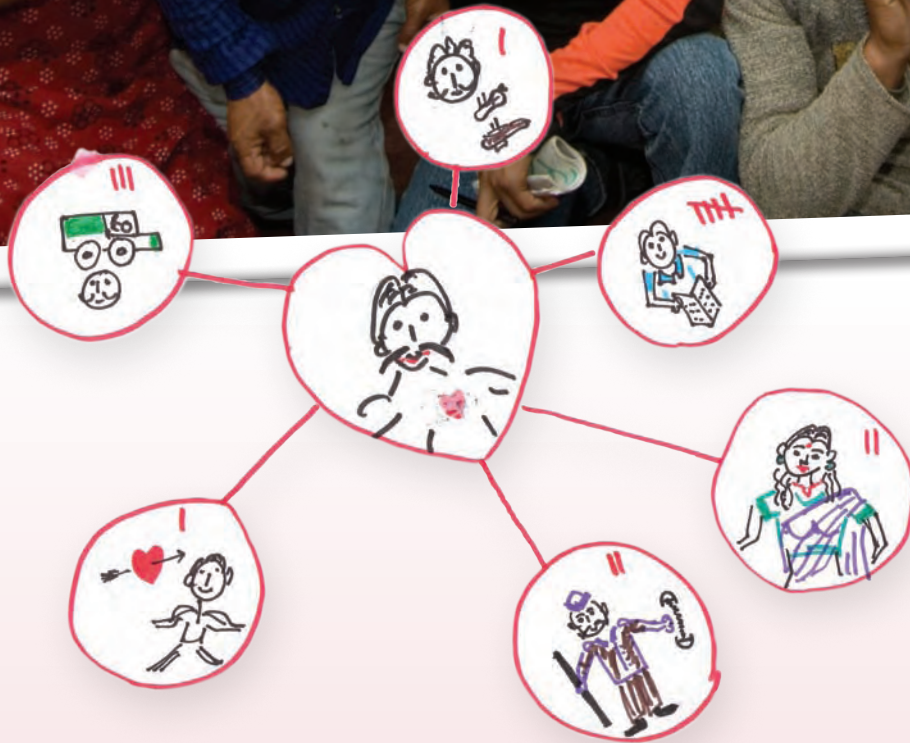
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>CBO</b>	community-based organisation
<b>FSW</b>	Female Sex Worker
<b>HIV</b>	Human Immunodeficiency Syndrome
<b>IDU</b>	intravenous drug user
<b>MSM</b>	males who have sex with males
<b>NGO</b>	nongovernmental organisation
<b>PSA</b>	participatory site assessment
<b>STI</b>	sexually transmitted infection
<b>TIGRIS</b>	Targeted Interventions for Groups at Risk project



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# Introduction

## What do we mean by “key populations”?

“Key populations” are groups of people most directly and acutely affected by HIV. Within the Indian context, they can include sex workers, males who have sex with males (MSM), people who inject drugs (IDUs), and people living with HIV.

Key populations are considered key to the dynamics of the epidemic, as they are (1) most likely to be infected and affected by HIV and/or (2) most likely to transmit the virus. Key populations are also key to the response to HIV, since evidence from around the world shows that if key populations are involved in designing and implementing interventions to prevent and contain HIV, the results are more likely to be effective and sustainable.

## Aim of this toolkit

This toolkit aims to help key population communities mobilise themselves for HIV prevention and to generate information to design HIV prevention interventions and services.

## Who this toolkit is for

This toolkit was developed by PATH for nongovernmental and community-based organisations (NGOs and CBOs) that intend to implement HIV risk-reduction projects and targeted interventions with key populations.

## Toolkit contents

### **Section A: Participatory Site Assessment**

Defines participatory site assessment (PSA), what it aims to achieve, and limitations of the process.

### **Section B: A Participatory Site Assessment Case Study**

Shows how PSA was carried out in ten districts in Maharashtra.

### **Section C: The Steps of Participatory Site Assessment**

Describes the four main steps in PSA: (1) recruitment, (2) training, (3) implementation, and (4) feedback.

### **Section D: Participatory Site Assessment Methods**

Explains why participatory methods are important in PSA and provides a guide to facilitation of five methods commonly used in PSA.

### **Section E: Maintaining the Quality of Participatory Site Assessment**

Details 17 standards that can be used by organisations to assess the quality of their PSA work.

### **Section F: Sample Participatory Site Assessment Training Schedule**

Shows areas that can be covered in PSA training sessions.

*A film about Participatory Site Assessment is included with this toolkit to help bring the process to life and for use in training and orientation.*





# Section A: Participatory Site Assessment

## What is participatory site assessment?

Participatory site assessment is a process of mapping and estimating the sizes of key populations at a selected site in order to understand the context within which they are vulnerable to becoming infected with HIV.

As the name suggests, PSA is participatory. This means that (1) it uses participatory methods to map and determine estimates, and (2) it is carried out by trained key population members for their perspective on and understanding of the situation.

## Participatory site assessment is both an assessment process and an intervention

In terms of providing an **assessment**, PSA is the process of working with key populations, NGOs, and other stakeholders to design intervention packages that aim to reduce HIV incidence amongst key populations.

In terms of being an **intervention**, PSA mobilises key populations to engage in HIV risk-reduction strategies and in the project as a whole.

## Limitations of participatory site assessment

The information generated by PSA is site-specific, and therefore, not easy to generalise and apply to other sites. A separate PSA must be conducted for each site.

The entire set of findings from a PSA may not provide uniformly useful information; therefore, it is important to encourage PSA team members to acknowledge when information generated is strong and when it is weak.

A PSA can be limited by a narrow definition of a key population. For example, in one PSA, the term “males who have sex with males” was defined very narrowly, and as a result, estimates made during the assessment did not reflect the full range of MSM at the site.

*PSA teams need to be careful not to raise expectations about the effects of assessment outcomes on services and interventions, in order to prevent disappointment amongst key population members and negative attitudes toward the project.*

## Outcomes of participatory site assessment

PSA generally tries to achieve one or all of the following three outcomes:

- 1** Generation of information to design a site-specific and population-specific intervention with key population support.
  - Estimate the sizes of key populations by site and by key population category.

- Map hotspots of HIV risk activity.
- Generate information on the mobility patterns of key populations within and outside of the site.
- Explore the HIV/sexually transmitted infection (STI) risks that key populations face and the factors that exacerbate vulnerability.
- Identify characteristics of key populations, as well as their HIV-related needs.
- Identify existing HIV interventions and highlight gaps within them.

## 2 Mobilisation of key population groups for HIV prevention.

- Generate awareness of HIV.
- Increase knowledge about risk-reduction strategies.
- Provide information on existing HIV/STI prevention interventions to key populations.
- Build social capital and solidarity amongst key populations.
- Promote a collective voice amongst key populations.
- Explore safe and private spaces for key populations to meet and work together.

## 3 Formation of a core group of PSA-trained key population members at each site to serve as an important resource for project implementation.

- Ensure key population inclusion and participation throughout their recruitment and training as PSA team members.

*Secondary sources and information from service providers can usefully support PSA findings, but at the heart of PSA is finding out how the key populations in each site live, think, and feel.*

## Why participatory site assessment is carried out by key populations

One of the ways to ensure that key populations are central to any response is by including them at every stage of intervention design. PSA is directly implemented by key population members—rather than by professional researchers from outside these groups—for the following reasons:

- Key population members best understand and empathise with their peers and are able to win their confidence so that information can be shared without fear or prejudice.
- They are able to communicate well with other key population members and use familiar, colloquial language.
- Estimates are more likely to be accurate, since insider knowledge is necessary to avoid underestimation.

*“Peer” is defined as anyone who accepts, respects, or follows the sexual norms and practices of a particular key population.*

- In order to successfully mobilise key populations, PSA should consider their priorities as well as their risk factors for HIV.*







# Section B: A Participatory Site Assessment Case Study

## Introduction

PATH and Pathfinder International jointly carried out a PSA for the Targeted Interventions for Groups at Risk (TIGRIS) project in Pune metropolitan area and nine other high-prevalence districts in Maharashtra state in India. The goal of TIGRIS is to reduce STI prevalence and the spread of HIV amongst key populations (sex workers, *Tamasha*<sup>1</sup> workers, *Mujra*<sup>2</sup> dancers, MSM, and transgenders), their clients, and their partners.

The objectives of the TIGRIS PSA were as follows:

- 1 To explore the extent and nature of HIV/STI risks and vulnerabilities of key populations in the TIGRIS operational areas.
- 2 To begin the process of mobilising key population groups for HIV/STI prevention.
- 3 To build core groups of key populations within the sites who can serve as important resources for project implementation.

## Methods and processes

**Recruitment and training.** Thirteen experienced key population consultants were recruited to implement the project. Over a period of 9 days, they interviewed and motivated a total of 120 key population members to join the PSA teams. These key population members were from diverse key population groups within the different geographical areas where PSAs were to be carried out.

A ten-day training was held in a hotel on the outskirts of Pune city. Some participants brought their young children and some brought their partners. The greatest challenge during this phase of the PSA process was to develop mutual trust between different key populations.

The training team played a major role in creating an informal, self-disciplined, and nonjudgemental learning atmosphere. The training aimed to help the PSA teams develop skills to implement the PSA. Several days were spent doing fieldwork and practicing to facilitate participatory assessment methods with other key population members.

**PSA implementation.** Out of the original 120 key population members selected for the training, 91 were recruited to become PSA consultants following the training. These PSA consultants were then divided into the ten teams needed to implement PSA in the ten districts. They spent 20 days in the field. Gaining the trust of key populations in the field was the most important and sometimes the most difficult step of the PSA implementation process. At best, key populations welcomed the PSA teams enthusiastically and cooperated in the discussions. In a few places, the PSA consultants were not so readily accepted. A reference letter provided by Pathfinder International helped in soliciting cooperation from gatekeepers and other stakeholders in the sites.

1. Traditional form of theatre in Maharashtra.  
2. Traditional dance.

The PSA teams facilitated the PSA methods with a total of 3,080 people, 2,723 of whom were from the key populations. The following participatory methods were used during the PSA:

**Broad mapping:** A broad map provides a geographical and social overview of a site, including area landmarks and the locations where key population members can be found.

**Numbers and trend mapping or “How hot is the spot?”:** This method is used to estimate how many members of each key population can be found at different hotspots<sup>3</sup> in a site, to show the mobility patterns of key populations and the times when they are available.

**Seva chitram or services mapping:** This map shows the availability and accessibility of different HIV/STI services intended for key populations in a site.

**E-gya-ke? or “Why is it so?”:** This method helps to analyse the risk and vulnerability factors experienced by key populations and that increase their chances of becoming infected with HIV.

**Sex life:** This method explores the range of sexual partners of key populations and the types and frequency of sex acts usually practiced.

**Feedback workshop and consultation meetings with NGOs.** The PSA consultants reconvened for a three-day feedback workshop, to share their experiences and compile and analyse the data they had gathered in each site. Once each team had consolidated their data, they practiced how to present their findings to the key stakeholders in each district.

The PSA consultants brought back touching stories from the field, as well as information about many new hotspots where key populations had no access to condoms or basic information on HIV.

The PSA teams then met with the TIGRIS partner NGOs and key population communities in each district. They shared and verified the information from each PSA and discussed strategies for redesigning project activities to cater to the needs of the local key populations. New key population sites, hotspots, and key population groups were identified. The findings showed many more MSM than had previously been estimated, and as a result, many NGOs in the TIGRIS initiative initiated MSM interventions.

**Other outcomes.** After completion of the PSAs, some PSA consultants were recruited as HIV workers by local NGOs. Other PSA consultants volunteered to become part of local projects that provide monitoring and feedback to committees in their localities. A group of PSA consultants formed an MSM collective and registered a CBO in Pune city.



3. “Hotspots” are defined as specific public locations where key populations cruise, solicit clients, are picked up, interact with other key populations, buy/use drugs, and/or have sex.

# Section C: The Steps of Participatory Site Assessment

PSA involves a four-step process:

- 1 Recruiting PSA teams.
- 2 Training PSA teams.
- 3 Implementing the PSA.
- 4 Compiling and analysing PSA findings.

The time required to complete a PSA varies according to the size of the assessment site, how easy or difficult it is to travel within the site, and the number of people on the PSA team.

## Step 1: Recruiting participatory site assessment teams

When selecting PSA team members, it is important to remember that they are being recruited not only to determine the key population situation at a particular site, but also to (1) analyse information, (2) help design or redesign HIV projects for key populations, (3) mobilise other key populations to support the project, and (4) potentially be a permanent part of the project in the future.

*Recruiting the right people for the PSA teams is critical to the success of the PSA process.*

### Criteria for selection

The key population members recruited as PSA team members should be true peers of the key populations in the site.

Besides knowing the site well, they should be well-known and accepted amongst the key populations in the site. They should be motivated to work with their peers on HIV, and they must be available throughout the entire PSA process. In addition, it is useful to recruit key population members who have had some experience facilitating group discussions, have good communication and interpersonal skills, are proficient in the language of the site, and can demonstrate some aptitude for analysis.

PSA team members who are recruited should be willing to listen and learn and be able to summarise and represent the views of other people even when they disagree with them. Although literacy is not an absolute requirement for PSA team members, it is useful if at least one in four is literate and has good mathematical skills for recording basic data.

PSA teams should also be well-balanced; each team should mirror the known diversity of the key population groups who will be part of the assessment.

### Recruitment process

Key population members should be recruited in a systematic and transparent manner, as paid consultants to the project.

It is useful to hire people with PSA experience to assist with recruitment. It is important that key population members are not chosen just from amongst those friendly with NGOs, but to recruit

key population members who do not use existing HIV services. Key population members who do not have contact with NGOs will be able to find and work with others like themselves and will better understand the barriers to service use.

Besides a reasonable fee, contracts for key population members recruited to PSA teams should include provisions for per diem, accommodations, and travel. There should also be a system to mitigate or minimise the risk of any harm to them that may arise from their work.

## Step 2: Training participatory site assessment teams

PSA training is intensive. The initial training should be 8 to 12 days long, depending on the existing skills of the recruits, and it is usually conducted as an onsite workshop, so that team members can focus exclusively on learning to effectively implement PSA. Experience has shown that having all the participants and preferably all the trainers from the key population groups enables the PSA teams to learn the methodology quickly and accurately. It also helps them develop confidence in their own ability and skills.

### Fieldwork

Fieldwork is a critical part of PSA training. Fieldwork should comprise at least three full days of the workshop and come in two or three separate blocks so that team members can analyse their first efforts and then try to improve upon them. Sites chosen for fieldwork training should be different from those that will actually be assessed.

Participants should be split into small groups and each assigned a geographical area in which to practice facilitating the PSA methods. They need to be given letters of introduction, and where necessary, the authorities need to be informed that they will be working in the area.

As part of the training, it is useful to invite local NGOs to hear and comment on the groups' findings from the fieldwork practice. Often, the findings are very accurate, and hearing others acknowledge the accuracy of their findings gives PSA team members confidence for when they implement PSA for real.

### Training objectives

By the end of the PSA training, all participants should have:

- 1** A common understanding of (a) the organisation undertaking the assessment, (b) HIV interventions in general, and (c) the specific HIV/STI project being planned/implemented with key populations.
- 2** An understanding of and the ability to articulate the objectives and mechanisms of PSA and the role of key populations in PSA.
- 3** A good understanding of the different types of key populations and of the criteria for determining key population membership.
- 4** The skills to facilitate PSA methods and record and report PSA findings.
- 5** Developed plans for PSA implementation (e.g., timeline and roles and responsibilities).

A sample PSA training schedule is included in Section F.

## Step 3: Implementing the participatory site assessment

PSA implementation is divided into two distinct stages. During **broad mapping**, PSA teams introduce the project to groups of key populations they meet in the site, as well as to people



who can help them access other, hidden key populations (such as home-based sex workers and IDUs).

PSA teams then begin the process of developing a broad map to gain an overview of the site and identify **hotspots**.

This is followed by **focused mapping**, which utilises the remaining participatory methods (numbers and trend mapping, services mapping, “Why is it so?”, and sex life). The teams visit each hotspot, meet with key population members, and generate the detailed information that is required to design HIV interventions.

*A hotspot is a specific public location where key populations cruise, solicit clients, are picked up, interact with other key populations, buy/use drugs, and/or have sex.*

Each day, the teams carry out a review to discuss the information generated thus far, in order to determine remaining gaps.

Ongoing technical support is given to the PSA teams by those with more PSA experience.

Logistics support is usually provided by the organisation that is carrying out the assessment.

### **Accessing key populations in the site**

PSA teams access the individuals and groups with whom they need to talk in an opportunistic manner; however, they must respect the needs and wishes of key population members with regard to privacy.

The key populations who are asked to share information during PSA should not be put at any kind of risk during the process, nor should participation in the process lead to a loss of income or clientele.

### **Introducing participatory site assessment methods**

The purpose of PSA and the methods involved are explained to all key population members approached by the PSA team. Those who are approached can then choose to participate or not. They are informed that the session will last about 40 minutes, and they are not obligated to stay to the end of the session if they do not wish. They are told where the session will be held, how the information they share will be used and kept secure, and that their participation in the PSA will remain anonymous.

PSA teams carry letters of introduction or business cards from the contracting organisation so that key populations and others who participate in the PSA understand that the teams’ work is legitimate, as well as to provide contact information if they would like to find out more about the project.

### **Identifying safe spaces**

As part of PSA, the teams must identify safe spaces where groups of around 10 to 20 key population members can discuss together in privacy. The spot for each group discussion needs to be carefully chosen so as to be private and secure. This does not have to be indoors, but at a place where the group will not draw large crowds or attract unwanted attention.

When the group comes together, the PSA team members need to introduce themselves and the purpose of the exercise. A range of participatory methods is then facilitated with each group to help team members generate information about the site for analysis.

Usually the teams offer participants water and fruit during the session. Often they also carry condoms, lubricant, and referral information to distribute upon request.

At the end of each session, the facilitators ask the group to identify other relevant participants.

The PSA teams stop accessing groups and individuals when no new information is offered.

## Recording information

PSA teams must ask permission from the key population groups before recording information on charts, maps, and drawings. These documents should be carefully labelled to include the:

- 1 Site name.
- 2 Hotspot name.
- 3 Number of people in the group.
- 4 Names of PSA team facilitators.

## The names of key population participants must not be recorded.

Other information should be noted in field diaries or on the charts themselves. Those who do not keep field diaries should easily be able to recall details of the discussion when reviewing the charts.

## Preliminary analysis

Each day, the PSA teams should review their “picture” of the key population situation at the site in order to fill in any gaps in information, and to recognise any overlaps or contradictions. The teams need to carefully consider and deliberate on the strength of the data generated.

At each daily review, the team should include new information in the overall picture, and make decisions regarding where to go and with whom to talk the following day in order to strengthen the existing picture.

Composite number maps of each hotspot should be developed by the PSA teams as new information from each session is analysed. This prevents double-counting, since landmarks characterise the boundaries on the maps and it is easy to see if there are overlaps (or gaps) in the estimates.

Other information from the sessions should be recorded using easy-to-use tools that are developed according to the needs of each project.

## Information security

Issues of security and/or privacy are of prime importance when mapping people whose behaviours are either outlawed or highly stigmatised, since estimates of group sizes and other information could be used against the key populations.

## Step 4: Compiling and analysing participatory site assessment findings

### Preparing feedback

Before providing feedback to organisations and stakeholders in the site, PSA teams must get together to share experiences and finalise their records. Often, multiple sites are assessed at the same time, so this is a good opportunity for different teams to share findings and insights with one another.

*To safeguard the interests of key population groups in the sites, it is vital that charts, maps, and other recorded information are kept confidential and in a secure place.*

During this time, PSA teams must prepare presentations on the PSA process, methods, and findings. This includes recommendations on the design or redesign of HIV prevention projects.

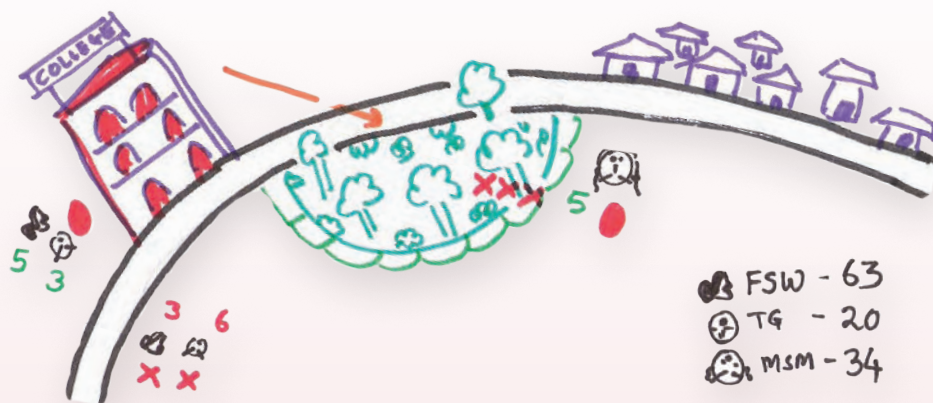
A great deal of information is generated during PSA. However, written reports are usually not needed, since the composite maps and charts generated during the PSA guide subsequent discussions and action. If a site-level or multi-site report is required, the organisation conducting the PSA will need to organise staff or consultants to document feedback from the teams and prepare the report.

### Providing feedback regarding the findings from each site

Each team must present their PSA findings in the site in which they worked. Usually this happens over one or two days. Key stakeholders, organisations, and local key population members are invited to hear and verify the findings and to discuss the implications for HIV prevention interventions.

Feedback generally includes the following components:

- Key population numbers.
- Characteristics of key population subgroups.
- Number and descriptions of hotspots.
- Times when key population members are available for interventions.
- Number, type, accessibility, and quality of existing services and commodities.
- Gaps in communications, services, and commodities.
- Information on injection drug use, sexual practices, and sexual partners.
- Vulnerability factors.
- Information on structural barriers to risk reduction.
- Risk-reduction practices and techniques currently used by key populations.







# Section D: Participatory Site Assessment Methods

A range of participatory, visual methods can be used in conducting a PSA. These include participatory site mapping, mobility charts, pie charts, drawings, seasonal and daily trend charts, causal diagrams, and flow charts. These are all based on a participatory learning and action approach.

The tools are designed to make the discussion of sensitive issues (sexuality, sexual behaviour) easier by focusing on the context within which such behaviours occur rather than focusing on individual people. Visual tools provide a valuable record of discussions and are useful in bypassing the need for a literate audience. Using visual tools also means that there is greater triangulation, since gaps and double-counting errors become evident.

PATH's experience has shown that the participatory nature of PSA is valued by key populations, who regard it as a practical learning exercise, especially when it is facilitated by trained peers. It also provides them with a unique opportunity to have someone listen to them talk about their lives and experiences. As such, key populations do not view the PSA process as an imposition on their time.

## Why are visual methods used?

Visual methods are used in PSA because:

- Literacy is not a prerequisite for participant involvement.
- They do away with the need for technical jargon and thereby enable key populations to use language with which they are familiar.
- Visual representations (situations) rather than individual (personal) behaviours are discussed; therefore, risk behaviours can be discussed as “general practice” rather than as personal behaviour.
- They provide a transparent record of discussions for post-session use by key populations and the PSA teams.
- They foster ownership and internalisation of discussion. Key populations learn through practice—by using their pictorial representations as a basis to problem-solving and working around barriers to HIV/STI risk reduction.
- Misinformation/myths can be corrected and gaps in information plugged during analysis of the visual representation.
- They can help build the problem-solving skills of key populations.

## Five easy-to-use participatory site assessment methods

A PSA can be executed using a number of different methods. The following five methods have proved both productive and easy to facilitate:

- 1** Broad mapping.
- 2** Numbers and trend mapping or “How hot is the spot?”

- 3 *Seva chitram* or services mapping.
- 4 *E-gya-ke?* or “Why is it so?”
- 5 Sex life.

Each method takes between 20 and 60 minutes to facilitate.

The only materials needed are large flipchart papers and marker pens.

***Each session should start with an icebreaker to put participants at ease.***

***At the end of each session, give the group time to reflect on what they shared and learnt during the session, then thank them for their time.***

At the end of the session, note on the back of each chart paper, the date, place, number of participants in the session (disaggregated by key population categories), and the PSA team number or the names of the PSA team members who facilitated the session.

Whilst facilitating the methods, let participants discuss amongst themselves to reach a consensus, especially when estimating numbers. Note any differences in participants’ points of view.

PSA team members should work in pairs for sessions with the groups. One person can facilitate the discussion and make sure every point of view is heard. The other can take notes, listen, and ask questions.

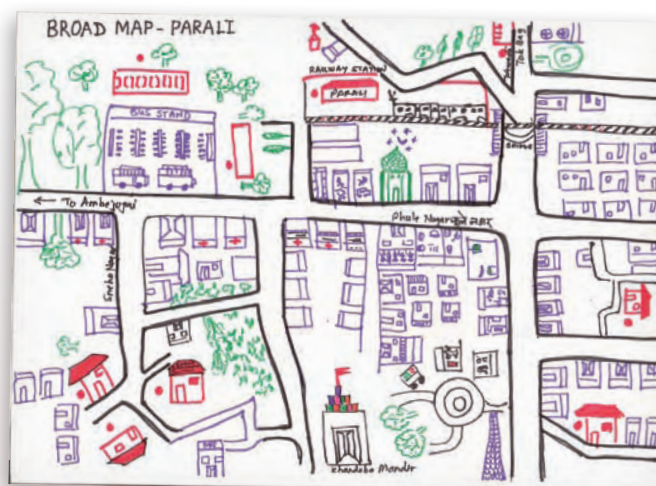
## Method 1: Broad mapping

### Purpose

A broad map provides PSA teams with a geographical and social overview of a site, including details regarding site landmarks and the locations of key population hotspots. Information about key population categories present at the site and about their mobility patterns can also be collected.

### Participants

This method is to be used with the general population as well as the key populations in the site. The PSA team can approach auto drivers, local shopkeepers, flower vendors, lodge owners, petty vendors, and liquor vendors, amongst others, near public parks and theatres and where key populations tend to gather. Anybody from the area (including key populations) who is familiar with the key populations and with the area can be involved in drawing the map.



### Locations

Anywhere within the site—usually within the vicinity of likely hotspots.

### Process

- 1 Start by asking general questions about the site. Spread chart paper on the ground, hand out sketch pens, and request the participants to draw the geographical outline of the area.

- 2** Request participants to mark the important landmarks in the area. Whilst marking landmarks, services such as government hospitals, popular dispensaries, and NGOs can also be marked on the emerging map.
- 3** Next, ask participants to mark the specific locations or hotspots where key populations tend to congregate.
- 4** Whilst the participants draw the map, ask them probing questions to generate information on categories of key populations at different hotspots. Note key information in a field diary.
- 5** Ask specifically about the mobility patterns of key populations—migration to and from the site as well as within the site. Obtain information on who migrates from where, which places they come from, which places they go, why they do so, when they do so, and in what numbers.

***At the end of the session, give the group time to reflect on what they shared and learnt during the session, then thank them for their time.***

## Method 2: Numbers and trend mapping or “How hot is the spot?”

### Purpose

To estimate the number of members of each different key population group and to find out how often they visit the hotspots.

### Participants

Visible and self-identified key populations.

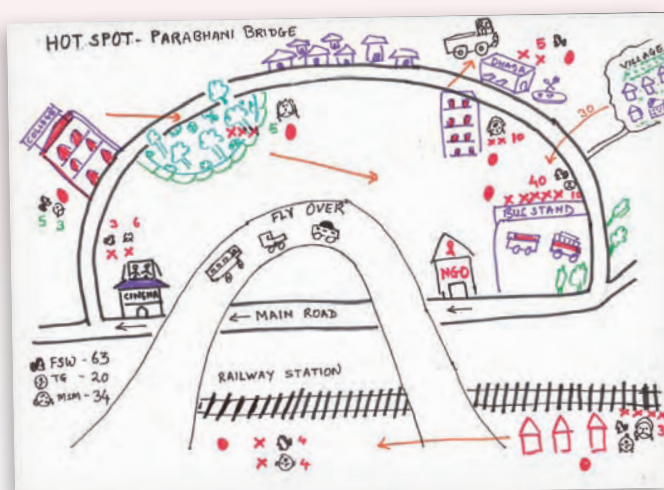
### Locations

All hotspots identified on the broad map. In addition, other hotspots that might be identified through the course of the PSA implementation.

### Process

- 1** Ask the group to draw a map of the hotspot, including any local landmarks to orient the map.
- 2** Ask the group to rank the hotspot using symbols for “high”, “medium”, and “low” to indicate the level of risk of HIV/STI infection amongst the key populations within the hotspot.
- 3** Ask the participants why they have marked the hotspot high, medium, or low. Is it according to (a) numbers of key population members who frequent that hotspot, (b) the particular risk practice usually carried out at the hotspot which may be associated with different levels of risk of HIV/STI transmission, (c) the frequency of risk practice, or (d) any other reason.
- 4** Ask participants to suggest general changes in order to downgrade a high hotspot to a medium or low hotspot. Then ask what individual key populations or small peer groups might do to reduce risk in this location.
- 5** Ask participants to estimate the number of key population members from each category who visit the hotspot on an average day. Ask participants to use different symbols for different categories of key populations and to place the corresponding number next to each symbol (numbers can be represented through symbols, too).

- 6 Ask participants to draw a clock (or a line representing 24 hours of a day) and indicate the times of day when the key population members they mentioned might be found at the hotspot. Ask them to mark with + and - signs, or with spots or bindis, to indicate how the number of members of each key population group who visit the hotspot might fluctuate throughout the day.
- 7 Ask participants to draw a line indicating seven days of a week and ask them to similarly mark the line to indicate fluctuations during a week.
- 8 Ask them to place symbols next to the hotspot(s) to indicate events or festivals in a year when the number might significantly go up or down.



**At the end of the session, give the group time to reflect on what they shared and learnt during the session, then thank them for their time.**

## Method 3: *Seva chitram* or services mapping

### Purpose

This is a method to assess the availability of services within the site and key populations' access to them.

### Participants

Visible and self-identified key populations.

### Locations

All hotspots identified on the broad map, and any other hotspot that might be subsequently identified through the course of the PSA.

### Process

- 1 Ask the participants to draw a map of the site, including key landmarks. Then, ask them to indicate the hotspot where the key population PSA team contacted them.
- 2 Ask the participants to identify any places or people on their map from which the key population group to which they belong can access HIV/STI prevention and treatment.
- 3 Ask the participants to mark the following next to each intervention:





- At the end of the session, give the group time to reflect on what they shared and learnt during the session, then thank them for their time.

## Purpose

WHY IS IT SO?

The diagram is a hand-drawn mind map. At the center is a circle containing a hammer icon with a red 'X' over it. Eight arrows radiate from this central node to eight peripheral nodes, each containing a different icon: a person with a heart, a person with a red cross, a person with a red cross and a heart, a person with a red cross and a heart, a person with a red cross and a heart, a person with a red cross and a heart, a person with a red cross and a heart, and a person with a red cross and a heart.

Visible and self-identified key populations.

All hotspots identified on the broad map, and any other hotspot that might be subsequently identified through the course of the PSA.

- 1 Ask participants to identify the types of behaviours that put people at risk of HIV/STI infection. Correct any misconceptions.
- 2 Pick any one of the risk behaviours.
- 3 Ask participants to mark this risk behaviour on the flipchart with a symbol drawn inside a circle.
- 4 Ask “Why is it so?” Invite them to draw and/or write the reasons for the risk behaviour in balloon call-outs.
- 5 Persistently ask “Why is it so?” Add reasons in connecting balloons until participants can think of no more.
- 6 Ask the participants what the diagram says about the following:

- What are the most important reasons (vulnerability factors) for risky behaviour?
- What are the ways in which key populations try to reduce risk behaviour?
- What further measures would help key populations avoid the risk behaviours marked in the diagram?

At the end of the session, give the group time to reflect on what they shared and learnt during the session, then thank them for their time.

## Method 5: Sex life

### Purpose

This method can be used to explore the number and range of sexual partners that a key population member has (e.g., clients, panthis, boyfriend/husband, fellow kotis, wife, other women). It also indicates the kinds of sexual acts that key populations usually practice with their sexual partners. This helps estimate the extent of penetrative sex and the project demand for condoms.

### Participants

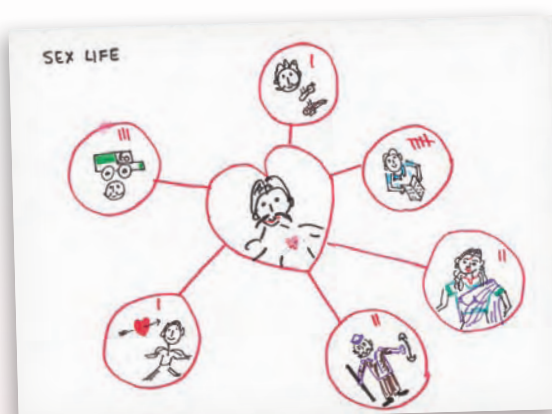
Visible and self-identified key populations.

### Locations

All hotspots identified on the broad map, and any other hotspot that might be subsequently identified through the course of the PSA.

### Process

- 1 Administer this method on a one-to-one basis with individuals from different key population categories.
- 2 Ask the key population member to draw a figure at the centre of the flipchart paper that represents him or herself.
- 3 Next, ask the participant to draw figures around this figure that represent his/her sexual partners. Call upon him/her to describe the partners (without naming them).
  - Who are they?
  - What do they do?
  - How old are they?
  - How are they related to the key population?
  - How they met.
  - Other questions as required.
- 4 Then, ask the key population member to indicate next to each partner's figure the number of times he/she practiced sex with that person in the previous week, as well as the nature of the sexual encounter (anal, vaginal, oral, nonpenetrative, etc.).



***At the end of the session, give the participant time to reflect on what he/she shared and learnt during the session, then thank him/her for his/her time.***

# Section E: Maintaining the Quality of Participatory Site Assessment

The following is a list of 17 basic standards for conducting PSA. The standards in this guide are useful only to the extent that users are committed to honest and critical reflection, and can be used by organisations to identify their own capacity-building needs, plan technical support, and monitor and evaluate their PSA progress.

These standards are not “indicators” that can be objectively measured; rather, they are designed to stimulate discussion within the organisation so that creative ways to optimise their PSA process can be found. The capacity standards should be used in planning, then checked throughout the PSA.

## Participatory site assessment standards

- 1** PSA team members recruited must be acceptable and credible to the key populations in the site. ✓
- 2** PSA teams must be made up of representatives of the different subgroups of key populations in the site, and at least one in four should have good literacy and mathematical skills for recording basic data. ✓
- 3** PSA team members must be recruited and remunerated as consultants. Their knowledge of and insights into the lives and vulnerabilities of other key populations means that they can provide specialised, expert inputs for the project, and this needs to be acknowledged. ✓
- 4** PSA team members must be selected in a transparent way so that key population groups in the site feel that those selected have been chosen fairly and on merit. ✓
- 5** A risk assessment should be carried out to understand possible risks and gains for PSA team members and to develop mechanisms for maximising gains, reducing risks, and minimising potential harm. ✓
- 6** PSA team members should be trained for a minimum of eight days. Training should be participatory and cover PSA objectives and methods, HIV, power, gender, and sexuality. A code of conduct for fieldwork should be developed during the training, and at least 30 percent of PSA training should be devoted to methods and field practice. A group of stakeholders from the site should be invited to attend one session during the training to hear and verify feedback from fieldwork practice. ✓
- 7** The presence of people who are not from the key populations should be minimal during training, so that the PSA team members gain confidence, and so that training can be geared toward their own pace and needs. All who attend the training should participate fully on all days. ✓
- 8** During PSA implementation, logistics support, and where necessary, technical assistance should be available for the PSA team members. PSA team members should carry project identification, and have access to someone in authority 24 hours a day for the duration of the PSA, in case they run into difficulties. It is useful to have experienced key population PSA facilitators embedded with each team who can mentor the team throughout the process. ✓

- 9** PSA team members should be equipped with sufficient flipchart paper, pens, post-it notes, and other stationery required to facilitate the PSA methods. They should be given the means, when necessary, to offer simple refreshments to their participants. They should also carry supplies of condoms and lubricants. ✓
- 10** PSA team members should not be asked to take photographs of participants during the PSA, unless a process for informed consent was established prior to the PSA. ✓
- 11** As a first step in PSA implementation, team members, and if necessary, project workers, should explain the process to local authorities and gatekeepers and request their cooperation. PSA happens at times when key populations are active, very often at night and in difficult environments, so it is crucial that team members and project workers have the support of those with power in the site. ✓
- 12** PSA teams need to spend the first few days compiling a broad map of the site, to locate the hotspots and to map mobility within and to and from the site. The PSA teams should then visit those hotspots with the highest level of activity, to carry out focused mapping. Focused mapping involves estimating the number of members of each different type of key population, analysing service provision, identifying the context within which risk behaviour takes place, and generating other information useful for project design. ✓
- 13** Methods used in PSA should be dialogue-based, highly participatory, and give the opportunity for key populations in the site to analyse barriers to reducing HIV risk and find solutions. In other words, as well as generating information for assessment, PSA should mobilise key populations and strengthen their ability to critically reflect on reducing HIV risk. ✓
- 14** Reporting formats should be developed that are easy for PSA team members to use. The teams should meet at the end of each day to assess the information generated, look at what gaps still remain, and plan PSA activities for the following day. ✓
- 15** During the PSA, the teams need to be very careful to keep information secure and confidential. They must also take care not to make false promises or raise unrealistic expectations about what will happen after the PSA. ✓
- 16** At the end of the PSA, a feedback and project design or planning meeting needs to be held immediately. All the main stakeholders, including the PSA team members and key population representatives from the site, should be present. The PSA team members should have time before this meeting to organise how they will present the findings, to make sure that confidentiality is maintained. ✓
- 17** If nothing happens, or there are no changes in the site after PSA, the momentum will be lost. Prior to PSA, funding must be secured for follow-up activities. Any activities initiated by the key populations themselves as a result of the PSA should be applauded and supported. ✓

# Section F: Sample Participatory Site Assessment Training Schedule

Day	Session 1	Session 2	Session 3	Session 4	Evening session
<b>1</b>	Understanding key population contexts: Who are we?	Understanding key population contexts: HIV risks and vulnerabilities (PSA method: Why is it so?)	Focused prevention: What it is, and the role of key populations	The what and why of PSA	Group activity on team-building
<b>2</b>	Understanding HIV/STI transmission	PSA methods: Broad mapping, numbers and trend mapping	PSA method: How hot is the spot?	PSA method: How hot is the spot?	Cultural performance by volunteers from amongst training participants
<b>3</b>	PSA method: Services mapping	Facilitation skills 1	Methods practice exercise at venue	Methods practice exercise at venue	Free
<b>4</b>	Review of methods practice: What have we learnt?	Working with key populations: Attitudes and values 1	PSA method: Services mapping	Planning fieldwork practice	Group activity on team-building
<b>5</b>	All-day field practice				
<b>6</b>	Review of fieldwork practice	Facilitation skills 2	PSA standards	PSA standards	Team game on gender
<b>7</b>	Working with key populations: The question of power	PSA method: Sex life	Methods practice exercise at venue	Methods practice exercise at venue	Group activity on team-building
<b>8</b>	All-day field practice				
<b>9</b>	Review of findings from fieldwork practice; invite local NGOs and key populations to verify findings	Lessons learnt regarding PSA implementation	Planning for PSA implementation	Planning for PSA implementation	Closing dinner







