National Guidelines for **Implementation** of **HIV Prevention Programmes** for **Female Sex Workers** in Nigeria

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National Guidelines for **Implementation of HIV Prevention Programmes for Female Sex Workers in Nigeria**

National Agency for the Control of AIDS,
Government of Nigeria

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Foreword

In the three decades of the global HIV/AIDS epidemic, more than 60 million people have been infected and over 30 million have died from AIDS-related causes. Nigeria has the second highest burden of HIV, with over 3.2 million people living with HIV. The major route of transmission of HIV is through sexual transmission (accounting for about 80% of HIV infections). The Most at Risk Populations (MARPs) including female sex workers contribute about 23% of new HIV infections and with their partners' contribute 40% of new infections.

In both concentrated and generalised epidemics, HIV prevalence is considerably higher among sex workers than in the general population. There are numerous reasons for this, including the type of work in which sex workers engage, unsafe working conditions, barriers to the negotiation of consistent condom use and unequal access to appropriate health services. Violence, alcohol and drug use in some settings also increase vulnerability and risk.

It is necessary to develop national guidelines that aims to improve the effectiveness and efficiency of HIV prevention programmes and services. The National Guidelines for Implementation of HIV Prevention Programme for Female Sex Workers in Nigeria is one of such guidelines that has been developed to provide strategic and operational information and guidance for the prevention of HIV infection among Female Sex Workers (FSWs). Strategically focused programmes for FSW using the combination prevention approach can help address social barriers to health and poor health-seeking patterns especially among female sex workers.

The purpose of this document is to support and strengthen the capacity of organisations and field workers to provide appropriate HIV prevention programming for female sex workers. This guideline is designed for use by public-health professionals, managers of HIV, AIDS and STI programmes, NGOs, including community and civil-society organisations; and health workers. Health workers, programme managers, community and local leaders should encourage high risk groups including sex workers to access HIV prevention methods and commodities and HIV testing services and HIV treatment. Emerging opportunities should be seized not only to promote the standardised implementation of HIV prevention programmes but to encourage appropriate structures that facilitate the efficient roll out of the HIV prevention programme.

It is hoped that these guidelines will serve as an important tool that will assist implementers at all levels in ensuring efficient and effective standardised perspectives in the planning and implementation of HIV prevention programmes to improve the health of female sex workers and their networks.

Prof. John Idoko
Director General, NACA

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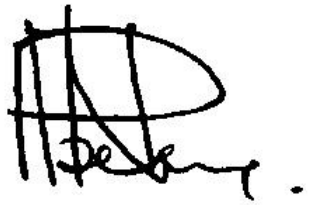
The exemplary leadership of Prof. John Idoko, the Director General of NACA, and drive to halt the HIV epidemic in Nigeria is commendable. The contributions of the Directors; Dr. Akudo Ikpeazu, Dr. Kayode Ogungbemi and Hajia Maimuna in developing this national guidelines are highly appreciated. NACA appreciates the dedication, support and efforts of members of the National Prevention Technical Working Group (NPTWG), staff of the Sexual Prevention Unit (Programme Coordination Department, NACA) for their overall guidance and direction in preparing this national guidelines.

Special commendation also goes to the University of Manitoba (UoM) team—local and international and the India Learning Network (ILN)—Bridge Project funded by the Bill and Melinda Gates Foundation (BMGF) under the South to South Initiative who helped with the process of thinking through and developing this national guidelines. Their unflinching financial and technical support made the process of developing and producing this plan an easy and seamless one. The initial printing of this document was made possible by the support of the (ILN)-Bridge Project. However, the contents of the report are the sole responsibility of NACA.

The process would not have been possible without the contributions of Project Managers, SACAs, CSO networks and the private sector. The financial and technical support of our development partners including the USG, UNAIDS, UNFPA, UNICEF, FHI 360, IHVN, the Society for Family Health (SFH) and the World Bank. We are especially thankful to all the community members and programme staff whose experiences have enriched this document.

Finally, the efforts of the NGOs, FBOs, CBOs, health care workers, community leaders and all others who have been on the field making it happen and providing all the support for the successful implementation of HIV prevention efforts in Nigeria are duly acknowledged. All your efforts are all coming together to enable us write a national HIV prevention success story.



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Abbreviations and Acronyms

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
BBFSW	brothel based female sex worker
CASI	computer-assisted self-interviewing
CBO	community-based organisation
CC	community committee
CCM	Community Committee member
CGPH	Centre for Global Public Health
CRIFF	Condom Requisition Information Forecasting Form
CSO	civil society organisation
CTX	cotrimoxazole
DIC	drop-in centre
DOTS	direct-observed therapy
FCT	Federal Capital Territory
FSW	female sex worker
GBV	gender-based violence
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
HPV	human papillomavirus
HSV2	herpes simplex virus 2
IBBS	Integrated biological and behavioural surveillance
IDU	injection drug user
LGA	Local Government Area
M&E	monitoring and evaluation
MARP	most at risk populations
MNCH	maternal and neonatal child health

MPPI	Minimum Prevention Package Intervention
MSM	men who have sex with men
NACA	National Agency for the Control of AIDS
NBBFSW	non-brothel based female sex worker
NGO	non-governmental organisation
NNRIMS	Nigeria National Response Information Management System
NPTWG	National Prevention Technical Working Group
OI	opportunistic infection
PBS	polling booth survey
PE	peer educator/peer education
PEP	post-exposure prophylaxis
PEP	peer education plus
PITC	provider-initiated counselling and testing
PITT	prevention intervention tracking tool
PLHIV	people living with HIV/AIDS
PM&E	participatory monitoring and evaluation
PMTCT	prevention of mother-to-child transmission
PPS	population size
SACA	State Agency for the Control of AIDS
SFH	society for family health
SOP	standard operating procedures
SSP	state strategic plan
STI	sexually transmitted infections
STPWG	State Prevention Technical Working Group
TB	tuberculosis
UOM	university of Manitoba
USP	uniformed service personnel

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Introduction

Nigeria is a federation, made up of the Federal Capital Territory (Abuja) and 36 States. The states are grouped into six geo-political zones: North West, North East, North Central, South West, South East, and South South. The national HIV prevalence among the general population was estimated at 3.4 percent in 2012,[1] and in 2010 the national HIV prevalence among women receiving antenatal care was 4.1 percent[2]. The HIV epidemic in Nigeria is complex, with substantial differences in HIV prevalence across different regions and subpopulations and with diverse factors driving the epidemic. The ANC 2010 survey showed that HIV prevalence among women accessing antenatal care (ANC) ranged from 2.3 percent in Ondo State to 12.7 percent in Benue State. Integrated biological and behavioural surveillance (IBBS) surveys were completed among key populations (female sex workers (FSWs), injection drug users (IDUs), and men who have sex with men [MSM]) in a few states in 2007. Among brothel-based female sex workers (BBFSW), HIV prevalence was found to range from 23.5 percent in Lagos to 49.2 percent in Abuja. Given the high prevalence of HIV prevalence among some key populations and the range of HIV prevalence across different parts of Nigeria, it is important to develop HIV prevention programmes at the local level to ensure that they will be as effective and efficient as possible in the local context. To do this, prevention strategies should be designed according to what is known about the local epidemic, considering both the epidemic's phase, local transmission pathways, and which specific populations have the highest prevalence (whether key populations, such as sex workers, or the general population, or both).

Female sex workers (FSWs) are particularly vulnerable to HIV and sexually transmitted infections (STIs) and, in many regions of the world, have a high burden of HIV infection. The vulnerabilities faced by FSWs relate not only to their individual risk behaviours but also to broader societal and community factors, including cultural norms, social marginalization, and criminalized work environments that limit their opportunities and access to services and make them vulnerable to discrimination and violence. Interventions designed to prevent HIV among FSWs will not only improve the health of individual sex workers but may slow down HIV transmission among the wider population connected to sex workers and their clients. Early

[1] Federal Ministry of Health, "National HIV/AIDS and Reproductive Health Survey, 2012," (NARHS Plus, Abuja, Nigeria: FMOH, 2013).

[2] Federal Ministry of Health, "National HIV Sero-prevalence Sentinel Survey, 2010," (Abuja, Nigeria: FMOH, 2010).

interventions in countries as diverse as Brazil, India, and Thailand have succeeded in reducing STI transmission in sex work. However, to be successful, these targeted HIV prevention programmes need to reflect both the broader structural (within the society and the community) and environmental challenges and respond to local issues as well as to the concerns of sex workers.[3]

Rationale for Developing these Guidelines

Given that the HIV epidemic in Nigeria is a complex, mixed epidemic, there is a need for rapid implementation of HIV prevention interventions targeting key populations at greatest risk of contracting HIV, populations that frequent high-risk venues and are involved with high-risk networks, and for behaviour change among members of the general population. HIV prevention among key populations such as sex workers should be prioritized in most parts of Nigeria. HIV prevention programmes must be tailored to specific contexts to ensure that the prevention response is appropriate and to make certain that resources are allocated to interventions that will have the greatest impact and make good use of the available funding.

Purpose and Structure of these Guidelines

The purpose of these guidelines is to outline the principles, procedures, and activities involved in developing and implementing evidence-based HIV prevention programmes reaching a large proportion of FSWs in Nigeria and to then evaluate these programs. Specific tools adapted to the Nigerian context are included in the Annexes.

Chapter 1 explains the rationale for HIV prevention interventions for FSWs, and presents the characteristics of this population, including their increased vulnerability to HIV. Chapter 2 provides an overview of the basic principles of HIV prevention among FSWs and the key programme components. Chapter 3 details these key programme components, categorised as outreach and behavioural interventions, biomedical interventions, and structural interventions for vulnerability reduction. Chapter 4 describes the approach to managing and scaling up HIV prevention programmes for FSWs, including how to use data to plan evidence-based programs. Chapter 5 describes an approach to programme monitoring and evaluation, including the measurement of outputs and outcomes.

Annexes with specific tools for mapping, programme implementation, management, and monitoring and evaluation are provided at the end of the Guidelines. These tools have been adapted for use in the Nigerian context.

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[3] WHO, "Prevention and Treatment of HIV and Other Sexually Transmitted Infections (STIs) for Sex Workers in Low- and Middle-income Countries, Recommendations for a Public Health Approach," (unpublished).

In Nigeria, female sex workers are at high risk of becoming infected with HIV. It is important to deliver high-quality HIV prevention programmes to female sex workers in a way that is likely to be most effective in the local area.

These guidelines are intended to provide non-governmental organisations and community-based organisations with an overview of the steps and tools needed to plan, implement, monitor, and improve the HIV prevention programmes that they deliver for female sex workers.

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Chapter 1. HIV Epidemiology and Sex Work in Nigeria

The first step in setting priorities for HIV prevention programmes is to understand the epidemic and what drives HIV transmission locally. This involves understanding the transmission dynamics that can indicate in which specific populations HIV prevalence and transmission is high. HIV epidemics can be considered to fall into one of three main categories (also called "typologies")[4]:

1. **Concentrated Epidemics** – An epidemic is classified as "concentrated" if effective HIV prevention among clearly identified key populations that are most at risk for HIV (e.g., sex workers, injection drug users [IDUs], and MSM) will halt, reverse, and control the epidemic.

2. **Generalised Epidemics** – "Generalised" epidemics are those in which the general behavioural patterns within the population drive the epidemic and clearly identified sub-populations that are most at risk contribute very little to the overall epidemic.

3. **Mixed Epidemics** – "Mixed" epidemics are a blend between concentrated and generalised epidemics. This means that there are important key populations (also called "most at risk populations" or MARPs) that contribute substantially to the epidemic, but among which the control and reversal of the epidemic cannot be fully realized with HIV prevention targeted only to those key populations. Instead, a combination of HIV prevention programmes that focus on MARPs and other vulnerable populations—including key segments of the general population—is required to control the HIV epidemic.

1.1. Nigeria's HIV Epidemiology

Overall, Nigeria has mixed HIV epidemics that vary in prevalence and transmission dynamics across different regions and populations, and there are indications that some states have mostly concentrated epidemics. In 2012, the average state HIV prevalence among the general

[4] D. Wilson and D.T. Halperin, "Know Your Epidemic, Know Your Response": A Useful Approach, If We Get it Right (Lancet 2008;372), 423–6.

population was 3.4 percent but was over 15 percent in certain geographic areas.[5] In addition, there is evidence of a high HIV prevalence among key populations at greater risk of HIV, particularly among FSWs (up to 46 percent in certain locations) and MSM (up to 37 percent), as well as substantial opportunities for transmission among IDU.[6] Also, other populations are at high risk of contracting HIV through high-risk venues and networks.

In the context of mixed epidemics, there is an urgent need for HIV prevention interventions that target key populations at greatest risk of contracting HIV, such as sex workers, MSM, and populations that frequent high-risk venues or are involved with high-risk networks. Finally, there also is a need for behaviour-change programmes among members of the general population. HIV prevention programmes must be tailored to a specific context to ensure that the prevention response is appropriate and that resources are allocated to interventions likely to be most efficient and have the greatest impact.

1.2. Rationale for Targeted Interventions among FSWs in Nigeria

It is important to understand that FSWs may be hesitant to access programmes and services, yet they may nevertheless be in need of them. There is also a public health obligation to protect and promote the health of FSWs and clients and to interrupt transmission to and from these subpopulations as a means of controlling STIs and HIV epidemics more broadly in Nigeria.

Among FSWs in 50 low- and middle-income countries, the overall HIV prevalence was 11.8 percent, ranging from 1.7 percent in the Middle East and North Africa to 36.9 percent in Sub-Saharan Africa, which is substantially higher than the prevalence among the general population in these regions.[7] In Nigeria, the highest recorded HIV prevalence of 27.1 percent was observed among BBFSWs, followed by 21.7 percent among NBBFSWs.[8]

Clearly, HIV infection among FSWs plays an important role in the development of HIV epidemics in many regions of the world and has significant potential to cause HIV transmission to the general population, with male clients serving as the bridging population.[9]

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5 NARHS Plus.

6 Federal Ministry of Health (FMOH), "Nigeria Integrated Biological and Behavioural Surveillance Survey (IBBSS)," 2010.

7 S. Baral, C. Beyrer, K. Muessig, T. Poteat, A. L. Wirtz, M. R. Decker, S. G. Sherman, D. Kerrigan, Burden of HIV among Female Sex Workers in Low-Income and Middle-Income countries: a Systematic Review and Meta-analysis, (Lancet Infect Dis., 2012, Mar 14).

8 IBBSS.

9 Niccolai LM, Odinokova VA, Safiullina LZ, Bodanovskaya ZD, Heimer R, Levina OS, Rusakova MM. *Clients of Street-Based Female Sex Workers and Potential Bridging of HIV/STI in Russia: Results of a Pilot Study* (AIDS Care. 2012, Jan 31). Pan S, Parish WL, Huang Y. *Clients of Female Sex Workers: A Population-based Survey of China*. (J Infect Dis., 2011 Dec 1, 204 Suppl 5) S1211-7.

Nigeria has a large population of FSWs. Mapping conducted in key cities and towns in eight states across Nigeria in 2012/3 identified 10,581 active FSW spots. Lagos had the highest number of spots, accounting for 40 percent of the spots, followed by the Federal Capital Territory (FCT) and Nasarawa. Also, Lagos had the highest estimated number of FSWs (46,691), followed by FCT (24,376)[10].

In Nigeria, the implementation of HIV prevention interventions targeting FSWs should be prioritized, and informed by input from the local population as well as by epidemiological data.

1.3. Definitions and Typology of FSWs in Nigeria

Female sex workers are women who exchange anal, vaginal, and/or oral sex for money or other items of value, primarily with men. In Nigeria, most sex workers are female. FSWs operate throughout the country and are diverse in age, socio-economic status, and the ways in which they are involved in sex work. For example, the way sex work is practiced can differ in terms of:

- *Frequency and pattern of sex work* – how often and when a FSW has clients and whether she defines herself as a sex worker.
- *Setting of sex work* – brothel, street, home, bars/nightclubs/casinos, hotels/lodges, and other settings.
- *Price per clientele* – high, medium, or low price; related to type of sex act (e.g., anal vs. vaginal sex).
- *Management structure* – whether she works for a pimp or brothel madam and how these gatekeepers are involved; relates to the amount of autonomy FSWs have over their working conditions.

The operational characteristics (or typologies) of FSWs vary considerably across Nigeria. For example, in Lagos, 40 percent of FSWs were found to be based in hotels or lodges, 27 percent were based in bars, night clubs, or casinos, 21 percent were based in brothels, and 6 percent solicited in public places. However, in Nassarawa, 30 percent solicited in public places such as the street, 30 percent were based in hotels or lodges, while only 14 percent were based in bars, nightclubs, or casinos, and 10 percent based in brothels.[11] These differences highlight the importance of understanding the local presence and distribution of different sex worker

[10] NACA, HIV Epidemic Appraisals In Nigeria: Evidence for Prevention Programme planning and Implementation, Data from the First Eight States (Abuja, Nigeria: 2013).

[11] "HIV Epidemic Appraisals In Nigeria Report."

typologies in order to design the most appropriate and effective HIV prevention programs. The list below describes the different typologies of sex work in Nigeria:

Brothel-Based Sex Work

Brothel-based sex workers operate from an establishment with a number of rooms that clients and SWs can use for sexual activities. Clients visit the brothel to drink and make contact with the sex workers. The client may use a room at the brothel or take the sex worker to another location. Madams who run these brothels usually facilitate the sex worker/client interaction and request a portion of the money the sex worker receives. Across the eight states in which mapping took place, 16 percent of sex work took place in association with brothels.

Street/Public-Based Sex Work

Street-based sex work is one of the most common and explicit types of sex work in the country. This type of sex worker solicits clients on the streets, in car parks, and/or other public places. Sexual services are provided on the side street, in the car, brothels, homes, or hotels. Taxi drivers or bar owners may facilitate access to FSWs but most FSWs operate independently. Across the eight states in which mapping took place, 14 percent of solicitation took place in streets and other public places.

Home-Based Sex Work

Home-based sex work is the exchange of sex for money in one's home, providing privacy. Clients contact sex workers directly and set up appointments to meet with them or they frequent the home of known sex workers. Across the eight states in which mapping took place, 5 percent of sex work took place in homes.

Venue-Based Sex Work: Bars, Night Clubs, and Casinos; Hotels and Lodges

Venue-based sex workers exchange sex for money in a designated location. These venue-based sex workers operate from locations such as bars, nightclubs, and hotels and lodges. Taxi drivers are known to facilitate this type of sex work. Across the eight states in which mapping took place, 28 percent of sex work took place in bars, night clubs, and casinos, and 32 percent of sex work took place in hotels and lodges.

Others

In addition to the specific sex work typologies noted above, there are a number of others that can be found in different settings. These include FSWs that work from hostels and university campuses, those who work from escort services and those that work from truck and trailer stops.

Key Messages

- → There are different types of FSWs.
- → Different types of FSWs may have different HIV prevention needs.
- → It is important to understand the particular mix of different types of FSWs in your catchment area in order to deliver the right kinds of services in the best way.

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Chapter 2. Programme Elements for HIV Prevention among FSWs

2.1. Basic Principles for HIV Prevention among FSWs

HIV prevention programmes should be developed locally to ensure that they match the local HIV epidemic and the needs of local FSW communities. This will ensure that funding is spent most effectively and programmes have the greatest impact on reducing new HIV infections among FSWs. HIV prevention programmes should be:

Evidence-based – information about the local HIV epidemic and the local FSW population should be used to plan what services to offer, how to deliver them, and what the programme targets will be. Programme implementers should conduct needs assessment for members of the FSW community to ensure that programmes will meet their needs and will be delivered in a way that will be acceptable to them.

- *Aligned with national guidelines* – The national guidelines developed by the National Prevention Technical Working Group (NPTWG) should be used to guide local programme implementation. This will also give validity to the programme. For enquiries about the national guidelines, contact the National Agency for the Control of AIDS (NACA) or other relevant authorities.
- *Community-centred* – the programme should consult with the FSW community and ensure that FSWs are involved in planning, running, and monitoring the programme. Members of the FSW community should be involved in the programme advisory committee. The programme should incorporate FSW community knowledge and develop the capacity of the FSW community to take ownership of it.
- *Integrated, in terms of risk and vulnerability reduction strategies* – the programme will not only focus on the biomedical (clinical) and behavioural interventions, but should also address vulnerability issues related to violence, stigma, and discrimination through structural interventions.
- *Cost-effective* – the programme should be cost-effective to ensure that funding is not wasted.

2.2. Key Components of HIV Prevention Programmes for FSWs

NACA advocates for a combination prevention approach that consists of behavioural, biomedical, and structural components for FSWs.

Behavioural interventions are offered directly to the sex workers by peer educators (PEs) through outreach, peer education, and condom distribution. Outreach is used to make initial contact with sex workers in their environment to connect them with programmes and services. The goal is to reduce the risk of HIV and STIs among FSWs. **Biomedical interventions** involve testing and diagnosis of infections, treatment, family planning, prevention of mother-to-child transmission, and other clinical services that improve the health of FSWs. **Structural interventions** address the critical social, political, and environmental systems and beliefs that increase the vulnerability of FSWs and contribute to the spread of HIV. The key elements of an HIV prevention programme for FSWs are summarized in Table 1 below and are described in the sections that follow.

Table 1. Key HIV Prevention Programme Elements

Key Component	Elements
Behavioural interventions	✓ Outreach ✓ Peer education ✓ Demonstration, promotion, and distribution of male and female condoms and water-based lubricants
Biomedical interventions	✓ STI Control and Management (testing and treatment) ✓ HIV Counselling and Testing ✓ PMTCT ✓ Condom and lubricant programming
Structural Interventions	✓ Community Mobilisation and Dialogue (empowerment and capacity building) ✓ Advocacy ✓ Individual Empowerment/Income-Generating Activities

2.3. Cross-Cutting Issues in Programme Implementation

In considering and implementing these guidelines, it is important for implementers, funders, and technical support agencies to consider the local context in which the programme is being

implemented. In particular, although there is a need to maintain consistency in the package of interventions provided to FSWs, the role of implementing agencies will likely differ depending on the availability of ancillary services in the private and public sectors. For example, the delivery of biomedical interventions such as STI management, HIV testing and counselling, and HIV treatment care and support can often be provided through referrals and linkages with local public and private sector providers. Similarly, the local social organisation of sex work and the local environment in which FSWs live and work differs; as such, it is important that implementers work closely with FSW communities to define priorities for structural interventions to reduce vulnerability.

Referrals and Linkages

Many of the key interventions—particularly biomedical interventions—might be provided through referrals and linkages to appropriate local service providers. In those cases, implementing organisations should ensure that the services are appropriate and acceptable to the local FSW community, that they are providing an appropriate range of services, and that they have effective referral and linkage systems to facilitate the use of these services by FSWs reached by the programme. This entails:

- Identifying appropriate local service providers through community consultations and local assessments;
- Developing mutually supportive relationships between the implementing organisation, the FSW community members, and the service providers; and
- Establishing an effective system for making and tracking referrals and service delivery.

In some cases, implementing organisations might require technical assistance in identifying and assessing appropriate service providers.

Local Adaptation in Structural Interventions

Structural interventions to reduce vulnerability form a core component of programmes for FSWs. However, the design and components of structural interventions might vary somewhat, depending on the local situation. In this regard, local assessments and planning with FSW communities should be incorporated into programmes to address key issues, including:

- Violence and harassment
- Stigma and discrimination, including exclusion from health and social services
- Economic vulnerability
- Low self-esteem and difficulty in contributing to community decision making
- Access to social entitlements

Therefore, each programme should engage in participatory assessments with FSW communities to prioritize vulnerability reduction activities and to develop appropriate local mitigation strategies.

Chapter 3. Managing and Scaling up HIV Prevention for FSWs

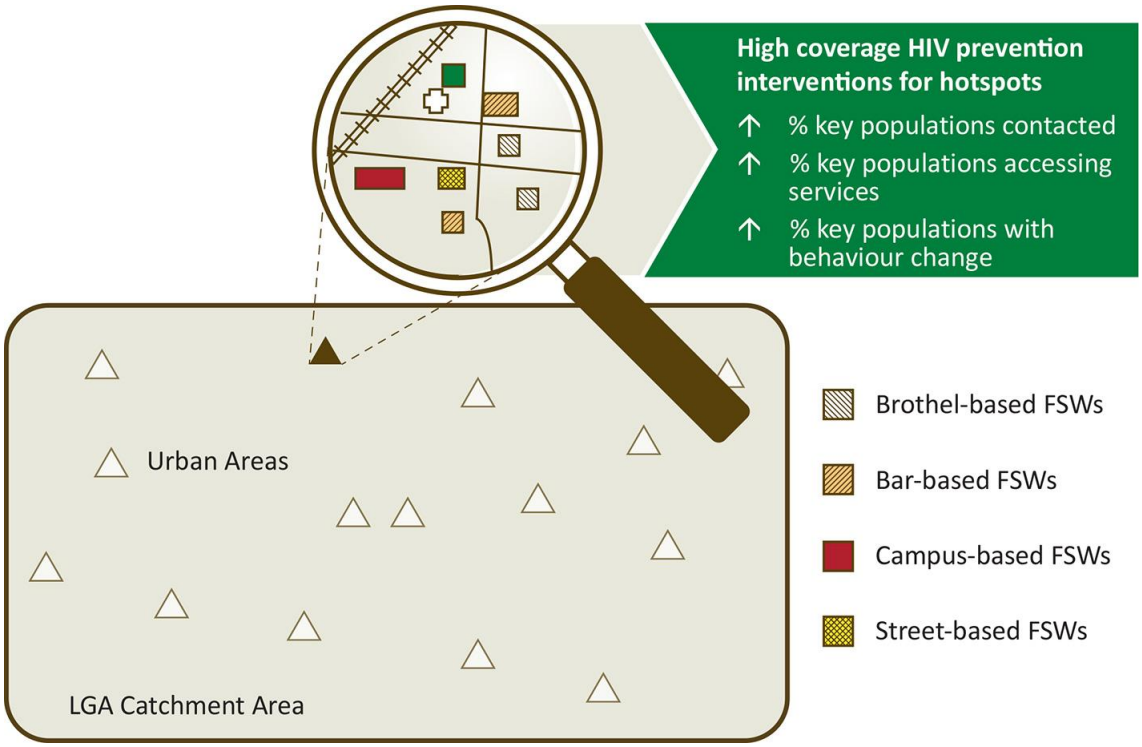
3.1. Using Data to Scale up HIV Prevention Programmes for FSWs

3.1.1. Coverage

HIV prevention programmes should aim to reach as many FSWs in their respective catchment areas as possible. Information about the number of FSWs in your catchment area and the way that this number was determined is available from your State Agency for the Control of AIDS (SACA). When planning your programme, it is important to understand how many FSWs your programme is targeting and to understand where they may be reached. Figure 1 provides an example of a map showing the areas where different types of FSWs spend time (these locations are called "hotspots"). These are good locations in which to deliver services, and knowing the type of FSW in different locations helps you to plan which types of services to provide in those locations and the best way to deliver them.

It is also important to track the number of FSWs your programme is reaching, with the aim of delivering services to at least 80 percent of them. Other indicators of programme success include having a high proportion of FSWs regularly accessing services and also demonstrating behaviour change. Your organisation can work with the SACA to find ways to regularly deliver services to a higher proportion of FSWs in your area. This may involve increasing the capacity of your organisation and/or partnering with another organisation to deliver the services.

Figure 1. Catchment Area Approach to HIV Prevention Intervention Design



3.1.2. Micro-Planning

Micro-planning is used to ensure that programmes and peer-led outreach are effective and efficient. Appropriate and effective planning and implementation of programmes to reach a high proportion of the key populations within hotspots are essential. Micro-planning has been developed on the premise that each hotspot and each sex worker in every hotspot have different risk and needs. The programme team should be able to understand this differential need and design a programme prioritising the needs and risks. Hence micro-planning involves the identification and/or validation of specific locations (hotspots) within the larger region where sex workers solicit or do sex work (mainly collected through mapping exercises) and the collection of more in-depth information about sex work in those locations. At the micro-level, achieving 100 percent coverage of sex workers within specific locations is the goal. Those locations or hotspots that have a high proportion of FSWs are prioritised for interventions. To perform micro-planning for each identified location or hotspot, programme teams, composed largely of local peer educators and outreach workers are needed. Peers have a unique understanding of the local situation and providing peers with skills and tools to contribute to the strategic planning of outreach and services facilitates the development of relevant, practical, and acceptable services. Micro-planning includes four main stages.

1. **Site Load Mapping:** peer-led mapping is used to systematically validate and define hotspots and their logical geographical boundaries.

2. **Spot analysis:** spot profiling is performed to inform the delivery and components of HIV prevention programs, per peer and per location. A simple tool collates relevant information on a particular location where FSWs are known to congregate.

3. **Contact mapping/Peer social network analysis:** In each location, the peer educators make a list of all the FSWs that they know personally, and then they compare lists. Decisions are made about which peer educator will take responsibility for outreach, education, and monitoring for which spot and which individual FSW (contact mapping).

4. **Registration:** enrolment of the sex workers in the programme and profiling their demographics and client volume to provide their risk and vulnerability.

The information obtained from these stages of planning is used to inform the implementation of appropriate outreach and services to maximise coverage and address the needs of the sex workers.

Another objective of micro-planning is to ensure that outreach is led by the FSW community or peers, and there are tools that can be used to facilitate this involvement. The tools are also very community-friendly and facilitate the processes through which the peers can analyse information, design interventions, and monitor their work in their sites. The tools aid the peer educators in becoming “hotspot managers” and help define the needs of the sex workers in the site and to design activities to address those needs. The involvement of the FSW community in the design, implementation, and monitoring of the outreach activities increases the appropriateness and acceptability of these programmes among the FSW community and may result in more efficient and effective programmes based on the needs and priorities of the FSW community.

Outreach mechanisms using micro-planning tools also increase a peer’s accountability to the FSW community and she is able to reflect on the outreach work that she has done without anyone telling her to or policing her. Micro-planning processes build capacity by providing opportunities for FSW community members to obtain relevant knowledge and skills, while improving perceptions of personal value, control, and agency. For the FSWs, this is an opportunity to form a sense of community and organise individuals into an articulate group to facilitate community action. Micro-planning processes enhance engagement with the FSW community and create a sense of ownership.

In summary, among their many benefits, micro-planning processes:

- Define a clear area of operation for each PE
- Help in the tracking and follow-up of each sex worker
- Allow teams to design outreach strategies according to the needs of each hotspot and its group of sex workers
- Facilitate planning among PEs in estimating the number of condoms and lubricants needed by sex workers in the hotspot for which they are accountable
- Improve data collection and reporting by tracking each individual KP at a site and providing dashboard metrics that empower PEs to act upon the data
- Allow PEs to monitor which peer is due for clinical services, such as testing for HIV or screening for STIs and tuberculosis (TB)
- Help PEs identify gaps in their outreach efforts and empower them to use data for decision making
- Shift the programme model from one of service delivery (push) by increasing demand generation for services from the community (pull)
- Enhance FSW community participation and ownership
- Build good relationships between the FSW community and the programme
- Promote continuous reflection on the gaps
- Lead to more acceptable and appropriate programmes and services
- Maximise coverage
- Create opportunities for capacity building within the FSW community
- Build accountability and responsibility among the peers

Implementation of the micro-plan should be informed by the geographic distribution of sex work, the number of sex workers and their volume of sex work, type of sex, typologies of sex work in that location, age of sex workers, time considerations, and other stakeholders involved in the lives of FSWs. The barriers to accessing prevention services will be considered and addressed by outreach.

- **Geography** is an important consideration when planning outreach services, as outreach should be implemented in each location and spot where sex work takes place, with attention given to the specific characteristics and needs in different contexts. For example, the bar-based hotspots in cities operate mostly after four o'clock in the afternoon and get very active after seven o'clock in the evening. Hence, the outreach in those sites will be done in the evening rather than in the morning.

- **Volume of sex** is relevant, as high-volume (ten or more clients per week) FSWs are more vulnerable and require prioritization over those FSWs operating at medium volume (5 to 9 clients per week) and low volume (4 or fewer clients per week).
- Outreach components will be tailored to the specific **types of sex** typically performed, given the fact that unprotected anal sex, for example, carries a higher risk than other activities.
- **Typology of sex** is important, as each typology has different characteristics and outreach needs to be designed with that in mind. The provision of outreach to urban FSWs who solicit on the street requires a strong peer network. In venue-based sites such as bars, brothels, or lodges, FSWs will need strong advocacy with the bar managers and other power structures.
- **Age** is an important consideration for outreach programme design, as younger FSWs have different concerns and needs than those who are older. For example, younger FSWs may be concerned with family planning or maximising their physical appearance and their client load. Older FSWs may be more concerned with finding economic alternatives to sex work and protecting their children.
- The experience of violence and the consumption of alcohol or drugs increase a sex worker's **vulnerability** to HIV and STIs, and hence profiling the sex workers' vulnerability and prioritising those who are more vulnerable is important.

When planning outreach, the specific context and various typologies of sex work that link to how FSWs organise their time should be considered to ensure feasibility of outreach, mobilisation and service uptake. The impact and influence that third parties, such as family members, FSW community leaders, pimps, and bar managers, have on the lives of FSWs should also be considered. These third parties may be able to promote condom use and service referral, and offer protection against harassment and violence (sexual, physical, and verbal/emotional).

Micro-planning Tools

Seven micro-planning tools have been field-tested for use in Nigeria. Based on their purposes, the tools can be sub-classified as follows:

- Tools for improving the quality of outreach: Spot Analysis, Contact Mapping, and Site Load Mapping
- Tools for improving service delivery: Preference Ranking, Condom Accessibility, and Availability Mapping
- Tool for continually improving the programme: Opportunity Gap Analysis
- Tool to facilitate the creation of an enabling environment: Stakeholder Analysis

Tool 1: Spot Analysis enables participants to compile all the information they have about a hotspot and plan outreach based on the analysis of this information.

Tool 2: Site Load Mapping helps participants assess the daily, weekly, and monthly load of sex workers in each of the hotspots.

Tool 3: Condom Accessibility and Availability Mapping benefits participants by mapping the condom availability points and to understand if they are easily accessible to FSWs.

Tool 4: Opportunity Gap Analysis helps participants understand opportunity gaps in each hotspot, reasons for the gaps, and ways to overcome them.

Tool 5: Contact Mapping helps participants map their contacts within the community of sex workers. On the basis of this understanding, participants then select peers and plan outreach activities in all different hotspots.

Tool 6: Preference Ranking helps identify the reasons for gaps in service uptake by the community and to develop resolutions to improve the service levels.

Tool 7: Stakeholder Analysis helps participants to identify the stakeholders and a careful analysis of the power structures in which FSWs are involved and the people whose support can help to create an enabling environment for the programme.

Details on each tool are provided in the Annexes.

Tools

Annex 4: Spot Analysis (micro planning tool 1)

Annex 5: Site Load Mapping (micro planning tool 2)

Annex 6: Condom Availability and Accessibility Mapping (micro planning tool 3)

Annex 7: Opportunity Gap Analysis (micro planning tool 4)

Annex 8: Contact Mapping (micro planning tool 5)

Annex 9: Preference Ranking (micro planning tool 6)

Annex 10: Stakeholder Analysis (micro planning tool 7)

3.2. Programme Management

3.2.1. Roles of Institutions

To monitor and improve the quality of interventions and achieve their intended outcomes, effective programme management is essential. The role of SACA and implementing agencies in programme management is also to ensure that these interventions are well monitored and that gap analysis is performed continuously to ensure that appropriate capacity building and handholding plans are developed with respect to the implementation and quality coverage of prevention programmes targeting FSWs. Various institutions are in place to ensure effective programme management.

Role of the State Agency for the Control of AIDS (SACA)

The overall responsibility for implementing programmes in the state belongs to the SACAs. The SACAs coordinate and monitor the activities of partner agencies' programmes to ensure adequate coverage and saturation of the state and also to avoid duplication of efforts. SACAs, in collaboration with the State Prevention Technical Working Group (STPWG), are responsible for ensuring that the interventions provided by the implementing agencies accomplish the state's desired goals and objectives, are in accordance with national guidelines, and fall within the standard for the minimum quality of interventions.

Role of implementing agencies

Agencies (non-governmental organisations [NGOs]/community-based organisations [CBOs]) implement interventions in their respective programme locations, as contracted by the SACAs. The implementing agencies develop a programme proposal and plan that guide the implementation of the intervention. The role of the agencies is to ensure that all targeted FSWs receive services and interventions as agreed in the contract/proposal. The agencies are responsible for initiating biomedical, behavioural, and structural interventions for FSWs as agreed in the contract and proposal, and in the prescribed location. The agencies report on their progress to their SACAs on a monthly basis. Additional responsibilities include local problem solving, recruitment of the local team, and setting up monitoring and evaluation (M&E) systems, as guided by SACAs.

3.2.2. Implementation Team

Programmes require team members with a variety of skills. The particular composition of your team will have to be determined based on the types of services to be provided, their delivery method, and the size of the FSW population your programme intends to reach. An implementation team intended to provide services to 1,000 FSWs might be structured as follows:

1. Programme Coordinator (1)
2. Accountant (1)
3. M&E Officer (1)
4. Doctor (1)
5. Nurse (1)
6. Counsellors (2)
7. Programme Officers (5)
8. Peer Educators (50)
9. Office Support Staff (1)

The intervention should have a programme coordinator responsible for the programme's overall implementation, an accountant charged with managing its accounts and expenses, and a monitoring officer responsible for generating reports and monitoring the quality of reporting. The team may also include doctors and nurses to provide the programme's biomedical components and counsellors to support the behaviour change process. The intervention unit will also include programme officers and PEs to handle the behavioural and structural interventions. One programme officer may be needed for every 200 FSWs, and 1 PE may be needed for a maximum of 20 FSWs. Office support staff is also needed.

Recruitment of staff

When hiring new staff, consider candidates whose attitudes, knowledge, and experiences will enable them to work successfully in the programme. They should be sensitive to issues of gender, sex, and sexuality, and be able to deliver services in a non-judgmental manner that does not make FSWs uncomfortable or stigmatize them. Sensitivity to and understanding of the challenges posed by poverty, discrimination, and violence facing FSWs are also essential. Staff members should include professional personnel as well as FSW community members, and professional personnel should include women as well as men to ensure gender balance.

Establishing roles and responsibilities

To minimize confusion and ensure the smooth operation of your programme, it is important to be clear about the roles and responsibilities of staff members, with room for flexibility so that staff are able to fill multiple roles as needed and in the interest of capacity building. As an employer, it is important to clearly communicate changing roles and responsibilities to your employees. The staff should be aware of what they are expected to do each time new duties are assigned. Furthermore, staff should be clear on the reporting lines and know to whom they are accountable.

3.2.3. Capacity Building

Capacity building of human resources is a key aspect of interventions targeting FSWs. Building the capacity of the implementing team to bring self-change and subsequently behaviour change among FSWs in the context of HIV can be challenging. To fulfil the intervention's objectives, efforts will be made to train the staff not only in technical knowledge but also to bring about attitudinal change. Staff need to understand the value of the role played by sex workers in these programmes and must have the skills to build their capacity, such that sex workers feel empowered and "own" the interventions.

Capacity of the staff will be built through classroom training, field exposure, practical sessions, and also through experiential and interactive sessions with sex workers.

Given the diversity of languages and cultural settings of communities across Nigeria, the key challenge will be to standardize the training scheme. It will have to take regional differences into account and provide adequate operational flexibility for the incorporation of local needs and issues. The training will be provided in the local language and the methodology will be adapted to suit the various cultural ethos and practices of the host communities.

Capacity-Building Plans

It is important to build capacity among the implementation team within NGOs/CBOs. The capacity building plan will have to follow implementation. In the scaling-up phase, the plan will be very intensive. In the continuing phase, capacities of staff will be built based on the needs emerging from the field. An emphasis will be placed on keeping the workforce motivated and sustaining the change.

Training modules will be developed for all the planned trainings. Each module will include a training/facilitator's manual and a participant's handbook that participants can keep and to which they can refer later on, if need be. These manuals and resource materials will be standardized across the country. The trainers using these manuals will, however, be trained to adapt the content to the local realities of each district/state.

Personnel involved in implementation will undergo modular training. While some of the sessions in the training will be conducted in a classroom setting and will focus on theory and concepts, other sessions will provide field-based experiences. The trainings will be conducted based on the skill needs of different cadres of staff involved in the interventions.

Tools

Annex 11: Job description of the implementation team, capacity building materials and resources, and crisis management system (These tools are being developed and will be made available on the NACA website.)

Chapter 4. Implementation of HIV Prevention Programmes

4.1. Behavioural Interventions

Behavioural interventions are offered directly to the sex workers and their clients by trained PEs. The goal is to reduce the risk of HIV and STIs among FSWs and their clients.

Table 2. Programme Behavioural Interventions

Programme Component	"Checklist" of Activities for Implementation	Tools
BEHAVIOURAL INTERVENTIONS		
Outreach: ▪ Small group discussions ▪ Interpersonal communication ▪ Community stakeholders' meetings (including FSW, pimps, madams) **Peer Education:** ▪ Social peers ▪ Counselling and skills building	**Entry level:** ▪ Identify key stakeholders in the community, e.g., brothel owners/managers, local pimps, chairladies, madams, law enforcement agents, others as applicable ▪ Conduct community stakeholder dialogue ▪ Key influencers/gatekeepers pre-intervention dialogue - Baseline PM&E - Validation of identified hotspots/intervention sites - Selection of PEs within respective FSW community **Intensive Level:** ▪ Train PEs on the programme ▪ PEs to conduct periodic outreach to the respective FSW communities (monthly) using drama/role plays,	**Entry level:** ▪ Validation format-tool (SFH/UOM) ▪ Stakeholder analysis tool ▪ Spot analysis tool for community mapping by civil service organisation (CSO)/community-based organisation (CBO) partners (review to suit Nigeria context) ▪ Site load mapping ▪ Baseline-PME (participatory monitoring and evaluation tool) **Intensive Level:** ▪ PITT (NACA)—to be reviewed by NPTWG

Programme Component	"Checklist" of Activities for Implementation	Tools
	film shows, games, etc.—refer to national FSW community tool PEP model ▪ Conduct monthly review and refresher meetings with trained PEs ▪ Conduct community stakeholders' update meetings regularly (quarterly) ▪ Process documentation and dissemination ▪ Drama/role play ▪ Film shows ▪ Games – board games, cards, community conversation toolkit **Exit level:** ▪ Formation of community-led social structures/groups ▪ Plan for sustainability of formed social structures/groups ▪ Promote voluntary PEs from the community ▪ End of project evaluation/dissemination ▪ Sustainable sexual behaviour programmes	▪ PE recruitment criteria tool—to be developed ▪ PEP manual—NACA ▪ Contact listing by PEs ▪ Community conversation tool kit (FHI—C-change) ▪ PE monitoring tool (SFH) ▪ Opportunity Gap Analysis **Exit level:** ▪ Evaluation tool ▪ Final reporting template ▪ Best practice document ▪ Success story format ▪ Opportunity Gap Analysis
Expected Results and Indicators Increased proportion of FSWs reached by outreach and behavioural education ▪ Percentage of high-risk groups (FSW) contacted with HIV/AIDS prevention programme ▪ Percentage of FSWs reached with Minimum Prevention Package Intervention (MPPI) ▪ Percentage of FSWs reached every month with MPPI		

Programme Component	"Checklist" of Activities for Implementation	Tools
Condom and Lubricant programming: ▪ Demonstration, promotion of use, and distribution of male and female condoms and water-based lubricants	**Entry level:** Identify a system of condom procurement Estimate condom requirement for FSWs **Intensive level:** ▪ Direct distribution and tracking of condoms to FSWs through outreach team ▪ Identify traditional/non-traditional outlets and establish distribution systems in all sites **Exit level:** ▪ Outlet sustainability of condom distribution	**Entry level:** ▪ Condom availability mapping ▪ PE card ▪ PEP manual **Intensive Level:** ▪ Condom accessibility and availability map ▪ Condom distribution tool (SFH) **Exit level:** ▪ Condom distribution format
Expected Results and Indicators Increased proportion of FSWs using condoms with clients and other partners ▪ Ratio of condoms distributed/condoms required (monthly) ▪ Percentage of FSWs receiving condoms as per the demand (monthly) ▪ Percentage of FSW reporting the use of condoms regularly with clients ▪ Percentage of FSWs using condoms regularly with other partners		

4.1.1. Outreach and Peer Education

Outreach is an important part of HIV prevention programmes and involves meeting FSWs at locations and times that they find most suitable. Often, members of the FSW community are trained as PEs to provide outreach services. There are five main goals of outreach:

- Build rapport and trust with the FSW community and foster a sense of solidarity and support
- Provide information about how to prevent HIV transmission and about available services

- Distribute condoms and lubricants
- Provide counselling
- Make referrals for behavioural and biomedical interventions

Peer education involves the selection and training of a member of the FSW community (current FSWs, in this case), accepted and trusted by the sex workers and motivated and committed to assisting their peers in reducing their risk and vulnerability. A PE normally shares similar demographic characteristics (age, typology of sex work, geography) with their peers.[12] Peer education is based on the premise that FSWs should be empowered to actively protect themselves and their sexual partners and is organised and provided by a member of the FSW community. PEs therefore share many of the same characteristics and life experiences as the population with which they work and should be selected to represent the various typologies and contexts of sex work present within the programme catchment area. Peers are knowledgeable about the challenges and stigma experienced by FSWs and this first-hand understanding fosters the PE's credibility and promotes trust within the FSW community. PEs act as a link between communities and programs, thereby facilitating FSW community participation in interventions.

Peer Education Plus

→ Refer to the Peer Education Plus Manual for details about peer education in Nigeria.
→ It is available online at http://www.sfhnigeria.org/The A to Z of the Peer.pdf

In recent years, the role of PEs has expanded to include supporting peers in times of crisis, informing them about their rights and entitlements, and mobilising the FSW community for collective action. There is enough evidence now to prove that peer education interventions significantly increase levels of knowledge about HIV, reduce the prevalence of STIs, and increase condom use with a variety of partners.

The role of the PE within a programme varies depending on the context and vision of the programme and may include contacting specific individuals regularly or making contact with a defined number of FSWs per week, distributing education and prevention materials, demonstrating and distributing condoms, making referrals, running education and training sessions, mobilising FSW community members, and advocating for rights and safety. A PE is given an incentive as per national costing guidelines developed by NACA. A strong supportive structure of full-time outreach staff is required to sustain continuity. An organised training programme for PEs is crucial for the success of this approach.

[12] L. Thompson, P. Bhattacharjee, et al. A Systematic Approach to the Design and Scale-up of Targeted Interventions for HIV Prevention among Urban Female Sex Workers, (KHPT, University of Manitoba and World Bank, 2012). Available online at http://www.scribd.com/doc/113881547/A-Systematic-Approach-to-the-Design-and-Scale-Up-of-Targeted-Interventions-for-HIV-Prevention-Among-Urban-Female-Sex-Workers.

Peer education is most effective when an ongoing relationship is established and maintained with peers over a period of time. A PE should meet her FSWs often, build trust, encourage and reinforce behaviour change, and support them in times of crisis. The elements of peer education and outreach for FSWs are:

- Provision of correct HIV/STI and reproductive health information
- Promotion, demonstration, and distribution of male and female condoms, as well as water-based lubricants
- Risk assessment and referral to services, including counselling
- Encouraging and motivating FSWs to use programme-related prevention and care services and commodities
- Advocacy with power structures
- Support for FSWs in crisis
- Accessing the needs of FSWs and, if necessary, referring them to additional components of the HIV/STI package
- Review meetings and training
- Service delivery reporting
- Counselling
- Referrals to behavioural and biomedical interventions

There are tools that may be used to assess the performance of an outreach and peer education programme. Opportunity Gap Analysis is used to determine why 100 percent FSW population coverage is not being achieved.

PE selection criteria

Sex workers who are selected as PEs should possess the following traits:

- A sex worker in the hotspot/site of intervention
- A recognized member and leader in the FSW community
- Acceptable to other members of the FSW community
- Knowledgeable about the local sex work context and network
- Has a good social network in the site where she works
- Able to organise and conduct educational sessions/provide information
- Highly motivated to mobilise the FSW community to protect itself
- Prepared to commit a certain amount of time to peer education activities

- Good listening, communication, and interpersonal skills
- Committed to being accessible to her/his peers in times of crisis

Process of PE selection/recruitment

A PE selection process should be transparent and should provide equal opportunities to all interested FSWs to participate and apply. Before selection of the peers, the implementation team needs to validate all the hotspots and cluster them into outreach sites so that they know how many peers are needed and where. Once the programme sites have been determined, the peer selection process should be well publicized within FSW networks so that all those potentially interested in serving as peers can apply for selection. Sex workers met during mapping or initial outreach by the programme team who meet the above-mentioned criteria should be encouraged to apply. Sex worker networks from the selected sites should also be encouraged to nominate their representatives. A basic interview to rank the candidates based on the criteria listed above can be conducted. A social network mapping of the candidates can be performed to ensure that they have a good number of FSW contacts in the targeted sites. It is important to discuss with all candidates the role of PEs, the commitment involved, reporting requirements, and the honorarium, so that those selected can make an informed choice.

Review and Rotation of PEs

Every six months, the performance of PEs should be reviewed against programme indicators related to contacts, condom distribution, and referral to services, which are the primary responsibility of the PE. The review should be conducted using the Opportunity Gap Analysis tool, which encourages self-reflection and self-review. This will ensure that the PEs are responsible and accountable for their performance, rather than have the programme team police and monitor their performance. The programmes can also organise reflection meetings every six months with the peers to whom the PE is accountable as a means of getting direct feedback on the PEs' performance. This also acts as a reminder that the PE is accountable not only to the programme but also to her FSW peers.

Counselling and skills building

Counselling and skills building are used to provide FSWs with the information and skills needed for risk reduction. When conducting a risk assessment, questions should focus on the frequency of oral, anal, and vaginal sex, the number of clients and regular partners, condom use with clients and regular sex partners, lubricant use, douching, dry sex, and substance use. The counsellor should be able to provide counselling in a non-judgmental way and avoid stigmatization and embarrassment. It can be provided in the clinics and drop-in centres (DICs) and must be conducted in a safe and private space where confidentiality can be maintained.

Counsellors should provide options to sex workers and encourage them to identify solutions to their problems. Risk-reduction plans should have behavioural goals and should follow the following steps:

1. Conduct an initial and ongoing individual HIV/STI risk assessment.
2. Develop a personalized risk-reduction plan in collaboration with the sex worker.
3. Monitor the progress of risk reduction routinely and modify/adjust the plan as needed.
4. Provide risk-reduction supplies (i.e., male/female condoms and lubrication).
5. Skills building to implement the personalized risk-reduction plan.
6. Routinely reinforce risk-reduction skills.
7. Identify other needs of the FSW and refer her to programmes that can address them.

Move beyond messages to encourage analytical thinking and problem solving among individuals and small groups of FSWs, so that they can arrive at and act on locally appropriate solutions to overcome their barriers to HIV/STI risk reduction, through peer-facilitated, dialogue-based interpersonal communication.

Tools

Annex 4: Spot Analysis – integrate with Site Loading

Annex 5: Site Analysis

Annex 7: Opportunity Gap Analysis

Annex 8: Contact Listing

Annex: Community Conversation Toolkit

Annex: PEP Manual

Annex: Dialogue-Based Interpersonal Communication by and with FSWs

4.1.2. Demonstration, Promotion, and Distribution of Condoms, Lubricants, and Other Commodities

Condom use is one of the best methods of STI and HIV prevention. Demonstration, promotion, and distribution of female and male condoms as well as lubricants and other commodities such as gels and tablets are important components of an HIV prevention programme. The objectives are:

1. Make condoms, lubricants, and other commodities available and accessible free of charge.

2. Distribute enough condoms, lubricants, and other commodities to meet the needs of FSWs.

3. Demonstrate and encourage the correct and consistent use of condoms and lubricants, and provide skills needed to negotiate the use of condoms with clients. Promote the use of condoms, lubricants, and other commodities.

Condoms, lubricants, and other commodities are distributed free of charge to sex workers through three main channels:

1. **PEs:** During their peer education sessions and in their informal contacts with sex workers, peer educators will distribute condoms and lubricants to FSWs free of charge.

2. **Outlets:** Outlets—which could take the form of shops, bars, or other venues—will be opened in identified hotspots.

3. **Clinics:** The static, outreach, and referral clinics will also distribute condoms to sex workers during visits.

Providing condoms according to the needs of FSWs is an important element of the programme and aims to prevent both condom waste and condom shortages. PEs assess the client volume of the sex workers in their peer group and ensure that, based on number of sex acts estimated, enough condoms are provided.

Water-based lubricants should be provided to FSWs and their use encouraged during both vaginal and anal sex.

Condom promotion must be done without any coercion. Advocacy with law enforcement agencies is important to ensure that possession of condoms is not used as evidence of sex-related criminal activity.

Tools

Annex 6: Condom Accessibility and Availability Mapping

4.2. Biomedical Interventions

Biomedical interventions are those that directly influence the biological systems through which the virus infects a new host, such as blocking, decreasing infectiousness, or reducing acquisition/infection risk. Specifically, these interventions involve testing and diagnosis of infections, treatment, family planning, prevention of mother-to-child transmission, and other clinical services that improve the health of FSWs. Biomedical interventions include STI screening and treatment, HIV counselling and testing—including provider-initiated counselling and testing (PITC)—HIV treatment and care, prevention of mother-to-child transmission (PMTCT), TB screening and linkages, post-exposure prophylaxis (PEP), condom distribution, and other clinical services that promote the health of FSWs. This intervention would be provided through community outreach and clinic-based activities.

Table 3.Programme Biomedical Interventions

Programme Component	"Checklist" of Activities for Implementation	Tools
BIOMEDICAL INTERVENTIONS		
STI Control and Management ▪ Screening and treatment of STIs ▪ Training on STI syndromic case management	**Entry level:** ▪ Identify sites where clinical services will be provided to FSWs ▪ Adapt the existing national standard operational guidelines to STI management ▪ Advocate to relevant stakeholders and policymakers for the inclusion of budgetary allocations ensuring the continuity of biomedical intervention for FSWs ▪ Identify and build capacity of existing community structures (CBOs, FSW leaders, and other community groups) to continue with support implementation after exiting programme **Intensive level:** ▪ Training and retraining of clinic staff (counsellors, nurses, doctors, prevention officers) on the SOP and needs of FSWs	**Entry level:** ▪ Preference ranking ▪ Community mapping tool ▪ Facility mapping tool ▪ Facility assessment tool **Intensive level:** ▪ National STI syndromic management guideline/tool

Programme Component	"Checklist" of Activities for Implementation	Tools
	▪ Provide counselling to all FSWs on STIs at the clinic ▪ Referrals and/or treatment of FSWs for STIs–syndromic management ▪ Partner notification and treatment (clients and non-paying partners) ▪ Institute follow-up systems for FSWs undergoing STI management in line with the national guideline ▪ Strengthen linkages between community-level activities and health care facilities to ensure sustainability **Exit level:** ▪ Strengthen linkages between community-level activities and health care facilities ▪ Institute forums for the continued engagement of community stakeholders with health facilities and FSW groups that would look at progress review, feedback processes, and recommendations for sustainability	**Exit level:** ▪ Format/tools for government referral linkages ▪ Format for community referrals
Expected Results and Indicators ▪ Percentage of FSWs referred for STI services in a month ▪ Percentage of FSWs accessing STI services within the month (reporting monthly) ▪ Percentage of FSWs that completed STI treatment within the month ▪ Percentage of FSWs accessing follow-up check-up for STIs within the quarter		
HIV Counselling and Testing (HCT): ▪ Mobile HCT ▪ Facility-based HCT ▪ Community-based HCT	**Entry level:** ▪ Adopt the national SOP for counselling and testing for HIV ▪ Identify organisations that can be linked to the programme to provide HCT services, if the programme does not provide these services directly	Adapt tools as per the national SOP

Programme Component	"Checklist" of Activities for Implementation	Tools
▪ Referrals	▪ Training of personnel (counsellors, nurses, community-based organisations) on HIV counselling ▪ Establish linkages between HCT service providers and comprehensive clinics in hotspots **Intensive level:** ▪ Follow-up of FSWs for regular testing and counselling (mobile HCT) ▪ Refer pregnant FSWs for HIV testing ▪ Facilitate access to appropriate PMTCT services for HIV-positive pregnant FSWs ▪ Promote community counselling systems, particularly PLHIV networks **Exit level:** ▪ Linkages with positive network	

Expected Results and Indicators

- Percentage of FSWs referred for HCT services within the quarter
- Percentage of FSWs referred for HCT services for the first time and it occurred within the quarter
- Percentage of FSWs referred for follow-up HCT services within the quarter
- Percentage of FSW who received HCT in the last 12 months and who know their results
- Percentage of FSW who tested HIV-positive

Programme Component	"Checklist" of Activities for Implementation	Tools
PMTCT: ▪ HIV treatment, care, and support ▪ Reproductive and allied health services, FP, ANC, and postpartum/natal care	**Entry level:** ▪ Follow/adapt the national SOP for treatment and care of FSWs **Intensive level:** ▪ Refer HIV-positive FSWs to PMTCT ▪ Refer for tests for LFT, RFT, and CD4 ***(where medical personnel is available)*** ▪ Initiate/refer for initiation of antiretroviral therapy (ART) and cotrimoxazole (CTX) ***(where medical personnel is available)*** ▪ Provide/refer for adherence counselling ▪ Follow-up of HIV-positive FSWs by HIV-positive peers or acceptable outreach staff ▪ Promote PMTCT among FSW as part of peer education package ▪ Refer FSWs for family planning services (pills, condoms, injectable contraceptives) ▪ Refer FSWs for cervical cancer, anal cancer, HPV, and HSV2s screening ▪ Refer FSWs for other services such as diabetes, hypertension screening, or additional services FSWs typically need ▪ Referrals to services related to rape support and underage sex workers	▪ Follow/adapt the national SOP for treatment and care of FSWs ▪ Adapt PMTCT guidelines ▪ Adapt tools from National Sexual Reproductive Health –SOP (Ministry of Health) ▪ MNCH training tool
Expected Results and Indicators ▪ Percentage of FSWs living with HIV who are pregnant and have been referred for PMTCT within the quarter ▪ Percentage of FSWs eligible for ART who are newly initiated on ART within the quarter ▪ Percentage of FSWs on ART who continue to receive PMTCT services within the quarter/year ▪ Number of FSW living with HIV and people affected with HIV/AIDS provided with a minimum of one clinical care service		

Programme Component	"Checklist" of Activities for Implementation	Tools
▪ Number of FSW living with HIV receiving home-based care (PLHIV) ▪ Number of FSW living with HIV/AIDS (PLHIV) receiving adherence support ▪ Number of FSW followed up by HIV-positive peers ▪ Percentage of FSWs counselled for family planning within the month ▪ Percentage of FSWs referred for other services within the quarter		

The mechanism of service delivery may be different in different sites depending on the need, expertise, and experience of the FSW community as well as those of the implementing organisation. Implementing organisations that do not have the expertise to provide clinical services may refer FSWs to existing services provided by other organisations. In such cases, staff at the existing facilities should be sensitized to the special needs of FSWs. Static clinics can also initiate outreach clinics to ensure the accessibility of clinical services to people in remote sites for whom access to static clinics is limited or impossible.

Service delivery may be provided through:

- **Intervention site-based clinic:** This ensures confidentiality, less marginalisation and better quality of care. Easy to follow up but difficult to sustain.
- **Mobile clinics:** These are vans that deliver services directly to locations that sex workers prefer, at convenient times for them.
- **Referral to the public sector:** Services can be free but lack confidentiality; quality of services cannot be predicted and marginalisation of FSWs could occur.
- **Referral to the private sector:** Confidentiality may be guaranteed and services may be sustained, but quality and costs are difficult to predict.

It is important to follow up with FSWs after they receive biomedical services; therefore, maintaining strong linkages with the outreach team is important. For FSWs who test positive for HIV, a process must be in place to ensure they are linked to HIV care; HIV-positive PEs may be involved with this follow-up, provided the FSW consents to it.

4.2.1. Establishment of a system of STI screening and provision of treatment

FSWs are at higher risk for sexually transmitted infections due to sex with multiple partners, increased frequency of partner change, and unprotected sex. The goal of STI screening and treatment for FSWs is to identify, treat, and prevent future STI occurrence and transmission.

Planning and mode of service delivery

Planning for STI services should be done with the FSW community. It is important to gather the following information:

- Preferred list of service delivery sites
- List of current barriers to accessing STI services
- Ways in which STI services can be made accessible and acceptable to FSWs in terms of location, operating hours, etc.
- Best mode of delivering STI services

Special attention should be paid to ensuring community-friendly service delivery options:

- Health care providers with the right attitude towards the FSW community;
- Availability of services according to the needs of the FSW community, e.g., late-night access, if appropriate;
- Accessibility of services at optimal location (i.e., not too far from the major sex work sites);
- Basic infrastructure facility (facilities should be maintained at the standards stipulated by National STI Guidelines);
- Confidentiality between the clinic team and the FSW community; and
- Effective prevention and treatment of STIs among FSWs attentive both to symptomatic and asymptomatic infections.

The prevention and treatment of STIs in interventions intended for FSWs should have the following two components:

- **Management of symptomatic infections** – using the national syndromic management flowcharts and laboratory diagnoses (where available)
- **Screening and management of asymptomatic infections** – quarterly history taking, physical examination, and simple laboratory diagnostics (where available)

The packages of HIV/STI services to be provided are (see WHO/National STI Guidelines):

- Health promotion and STI prevention activities, such as promoting correct and consistent use of male condoms (and female condoms, where available) and water-based lubricants, as well as other safe sexual practices;
- Provision of free male condoms (and female condoms, if available) and lubricants;
- Immediate diagnosis and clinical management of STIs;
- Provision of STI medicines and directly observed therapy for single-dose regimes;

- Pre- and post-exposure prophylaxis for HIV;
- Health education and counselling for treatment compliance, correct and consistent use of condoms, and regular partner treatment;
- Periodic check-ups, syphilis screening, and treatment of asymptomatic infections;
- Partner management programmes (i.e., contact referral; includes clients and non-paying partners, such as boyfriends and husbands);
- Follow-up services for FSWs with STIs;
- Referral links to HIV counselling and testing centres, HIV care and support, and other relevant services;
- Strong linkages with outreach activities targeted at FSWs.

The clinics/facilities in the interventions will follow the national guidelines for STI screening and treatment. Sex workers should be screened syndromically, at least quarterly, and provided treatment for STIs based on national syndromic management guidelines. Quarterly screening should provide an opportunity to detect and treat STIs early, as well as provide risk-reduction counselling and access to male and female condoms, water-based lubricants, and other commodities, such as gels and tablets. Preference ranking is used to identify the reasons for gaps in services available to FSWs and to prioritize these so they can be specifically addressed to increase uptake of project services. Outreach teams and PEs can use this tool for a variety of purposes, such as:

- understanding barriers;
- planning interventions for outreach;
- understanding the FSW community's priorities for good service; and
- prioritising specific needs of FSWs.

Tools

Annex 9: Preference Ranking

4.2.2. Provision of HIV Counselling and Testing

HIV counselling and testing is an integral component of HIV prevention and care strategies worldwide. As part of the interventions, client-initiated HIV testing and counselling will be promoted. Clinical staff will be trained on topics such as the importance of informed consent, privacy and confidentiality, and possible adverse outcomes of disclosure of results; staff is supervised and monitored very closely. Provider-initiated HIV testing and counselling will also be initiated in order to utilise these opportunities to diagnose and counsel FSWs who come to

the clinic for other services. The interventions will follow the national guidelines for HIV testing and counselling.

HIV testing and counselling includes the provision of effective referrals to appropriate follow-up services (e.g., ART, PMTCT) as indicated, including long-term prevention and treatment support.

4.2.3. Prevention of Mother-to-Child Transmission

Provision of HIV treatment, care, and support

The goal of HIV care and treatment is to restore the immune system, reduce HIV and AIDS-related morbidity and mortality, improve quality of life, decrease viral load, and reduce HIV transmission to partners of sex workers. HIV-positive sex workers must have access to HIV care and treatment in line with national guidelines. In the interventions, sex workers will have access to a core package of HIV care and treatment services, which includes assessment for staging and CD4 count, provision of co-trimoxazole prophylaxis, ART for those eligible, PMTCT for pregnant FSWs, management of opportunistic infections (OIs), and psychosocial support. A follow-up mechanism will be developed to ensure that the drop-out rate is minimized, while maintaining principles of confidentiality.

Provision of Reproductive and Allied Health Services

Facilities should provide options for various family planning methods and reproductive care, including condoms, pregnancy screening, counselling and referral to other services, if needed. In addition, the clinics will also have very active referral linkages with organisations that provide both medical and psychosocial services to rape victims. Furthermore, linkages will be developed with organisations that provide services such as vocational skills training to sex workers.

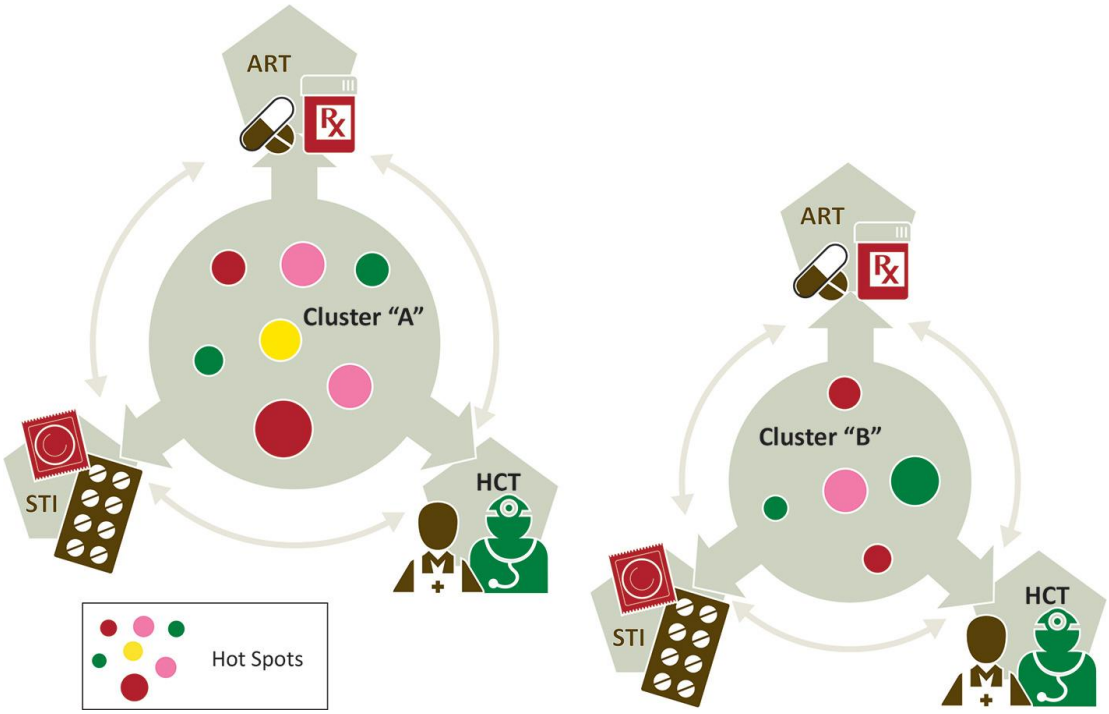
4.3. Cluster Approach to Service Delivery

As outlined in the previous sections, it is essential that the FSWs be provided with access to a range of biomedical services to improve and maintain their reproductive and sexual health and to ensure that those living with HIV are able to receive appropriate treatment and care. Some larger implementation programmes can offer some or all of these services directly, but in many situations their role will be to identify and partner with appropriate local service delivery organisations and institutions and establish effective referral mechanisms for the

FSWs operating within their programme catchment. To do this efficiently, a "cluster approach" is recommended for organising service delivery.

The following diagramme depicts the "cluster" concept, with clusters of hotspots linked to a network of services within close proximity to the hot spots within each cluster.

Figure 2 "Cluster approach" to service delivery for FSWs



The "cluster approach" involves the following key steps:

- List and characterise all of the FSW "hotspots" identified through programmatic mapping within a state and by Local Government Area (LGA). This will provide information on the localized distribution of FSWs.
- List, describe, and map the key services available in each LGA through health centres, clinics, and other service delivery points (e.g., primary care centres, hospitals, HCT centres, PMTCT centres, ART providers, etc.).
- Within each LGA, organise the FSW hotspots into geographic "clusters" based on their proximity. This will result in the establishment of service delivery "catchment areas" for FSWs, so that nearby services can be identified and provided.
- List and describe the available appropriate services for each FSW cluster. This should include consultation with FSW community groups to determine which types of services and which specific providers are preferred within the cluster. This will provide implementing organisations and FSWs with a list of services that can serve as a local referral network for FSWs.

- Identify key gaps in service availability within each cluster so that these gaps can be filled by the recruitment/establishment of new service delivery points.
- Provide sensitization and training for local service providers and establish an efficient referral system for FSWs to the preferred providers within each cluster.
- Incorporate an active referral and follow-up system within the outreach processes of the implementing organisations to ensure that FSWs are linked to appropriate available services within each cluster.

In addition to the development of service delivery networks within each cluster, implementing organisations should map other key services, including local police stations and social support organisations. Implementing organisations should work proactively with law enforcement officials to support local HIV prevention programmes for FSWs and to mitigate the violence and harassment that FSWs face.

4.4. Structural Interventions for Vulnerability Reduction

Structural interventions address the critical social, legal, political, and environmental systems and beliefs that increase the vulnerability of FSWs and contribute to the spread of HIV. The vulnerabilities of FSWs relate not only to their individual risk behaviours but also to broader societal and community factors, including cultural norms, social marginalization, and criminalization, which limit their opportunities and access to services and make them vulnerable to discrimination and violence (sexual, physical, and emotional). Stigma and discrimination by society and the health care system, as well as structural and policy barriers, gender economic and power inequities, cultural norms, violence and rape, and mobility are some of the factors that increase sex workers' vulnerability to HIV. Structural interventions, aimed at reducing the vulnerability of FSWs, should focus on creating an enabling environment for improving access to health services and commodities and the protection of rights. Some of these activities may be beyond the scope of individual NGO/CBOs and the organisations should therefore make connections with organisations that can address these issues and work with them to develop a comprehensive prevention strategy for the local area.

Table 4. Programme Structural Interventions

Programme Component	"Checklist" of Activities for Implementation	Tools
STRUCTURAL INTERVENTIONS to address stigma and discrimination, gender issues, policy issues, socio-cultural norms and individual empowerment issues		
Strategies: ▪ Community Mobilisation and Dialogue ▪ Advocacy ▪ Individual Empowerment/ Income-generating activities	**Entry level:** ▪ Analyse environmental context (social, cultural, economic, and geographical) of sex work within locality ▪ Conduct stakeholder analysis (internal, external, clients) ▪ Analyse key issues relating to stigma and discrimination; violence (physical, sexual, emotional), and exploitation of members of local FSW communities (law enforcement agencies, bar men, brothel owners, area boys, boyfriends, etc.) ▪ Prioritize key issues to be addressed and develop mitigation plan **Intensive level:** ▪ Engagement with internal FSW community (bar owners, managers) through awareness creation and dialogue ▪ Engagement with external community (host communities, law enforcement agencies, and transport worker associations) through formal and informal policy change, institutional capacity development ▪ Improve access to financial mitigation activities through partnerships with relevant public and private sector organisations and entities ▪ Strengthen self-worth through life skills training **Exit level:** ▪ Development of sustainability plans by internal and external FSW community	**Entry level:** ▪ Venue/community profiling tool ▪ Stakeholder analysis tool ▪ Risk and vulnerability assessment tool **Intensive level:** ▪ Crisis analysis tool ▪ Community Committees ▪ Tools for linkages for IGA programming **Exit level:**

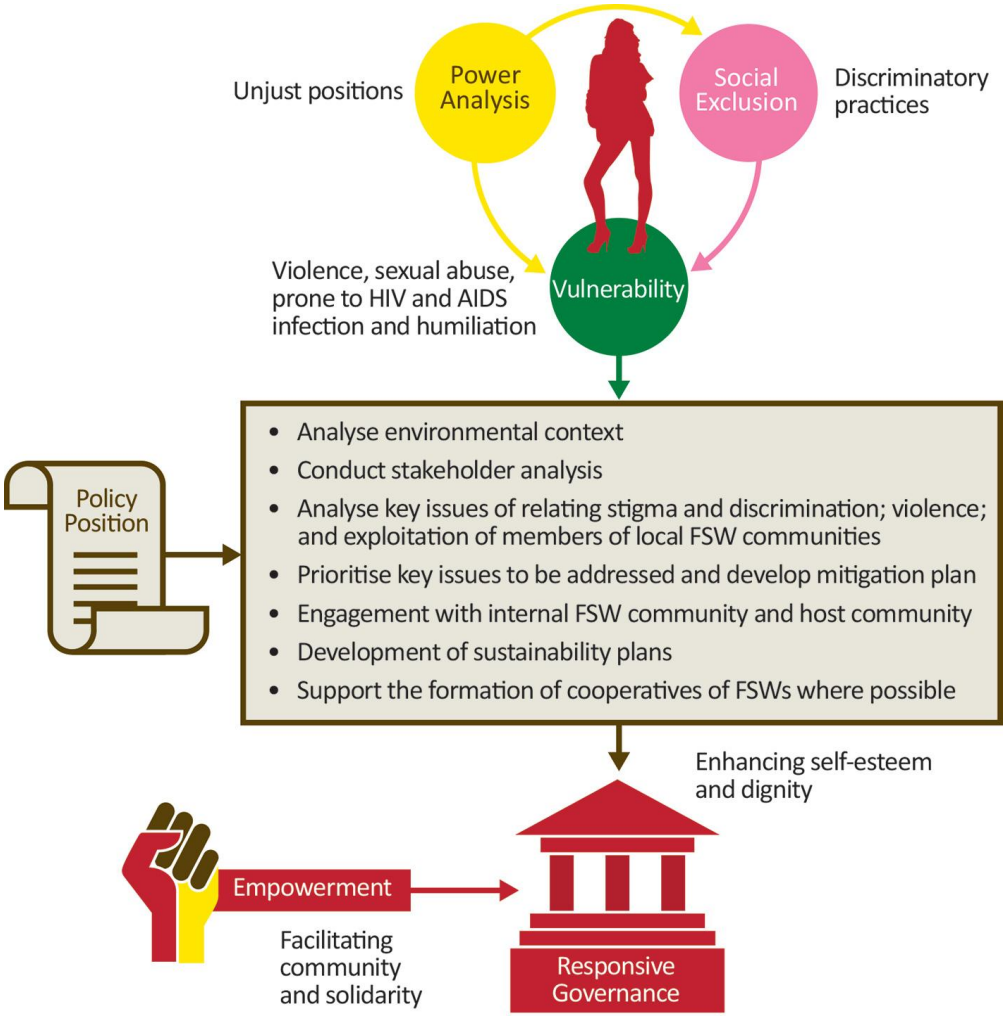
Programme Component	"Checklist" of Activities for Implementation	Tools
	▪ Support the formation of cooperatives of FSW, where possible	National PE guide

Expected Results and Indicators

- Percentage of FSWs that report physical and/or sexual violence within the month.
- Percentage of FSWs that report stigma-related barriers to accessing health and/or social services within the quarter.
- Percentage of FSWs that report harassment and discrimination in relation to accessing programmes and services within the quarter.

Programmes may address the priorities and needs of local FSWs by mobilising and organising the sex workers to address these needs. This cohesion can be later built upon to advocate for increased collective power and to take up collective action towards ensuring that programmes are responsive to the needs of the community and acceptable and accessible to them.

Figure 3. Mobilisation of FSW Flow Diagramme



Violence (physical, sexual, emotional, and verbal) and discrimination are common among female sex workers. FSWs experience sexual violence from their clients (82 percent), from law enforcement (27 percent), and from strangers (23 percent).[13] Sexual violence is rarely reported by FSWs, though it is experienced regularly. In the interventions, the issue of violence will be addressed in a structured way. Intervention teams can partner with sex workers rights organisations or other organisations working on gender-based violence (GBV) in the area to provide these services.

The activities include:

- Sensitization of law enforcement agencies to ensure that they understand the need to improve public health, including the health of sex workers.
- Training of selected peers and outreach workers in legal issues, so they can act as contact points for sex workers who experience any kind of violence. They will be trained in fundamental human rights, as stipulated in the Nigerian constitution, so they can support sex workers who experience violence.
- Legal support, psychosocial support, medical support for the victim of violence.
- Mobilisation and sensitization of the larger FSW community to understand its rights and entitlements and collectively fight violence.
- Documentation of experiences of violence and how these occurrences were addressed.
- Regular collection of information by clinics on the experience of violence; subsequently, clinics can provide/refer for relevant services, such as post-exposure prophylaxis (PEP), emergency contraception, or post-trauma services.

4.4.1. Community Mobilisation and Dialogue

Community mobilisation is the process of engaging the FSW community in discussing issues that affect FSW and involving them in planning, running, and monitoring the programme. This will increase awareness of rights and entitlements and build solidarity and support among the FSW community.

FSWs who show leadership potential should be encouraged to develop their skills and should be given meaningful roles in the programme so that they can take on its leadership. Building the capacity of the sex workers and outreach workers to document, report, and act as liaisons

[13] "United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations (2000) Convention against Transnational Organised Crime" (Palermo Protocol).

between the sex worker community and the legal system is also imperative. Liaisons should be trained in human rights issues, legal provisions within the Nigerian constitution, and reporting/redress mechanisms. It is also important that a crisis response team be instituted, composed of liaisons and other volunteers able to respond to emergency situations faced by FSW 24 hours a day.

Furthermore, FSWs should be encouraged to form cooperatives, where possible, as a medium for channelling economic strengthening support as well as building solidarity within the community. The formation of community committees (CC) should be supported to engage the larger FSW community in programming.

The host community should also be mobilised and sensitized in order to reduce the risk of violence perpetuated by community representatives, reduce the attraction of criminal entities as a result of the existence of sex work within a community, and strengthen the relationship with law enforcement agencies. Efforts should also be made to facilitate the dialogue between law enforcement and the sex work community to explore areas of common interest focused on reducing violence and criminality. Moreover, routine engagement and dialogue between programmes and local stakeholders working on FSW issues would be productive and important.

Tools

Annex 12: Community Committees

4.4.2. Advocacy

It is important to engage the leadership of law enforcement agencies and the legal system in creating an environment for the protection of vulnerable women—including FSWs—from GBV. The health sector and department of social welfare also need to provide responsive HIV- and GBV-related services, particularly to FSW. Furthermore, the capacity of law enforcement agencies must be strengthened to enable them to adopt the use of non-violent means for enforcing the law. Sexual or physical violence should not be used.

4.4.3. Individual Empowerment/Income-Generating Activities

The self-worth of FSWs should be strengthened through the provision of life skills training and education, as well as by building their capacity to establish and maintain small-scale income-generating activities. They should also be provided access to financial mitigation activities through partnerships and linkages with relevant public and private sector

organisations and entities. Drop-in centres can also be established to facilitate access to legal support, psychological support, and medical support for victims of violence.

Linkages and Integration

It is important that linkages and channels for integration be established and properly instituted within the programme. This can be achieved by:

- Strengthening the linkages between behavioural and bio-medical components with structural intervention components
- Strengthening the linkage between sexual prevention programmes for uniformed service personnel (USP) and structural interventions for sex workers
- Strengthening the capacity and creating linkages with social welfare units within state ministries of women's affairs and LGA counterparts
- Engaging and strengthening the capacity of legal aid councils/legal clinics to provide

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Chapter 5. Monitoring and Evaluation

A monitoring and evaluation (M&E) plan ensures dynamic programming that identifies gaps and evolves quickly in response to changes in the population, behaviours, and transmission dynamics. M&E of the implementation and outputs of an HIV prevention programme provides an indication of the effectiveness and efficiency of the programme. M&E can also provide opportunities for the identification and characterisation of gaps that should be addressed in order to increase the programme's impact.

The specific strategy for ongoing M&E should be developed during programme preplanning and should incorporate the participation of FSW community. The goal, along with the short-, medium-, and long-term objectives of each component of the programme, should be clearly outlined. M&E indicators are developed to ascertain whether objectives are being achieved and assess the success of each programme component.

Evaluative data should include a variety of methodologies, including epidemiological data, quantitative management measurements, and mathematical modelling, along with qualitative research, which can inform issues ranging from programme management to empowerment and is essential in clarifying quantitative indicators.

Biological and behavioural baseline data should be collected at the beginning of the programme to facilitate the future evaluation of the effectiveness of interventions. To avoid underestimating the importance of the public sector to the results, an in-depth analysis of existing government HIV prevention interventions should take place at the outset of programme implementation and over time.

Programme staff and members of the FSW community should be involved in the development of a detailed description of programme interventions and expected outcomes. This programme "logic model" makes explicit the relationship between programme interventions and expected outcomes and the associated underlying assumptions, identifies programmatic gaps, and acts as a tool to communicate programme components and expected outcomes, both internally and externally.

To track changes in behaviours and other key outcomes at the implementation level, "Polling Booth Surveys" are recommended. The methods for implementing Polling Booth Surveys are provided in Annex 13.

A participatory approach to developing a programme "logic model" provides a sense of ownership over the programme, while building the capacity of staff and of the FSW community thanks to valuable first-hand knowledge about the needs of the FSW community as well as progress, obstacles, strengths, and weaknesses of the programme.

Initially, it is important to clearly define the goal and objectives of an HIV prevention programme for FSWs. A sample goal might be "To reduce the transmission of HIV and other sexually transmitted infections" within a specific and defined context. Programme objectives are used to define the major activity components of the programme. Specific and measurable objectives provide benchmarks against which to measure success and might include:

- Increased condom use
- Reduced incidence of STIs
- Provision of outreach and clinical services
- Addressed social inequities and structural barriers to HIV prevention

For each objective, specific indicators with which to track progress towards achieving the objective need to be identified. Data that was collected as a baseline should be entered here in order to measure a programme's impact. When the programme objectives, indicators, and expected outcomes are included, this "logic model" provides a clear plan for ongoing programme monitoring.

5.1. Performance Measurement Framework

The performance measurement framework for the evaluation of HIV prevention programmes for FSWs is as follows (Table 5).

Table 5. Measurement Framework for HIV Prevention Programmes for FSWs

HIV Prevention Programmes for Female Sex Workers – Measurement Framework		
Impact	**Indicators**	**Source of Measurement**
Reduction in prevalence of HIV in Nigeria	% reduction in HIV prevalence among FSWs	Integrated Biological and Behavioural Survey or Surveillance Studies
Programme Element: Evidence-based planning and implementation for increasing coverage of FSWs with HIV prevention, care, and support programs		

HIV Prevention Programmes for Female Sex Workers – Measurement Framework		
Outcome	**Indicators**	**Source of Measurement**
Outcome 1: Establishment of HIV prevention, care, and support programmes to cover at least 20% of the estimated FSWs within the state	Costed state strategic plan (SSP) with defined plans for scaling up of FSW programs	Review of SSP
Outputs	**Indicators**	**Source of Measurement**
Output 1.1: Completion of epidemic appraisal in all LGAs to derive estimates and distribution, and characteristics of FSWs	% of LGAs in which mapping has been completed, with population estimates and specification of FSW locations and typologies	Epidemic appraisal report
Activities 1. Use the national mapping protocols 2. Recruitment & training of field team 3. Field work and data collection by the team 4. Supervision of mapping 5. Analysis of collected data 6. Report writing 7. Dissemination of mapping report		
Output 1.2: CSO with improved institutional capacity to implement FSW prevention programme	Number of CSOs with the agreed target score of a capacity assessment tool Number of CSOs delivering on agreed programme objectives	Review of the capacity assessment tool Programme reports; evaluation reports
Activities 1. Selection and engagement of CSO based on pre-determined criteria 2. Obtain baseline score from the assessment tool 3. Build capacity of CSO on the key thematic areas of prevention 4. CSO engaged in FSW prevention intervention 5. Conduct mid-term and end-term review of capacity assessment tool and programme implementation		

HIV Prevention Programmes for Female Sex Workers – Measurement Framework		
Output 1.3: Completion of venue-specific implementation plans to reach at least 20% of FSWs within their programme areas.	Number of venues with plans updated at least every two years	Review plans of CSO
Activities 1. Identification, listing and prioritization of venue by NGO/CBOs 2. Completion of participatory site assessments for intervention locations/hotspots 3. Buy-in into the generic venue-specific plan		
Programme Element: Outreach and Behavioural Interventions		
Outcome	**Indicators**	**Source of Measurement**
Outcome 2: Reduced-risk behaviours by FSWs within the programme areas	% of FSWs consistently using condoms with clients % of FSWs consistently using condoms with non-client partners	Integrated Biological and Behavioural Survey or Surveillance Studies Polling Booth Survey
Outputs	**Indicators**	**Source of Measurement**
Output 2.1: Increased proportion of FSWs reached by the minimum prevention package intervention.	% of FSWs contacted through PEs at least once in the year % of FSWs met by the outreach and peer education team at least every three months % FSWs met by the outreach team (PE or outreach worker) every month	Programme-level monitoring reports and registers
Activities 1. Constitute Programme Team 2. Recruit/select outreach workers 3. Advocacy/FSW Community Mobilisation Recruit/select PEs 4. Train PEs in the programme 5. Identify/validate the hotspots/intervention sites and optimum timing for outreach 6. Contact sex workers and inform them about the programme 7. Contact FSWs regularly and build rapport/trust		

HIV Prevention Programmes for Female Sex Workers – Measurement Framework		
8. Conduct outreach to the sites regularly (NB: Comply with basic SOPs in developing the activities)		
Output 2.2: Promotion, Demonstration, and Distribution of Male and Female Condoms and Lubricants	% sites for which a condom plan is completed, including estimation of the monthly condom/lube requirement % sites have condom and lube stocks and supplies (shops, boxes, outlets) Ratio of the number of condoms/lubricants distributed to the estimated monthly requirement % of FSWs who receive enough condoms and lubes to meet their estimated requirement (i.e., sexual partners per month)	Peer micro-plans Stock registers Outreach registers (Refer to Condom Requisition Information Forecasting Form [CRIFF])
Activities 1. Identify a system of condom and lube procurement 2. Estimate condom requirement for FSWs 3. Estimate lube requirement for FSWs 4. Direct distribution and tracking of condoms to FSWs through outreach team, according to their requirement 5. Direct distribution of lubes to FSWs through outreach team, according to their requirement 6. Establish mechanism of condom and lube outlets in all sites		
Programme Element: Biomedical Interventions		
Outcome	**Indicators**	**Source of Measurement**
Outcome 3: Increased proportion of FSWs accessing STI- and HIV-related services	% of FSWs who visit a designated programme or referral clinic regularly (at least once in 3 months) for STI screening/diagnosis % of FSWs who undertake HIV testing at least every 3 months	Programme monitoring data Behavioural tracking surveys

HIV Prevention Programmes for Female Sex Workers – Measurement Framework		
	% of FSWs who are referred for reproductive health services with linked providers [% of FSWs who access reproductive health services at least twice per year] [% of FSWs who seek emergency services such as PEP, etc.] [% of HIV-positive FSWs who seek care and treatment]	
Output	**Indicators**	**Information Source**
Output 3.1: Strengthening the existing system of STI services	% of FSWs for whom targeted STI services have been established (i.e., through programme-run clinics and/or referral clinics) % of FSWs who are referred for STI services (programme-run clinics or referral to linked services) % of FSWs visiting a clinic for STI services at least once	NGO/CBO service delivery

HIV Prevention Programmes for Female Sex Workers – Measurement Framework

Activities

1. Review and adapt the existing national standard operating procedures (SOP) for testing and treatment, especially bearing in mind the needs of FSWs
2. Identify sites where clinical services will be provided to FSWs in consultation with FSWs (programme clinic or referral clinic)
3. Train and retrain clinic staff (counsellors, nurses, doctors, prevention officers) on the SOP and needs of FSWs, including sexual diversity training
4. Provide health education at the clinic to all FSWs
5. Contact tracing through outreach for follow-up
6. Treatment of regular partner
7. Treatment of sex partners
8. Provide counselling to FSWs on completion of treatment and on condom and lubricant use, etc.
9. Follow up after a week of enrolment or registration in the clinic
10. Regular check-up and follow-up every 3 months

Output 3.2: Provision of HIV counselling and testing	% of FSWs for whom targeted HIV counselling, testing, and referral services have been established % of FSWs who are referred for STI services (programme-run clinic or referral to linked services) % of FSWs attending a clinic/service for the first time counselled and tested for HIV	Clinic reports

Activities

1. Review the national SOP for counselling and treatment
2. Identify facilities providing counselling and testing (programme-owned or referral)
3. Training (including refresher training) of staff (counsellors, nurses) on HIV counselling
4. Organise/link up with comprehensive moonlight clinics (outreach clinics) in hotspots
5. Motivation of regular partners for HIV counselling and testing
6. Provision/referral for provision of PEP
7. Follow-up of FSWs for regular testing and counselling

HIV Prevention Programmes for Female Sex Workers – Measurement Framework		
Output 3.3: Provision of HIV care and treatment	% of FSWs living with HIV who have been referred for pre-ART assessments % of FSWs eligible for ART that have been initiated on ART % of FSWs on ART who remain in care and adherent to treatment regimens	Clinic reports
Activities 1. Follow/adapt the national SOP for treatment and care of FSWs 2. Enrol/refer HIV-positive FSWs, as appropriate 3. Screening of HIV-positive FSWs for OI and staging 4. Conduct/refer for tests for LFT, RFT, and CD4 5. Initiate/refer for initiation of ART and CTX 6. Provide/refer for adherence counselling 7. Follow-up of HIV-positive FSWs by HIV-positive peers or acceptable outreach staff		
Output 3.4: Provision of other reproductive health and allied services	% of FSWs referred for counselling on family planning % of FSWs referred for other services	Clinic reports
Activities 1. Provide family planning services (pills, condoms, injectable contraceptives) to FSWs 2. Provide/refer for cervical cancer, anal cancer, HPV and HSV2s screening for FSWs 3. Refer FSWs for other services, such as diabetes and hypertension screening, along with other services that FSWs need 4. Referrals to services related to rape support and underage sex workers		
Programme Element: Structural Interventions to Reduce Vulnerability		
Outcome	**Indicators**	**Source of Measurement**

HIV Prevention Programmes for Female Sex Workers – Measurement Framework		
Outcome 4: Reduction in violence, stigma, and discrimination experienced by FSWs	% of FSWs that report physical and/or sexual violence % of FSWs that report stigma-related barriers to accessing health and/or social services % of FSWs that report harassment and discrimination in relation to accessing programmes and services	Behavioural tracking surveys Special behavioural studies
Output	**Indicators**	**Information Source**
Output 4.1: Completion of an assessment of the vulnerabilities and sources of violence, stigma, and discrimination	% of programmes that have completed an assessment of vulnerabilities	Programme reports
Output 4.2: Provision of appropriate vulnerability reduction services	% of programmes with vulnerability reduction initiatives, which could include: ▪ Crisis response systems ▪ Safe spaces for FSWs ▪ Police sensitization ▪ Stigma reduction programs ▪ Development of economic empowerment initiatives ▪ Community strengthening and mobilisation ▪ Enhanced access to social entitlements	NGO/CBO programme documents
Activities 1. Conduct participatory assessments with FSWs to assess and prioritize sources of vulnerability. 2. Develop local vulnerability reduction plans. 3. Implement local work plans for vulnerability reduction.		

HIV Prevention Programmes for Female Sex Workers – Measurement Framework		
Output 4.3: Mitigate violence against sex workers – not clear at this point if the package will include violence reduction; maybe not minimum because only relevant in some places	Establish programme advisory committee responsible for violence reduction and advocacy % increase in reporting of violence among sex workers	Violence reporting formats
Activities 1. Conduct sessions with sex workers on self-esteem, mobilisation, and collectivisation 2. Conduct sensitization meetings with key law enforcement/administrative agencies 3. Identify legal aid organisations that can provide representation for sex workers regarding violence e.g., Association of Nigerian Female Lawyers 4. Establish linkages with human rights organisations 5. Sensitise sex workers on their human rights		
Output 4.4: Address issues related to dignity and stigma and discrimination against sex workers	Number of stakeholder meetings conducted that specifically raise the issues of stigma and dignity	Meeting minutes Media reports
Activities 1. Conduct training for programme team to sensitise members on issues of stigma and discrimination 2. Organise learning exchange across sites Conduct self-esteem/empowerment trainings for sex workers 3. Develop speakers among sex workers who can advocate with stakeholders 4. Sensitisation meeting with media on stigma and discrimination and advocacy to reduce negative reporting		
Output 4.5: Formation of community-based organisations (CBOs)	Number of CBOs of FSWs formed Number of CBO members trained in governance and management % of CBOs with good system of management and governance	Registration Training reports Assessment reports
Activities 1. Conduct training for FSWs and facility staff on perspective building and critical thinking 2. Organise learning exchange with other CBOs, including best practices and how to avoid		

HIV Prevention Programmes for Female Sex Workers – Measurement Framework

pitfalls

3. Conduct training for FSWs on governance and management of CBOs
4. Register CBOs of FSWs
5. Develop a sound system of governance and management for CBOs

5.2. FSW Guideline Operational Framework

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
Outreach: ▪ Small group discussions ▪ Interpersonal communication ▪ Community stakeholders meetings (including female sex workers, pimps, madams) **Peer Education:** ▪ Social peers ▪ Age peers ▪ PLHIV ▪ Counselling and skills building	To reduce the risk of HIV and STIs among FSWs and their clients	**Entry level:** ▪ Identify venues and optimum timing for outreach by CSO ▪ Identify and engage outreach coordinators ▪ Meet with gate keepers ▪ Contact sex worker community and inform them about the programmes **Intensive Level:** ▪ Identify potential PEs ▪ Train PEs in the programme ▪ PEs conduct periodic	Nigeria National Response Information Management System (NNRIMS) tools **Entry level Examples:** Validation format-tool (SFH/UOM) Community mapping (NACA review and adapt national mapping tool) Spot analysis Baseline-PME (participatory monitoring and evaluation tool) Stakeholder analysis tool	% of FSWs reached with Minimum Prevention Package Intervention (MPPI) **Numerator:** Total Number of FSW reached with MPPI **Denominator:** Total Number of FSW targeted Number of FSWs reached every month with MPPI.	**Programme reports** **PITT (Prevention Intervention Tracking Tools)** *Example:* PE diary ORW format Group meeting format Monthly outreach format MIS records	Yearly Quarterly Monthly Monthly

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
		outreach to the sites (frequency needs to be stated) ▪ Periodic reviews to strengthen interpersonal communication among PEs (monthly) and build rapport and trust ▪ Plan and conduct community meetings regularly (monthly) ▪ Develop and support small peer support groups of FSWs ▪ Process documentation and dissemination **Exit level:** ▪ Formation of FSW-community protection	PE recruitment criteria tool Site load mapping **Intensive level:** NNRIMS tools Contact mapping Community conversation tool kit			

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
		committees ▪ Plan for continuation by CBOs ▪ Promote voluntary PEs from the community ▪ End of project evaluation/dissemination ▪ Sexual Behaviour sustainability	(FHI- C-change) PE monitoring tool (SFH) PEP plus- NACA Opportunity gap analysis **Exit level:** Evaluation tool Final reporting template Best practice document Success story format			
Condom and Lubricant programming ▪ Demonstration, promotion, and distribution of male and female	Promote consistent and correct use of condoms (male and female) by FSWs with all sexual partners	**Entry level:** ▪ Identify a system of condom procurement ▪ Estimate condom requirement for **FSWs (use IBBSS client per day data/programme**	Condom availability mapping			

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
condoms and water-based lubricants		**data** ▪ **IBBSS- 5 clients per day among brothel FSW** ▪ **150 condom monthly average)** **Intensive tool:** ▪ Direct distribution and tracking of condoms to FSWs through outreach team ▪ Identify traditional/non-traditional outlets and distribution systems established in all sites **Exit level:** ▪ Initiate social marketing of condom ▪ Outlet sustainability	PE card Condom distribution tool (SFH) Condom distribution	Increased proportion of FSWs using condoms with clients and other partners: ▪ Ratio of condoms distributed/ condoms required (monthly) ▪ % of FSWs receiving condoms as per the demand (monthly) ▪ % of FSW reporting the use of condom with their last client ▪ % of FSWs using condoms regularly, self-reporting	Condom stock register IBBSS	Monthly Monthly Monthly

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
		of condom distribution	format			
Biomedical Interventions						
▪ STI Control and Management ▪ Screening and treatment of STIs ▪ Training on STI syndromic case management	▪ Referral to facility for STI treatment for FSW and sexual partners ▪ Provision for mobile STI syndromic management	**Entry level: (PEP document)** ▪ Identify sites where clinical services will be provided to FSWs ▪ Adapt the existing national standard operational guideline for STI management **Intensive Level:** ▪ Train and retrain clinic staff (counsellors, nurses, doctors, prevention officers) on the SOP and needs of FSWs ▪ Provide counselling for STI at the clinic to all FSWs	Preference ranking Community mapping tool Facility mapping tool Facility assessment tool National syndromic management guideline/tool	▪ %FSWs referred for STI services in a month ▪ % of FSWs accessing STI services within the month (reporting monthly) ▪ % of FSW that completed STI treatment within the month ▪ % of FSW accessing follow-up check-up for STI within the quarter	Referral register/forms	Monthly Monthly Monthly Quarterly

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
		▪ Referrals/treatment of FSWs for STI – syndromic management ▪ Partner notification and treatment ▪ Follow-up after a week of enrolment or registration in the clinic ▪ Regular check-up and follow-up every 3 months **Exit level:** ▪ Strengthen linkages of community with government health care system ▪ Establish Community referral structure for linkages				

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
HIV Counselling and Testing ▪ Mobile HCT ▪ Facility-based HCT ▪ Community-based HCT ▪ Referrals	Referral to facility for HCT t for FSW and sexual partners Provision for mobile HCT s Community based HCT	**Entry level:** ▪ Adopt the national SOP for counselling and treatment for HIV ▪ Identify HCT service providers (programme owned or referral/) ▪ Training of staff (counsellor, nurses) on HIV counselling ▪ Organise/ link up with comprehensive moonlight clinics (outreach clinics) in hotspots **Intensive level:** Follow-up of FSWs for regular testing and counselling (mobile HCT) Refer pregnant FSWs for	Adapt tools as per the national SOP	▪ % of FSWs referred for HCT services within the quarter. ▪ % of FSWs referred for HCT services first time within the quarter. ▪ % of FSWs referred for follow-up HCT services within the quarter.	Referral register/forms	Quarterly Quarterly Quarterly

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
		HIV testing ▪ Facilitate HIV-positive pregnant FSWs' access to appropriate PMTCT services ▪ Promote community counselling systems **Exit level:** ▪ Linkages with positive network				
PMTCT ▪ HIV treatment, care, and support ▪ TB Screening and referral to treatment	Strengthen referrals and linkages	**Entry level:** ▪ Follow/adapt the national SOP concerning treatment and care for FSWs **Intensive level:** Enrol/refer HIV-positive FSWs to care Screening of HIV-positive FSWs for OI and	Adapt tools from national guidelines PMTCT guideline	▪ % of FSWs living with HIV who have been referred for care within the quarter ▪ % of FSWs eligible for ART who are newly initiated on ART within the quarter ▪ % of FSWs on ART	Referral register/forms	Quarterly Quarterly

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
		staging Conduct/refer for tests for LFT, RFT, and CD4 ▪ Initiate/refer for initiation of ART and CTX ▪ Provide/refer for adherence counselling ▪ Follow-up of HIV-positive FSWs by HIV-positive peers or acceptable outreach staff ▪ Promote PMTCT among FSW as part of peer education package **Exit level:** ▪ Linkages with positive networks and other support		who remain in care and are adherent to treatment regimens within the quarter/year		Quarterly Yearly

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
		services				
▪ Reproductive and allied health services FP, ANC, and postpartum/natal care	Strengthen referrals and linkages	▪ Provide FSWs with family planning services (pills, condoms, injectable contraceptives) ▪ Provide/refer FSWs for cervical cancer, anal cancer, HPV, and HSV2s screening ▪ Refer FSWs for other services, such as diabetes and hypertension screening, or other services that FSWs need ▪ Referrals to services related to rape support and underage sex workers **Exit level:**	Adapt tools from national sexual reproductive health–SOP (Ministry of Health) MNCH training tool	▪ % of FSWs counselled for family planning within the month. ▪ % of FSWs referred for other services within the quarter	Counsellor diary Referral slip Referral register	Monthly Quarterly

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
		▪ Linkages with relevant support services				
Structural Interventions						
Community Dialogue **Advocacy** **Income-Generating Activities** ▪ Stigma and discrimination ▪ Gender issues ▪ Policy issues ▪ Socio-cultural norms ▪ Individual empowerment	Identify key structural issues for FSWs and initiate action to address these issues	**Entry level:** ▪ Identify and analyse key issues of stigma, discrimination, violence, exploitation and gender with members of local FSW communities (law enforcement agencies, bar men, brothel owners, area boys, boyfriends, etc.) ▪ Articulate a clear position on the issues **Intensive level** ▪ Develop mitigation plans with the	**Entry level:** Stakeholder analysis Risk and vulnerability assessment tool Crisis analysis tool	▪ % of FSWs that report physical and/or sexual violence within the month ▪ % of FSWs that report stigma-related barriers to accessing health and/or social services within the quarter ▪ % of FSWs that report harassment and discrimination in relation to accessing programmes and	Crisis reporting format Stigma reporting Format IGP quarterly report	Monthly Quarterly Quarterly

Behavioural Interventions:						
Intervention Package Elements as per National MPPI	**Goal**	**"Checklist" of Activities for Implementation**	**Suggested field tools**	**Expected Results and Indicators (as per NOP)**	**Means of verification**	**Frequency of reporting**
issues		community, including through individual empowerment, working with power structures, and addressing policy issues ▪ Integrate income-generation programme with the support of other ministries, CSOs, etc. **Exit level:** ▪ Development of sustainability plans by internal and external FSW community ▪ Support the formation of cooperatives of FSWs where possible		services within the quarter		

Annex 1. Key activity/Process level Indicators based on MPPI activities

Behavioural

1. Number of peer sessions held
2. Number of new peers attending Peer sessions
3. No of peers that participated in PE session
4. Number of condoms distributed
5. Number of individuals provided condoms
6. Ratio of condoms distributed / condoms required (monthly)
7. Number of lubricants distributed
8. Number of individuals provided lubricant
9. Ratio of Lubricants distributed / Lubricants required (monthly)
10. Number of NTO selling condoms and condom lubricants

Biomedical

11. Number of beneficiaries referred for STI services
12. % beneficiaries referred for STI services in a quarter.
13. % of beneficiaries accessing STI services within the Quarter
14. % of beneficiaries who uptake STI services
15. Number of beneficiaries treated for STIs that go for a follow-up visit for STI treatment within the quarter.
16. Number of individuals referred for HCT services
17. % of beneficiaries referred for HCT services within the quarter.
18. Number of individuals counselled and tested
19. Number of individuals counselled, tested and received their result
20. % of beneficiaries who received HCT in the last 12 months and who know their results
21. % of beneficiaries who tested HIV positive
22. Number of pregnant beneficiaries referred for ANC services within the month

23. Number of individuals referred for other services: e.g. drug rehabilitation, Non Communicable Disease (NCD);

Structural

24. Number of MARPS influencers that participated in community dialogue
25. Number of community dialogues held
26. Number of individuals referred for IGA
27. Number of IGA held in the quarter
28. Number of MARPs that benefited from the IGA.
29. % of beneficiaries that report physical and/or sexual violence within the month
30. % of beneficiaries that report stigma-related barriers to accessing health and/or social services within the quarter
31. % of beneficiaries that report harassment and discrimination in relation to accessing programmes and services within the quarter

Exposure to MPPI

32. % of beneficiaries reached with Minimum Prevention Package Intervention (MPPI) in a quarter

Annex 2. MARPs HIV Prevention Intervention Monitoring Indicators Definition Sheet

Indicator 1	Number of peer education sessions held
Purpose	Trained Peer educators are expected to run either small group or one on one peer education sessions. On the minimal, a peer educator is expected to have at least 2 peer education contacts with her/his peers on a monthly basis. The assumption is that at two peer contacts in a month, a peer should participate in 6 sessions in three months which is enough to cover minimal peer education curriculum. It is important to know the number of sessions conducted periodically by peer educators.
Definition	This indicator tracks number of Peer sessions conducted by Peer Educator (PE session includes one on one sessions, small group discussions)
Disaggregated by	By target group (MSM, FSW, IDU)
Measurement (how to calculate it)	Count the number of sessions held
Source of data	Attendance Sheet, Peer Education Monthly tracking tool
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 2	Number of new peers attending Peer sessions
Purpose	Peer Educators are expected to hold their peer sessions with selected peers on a monthly basis. It is possible PEs will recruit new peer until the maximum number per PE is reached. To avoid the possibility of over counting the number of peers reached, it is important, new peers are reported on a monthly basis. This indicator will provide information on number of new peers which will be added to the number of peers that were reached in the previous month to arrive at total number of peers reached within the reporting period.
Definition	This indicator captures new Peers attending Peer sessions during the reporting period. A new peer refers to a member of the target group that joins a selected peer education group for the first time. It excludes a peer that is a member of a peer group that has been away for a period of time

Indicator 2	Number of new peers attending Peer sessions
	and returned to the same group within the same site
Disaggregated by	Target group (FSW, MSM, IDU) and Sex. *Sex disaggregation applies only to IDUs*
Measurement (how to calculate it)	Counting new peers in attendance at Peer sessions
Source of data	Attendance sheet, Peer Education Monthly tracking tool
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 3	No of peers that participated in PE session
Purpose	Number of peers that participate in a peer session provides information on coverage of programme intervention among a selected group. This is important as coverage is an important indicator in Nigeria HIV&AIDS Strategic Plan.
Definition	This indicator would track persons who attended Peer sessions within the reporting period. It is the sum of old and new peers that participated in a peer session within the reporting period
Disaggregated by	By target group
Measurement (how to calculate it)	Monthly: Count all peers that participated in peer sessions in the month Quarterly: Peers in Month “1” + New Peers in month “2” + New Peers in Month “3”.
Source of data	Peer Education Monthly tracking tool , Peer Educators Monthly summary form
Frequency of reporting	Monthly and Quarterly
Baseline	
Target	

Indicator 4	Number of condoms distributed
Purpose	Records of condoms distributed to a selected group are important for planning, availability and proxy indicator for use. This indicator will track condom distribution
Definition	This indicator counts pieces of condom distributed. This refers to condoms distributed freely and sold
Disaggregated by	By type of condom (Male or Female Condom) and whether sold or freely given
Measurement (how to calculate it)	Count pieces of condoms
Source of data	Condom distribution tracking tool, Peer Educator's monthly summary form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 5	Number of individuals provided condoms
Purpose	This indicator will provide data on the number of persons who were provided either male or female condoms within a reporting period. It will help in guiding programmers on availability of condoms to MARPs.
Definition	This indicator measures individuals who received condoms (male or female condoms) freely.
Disaggregated by	By target population and type of condoms
Measurement (how to calculate it)	Monthly: Counting individuals given condom during the reporting period Quarterly: Number of persons in Month "1" + New individuals in Month "2" + New individuals of persons in Month "3"
Source of data	Condom distribution tracking tool, Peer Educator's monthly summary form
Frequency of reporting	Monthly and Quarterly
Baseline	
Target	

Indicator 6	Ratio of condoms distributed to condoms required (monthly)
Purpose	Based on the needs of each peer, it is important to know to what extent the needs of the group arebeing covered within a reporting period. This information will help in knowing whether projects are adequately meeting condom needs of the target group or not.
Definition	This indicator is a proportion of condom freely distributed as against condom needs of the group.
Disaggregated by	Target group
Measurement (how to calculate it)	Number of Condoms freely distributed* / Number of condom needed by the group. NB* (refer to previous indicator sheet) Denominator: Condom need of the group is the sum total number of condoms required for the period as expressed by each peer
Source of data	Peer Educator's monthly summary form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 7	Number of lubricants distributed
Purpose	Efficacy of condoms improves with the use of a condom lubricant. Tracking the number of lubricant distributed will provide information on needs and coverage of condom lubricant distribution among the selected group.
Definition	This indicator counts pieces of Lubricants distributed either freely or sold
Disaggregated by	Type of MARPs and whether free or sold
Measurement (how to calculate it)	Counts units of Lubricants
Source of data	Peer Educator's monthly summary form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 8	Number of individuals provided lubricant
Purpose	The record of the number of persons provided condom lubricant is indicative of the coverage and use of condom lubricant. This indicator will record the number of individuals provided Lubricants within a reporting period
Definition	To track number of individuals who received Lubricants within the reporting period. This indicator captures both those that were given free and socially marketed lubricants.
Disaggregated by	Type of MARPs and whether free or socially marketed
Measurement (how to calculate it)	Monthly: Actual count of persons given lubricant. Quarterly: Number of persons in Month "1" + New Individuals in Month "2" + New Individuals in Month "3"
Source of data	Peer Educator's monthly summary form
Frequency of reporting	Monthly and Quarterly
Baseline	
Target	

Indicator 9	Ratio of Lubricants distributed / Lubricants required (monthly)
Purpose	Based on the needs of each peer, it is important to know to what extent the needs of the group are being covered within a reporting period. This information will help in knowing whether projects are adequately meeting condom lubricant needs of the target group or not.
Definition	This indicator is a proportion condom lubricant freely distributed as against condom lubricant needs of the group.
Disaggregated by	Target group and type of package
Measurement (how to calculate it)	Numerator : Lubricants distributed within the reporting period NB* (refer to previous indicator sheet) Denominator: Lubricant required is calculated by aggregating number of sex acts reported by the MARP
Source of data	Peer Educator's monthly summary form

Indicator 9	Ratio of Lubricants distributed / Lubricants required (monthly)
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 10	Number of Non Traditional Outlets selling Condoms and condom lubricants
Purpose	Availability of condoms is a very important determinant of condom use. Non Traditional outlets within hotspots selling condoms will improve access to condoms. This indicator will track whether the number of traditional outlets selling condoms is increasing or not
Definition	This indicator tracks all Non-traditional outlets selling condoms within that reporting period. Within the context of MARPs programming, Non Traditional Outlets (NTOs) we refer to all outlets where condoms are sold other than Pharmacies, PPMVs (Chemist), Super markets and Hospitals where condoms. Specifically we refers to outlets like Kiosks, Hawkers, Peer Educators / community outreach teams etc.
Disaggregated by	
Measurement (how to calculate it)	Count
Source of data	Condom Outlet tracking tool (COTT)
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 11	Number of beneficiaries referred for STI services
Purpose	MARPs are expected to go access STI services at least once in a quarter. To facilitate this, peer educators are expected to refer peers to a designated STI service provision center for STI services periodically. This indicator will provide information on the number of individuals referred for STI services
Definition	This refers to the total number of persons referred for STI services

Indicator 11	Number of beneficiaries referred for STI services
Disaggregated by	By Age, sex and target group *Sex disaggregation applies only to IDUs
Measurement (how to calculate it)	Count the total number of referral forms issued for STI services in the month In a quarter, total number referred monthly should be aggregated.
Source of data	Referral form, Referral Register and Monthly Summary Form
Frequency of reporting	Monthly and Quarterly
Baseline	
Target	

Indicator 12	% beneficiaries referred for STI services in a quarter
Purpose	While number referred is being tracked, also important is the coverage. This indicator will provide information on the total number of persons referred for STIs as a proportion of total number of peers in the group.
Definition	This is the percentage of beneficiaries that were referred for STI services within the quarter
Disaggregated by	By Age, sex and target group Sex disaggregation applies only to IDUs
Measurement (how to calculate it)	Total number referred in a quarter / total number of peers in the group multiplied by 100
Numerator	Number of beneficiaries referred for STI services in the quarter
Denominator	Total number of beneficiaries in the quarter
Source of data	Referral form, Referral Register and Monthly Summary Form
Frequency of reporting	Quarterly
Baseline	
Target	

Indicator 13	% of beneficiaries accessing STI services within the Quarter
Purpose	The proportion of individuals that access STI services provides very useful information for programming among MARPs. This indicator will track the percentage of beneficiaries accessing STI services in the quarter
Definition	This is the percentage of beneficiaries who were referred and accessed STI services in the quarter. Within this context, accessing means the referred individual visited the health facility.
Disaggregated by	By Age, sex and target group Sex disaggregation applies only to IDUs
Measurement (how to calculate it)	Total number that accessed STI services / Total number of peers that were referred* 100
Numerator	Number of beneficiaries referred for STI services that access the service in the quarter
Denominator	Total number of beneficiaries referred for STI services in the quarter
Source of data	Referral form, Referral Register and Monthly Summary Form
Frequency of reporting	Quarterly
Baseline	
Target	

Indicator 14	% of beneficiaries who uptake STI services
Purpose	To track percentage of beneficiaries that received STI services in the quarter
Definition	This refers to the proportion of beneficiaries that were referred and received STI services in the quarter
Disaggregated by	Age, Sex and target group Sex disaggregation applies only to IDUs
Measurement (how to calculate it)	Total number referred that received STI services /Total referred *100
Numerator	Number of beneficiaries referred who received STI services in the quarter
Denominator	Total number of beneficiaries referred in the quarter

Indicator 14	% of beneficiaries who uptake STI services
Source of data	Referral form, Referral Register and Monthly Summary Form
Frequency of reporting	Quarterly
Baseline	
Target	

Indicator 15	Number of beneficiaries treated for STIs that go for a follow-up Visit for STI treatment within the quarter
Purpose	To track the number of beneficiaries that were treated for STI and had a follow-up visit as required by the MARPS implementation guide
Definition	This refers to the number of beneficiaries that were treated for STI and had a follow-up visit
Disaggregated by	Age, Sex and target group Sex disaggregation applies only to IDUs
Measurement (how to calculate it)	Count number of beneficiaries that were treated for STI and had a follow up visit
Source of data	Part B of referral form
Frequency of reporting	Quarterly
Baseline	
Target	

Indicator 16	Number individuals referred for HCT services
Purpose	To track number of all individuals (target group and General Population) referred for HCT services
Definition	This refers to the number of all individuals referred for HCT services
Disaggregated by	Age and Sex
Measurement (how to	Count number of referrals made for HCT services in the month

Indicator 16	Number individuals referred for HCT services
calculate it)	
Source of data	Referral form, Referral Register and Monthly Summary Form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 17	% of beneficiaries referred for HCT services within the quarter.
Purpose	To track percentage of beneficiaries that are referred for HCT services in the quarter
Definition	This refers to the percentage of beneficiaries that were referred for HCT services within the quarter
Disaggregated by	Age, sex and target group
Measurement (how to calculate it)	Divide the numerator/denominator and multiply by 100
Numerator	Number of beneficiaries who were referred for HCT services in the quarter
Denominator	Total number of beneficiaries referred in the quarter
Source of data	Referral form, Referral Register and Monthly Summary Form
Frequency of reporting	Quarterly
Baseline	
Target	

Indicator 18	Number of individuals counselled and tested
Purpose	This helps to report number of individual who had gone through the process of counselling and testing for HIV.
Definition	This indicator defines the number of men and women who were counselled and tested for HIV

Disaggregated by	disaggregated by sex, age, facility type, type of MARPs
Measurement (how to calculate it)	Count total number of clients who were counselled and tested from CT Register, HCT Monthly summary form and client intake form
Source of data	Part B of referral form, Monthly summary form, Client intake form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 19	**Number of individuals counselled, tested and received their result**
Purpose	This helps to report number of individual who had gone through the process of counselling, testing for HIV and receive their result.
Definition	This indicator defines the number of men and women who were counselled and tested for HIV and receive their result.
Disaggregated by	disaggregated by type of MARPs, sex, age, sero status, facility type, location (LGA, State)
Measurement (how to calculate it)	Count total number of clients who were counselled, tested and know this status from CT Register, HCT Monthly summary form, result form and client intake form
Source of data	Part B of referral form, Monthly summary form, Client intake form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 20	**% of beneficiaries who received HCT in the last 12 months and who know their results**
Purpose	To know the proportion of individuals that received HCT services and know their status in the last 12 months
Definition	This indicator is designed to show the proportion of individuals that were counselled, tested and received their results and know their status in the

Indicator 20	% of beneficiaries who received HCT in the last 12 months and who know their results
	last 12 months
Disaggregated by	disaggregated by type of MARPs, sex, age, sero status, facility type, location (LGA, State)
Measurement (how to calculate it)	Total number of individuals who were counselled, tested for HIV and received result and know their status as a percentage of total number of individuals who were counselled and tested for HIV
Source of data	Monthly summary form
Frequency of reporting	Annually
Baseline	
Target	

Indicator 21	% of beneficiaries who tested HIV positive
Purpose	To know the proportion of individuals that received HCT services and tested positive for HIV.
Definition	This indicator is designed to show the proportion of individuals who received HIV counselling and testing services and tested positive for HIV in last 12 months
Disaggregated by	disaggregated by sex, age, facility type, location (LGA, State)
Measurement (how to calculate it)	Total number of individuals who received HIV counselling and testing services and tested positive for HIV as a percentage of total number of individuals who were counselled and tested for HIV
Source of data	Client intake form, facility record
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 22	Number of pregnant beneficiaries referred for ANC services within the month
Purpose	ANC services create opportunity for PMTCT services which is important for minimising mother to child transmission of HIV. This is indicator will provide information on total beneficiaries that are pregnant were referred for ANC services
Definition	This is designed to determine the number of pregnant beneficiaries who were referred for ANC services.
Disaggregated by	disaggregated by age, facility type, location (LGA, State)
Measurement (how to calculate it)	Counting total number of pregnant beneficiaries who were referred for ANC services within the month from the referral registers.
Source of data	referral registers
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 23	Number of individuals referred for other services: e.g. Family Planning drug rehabilitation, Non Communicable Disease (NCD), Income Generation activities (IGAs), TB
Purpose	To ensure that beneficiaries are linked to other services as required. This is designed to know the number of individuals who were referred to access other services
Definition	This is the total number of individuals referred for services (FP, drug rehabilitation, , NCD, TB, ART etc).
Disaggregated by	disaggregated by type of service, sex, location (LGA, State)
Measurement (how to calculate it)	Counting total number of beneficiaries who were referred to other services which are non HCT related.
Source of data	Monthly summary form
Frequency of reporting	Monthly

Indicator 23	Number of individuals referred for other services: e.g. Family Planning drug rehabilitation, Non Communicable Disease (NCD), Income Generation activities (IGAs), TB
Baseline	
Target	

Indicator 24	Number of MARPS influencers that participated in community dialogue
Purpose	It is important to identify who the influencers within the community are and their characteristics. It is also important that the more diverse the influencers that actively and regularly participate in community dialogue are, the better the chances of an enabling environment. Measurement of the existence of who the influencers are, the roles they play in creating enabling environments and number of times they meet and decisions taken is important for programme effectiveness, ownership and sustainability
Definition	This indicator provides the number of influencers in the community that were engaged to create enabling environment for the target group
Disaggregated by	Occupation, position, and sex
Measurement (how to calculate it)	Count
Source of data	Attendance form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 25	Number of community dialogues held
Purpose	Some issues such as SD, violence, may require more sessions to address. Measuring the number of dialogues held is important to understand the levels of community involvement in addressing and resolving pertinent

Indicator 25	Number of community dialogues held
	structural issues It is important to understand the goal, objectives and the number of sessions held.
Definition	This indicator provides the number of community dialogues in the community
Disaggregated by	Participants' type and sex, type of sessions, issues discussed
Measurement (how to calculate it)	Count
Source of data	Attendance form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 26	Number of individuals referred for IGA
Purpose	It is important to identify persons referred for IGA and their, typology. It is also important to identify the type of IGA referred for. It is also important that IGA referred must meet feasible and meet the required needs of the beneficiary. This provides opportunity for individual empowerment and vulnerability issues
Definition	This indicator provides the number of persons referred and the type of IGA referred.
Disaggregated by	Type of IGA, number of people referred, typology of people referred, age and sex
Measurement (how to calculate it)	Count
Source of Data	Referral register

Indicator 26	Number of individuals referred for IGA
Frequency of reporting	Quarterly
Baseline	
Target	

Indicator 27	Number of IGA held in the quarter
Purpose	It is important to build capacity of the community members on alternative source of income It is important community members acquire skills for future utilization This helps to identify structural needs that have been addressed via IGAs
Definition	This indicator provides information on the number of income generating activities implemented in the quarter
Disaggregated by	Type of IGA, Type of MARPs
Measurement (how to calculate it)	Count
Source of data	Attendance sheet
Frequency of reporting	Quarterly
Baseline	
Target	

Indicator 28	Number of MARPs that benefited from the IGA.
Purpose	This helps to identify structural needs that have been addressed via IGAs
Definition	This indicator provides information on beneficiaries of income generating activities
Disaggregated by	Age, sex, type of MARPs
Measurement (how to calculate it)	Count

Indicator 28	Number of MARPs that benefited from the IGA.
Source of data	Referral form
Frequency of reporting	Quarterly
Baseline	
Target	

Indicator 29	% of beneficiaries that report physical and/or sexual violence within the month
Purpose	Physical and sexual violence socially affects MARPS and reduces their interaction with other members of the community. A measure of the proportion of the beneficiaries experiencing and report these incidences will improve programme effectiveness by giving an indication of if/where further advocacy is required.
Definition	This indicator portrays the proportion of FSW and other MARPs that experience physical and/or sexual harassment from members of the community
Disaggregated by	sex and age of perpetrators, type
Measurement (how to calculate it)	Numerator: number of the target group reporting physical/sexual harassment Denominator: Total number of the target group
Source of data	Registration form, Peer Education Monthly tracking tool , Peer Educators Monthly summary form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 30	% of beneficiaries that report stigma-related barriers to accessing health and/or social services within the quarter
Purpose	Members of FSW and other MARPs need access to health care and social

Indicator 30	% of beneficiaries that report stigma-related barriers to accessing health and/or social services within the quarter
	services. Stigmatization and discrimination prevents them from accessing such services. Proportion of the MARPs experiencing these barriers and sources/types of incidence will better inform programme decisions on the prevalence of stigma-related barriers and which health/social facilities provider requires advocacy interventions
Definition	This indicator portrays the proportion of FSW and other MARPs that experience physical and/or sexual harassment from members of the community
Disaggregated by	Type of stigma
Measurement (how to calculate it)	Numerator: number of the target group reporting stigma-related barriers to accessing health and/or social services Denominator: Total number of the target group
Source of data	Crisis management summary form
Frequency of reporting	Quarterly
Baseline	
Target	

Indicator 31	% of beneficiaries that report harassment and discrimination in relation to accessing programmes and services within the quarter
Purpose	Programmes have shown a high level of harassment of MARPs in various communities. The situation in most cases has increased vulnerability of these groups and in particular heightened the risk of HIV and other infections. It is important that cases of harassment and discrimination are reported, on a regular basis, for improved programming and prevention of negative consequences (in particular new infections). The indicator therefore measures the extent to which harassment and discrimination occurs in respective communities. It is important to know these levels, so that programme managers can track whether or not awareness programmes are reaching the intended target populations.

Indicator 31	% of beneficiaries that report harassment and discrimination in relation to accessing programmes and services within the quarter
Definition	This indicator provides information on the proportion of beneficiaries reached with awareness programmes that eventually report cases of harassment and discrimination to authorities, as appropriate. An increase in this indicator over time may suggest improvements in the programme interventions aimed at reducing levels of harassment and discrimination in the communities. Also although the levels of harassment and discrimination will ideally go up, this may mean that the target populations are more aware of the occurrence and the meaning of the problem – which in many ways may indicate successful programming.
Disaggregated by	Age, Sex and type of target population (sex worker [f/m]; Intravenous drug user; men that have sex with men)
Measurement (how to calculate it)	Numerator: number of individuals (beneficiaries) accessing programmes and services reporting cases of harassment and discrimination Denominator: total number of individuals (beneficiaries) accessing programmes and services
Source of data	Crisis management summary form
Frequency of reporting	Monthly
Baseline	
Target	

Indicator 32	% of beneficiaries reached with Minimum Prevention Package Intervention (MPPI) in a quarter
Purpose	Prevention interventions that are delivered in combination have been shown to be effective in reducing HIV transmission risk behaviors. Delivering these interventions with intensity to the appropriate populations is an important component of minimum prevention package strategies. It is important to know how many people complete an intervention in order to monitor how well programmes are reaching the intended target population with HIV prevention programming. Programme managers can use this information to plan and make decisions on how well a certain target population is being reached with specially tailored interventions. If a small percentage of the intended target population is being reached with the intervention, then it would be

Indicator 32	% of beneficiaries reached with Minimum Prevention Package Intervention (MPPI) in a quarter
	recommended that activities are adjusted to improve reach. If a large percentage of the intended target population is being reached, then a programme manager would want to take these lessons learned and disseminate them to other communities. The community can use the information to improve upon the quality of the programme as well as scale-up successful models.
Definition	This indicator provides information on the proportion of the target population (based on the size estimation) that are reached with Minimum Prevention Package Interventions. These interventions are based on evidence and/or meet the required minimum standards. The indicator will help the community teams to determine reach (if no denominator) and coverage (if denominator is also collected) to help programme managers understand the extent and reach of evidence-based interventions for further expansion.
Disaggregated by	Age, Sex and type of target population (sex worker [f/m]; Intravenous drug user; men that have sex with men)
Measurement (how to calculate it)	Numerator: number of individuals (beneficiaries) reached with MPPI Denominator: total number of individuals (beneficiaries) in specific communities
Source of data	Monthly summary form
Frequency of reporting	Quarterly
Baseline	
Target	

Annex 3. Routine Monitoring Forms and Registers

Prevention Monitoring Tools		
Tool Type	**Monitoring Tools**	**Frequency**
Registration	FSW Registration Form	Once
Behavioural and Biomedical Intervention	PE Attendance Sheet	Activity-Driven
	PE Monthly Tracking form	Monthly
	Referral Form	Activity-Driven
Collation	Peer Educator Supervisor Monthly Summary Form	Monthly
	Referral Register	Activity-Driven
Summary	National Prevention Monthly Summary Form	Monthly
	Quarterly PITT	Quarterly
Structural Intervention	Advocacy And Community Dialogue Form	Activity-Driven
	IGA Attendance Form	Activity-Driven
	Crisis Management Form	Activity-Driven
	Advocacy And Community Dialogue Summary Form	Monthly
	Income Generating Activity Summary Form	Monthly
	Crisis Management Summary Form	Monthly

The following forms are recommended for use for MARPs HIV prevention intervention.

S/N	Forms and Registers	Completed by whom
1	Recruitment form	Implementing partner Programme team / PE Supervisor
2	Peer session attendance form	Peer Educator
3	Peer Educator Monthly tracking form	Peer Educator
4	PE Supervisor's Monthly summary form	CBO / CSO Staff
5	Quarterly PITT	CBO / CSO Staff

S/N	Forms and Registers	Completed by whom
6	Referrals forms	Peer Educator / Service provider / Person referred
7	Client summary form	CBO / CSO Staff
8	Structural intervention tracking form	CBO / CSO Staff
9	Structural monthly summary form (IGA, Advocacy form, Community dialogue, Crisis management	CBO / CSO Staff
10	Condom Distribution Outlet register	CBO / CSO Staff
11	Summary forms	CBO / CSO Staff

Annex 4. Micro-planning Tool 1: Spot Analysis

Overview: The Spot Analysis tool is designed to aid in the compilation of information related to a spot/site in the respective project areas in order to facilitate planning. It helps the participants to collect information about each site, which will be useful in planning outreach activities.

Suggested training method: Large group discussions and small group work.

Materials/Preparation Required: Chart paper and coloured markers.

Duration: 2 hours and 30 minutes.

Process

1. **What is a Hotspot?**

   Explain that a hotspot is the smallest geographic location targeted by the intervention and that it is important to plan for each and every spot.

2. **Why do we need a Micro-plan?**

   A Micro-plan is developed for the following reasons:

   - Each spot is different and outreach plans need to be spot-specific.
   - Other characteristics, such as age of the sex workers, operational timing of the spot, number of clients or partners per FSW, and the extent of violence in the spot have to be factored into the planning to prioritize outreach.
   - Spot analysis should facilitate prioritisation of spots for outreach and the selection of peers who are most suited for each spot.

3. **Ask the participants to divide themselves into groups. Ask each group to identify a well-known spot in their city/area/zone. Ask the groups to analyse their spot according to the following information:**

   - Typology of the spot: street, hotel, brothel.
   - Client/partner turnover for sex workers in the spot – high (more than 5 clients/day); medium (more than 10 clients/week); low (fewer than 10 clients per week).
   - Age of sex workers frequenting the spot.
   - Days the sex workers frequent the spot: daily/weekly/monthly.
   - Time when the sex workers frequent the spot: morning, afternoon, etc.
   - Prevalence of violence against sex workers in the spot: high, medium, low.

4. **Give the participants one hour to complete the exercises, and then ask each group to present its work.**

5. **After the presentations have been made, ask the participants:**
    a. Is this specific spot a high-priority spot and why?
    b. What kind of peer would you select in this spot?
    c. What are the other things that you would have to take care of in this spot?

6. **Summarise by stating the following**
    a. Spots that have a high number of sex workers frequenting them daily, or/and have a large number of high-client volume sex workers, are priority spots.
    b. The peers in those spots should be selected based on the profile of the sex workers frequenting the spots.
    c. The outreach in each spot should be planned based on when the sex workers frequent the spots.

Tool 1. Spot Analysis Tool

High Volume >10 Clients/ Week	Number															
	Age	>20					20-30					31-Above				
	Frequency															
	Time	Daily			Weekly	Monthly	Daily			Weekly	Monthly	Daily			Weekly	Monthly
		M	E	N			M	E	N			M	E	N		
High Volume >10 Clients/ Week	Number															
	Age	>20					20-30					31-Above				
	Frequency	Daily			Weekly	Monthly	Daily			Weekly	Monthly	Daily			Weekly	Monthly
	Time	M	E	N			M	E	N			M	E	N		
High Volume >10 Clients/ Weekly	Number															
	Age	>20					20-30					31-Above				
	Frequency	Daily			Weekly	Monthly	Daily			Weekly	Monthly	Daily			Weekly	Monthly
	Time	M	E	N			M	E	N			M	E	N		

Note: *The Spot Analysis Tool has not been tested with street-based sex workers in Nigeria and the categorisation of risk to high, medium and low needs to be defined in the local context.*

In the format, the volume of clients needs to be recorded on a daily or weekly basis, as per the definition of client volume in the local settings.

Annex 5. Micro-planning Tool 2: Site Load Mapping

Overview: Site load mapping is a tool that helps participants to understand how estimates of sex workers in each hotspot can change over time, in a single day, a week, or a month. This tool can highlight peak/busy days at the hotspot over the course of a month. It can identify the busiest spot and prioritise the same in outreach planning. Site load mapping is a visual exercise and provides a very thorough understanding of the geography of the specific hotspot being mapped. An overall understanding of hotspots will emerge at this stage.

Suggested training method: Group discussions and small group work.

Materials/Preparation Required: Chart paper and coloured markers.

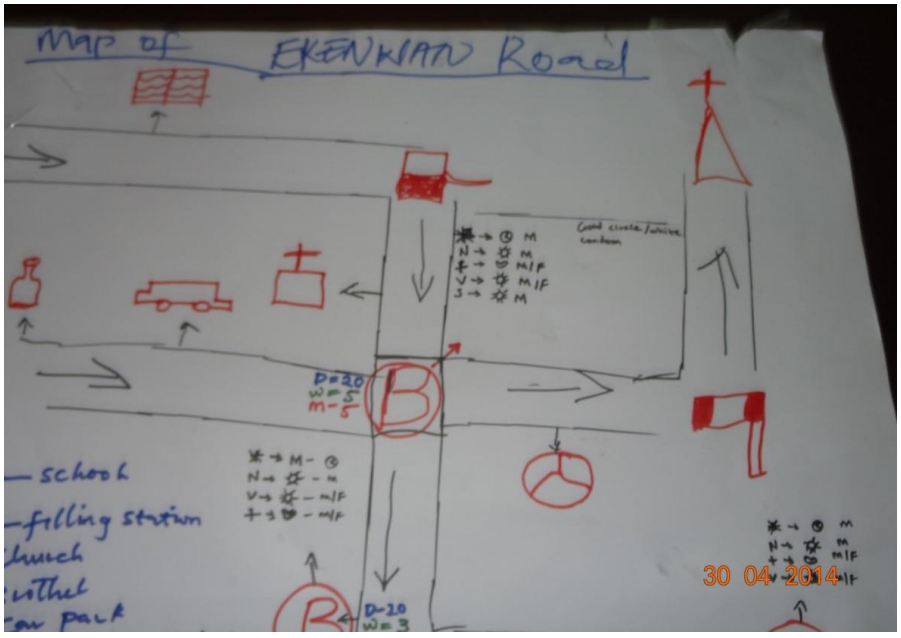
Duration: 2 hours and 30 minutes.

Process

1. **Ask the participants to draw a map of the area where they operate.**
2. **Ask them to mark the major locations, such as Police Stations, Petrol Stations, etc.**
3. **Ask them to also mark the different brothel sites on the map.**
4. **Ask them to mark the number of FSWs available there DAILY as D in Blue.**
5. **Ask them to mark the number of FSWs available there WEEKLY as W in Green.**
6. **Ask to Mark the number of FSWs available there on MONTHLY Basis as M in Red.**
7. **Conclude the session as follows:**

   All days of the month are not same. Certain days, such as weekends or the beginning of the month, may bring more sex workers to the spots/brothel. It is important to strengthen outreach on these days.

Figure A.1. A photograph of a sample map drawn by a group of PEs in Benin City, Nigeria.



Annex 6. Micro-planning Tool 3: Condom Availability and Accessibility Mapping

Overview: This tool is used to map condom availability points and to understand if they are easily accessible to FSWs.

Objective: Using maps, participants identify condom availability points and analyse their accessibility by FSWs.

Suggested training method: Large group discussions and small group work.

Materials/Preparation Required: Chart paper and coloured markers.

Duration: 1 hour and 30 minutes.

Process

The process begins with a discussion on the importance of condoms.

1. **Ask the groups to draw a map of their spots, locating all the different types of condom-dispensing units, such as brothels, chemists, pharmacies, and shops in a particular site.**
2. **Ask participants to use different symbols for different types of condom-dispensing outlets in the spot.**
3. **Ask them to note whether the condom-dispensing outlet functions during the day or at night.**
4. **Conclude the session by discussing the following questions**
   - Are there condom depots in all brothels sites?
   - Are the condom deports accessible to the KPs?
5. **State the importance of access to condoms at the right time and plan to fill the gaps if any.**

Figure A.2. A Photograph of a sample Condom Availability and Accessibility Tool by PEs from Abuja, Nigeria.

Annex 7. Micro-planning Tool 4: Opportunity Gap Analysis

Overview: Opportunity Gap Analysis helps participants understand opportunities and gaps in each spot, the reason for the gap, and ways to overcome it. By using this tool, participants will be able to identify specific obstacles—internal or external—that hinder sex workers from accessing different services. Once this is understood, participants can develop specific action plans to overcome both internal and external factors.

Suggested training method: Presentation of the tool in plenary, group discussion, followed by presentations.

Materials/Preparation Required: Flip chart paper and coloured markers.

Duration: 2 hours and 30 minutes.

Process

1. **Explain to participants that it is very important to understand and periodically analyse sex workers' access to various services offered by the project. As every spot is unique, this analysis should be conducted at the spot level, or PE level in order to develop an outreach plan specific to each spot.**

   Various outreach processes take place in the field, and it is important that the team regularly analyse the gaps and the reasons they exist, particularly in conjunction with the sex workers themselves, in view of developing an efficient outreach plan that is responsive to the needs of the community in question.

2. **Divide the participants into groups and ask them to identify one spot in their area and to:**
   a. Identify gaps in that spot
   b. Identify the internal and external reasons for those gaps
   c. Draw up an action plan to overcome these gaps

3. **Ask the groups to share their analysis in their plenary**

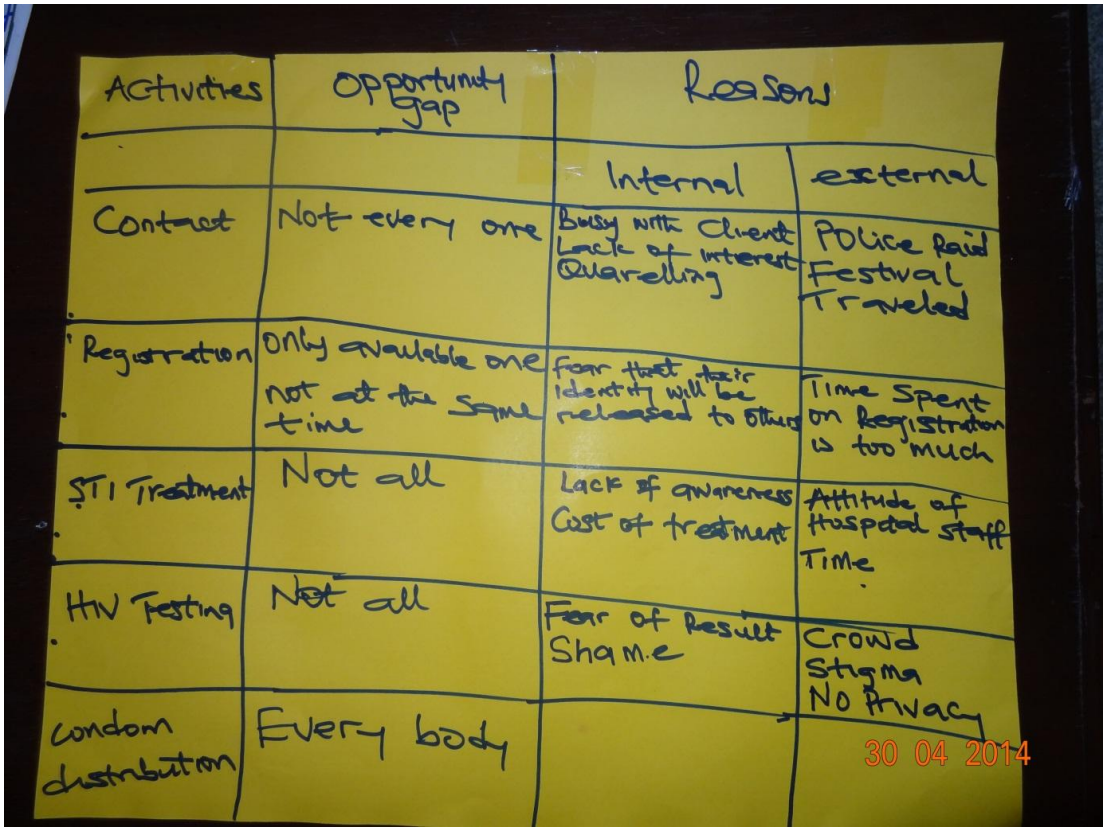
4. **Conclude the session by telling participants that:**
   a. This analysis needs to be done every month in every spot at the PE's level in order to analyse and understand access to services and any gaps.
   b. The factors or reasons that cause gaps may vary from individual to individual within a community.
   c. The project should develop systems to assess opportunity gaps at every level by using both qualitative and quantitative information.

Tool 4. Opportunity Gap Analysis Tool

Activities	Targets	Status	Opportunity Gaps	Reasons	
				Internal	External

Note: *For efficient use of the tool, programmes need to have targets in order to access the real/monthly performance against the desired performance for each service indicator.*

Figure A.3. Photograph of sample Gap Analysis carried out by PE in Benin City, Nigeria.



Annex 8. Micro-planning Tool 5: Contact Mapping

Overview: Contact mapping helps participants to map their contacts in the spots they are responsible for managing. It helps them plan outreach activities based on these contacts and on the needs expressed in different spots. It additionally helps prevent duplication of efforts and aids in the efficient allocation of spots to peer educators (PEs). As FSW profiles become increasingly more detailed in a particular spot, that information can serve to help determine a suitable PE.

Suggested training method: Brainstorming and discussions within large groups, further discussion in smaller groups, plenary discussion.

Materials/Preparation Required: Flip chart paper and various coloured markers.

Duration: 2 hours and 30 minutes.

Objective: To map the peers' contacts in each spot.

Process

1. **Draw a map of the town, street, and spot.**
2. **Ask participants to list the brothels.**
3. **Ask PEs to list out the number of contacts of FSWs/peers that each PEs has in each brothel Use a different colour code for each participant.**
4. **List the PEs' contacts in different colours on the map**
5. **Using these lists, calculate the estimated number of sex workers in each site, making sure no duplication occurs.**
6. **Conclude the session by highlighting:**
    a. The issue of duplication addressed through contact mapping.
    b. This tool is more efficient when developing a street-based typology of sex workers than a brothel-based one.

Tool 5. Contact Mapping Tool- A

Sl. No.	Name of Site	Peer 1 No. of contacts	Peer 2 No. of contacts	Peer 3 No. of contacts	Peer 4 No. of contacts
1					
2					
3…					
Total					

Tool 5. Contact mapping tool- B

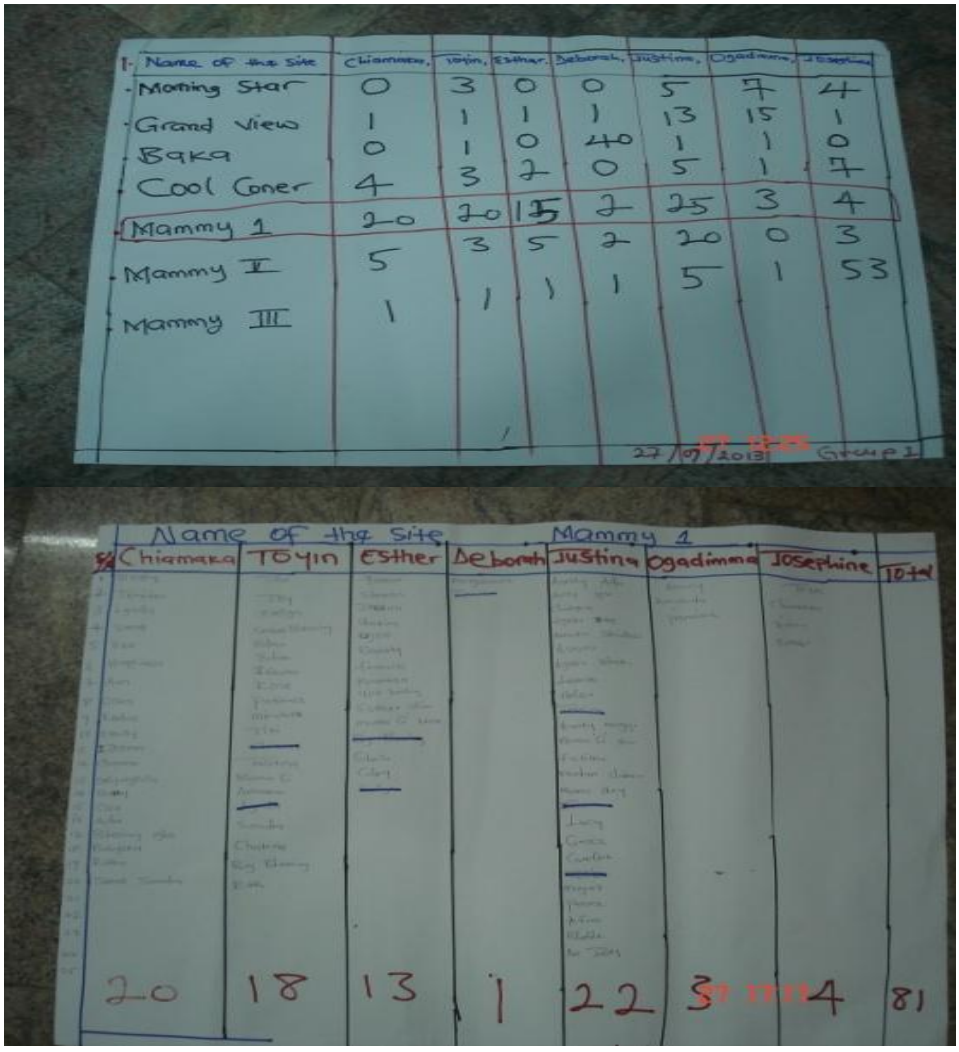
City:	**Zone:**	**Site:**	**Date of Exercise:**
Estimated number of sex workers in the site:			
Contacted number of sex workers in the site:			

Sl.no	**Peer 1**	**Peer 2**	**Peer 2**	**Outreach staff 1**	**Outreach staff 2**
	Name of contact	Name of contact	Name of contact	Name of contact	Name of contact
1					
2					
3 …					
	Number of contacts known very well				
	# of contacts	# of contacts	# of contacts	# of contacts	# of contacts

Note: *This tool has not been tested with street-based sex workers in Nigeria.*

It has limitations when it comes to brothel-based sex workers, where each brothel is considered a single site with no interaction among peers from one brothel to another.

Figure A.4. Photographs of sample Contact Mapping Tools by Peer Educators from Abuja, Nigeria.



Annex 9. Micro-planning Tool 6: Preference Ranking

Overview: Preference Ranking is a participatory technique that helps participants to analyse and identify problems or preferences community members have related with respect to service uptake. By using this tool, participants can identify the reasons for gaps in service uptake, such as clinic attendance. PEs list pictorially the reasons why KPs do not access services.

Suggested training method: Presentation of the tool in plenary, group discussion, followed by presentations.

Materials/Preparation Required: Flip chart paper and coloured markers.

Duration: 2 hours and 30 minutes.

Process

1. **Begin by discussing the general reasons why sex workers do not access clinical services.**
2. **Ask participants to list the main problems regarding low HIV testing.**
3. **Afterwards, ask them to rank these problems in order of primacy.**
4. **Facilitator shows the "problem cards" two at a time, each time asking, *"Which of the two is the bigger problem related to the particular question?"* As the participants make the comparisons, the results are recorded in a matrix.**
5. **Ask the group to rank them in order of priority and develop plans to address the reasons once the matrix is completed.**
6. **Conclude the session by going over the following points:**
    a. Identifying the most important reason/ barrier/gap which the community members shared is very crucial to addressing the gaps.
    b. Explain to participants that this tool can help them to prioritise the reasons for existing gaps and to develop priority actions for increasing service uptake.

Tool 6. Preference Ranking Tool

Preference	Reason -1	Reason -2	Reason -3	Reason -4
Reason -1				
Reason -2				
Reason -3				
Reason -4				

Figure A.5. A photograph of the Preference Tool Ranking developed by a group of Peer Educators in Benin City, Nigeria.

Annex 10. Micro-planning Tool 7: Stakeholder Analysis

Overview: Stakeholder analysis helps participants to identify and strategically address the various stakeholders that influence FSWs—directly or indirectly, positively or negatively. These are the people whose support can help to create an enabling environment for the programme. This exercise allows the community to identify the stakeholders and carefully analyse the power structures in which FSWs operate.

Suggested training method: Presentation of the tool in plenary, group discussion, followed by presentations.

Materials/Preparation Required: Flip chart paper and coloured markers.

Duration: 2 hours and 30 minutes.

Process

1. **Explain to the participants what we mean by "stakeholder."**
2. **Ask participants to list the various stakeholders.**
3. **Ask participants to assess the level of influence of each stakeholder on the programme and their work as high or low.**
4. **Ask participants to assess their level of involvement in the programmes and their work as high and low.**
5. **Explain the matrix and help the group put together all the stakeholders who have significant influence and high involvement, as well as those with little influence and low involvement.**
6. **Conclude the session by:**
    a. Discussing each of the stakeholders identified by the participants and the power structures associated with each stakeholder for the implementation of the programme.
    b. Discussing the type of intervention required with every type of stakeholder.

Tool 7. Stakeholder Analysis Tool

S. No.	Stakeholders	Level of Influence		Level of Involvement		Intervention
		High	Low	High	Low	

Figure A.6. Photograph of the Stakeholder Analysis Matrix developed by a group of Peer Educators in Benin City, Nigeria.

Annex 11. Tools Being Developed

The following tools are being developed and will be made available on the NACA website (www.naca.gov.ng):

- Job description of the implementation team
- Capacity-building materials and resources
- Crisis management system

Annex 12. Community Committees

Rationale for Community Committees

Community Committees (CCs) are a model for the empowerment of FSWs, as well as a key tool for the effective provision of services. As such, they should be formed in close consultation with members of the FSW community, and the structures, roles, and responsibilities of these committees should be developed jointly by the programme and its members. A CC is based in each intervention location (NGO), with one representative from each site. The committee acts as a monitoring agent for the programme in each location and holds periodic meetings to address issues that arise. Effort is required to bring people together, to build trust, and to encourage participation on the part of the FSW community. Community Committee members (CCMs) should represent the different typologies of sex workers, so that each group's interests are sustained. They should be rotated in regular intervals so that a maximum number of FSW community members have an opportunity to serve.

Objectives of the Community Committee

- Identifying the needs of the key population members in their area
- Helping members of high-risk groups attain goals of health, socioeconomic empowerment, and improved quality of life
- Assisting in planning and implementation of the programme
- Working on advocacy, legal help, and issues such as prevention of trafficking
- Creating demand for quality STI and HIV/AIDS services
- Motivating members of high-risk groups to have regular medical check-ups
- Organising cluster-level events, such as a Women's Day and an annual day on other issues which affect the lives of FSWs
- Promoting the collectives of the FSW community and strengthening them
- Promoting Self-help Group formation

Method of Functioning

- CCs meet once every fortnight and the venue and time are fixed by members based on their convenience. A meeting can only be conducted with at least 60 percent attendance.
- The CCs maintain an attendance register, minutes book, and follow-up File of their meetings and activities.
- A Community Advisor participates in one CC meeting each month as an observer.

- The minutes of the meeting are given to the NGO.
- The programme/NGO may take action in the programme or respond to issues based on the recommendations of the CC.

Subcommittees

FSW community members may be part of various subcommittees at the NGO level. These subcommittees are responsible for the various components of the NGO's activities (e.g., clinic committee, crisis committee, etc.) It may be found optimal to have three to five FSW community members on each subcommittee. Ideally, one committee member from each subcommittee is available on a daily basis to carry out the duties of their respective committee. Examples of two subcommittees and their roles and responsibilities are presented below.

Clinic Committee

Objective

To create an environment for the smooth functioning of clinics, motivating the FSW community members to visit clinics and encouraging clinic staff to provide sensitive and FSW community-friendly services.

Roles and Responsibilities

- Review clinical caseloads and efficiency of services
- Ensure cleanliness of the clinic
- Facilitate hospitality before and after check-up
- Motivate the FSW community member for speculum/lab investigation
- Participate in periodic review meetings with clinic staff
- Get feedback from the FSW community on the functioning of the clinic and programme staff
- Provide ideas on follow-up of drop-outs

Crisis Committee

Objective

To encourage sex workers to report situations of violence and crisis and to ensure effective and efficient support from the programme at the time of crisis.

Roles and Responsibilities

- Educate the FSW community on situations of violence and the types of support offered by the programme
- Review monthly cases of violence and the support provided by the programme
- Develop plans to ensure crisis situations can be prevented
- Get feedback from the FSW community on the functioning of the crisis management system
- Advocate with police and other power structures during sensitisation meetings
- Provide support to the crisis management team at the time of crisis by going to the site of crisis or arrest, etc.

Annex 13. Polling Booth Survey Protocol

Protocol

Polling Booth Survey for Measuring Behavioural Outcomes among Female Sex Workers

Table of Contents

Appendixes

Background and Rationale

The development of appropriate HIV prevention strategies and policies at a national or sub-national level is critical to ensure that the prevention response is appropriate for the local context and to make certain resources are allocated to interventions that will have the greatest efficiency and impact. To do this, it is imperative to match prevention strategies to the local epidemic based on a Programme Science approach. The Programme Science Initiative, led by the World Bank and Centre for Global Public Health (CGPH) at the University of Manitoba, is defined as the systematic application of theoretical and empirical scientific knowledge to improve the design, implementation, and evaluation of public health programmes. [1] The Programme Science approach provides a framework that closes the gap between science and programmes by addressing complex public health choices and trade-offs to ensure appropriate focus on selected geographic areas, high-priority groups, a right mix of interventions, optimal delivery mechanisms and options, real-time monitoring, and tactical and strategic adaptations.

Monitoring and evaluation (M&E) is integral to the Programme Science approach. M&E is generally concerned with efficiency, effectiveness, and the impact of interventions. Efficiency refers to how well resources (people, money, skills, time, and so on) are applied to achieve programme goals and objectives. Effectiveness is concerned with the extent to which programme activities bring about desired changes in the lives of the people and communities targeted; for example, improved quality of healthcare services leading to the adoption of preventive behaviours against HIV, and improved quality of life among people living with HIV. Impact relates to the long-term results from a concerted response to a problem; for example, reduced levels of HIV incidence at the national or sub-national level, over a given period of time. An M&E framework is designed to help provide data or evidence that programme activities are meeting objectives of efficiency and effectiveness and contributing towards impact. Monitoring helps to establish what is being and/or has been done, while evaluation examines what has been achieved. [2]

The common M&E framework considers developmental change as a chain of interrelated components, consisting of inputs, processes, outputs, outcomes, and impacts. Inputs include a variety of resources that are brought to bear on a programme (staff, skills, equipment). These inputs are transformed into outputs through activities undertaken or services delivered. The transformation of inputs into outputs entails a process that requires attention to quality, unit costs, access, and coverage of services. M&E focusing on inputs, the process of their transformation, and outputs is also referred to as process monitoring, in contrast to outcomes/effectiveness and impact evaluation. [3] Effectiveness or outcome and impact evaluation often require targeted studies conducted at the beginning and repeated after a considerable period of programme implementation, sometimes with a control or comparison group.

Outcome evaluation or assessment seeks to determine if, and by how much, programme activities are achieving their intended effects in the target population. An outcomes evaluation or assessment needs to answer two key questions: a) Are the desired outcomes being observed in the target population? and b) Are the observed changes likely to be the result of the programme or intervention? [4] Outcomes evaluation for MARPs programmes typically collects questions on knowledge, attitudes, practices, or behaviour and structural influences on the same, over time. [5]

Outcomes Assessment Methodology

Key design considerations for outcomes assessment include determination of an appropriate sampling strategy (including both sample size calculation and sample selection procedures), periodicity of data collection, and data collection and analysis methods. For representativeness, sampling should be based on probability sampling techniques that provide an equal chance to all programme participants meeting defined criteria to be included in the outcomes assessment study. The periodicity of data collection can vary, but at the minimum should provide baseline-level indicators and post-intervention or follow-up indicators to permit the assessment of changes that are likely to have resulted from the intervention. As regards data collection, a variety of methods exist, which include face-to-face interviews, self-completed questionnaires, computer-assisted self-interviewing (CASI), and other innovative approaches, such as polling booth surveys (PBS). PBS, described further below, is proposed as a key outcomes assessment methodology for FSW programmes in Nigeria.

Polling Booth Survey (PBS)

Accurate and reliable data on the knowledge, behaviours, and practices influencing HIV transmission and acquisition are critical for effective HIV prevention programme design and implementation, but are often difficult to obtain due to the sensitivity surrounding sexual behaviour. Accurate reporting of sexual behaviour is heavily influenced by personal and contextual barriers, such as predisposition to self-disclosure, poor recall, perceptions of confidentiality, and social desirability bias, among others. [6] For this reason, survey methods that offer a greater level of privacy for respondents and assure anonymity of their response are more likely to elicit comparatively accurate data. [7] Polling Booth Survey (PBS) is such a survey method that seeks to overcome sexual behaviour reporting biases associated with face-to-face interviews and self-administered questionnaires.

PBS is a group interview method, where individuals submit their responses through a ballot box. The individual responses are anonymous and unlinked. The anonymity of the respondent is thought to increase the sense of confidentiality among respondents, hence their accurate reporting on sensitive and personal information. Participants are selected using a probability sampling procedure and organised into small homogenous groups of 10 to 12 people. Participants may be stratified by any factor of interest, such as type of sex work, for example,

venue-based sex workers and street-based sex workers, or by age. Being a group interview, questions need to be kept few, short, and simple, and dichotomised for ease of response. The method is not individualised and is therefore not suitable for analysing correlates of sexual behaviour. Studies that have employed this method have confirmed its benefits over face-to-face interviews and self-administered questionnaires in eliciting sensitive sexual behaviour information. [8; 9] (See Appendix 1 for the PBS Questionnaire).

Sampling

Background

To be representative, a sampling strategy for outcomes assessment should be based on probability sampling techniques that provide an equal chance to all programme participants meeting defined criteria to be included in the study. The determination of an appropriate sample size for a single study domain is usually based on the following considerations: a) the number of measurement units in the population; b) the initial or baseline level of the indicator of interest; c) the magnitude of change between one time-point and another (e.g., a baseline and follow-up survey) or difference between groups that is expected to be detected; d) the degree of confidence by which it is expected to rule out chance as the explanation for the magnitude of change or difference observed between groups (level of statistical confidence); and e) the degree of accuracy with which it is expected to be certain that the magnitude of change or difference will be detected (statistical power). [10] In addition to these factors, practical considerations, such as available time and financial resources, also have a bearing on an appropriate study sample size. An optimal sample size is obtained when the baseline indicator is set at 50 percent or less.

Sampling

The sampling procedure proceeds in two stages. In the first stage, the required number of spots per spot typology will be selected using probability proportional to estimated population size (PPS) in each FSW typology. The number of spots selected in each spot stratum will be determined by the following factors:

- The distribution of FSWs in the programme area by spot typology;
- The target of approximately 12 FSWs per PBS session; and
- The target to select approximately five or more FSWs per spot.

In the second stage, the required number of FSWs will be selected using a systematic random sampling method based on the list of FSWs to be prepared by PEs at the spots.

Selection of individual respondents

PEs are trained to recruit a random sample of individual female sex workers from the sampled hotspots. A schedule is developed for inviting individual sex workers from the selected spots

to the interview venues. Interview venues are agreed to in consultation with PEs. Up to 12 individual FSWs are organised by spot typology into homogenous groups.

PEs are trained on the sampling procedure. PEs then develop a list of FSWs frequenting the sampled hotspots and select those to participate in the PBS using a systematic random sampling approach. The recruitment of PBS participants is arranged to coincide with the peak days and hours when a large number of sex workers can be found at the selected spots. Those selected will be provided with information on the day, time, and venue of their PBS session. Reasons for not reaching or finding any of the sampled individuals or non-attendance of PBS sessions by those who have been contacted by peer leaders and outreach workers are recorded. Throughout this mobilisation process, it is to be emphasised to the participants that participation in the PBS will be by free consent and that non-participation for whatever reason will not jeopardise their access to services provided by the programme. Further, PEs and supervisors are instructed to follow a random selection procedure rather than focus only on those FSWs that have enrolled in the programme.

Steps in conducting PBS

Participants are invited to the PBS in groups of up to 12 individuals, organised by typology, on specific days and times. The PBS sessions proceed as follows:

1. Participants invited to the PBS are given an individual polling booth in the study venue. The polling booths are separated by at least 1 meter from each other to provide privacy to each individual respondent and assure them of the confidentiality of their responses. Such an arrangement increases the potential for genuine responses to the questions from the respondents.

2. Each participant is given three boxes, coloured Red, Green, and White.

3. Each participant receives a pack of cards. The cards are numbered corresponding to the number of questions in the questionnaire.

4. The cards will be stacked in a serial/sequential order. The moderator confirms that each participant has the right number of cards arranged in the correct order before starting to administer the questions.

5. The moderator asks questions, one at a time, and ensures that the questions are clearly understood by the respondents.

6. In terms of responses, the moderator explains the following:

    a. If the response to the question is YES, the respondent will put the card with the number corresponding to the question into the GREEN box.

b. If the response to the question is NO, the respondent will put the card with the number corresponding to the question into the RED box.

c. If the question does not apply to the respondent, the respondent will put the card with the number corresponding to the question into the WHITE box.

d. If the person DOES NOT WANT TO ANSWER the question, the corresponding card will be KEPT OUTSIDE of the provided boxes.

7. The moderator explains the PBS with an example and a practice session. This example is to assure participants that their responses will remain anonymous and unlinked.

8. The moderator reads the questions one by one. While doing so, the moderator strives to:

   a. Make the exercise lively;

   b. Read each question clearly, slowly, and loudly, so that each participant hears the question clearly;

   c. Read out the questions in a clearly understood language;

   d. Repeat the question, if necessary;

   e. Use situations/stories while asking the questions;

   f. Use local terms; and

   g. Give sufficient pause and take care not to hurry through the questions.

9. After administering the questions, the moderator:

   a. collects the cards separately for each of the boxes: Green, Red, and White; and

   b. counts the number of cards in each box for each question, recording the tallies in a prescribed reporting form (see Appendix 2).

10. The moderator shares the responses with the respondents. Based on the results, the moderator asks follow-up questions to the participants in a focus group discussion setting to understand the response patterns.

11. The moderator and the assistant document the group discussion points.

12. All data generated through the entire PBS process are then provided to the supervisor.

Data analysis

The PBS generates descriptive data that is analysed to show numbers and proportions pertaining to a particular indicator. The data generated from the multiple PBS sessions are aggregated to provide site-wise estimates for specific indicators, with spot typology breakdowns (The Tallying Form is provided in Appendix 3).

Ethical considerations

The PBS as described in this protocol is not a research activity, but rather a programme monitoring and evaluation tool. Data collected through the process will be anonymous and unlinked. No risks from participation in the PBS are anticipated. Individual participants sampled for the study will participate in the study voluntarily without coercion or undue influence. No incentives will be provided to participants for taking part in the PBS. Individual participants will only be reimbursed the costs of travelling to the venue for the PBS.

Field team and logistical arrangements

The PBS is to be conducted in the area covered by the programme. The same protocol is to be followed in all sites. For each site, the field team will include a moderator, an assistant, and a supervisor (instructions for the PBS study team are provided in Appendix 4). In addition, support of peer leaders and outreach workers in contacting sampled FSWs is critical.

The materials required for the PBS include the following:

- Three different coloured boxes – green, red, and white
- Card sets
- Sample list
- Questionnaires
- Polling booth cartons
- Reporting forms

Budgetary considerations

Key budget items include the following:

- One-off allowance to PEs for mobilising peers
- Transport reimbursement for participants
- Refreshments during PBS sessions
- Stationery – cartons, cards, pens, etc.

Appendix 1. **Polling Booth Survey Questionnaire**

1. The last time you had sex with any paying client, did he use a condom?
2. During the past 1 month, was there any occasion when you had sex with any paying client without using a condom?
3. Do you have a regular partner who does not pay you for sex? *(a regular non-paying partner may include live-in partners and spouses)*.
4. The last time you had sex with a regular non-paying partner, did he use a condom?
5. During the past 1 month, was there a time when you wanted to use condoms during sex with any of your sexual partners but did not because the sexual partner did not want to wear a condom?
6. During the past 1 month, was there a time when you intended to use a condom with any of your sexual partners but did not use it because either of you had been drinking alcohol?
7. During the past 1 month, was there a time when you intended to use a condom with any of your sexual partners but did not use it because a condom was not available at that time and place?
8. During the past 1 month, did you have sex without a condom because the client paid you more money for sex without a condom?
9. Have you ever had anal sex?
10. Did you have anal sex in the past 1 month?
11. The last time you had anal sex, was a condom used?
12. Did you take an HIV test during the past 3 months?
13. Have you ever been registered in ART programme (Antiretroviral Therapy for HIV management)?
14. Are you currently taking ARV (antiretroviral drugs for HIV management)?
15. In the past 6 months, were you ever beaten or otherwise physically forced to have sexual intercourse with someone even though you did not want to?
16. In the past 6 months, were you ever arrested or beaten up by police when you were doing sex work or at a sex work spot?
17. Do you belong to any groups consisting of at least 6 members that are specifically formed by and for female sex workers?
18. The last time any of your sexual partners used a condom, did it burst or slip away?
19. Can HIV be transmitted by mosquitoes?
20. Can one get HIV by touching and hugging someone who has HIV?
21. Do you think you can tell by looking at someone if they have HIV? (Can a healthy looking person have HIV?)
22. Some people say condoms can protect you against HIV. Do you think it is true?
23. Do you currently experience any of the following symptoms of a sexually transmitted

infection – foul smelling discharge from the vagina, ulcer/wound around vagina, or severe lower abdominal pain during intercourse?
24. In the last 3 months, did you ever visit a programme clinic?
25. In the last 3 months, were you treated for any sexually transmitted infections (STIs)?

Appendix 2. **Polling Booth Survey Reporting Form**

City/Town:_____ PBS#:_____

Date of PBS: Day_____Month_____Year_____

Time PBS started (24 hours):_____ Time PBS ended (24 hours):_____

Number of participants in the PBS session:_____

Name of Moderator:_____

Name of the Assistant:_____

Details of participants		
Serial No.	Name of Hotspot	Age
1.		
2		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10		
11.		
12.		
13.		

Appendix 3. **Polling Booth Survey Tallying Form**

City/Town:_____ PBS#:_____

Date of PBS: Day_____Month_____Year_____

Time PBS started (24 hours):_____ Time PBS ended (24 hours):_____

Number of participants in the PBS session:_____

Name of Moderator:_____

Name of the Assistant:_____

Question	Yes	No	Not Applicable	No Answer	Total
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Question	Yes	No	Not Applicable	No Answer	Total
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

Appendix 4. **Instructions to Polling Booth Survey Moderators**

Introduction

Hello. My name is_____ I am from the_____(name of NGO/Programme). The (Programme) has been working for the prevention of HIV among female sex workers (FSWs) in (name area). In order to get an understanding of the prevailing knowledge and behaviour related to HIV/AIDS, the (NGO name) is doing a survey of randomly selected FSWs in this area. Since HIV/AIDS has close linkages with sexual behaviour, the survey questions are very sensitive and people may not like to answer these questions in a face-to-face interview. In order to facilitate more honest answers and reduce the embarrassment and fear of disclosure, we are using a special method called Polling Booth Survey. Similar to the confidential voting that we adopt in elections, here, people will give their answers to the questions by secretly putting the cards into one of three boxes. Just as it is done in the election, all the votes will be pooled together, to measure the prevalence of a certain knowledge and behaviour in the group. However, no one will know who gave what answer to which question. There is no way of linking a particular response to a particular person

Three coloured boxes—one green, one red, and one white—are provided to you, along with a set of cards bearing the question numbers. These cards are pre-arranged. So please do not disturb the order of these cards or please do not shuffle. You will have to take the cards one by one from the top of the set.

You are made to sit separately and the three boxes are provided inside an enclosure created by cardboard. No other person can see which card you are putting in which coloured box for which question. Your name or any other identification is not in the card or the boxes.

I will read out the questions one by one. Listen to these questions carefully, and you may ask me for clarifications if you have not understood the question. Please do not cast your vote before you have understood the question or before I have instructed you to cast your vote.

Before I read out the question, I will ask you to pick up the card from the top of the pile of cards, and show me. This is to make sure that all of you have taken the card corresponding to the question number. Please keep holding this card until you have understood the question and until I tell you to put the card in one of the boxes.

Please do not put two cards at a time.

During this entire session, there is no need for you to talk to each other. You don't have to say YES or NO. Do not prompt others to put the card in a particular box.

As I mentioned earlier, there are many personal and sensitive questions asked. These

questions are formulated based on the scientific understanding of the knowledge and behaviours related to HIV/AIDS. You may feel embarrassed, you may feel shy, or you may sometimes feel angry to hear these questions. Please do not consider the appropriateness of the questions in view of our social and cultural norms. Instead, consider these items as useful for designing the content of HIV prevention programmes. You may like to discuss these issues with our team separately after this session.

We also ask you to be totally honest in answering these questions.

Let us start with an example. Please hold up the first card, bearing the number one. [Moderator and Assistant make sure that everyone has held Card number 1.] **Have you eaten a banana in the past one week?** If you have eaten a banana in the last one week, please put this card into the GREEN box. If you have not eaten a banana in the past one week, please put the card into the RED box. Has everyone put their cards into either the GREEN or the RED box?

[Moderator and Assistant to collect the cards separately and count the cards in Green and Red boxes. Discuss with the participants about the confidentiality process, about how we only come to know the percentage of persons who ate banana in the past one week and we will not know who ate the bananas. Give back Card One and the Green boxes to the respondents]

We will now start with the first question.

1. *Now pick up the card bearing number 1 and listen carefully to the question:*
   The last time you had sex with any paying client, did he use a condom?

   If your last paying client had used a condom in the last sex, please drop the card into the GREEN box. If your answer to this question is NO, drop this card into the RED box. If you DO NOT WISH TO ANSWER this question, drop this card OUTSIDE the 3 boxes.

2. *Now pick up the card bearing number 2 and listen carefully to the question:*
   During the past 1 month, was there any occasion when you had sex with any paying client without using a condom?

   If your answer is YES to this question, please drop the card bearing number 2 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you DO NOT WISH TO ANSWER this question, please drop this card OUTSIDE the 3 boxes.

3. Do you have a regular partner who does not pay you for sex? *(A regular non-paying partner may include live-in partners and spouses).*

4. The last time you had sex with a regular non-paying partner, did he use a condom? *(NB: For some, this question might not be applicable if they do not have a regular partner.)*

5.	During the past 1 month, was there a time when you wanted to use condoms during sex with any of your sexual partners but did not because the sexual partner did not want to wear a condom?
6.	During the past 1 month, was there a time when you intended to use a condom with any of your sexual partners but did not use it because either of you had been drinking alcohol?
7.	During the past 1 month, was there a time when you intended to use a condom with any of your sexual partners but did not use it because a condom was not available at that time and place?
8.	During the past 1 month, did you have sex without a condom because the client paid you more money for sex without a condom?
9.	Have you ever had anal sex?
10.	Did you have anal sex in the past 1 month? *(NA: For some, this question might not be applicable, if they have not had anal sex – refer to Q.10.)*
11.	The last time you had anal sex, was a condom used? *(NA: For some, this question might not be applicable, if they have not had anal sex – refer to Q.10.)*
12.	Did you take an HIV test during the past 3 months?
13.	Have you ever been registered in ART programme (Antiretroviral Therapy for HIV management)?
14.	Are you currently taking ARV (Antiretroviral drugs for HIV management)?
15.	In the past 6 months, were you ever beaten or otherwise physically forced to have sexual intercourse with someone even though you did not want to?
16.	In the past 6 months, were you ever arrested or beaten up by police and City Askaris when you were doing sex work or while at a sex work spot?
17.	Do you belong to any groups consisting of at least 6 members that are specifically formed by and for female sex workers?
18.	The last time any of your sexual partners used a condom, did it burst or slip away?
19.	Can HIV be transmitted by mosquitoes?
20.	Can one get HIV by touching and hugging someone who has HIV?
21.	Do you think you can tell by looking at someone if they have HIV? (Can a healthy looking person have HIV?)
22.	Some people say condoms can protect you against HIV. Do you think it is true?
23.	Do you currently experience any of the following symptoms of a sexually transmitted infection: foul smelling discharge from the vagina, ulcer/wound around vagina, or severe lower abdominal pain during intercourse?
24.	In the last 3 months, did you ever visit the SWOP clinic? *(NB: If you do not know what*

SWOP is, put the card in the RED box.)
25. In the last 3 months, were you treated for any sexually transmitted infections (STIs)? *(NB: If you never had an STI in the last 3months, put the card in the RED box.)*

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