Republic of Zambia

STANDARD OPERATING PROCEDURES

FOR HIV/STI PREVENTION PROGRAM WITH SEX WORKERS IN ZAMBIA

ABBREVIATIONS

AIDS   Acquired Immuno Deficiency Syndrome
AMR   At Most Risk
ART   Anti Retroviral Treatment
BCCO   Behaviour Change Communication Officer
C&T   Care and Treatment
CBO   Community Based Organization
CV   Community Volunteer
GO   Government Organization
FIR   First Information Report
FSW   Female Sex Worker
HIV   Human Immuno Deficiency Virus
HRG   High Risk Group
HTC   HIV Testing and Counseling
ID   Identification Document
IDU   Intravenous Drug User
IEC   Information Education Communication
IP   Implementing Partner
ITS   Individual Tracking Sheet
KP   Key Population
LT   Laboratory Technician
LRP   Legal Resource Person
M&E   Monitoring and Evaluation
MIS   Management Information System
MOA   Memorandum of Association
MOU   Memorandum of Understanding
MPS   Minimum Package of Services
MSM   Men having Sex with Men
NAC   National AIDS Council
NGO   Non-Governmental Organization
OW   Outreach Worker
PP   Peer Promoter
PAG   Project Advisory Group
PLHIV   People Living with HIV
PPP   Public Private Partnership
PM   Program Manager
RPR   Rapid Plasma Reagin
RRS   Rapid Response System
SBC   Strategic Behavior Communication
SM   Site Manager
SHG   Self Help Groups
SOP   Standard Operating Procedure
STI   Sexually Transmitted Infection
SW   Sex Worker
TB   Tuberculosis
ToT   Training of Trainers
VCT   Voluntary Counseling and Testing
WB   Western Blot
WHO   World Health Organization

SOP FOR STI/HIV PREVENTION PROGRAM WITH SEX WORKERS IN ZAMBIA

FOREWORD

In the foreword of the Minimum Package of Services for Female Sex Worker in Zambia, I stated that the National AIDS Strategic Frame work of the National AIDS Council in Zambia recognizes female sex workers as a key population in the HIV response.

This standard operation procedure is an important tool in standardizing the guidelines and operating procedures for implementing a harmonized multi-sectorial response against HIV among FSWs, hereinafter referred to as KP, in a consistent manner based on the best available evidence. While the development of customized solutions and approaches to address local challenges is crucial for effective programming, the standardization of definitions, norms and expected outputs is also necessary to provide the foundation for assuring a minimum accepted quality standards and serves as a guidepost to inform continuous quality improvement activities.

The target users of these SOP are service providers, which includes any individual providing services to KP such as health care workers, peer educators/peer promoters, program staff and implementers, as well as policy makers.

The effort by FHI360's Corridors of Hope Project in Zambia and the Bridge Project in India in developing this SOP is commendable. This SOP is not targeted for the FSW in the sites where COH III is implementing activities only but for any organization that is involved in implementing or providing services to sex workers and their clients.

This document has sections on Project management, Behavioral Interventions Biomedical Interventions and structural interventions, necessary to provide quality services that would improve lives of FSWs in a significant way.

I am therefore happy to see the contribution of FHI360 through the Corridors of Hope III project and other partners. I wish all those involved in providing services to marginalized population such as FSW, all the success.

Dr. Jabin Mulwanda
Director General, National AIDS Council.

ACNOWLEDGEMENTS

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PART- A
INTRODUCTION

The Standard Operating Procedures in this document provide detailed steps for every program aspect of the project, providing the reader with the context for the development of the strategy/activity as well as the structure, individual responsibilities and monitoring plan. While these Standard Operating Procedures are based on the FHI360's two programs: Bill and Melinda Gates supported Aastha Project in Mumbai and Thane, Maharashtra State, India and USAID supported Corridors of Hope Program in 10 districts of Zambia, they can be used for replication in any setting and with any sex worker typology, as they explain the fundamental concepts of each strategy. Each Standard Operating Procedure has been written to provide the reader with a comprehensive understanding of that specific strategy as well as linkage to others related to it, for a broader perspective.

Our Partners and community members have been instrumental in the testing and implementation of the strategies described herein. These Standard Operating Procedures have formed the very strong foundation of the project.

RATIONALE:

HIV and AIDS continue to be a major developmental challenge for Zambia, which still has one of the highest HIV prevalence rates in the world. The National AIDS Strategic Framework 2011-2015 (NASF 2011-2015) has been the cornerstone on which our response has been built over the past two years. Several successes have been made in the midst of various challenges in the all the priority areas that underpin the NASF 2011-2015.

The Revised National AIDS Strategic Framework (R-NASF 2014-2016) recognizes female sex workers as one of the key populations in the HIV response in Zambia. Current evidence shows that a female sex worker is over 10 times more likely to be infected with HIV and other STIs than other women in the general population. There are numerous reasons for this scenario which includes engaging in unprotected sex for higher pay, inability to negotiate safer sex including consistent use of condoms, lack of access to appropriate health services, social stigma and criminalization, sexual violence, drugs and alcohol abuse thereby increasing their vulnerability. Sex worker clients, the majority who may be married men and may have other girlfriends contribute to transmission of infection to and from sex workers and into and from the general population.

Thirty years since the first case of HIV was reported in Zambia, sex workers continue to face barriers to access quality HIV prevention and treatment services. To ensure the quality HIV prevention and treatment services Standard operating procedures(SOPs) and minimum standards were developed . These SOPs will help implementing agencies effectively design, manage, implement and monitor quality of HIV interventions in the country with SWs in a harmonized and coordinated manner.

These SOPs will serve as guideline for the HIV prevention project implementing agencies to ensure up-scaling prevention efforts and saturating the coverage in SWs to provide minimum packages of services to them in a systematic manner. SOPs will also provide step by step guidance to the implementers to standardized service delivery mechanisms and to assess and improve the quality of the interventions.

OBJECTIVES:

- To provide guidance on the development of project strategies and activities to up-scale prevention and saturate coverage among the SWs.
- To provide information about essential requirements and detailed processes for the development, delivery and monitoring of activities, keeping in mind the risk levels of the SWs.

- To provide guidance towards the building of the community empowerment process to build ownership of each activity.

UPSCALING PREVENTION:

Despite the high HIV prevalence in the country, 86.7% of the population is uninfected. NAC aims to reduce new infections in all categories and prevent spread to and from female sex workers and the general population. A behavior change communication strategy based on an effective BCC campaign and supported by appropriate services will be implemented. Timely and accessible service delivery will ensure continuum of care at every level. A package of clearly defined and inter-linked services along with clarity on where they are available will enhance utilization.

SATURATING COVERAGE IN SWs

NAC aims to saturate 80% of SWs with the aim of reducing infection amongst this group.

- Behaviour Change Communication (BCC) interventions to increase demand for products and services
- provide STI services including counselling to increase compliance of patients to treatment regimens, provide risk reduction training, and focus on partner referral;
- promote demand for condoms and ensure availability and easy access
- create an enabling environment to motivate practice of safe behaviours;
- increase programme sustainability through community organizing and ownership amongst SWs; and
- integrate prevention with care, support and treatment to facilitate access and use of these services by SWs.

These SOPs will contribute to HIV prevention strategies for SWs described under the National AIDS Strategic Framework (2014-2016) and enable Zambia to reduce number of new HIV infections among the SWs. An issue of consideration when targeting SW is that a high number of them, up to 65 percent (BBSS study in Ndola are living with HIV) are key population within key population.

MINIMUM PACKAGE FOR FEMALE SEX WORKERS

Targeted outreach and empowerment interventions through Peer Promoters:

Peer Promoters should visit each SW at least once a month and provide at least two services; (e.g. either a Behavior Change Communication (BCC) session, condom, clinical service)

- Prevention education All SWs will be reached with preventions education.
- Complete personal risk assessment: All SWs will have a session on HIV self-risk assessment.
- BCC: A quality BCC session should be provided to all SWs once a month
- Alcohol and substance misuse session to all SWs every quarter
- Life skills education all SWs every six months

Condom:

Barrier Methods: Condoms and lubricants promotion, demonstration distribution, and negotiation. Quality condoms and lubricants should be provided every week to SWs (based on condom demand)

Clinical Services:

- STI screening and treatment: STI related services/ clinical services should be offered to all SWs every quarter by qualified personnel.

- Family planning information and services: All SWs will be reached with family planning information and services. Dual protection use of condom as or with another family planning method to prevent HIV/STIs and pregnancy.

- Screening for Tuberculosis and referral for diagnosis: All SWs will be screened for Tuberculosis with referral for diagnosis.

- Cervical cancer information and referral for service: All SWs will be reached with cervical cancer information and referral for service.

HTC:

HIV Testing and Counseling: HTC service should be provided to SWs every six months. Repeat HTC should be carried out on previous or last HIV test negative or first time participants.

Continuum of Care for PLHIV SWs:

- HIV care and treatment: All HIV positive SWs will be referred and linked for care, support and treatment services

Gender Based Violence Screening:

- Gender based violence session All SW s will be offered and screened for SGBV at least once in a year

- Gender-Based Violence and supportive services: Rapid response to address violence issues as and when needed

- Legal/psychosocial support to all SWs as and when needed

Access to other health/social services as feasible:

- Family planning and emergency contraception to all SWs

- Post-abortion care to all SWs

- PEP to all SWs

- Harm reduction/Treatment for drug and alcohol abuse to all SWs

- Cervical cancer screening to all SWs
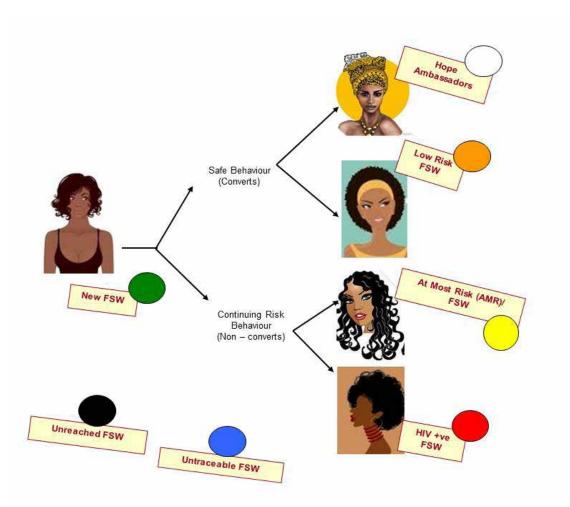
Referral linkages between services:

Economic strengthening, clinical and behavioral prevention interventions.

• Formation of GSLA groups as an entry point in all Economic Strengthening interventions to all SWs.

• Market assessments & linkages to other service providers for all SWs.

• Productive training in value adding ventures for all SWs.

• Utilization of GSLAs as a platform for accessing Clinical and behavioral prevention interventions.

RISK BASED SEGMENTATION OF SW:

Even though all SWs fall within the overall MARPs category, it is understood that certain SWs might have specific behaviors which increase their vulnerability and therefore are at a comparatively higher risk of acquiring STIs/HIV.

SEGMENT	DEFINITIONS (Behavioral and Clinical characteristics)
New FSW	• New in project (site or profession) in the month. • Should be registered with COH III within one month.

Low Risk	**Behavioral:** • Known to have a low client volume (5 or less than 5 clients in a week) • Uses condoms regularly with all clients. • Reporting regular condom use with clients, when offered more money • Sometimes falters in using condoms with regular partner/ permanent boyfriend/ lover boy. • Takes her health as a priority and lives a healthy lifestyle (includes eating habits, no addictions, and so on). • Reporting no incidences of GVB. **Clinical:** • Is asymptomatic currently and has not shown any symptoms in the last three clinic visits. • Visits clinic regularly (at least four times in the last six months). • Gets herself tested for HIV once in every six months. • HIV negative
High Risk	**Behavioral:** • Reporting low condom use with lovers/regular /nonpaying partner (as shared with the peer promoter). • Reporting low condom use with clients, when offered more money. • FSW new to the profession (1 month). • Working in the local drinking establishments • Known to have a high client volume. • Known to have substance abuse issues (alcohol, drugs) – as shared with the peer educator. • Known to indulge in sexual practices other than vaginal sex (as shared with the peer promoter). **Clinical:** • Has repeated STIs, same or different. • Reported an STI after a previous asymptomatic visit. • HIV positive.
PLHIV	**Clinical:** • Is detected HIV Positive and has disclosed her/ his status to PP.
Hope Ambassador	**Behavioral:** • Has attended COH III SHG meetings for the last six months consecutively. • Uses condoms regularly with all clients, lover and regular partners. • Takes her health as a priority and lives a healthy lifestyle (includes eating habits, no addictions, and so on). • Reporting no incidences of GVB. **Clinical:** • Has been asymptomatic for the last six months consecutively. • Visits clinic regularly (at least four times in the last six months). • Gets herself tested for HIV once in every six months.

RISK BASED SEGMENTED SERVICE DELIVERY PACKAGES:

Minimum Package of Services (MPS)

This package is provided to all New SWs registered with the project, it comprises:

- One quality SBC session provided each month to the registered SWs by the PP.
- Referred by the PP to clinical services offered by the doctor to the registered SW every month.
- SHG membership to the registered SW by the PP.
- Quality condoms provided every week to registered SWs by the PP
- HTC service should be provided to SWs every six months.
- Screening or referral for cervical cancer

These essential services are provided for a period of three to six months within which the individual SW is segmented by the outreach team on the basis of his/her risk profile.

Hope ambassador / Low Risk Service Delivery Package

This package is provided to Ambassador or Low Risk SWs, it includes:

- One quality SBC session provided once a quarter by the PP.
- Referral for Clinical services every quarter.
- Participation in SHG meetings every month
- Quality condoms provided by the PP every week.
- HTC service should be provided to SWs every six months
- Screening or referral for cervical cancer

At most risk services packages

This package is provided to High Risk SWs (repeatedly coming with STI symptoms) or PLHIV SWs who are not on ART, it includes:

- Quality condoms provided by the PP every week
- One quality Internal Check Up/Monthly Screening provided by the health care provider/doctor every month.
- One quality focused STI Counseling/positive prevention counseling session provided by the counselor.
- One to one quality SCC session and risk reduction counseling from the peer promoters/lay counselor/nurse/BCC team every month
- Peer promoter will accompany the SW for clinical services at Wellness Centre once a month
- Partner tracing and treatment
- HTC service should be provided to SWs every six months
- One Quarterly Partner Meeting (of SHG members).
- Attendance in one PLHIV Support Group / SHG Meeting every month.

- Pre ART Registration within 1 month by counselor/PP/buddy.
- CD4 Testing / 6 Months.
- Screening or referral for cervical cancer

PLHIV service package

This package is provided to PLHIV SWs who are on ART

In addition to the services included in the High Risk Service Delivery Package, it includes:

- Monthly accompanied referrals to the ART Center for first six months by the counselor / PP / Treatment Buddy
- Monthly Nutrition Counseling within 1st three months of initiation of ART by the counselor
- SW will be linked to the nearby Government health facility within one week by Peer promoter/Nurse/Lay Counselor
- SW will be included in the positive person's group for weekly sessions
- CD4 Testing/6 Months.
- Screening or referral for cervical cancer

WHO WILL USE THE SOPs

The SOPs in this document would be used by the National AIDS Council and any organization working towards the prevention of STIs/HIV amongst SWs of differing risk levels with in Zambia and could be adopted for the use by other countries. The SOP would provide specific clarity for the designing and implementing of a comprehensive, combination prevention services program with an inbuilt monitoring mechanism. The SOPs will serve as a code of instructions in designing and implementing HIV prevention projects for the Sex workers. Specific SOPs might interest individuals with a certain background; for example clinic team member, lawyer, social worker etc but the language has been kept simple to ensure that individuals of all backgrounds would understand and would feel confident to apply the same in their settings.

This document is subdivided into four sections:

1. The Project Management section provides a series of SOPs that describe standards to guide SW focused programs through the project cycle. This includes guidelines for designing tailored and customized programs for SW, ensuring adequate human and other resources are available, identifying capacity building needs, and developing systems for effective implementation, monitoring and evaluation (M&E), quality assurance and quality improvement, as well as guidelines for partner coordination. This section supports all other sections and SOPs in this document.

2. The Behavioural Interventions section provides guidance on how to develop a behaviour change communications (BCC) strategy, including materials development; how to effectively establish and support a peer education network; and how to establish and support a Wellness Center.

3. The Biomedical Interventions section outlines the procedures for establishing SW friendly clinical services to increase uptake both at facilities and through outreaches. Biomedical interventions for SW addressed in this section are STI management, HIV counselling and testing, and sexual and

reproductive health. This section also specifies the step by step process to ensure occupational infection control, including infection prevention and biomedical waste disposal.

4. The Structural Interventions section provides SOP for addressing social, cultural, political, economic, and legal or policy aspects of the environment that increase the vulnerability of SW and contribute to the spread of HIV. Structural interventions should focus on creating an enabling environment for improving access to health services and commodities and the protection of rights. This includes establishing a robust referral network, community mobilization and establishing a system of redress in cases of identified human rights violations or sexual or gender based violence (SGBV).

A table overview of the SOPs can be found in **Annexure No.**

PROCESS

This document was developed in consultation with key community members (SW), implementing partners and NAC staff through on-site discussions and detailed review of existing project documentation. The Standard Operating Procedures (SOPs) have been written for Zambian context and more specifically, the COH Project context. They would need to be adapted to suit different local context.

CONTEXT: SEX WORKER"S TYPOLOGIES

Sex work, is widely recognized as the provision of sexual services for money or its equivalent in kind. The revised Strategic Frame (2014-2016) Sex work in Zambia is more pronounced among females but sex workers in general include male, female, or transgendered in isolated cases, and the boundaries of sex work are vague, ranging from erotic displays without physical contact with the client, through to high risk unprotected sexual intercourse with numerous clients. Individuals may occasionally and opportunistically demand a fee or gift for a sexual favor without perceiving themselves to be sex workers, or they may engage more or less full time in the explicitly commercial provision of sex services. This variability results in a spectrum of implications for public health and health service provision; yet sex work is typically stigmatized and often criminalized in Zambia. Often sex workers are rounded up by police and charged for an offence of loitering lackly to disturb peace.

Currently most sex work has a strong economic basis, primarily as a source of income for sex workers, but also for dependent relatives and associates including pimps and queen mothers. Individual sex workers have very different levels of need ranging from survival, debt, drug dependency, coercion, and social connection, to desire for wealth and social mobility. These underlying motives affect the sex worker's autonomy and ability to respond to health promotion messages.

Different types of sex workers are prevalent in Zambia identified according to worksite or primary mode of soliciting clients. The broad categories of "high class" and "low class," reflecting the sex worker's income, is generally considered although income is a continuum and different "classes" of sex worker can be found in any one type of sex work.

Queen mothers and sex workers

Most young sex workers operate under tutelage and protection of a queen mother. Queen mothers are older and experienced sex workers in the trade. They know the geography of the area and show the lopes of the trade to young and new sex workers. They work as 'pimps' for clients and in return receive commission from the sex workers and their clients. The queen mothers play significant and influential roles in the business life of sex workers.

Street based (freelance) sex workers

Street or other public place sex work is probably the most widespread type of sex work in Zambia. Street-based sex workers generally work for themselves, typically meeting clients on the street or in parks and lay-byes, near hotels and utilizing local guest houses for transactions. Often times, instead of waiting for passing trade, some sex workers actively seek their clients in male dominated venues such as pubs, clubs, hostels or hotels. Others frequent transport hubs, such as track parks servicing Truck Drivers and Lorry boys for cash or intercity travel. Street based sex workers usually have previous experience in sex work in other settings, including brothels, bars and taverns.

Many sex workers prefer the relative autonomy and unregulated conditions of outdoor work and the fact that they are able to retain all of their earnings as a benefit of street-based work. Nevertheless some regard street work as undesirable because of the danger of violence and other forms of social hostility. Sometimes the lack of privacy limits services to providing oral sex or anal sex thus increasing associated health risks.

Women working on the street have fewer economic options and are subject to greater pressures resulting in unsafe sex and long hours working shift. Thus, street-based SWs are more likely than other sex workers to report having unprotected sex in return for increased payment. They also have limited access to condoms mostly operating in networks with night security guards who provide them venues to meet their clients.

Brothel based sex workers

In Zambia indoor sex work is typified by brothel sex work. Brothels vary enormously in their size and décor from mere small shelters through block of flats, bedrooms in a 'boarding house' to elaborate guest house rooms. Brothels also vary in their administration from individual "houses" to fully staffed business enterprises. The human rights and working conditions of brothel prostitutes are similarly varied, but brothels generally offer greater security than the street in terms of personal safety and the ability to provide some health care and education.

Brothel sex work is found mostly in border towns and shanty compounds in the cities where the general clientele have significant disposable income. It is the form most likely to be the subject of state regulation. 'It is worth noting however, that laws against sex work may temporarily reduce the activity but also drive it into more hidden forms. Laws punishing sex workers further reduce their power to protect themselves and leave them vulnerable to arbitrary and corrupt behaviour by officials'.

Another common trend among brothel sex workers is that they are highly mobile and tend to practice 'escort sex work' where sex workers are contacted by phone and travel to the clients' premises which is out of town in most instances. Escort services have the advantage of being secret and are therefore better tolerated by law enforcers and the communities at large as women are perceived as 'legal spouses'. However, escort sex workers are potentially exposed to violence from clients and may have less access to health care than brothel workers.

An important variable affecting health and welfare of brothel based sex workers is the increased number of clients a sex worker sees during a typical working shift. Undoubtedly, high volumes of clients over relatively short periods are linked to high levels of STI and other poor health outcomes. However, this is dramatically modified by the consistent use of condoms and the relative prosperity of sex workers and their community.

Thefts among brothel based SWs are common, thus some women 'bank' their earnings with brothel owners, withdrawing small amounts for makeup, clothes and medicine, as well as sending remittances

to their families. This type of informal banking system where brothel owners keep the accounts often lead to sex workers accumulating significant savings. Shockingly women are vulnerable to being cheated by owners who manage their finances and women who are illiterate are at an increased disadvantage because they are unable to dispute the accounts and run risks of having debts. Drunken clients are often experience thefts of money from their pockets and wallets.

Home based sex workers

Home based sex workers working alone or in small groups from 'residential' premises is highly prevalent in mostly Shanty compounds and other high density areas in Zambia. This type is mainly associated with relatively young sex workers or 'amateur prostitutes' who live with either parents or guardians (generally impoverished households). The relative desperation and poverty of the girls force them to practice sex work for survival or other necessities. These girls often visit nearby beer halls to solicit for clients but do not stay late in the night for fear of guardians. The girls are associated with irrational and addictive behaviour involving drugs, alcohol, or gambling which motivate sex work and increase the number of clients.

In this setting the sex transaction may not be recognized as sex work. Some sexual partners may interpret a transaction as prostitution, while others understand it as casual sex or short term companionate love. Frequently, both the sex worker and the client view these transactions as unplanned, spur of the moment decisions. Consequently the personal and public health risks may be greater than for those found in brothels. In this case, it is difficult to measure the sexual health and welfare parameters of these sex workers because they work secretly. Therefore, sexual health precautions are unlikely to be observed and the participants may not recollect the acts as potentially risky 'sex work'. Often they will have consumed quantities of drugs or alcohol before having sex. Sexual encounters, often happens outdoors or in places without hygiene facilities and where haste overrides other precautions. As noted above the presence of intoxicants reduces the judgment and caution of sex workers in health matters.

Pub, Bar / Night club based sex workers

Sex worker's vulnerability is well integrated into the entertainment industry in Zambia, and appear as if it is one of many services on offer. Night club-based sex workers are women who resides in different places but migrate to night clubs late in the night, i.e. after 22:00 hours in search for clients. Despite the opportunities they present for women to engage in commercial sex transactions, night clubs are differentiated from brothels in that they are primarily designated as environments for drinking, listening to music, dancing and other entertainment packages. In night clubs, sex encounters mostly happen after a transaction, such as the purchase of beer, or drug exchange, or some form of entertainment like erotic dancing, has occurred. Often times, sex negotiated in night clubs is transacted off-premises in guest houses and nearby lodges or any other place of clients' choice. In this occupational setting where ladies work late at night, the main themes influencing women's vulnerability to HIV/STI include limited access to health education, intoxication with alcohol and other drugs, exposure to violence and policing practices.

Street vendors and road traders sex workers

Ostensibly marketing rural produce or other goods but supplementing income with sexual services. Moreover, women who sell drinks in cooler boxes, fruits, groundnuts, eggs and other meagre merchandise along the streets in bus stops tend to engage into transactional sex after hours to subsidise their low incomes. Sex negotiated off the streets is transacted in guard houses, make-shift shops and even in trucks which are marooned and awaits clearing. Many sex workers have to see more clients because they are unable to charge an appropriate fee for services. Often very young and older sex workers are exploited

in this way. Similarly, illegal immigrant, homeless, mobile, and/or physically and socially isolated sex workers are less able to negotiate adequate prices for their services, particularly when many of their clients are similarly disadvantaged. Sex workers who sell along the streets earn little, have busy working schedules chasing after customers at bus stops and have very limited, if any, access to condoms and other health services.

Corporate or white collared sex workers

Employed and working for Chief Executives as secretaries but leading a life of beyond their means. They may be married or single. They have different clients responding to their different needs. E.g. Fuels, Education, Housing clothing e.t.c. Usually they target foreigners or fellow working class who in most cases are married men usually referred to as side plate of mai NINI literally translated as side plate of a 'senior wife' . Here condom use is very low.

Developing comprehensive sexual health promotion programmes requires a complete understanding of the types of sex work in a particular area. The public health implications of sex work vary widely. In general, policing sex work can change its classification and location but its prevalence is rarely affected. Typically social and legal sanctions against sex workers merely succeed in displacing the activity into other localities or into a different kind of working arrangement.

CHALLENGES:

The key challenges while working with SWs is their high volume and diversity in terms of economic status, cultural background, type of sex work and place of residence, which makes tailor made strategies essential. Frequent migration, mobility within the districts and provinces themselves as well as changes in the typologies (for example, a street based SW works from a bar for a few months) make tracking of SWs and service delivery challenging. SWs also do not consider their health a priority. Finding money is their main aim along with the feeding and future of their children (if they have any). On average a female sex worker in Zambia has 2 children. Many SWs, especially bar girls consume a lot of alcohol while they are at work because of which they sometimes forget to use or negotiate for condoms. This additionally compounds their risk of contracting STIs/HIV. SWs also have multiple regular partners, including their spouse and lovers, making provision of services to the partners difficult.

While working with each typology has its own challenges (as mentioned earlier), working with a mixed group of typologies poses separate difficulties.

• Most typologies do not like to mix with each other, may be due to rivalry or fighting for a client making collectivization difficult whether in the context of self-help groups, CBOs or even meetings.

• Hidden populations; for example home based SWs, do not like to come together with brothel-based or floating SWs for fear that they might be associated and their profession found out.

• SWs are spread out across the districts and interventions with them involve great time and personnel investment. This distance only means that the SWs themselves find it difficult to come together for meetings, camps etc as this means they would have to invest time spent away from their families or their profession.

• Most SWs have lived a life of betrayal and discrimination, making it difficult for them to trust strangers and even each other. Due to this, they take a long time to involve project staff in their lives. The existence of a rapid response system to provide crisis support or the designing of services focused on the needs of the SWs goes a long way in building trust.

PART- B
SOPs

SECTION 1 - OUTREACH PROGRAM MANAGEMENT

This section describes national standard operating procedures for effective planning and management of interventions with specific focus on peer education with SWs. It builds on the National AIDS Strategic Framework (2014-2016) for SW HIV prevention program. It is closely linked to and supports all other SOPs in this document.

Keys to planning and implementing successful projects include participatory and informed planning and program design; a focused and detailed implementation plan, identifying and ensuring availability of needed resources; a functioning M&E plan; a system for quality assurance and improvement; and strong coordination among partners and implementers. Ensuring the participation of the beneficiaries and community stakeholders during all stages of the intervention helps to ensure that programs are responsive to the particular needs of the SW and mobilizes community and stakeholder buy-in thus increasing both efficiency and effectiveness. Well-developed M&E systems will further improve the overall quality of programs through systematic gathering of standardized, quality data and a strong feedback mechanism. Instituting effective QA/QI systems helps to achieve efficient, cost-effective, quality program results, and helps to detect and address gaps in HIV service quality measured against established national standards in a timely manner. Coordination at all levels further increases efficiency by reducing duplication and ensuring harmonized approaches to implementation.

List of SOPs:

SOP 1.1 Planning and designing a focus peer education interventions

SOP 1.2 Mapping and size estimation of SWs at intervention level

SOP 1.3 Budgeting and ensuring adequate resources

SOP 1.4 Human resources (HR) and capacity building

SOP 1.5 Monitoring and evaluation

SOP 1.5.1 Management Information System

SOP 1.5.2 Data quality assurance

SOP 1.5.3 Developing feedback mechanisms

SOP 1.5.4 Program Reports

SOP 1.6 Quality assurance and quality improvement (QAQI)

SOP 1.7 Establish coordination mechanisms

SOP 1.7.1 Partner coordination

SOP 1.7.2 Outreach and clinical coordination

SOP 1.1

PLANNING AND DESIGNING A SW FOCUSED PEER EDUCATION INTERVENTION

Objective:

To set standard guidelines for the planning and designing of evidence-informed, rights-based, and community-owned HIV prevention interventions among SWs.

Users:

Executive directors, program managers, program design teams

Context:

HIV prevention program for SWs in Zambia has been evolving due its constant endeavor to improve its quality to reduce the number of new infection among the SWs and their clients. This is an effort to design a program specifically targeting SWs and their clients who are at high risk for acquiring HIV. This section ensures that planning and implementing successful projects include participatory and informed planning and program design; a focused and detailed implementation plan, identifying and ensuring availability of needed resources; a functioning M&E plan; a system for quality assurance and improvement; and strong coordination among partners and implementers. Ensuring the participation of the SW community and community stakeholders during all stages of the intervention helps to ensure that programs are responsive to the particular needs of the SWs and mobilizes community and stakeholder buy-in thus increasing both efficiency and effectiveness. It is closely linked to and supports all other SOPs in this document.

Key Features:

- To set standard guidelines for the planning and designing of evidence-informed, rights-based, and community-owned HIV prevention interventions among stakeholders

- This is expected to be utilized by program managers and planners who are planning

- This SOP presents critical components for effective planning: participatory planning, evidenced based understanding the unique vulnerabilities of the focus SWs and the intervention area characteristics,

- To develop a clear and thorough and realistic implementation plan. The work plan should outline key activities with time lines for implementation and serves as a basis for monitoring and evaluation.

- The budget identifies needed inputs. Ensuring that each of these components is considered when designing your implementation plan sets the stage for successful implementation from the beginning.

- The implementation plan serves as both a planning and management tool, providing a framework of how and when you will carry out the scope of work and serves as a basis for monitoring progress, reporting systematically, and making evidence- based and considered changes or adjustments to your plan as necessary.

Procedures:

1. Ensure participatory planning.

1.1   Map out stakeholders and service providers connected with the SW interventions at district, site and hotspot levels. A stakeholder is anyone or any group, institution or individual that has any kind of stake in the project (e.g. beneficiaries, community leaders, gatekeepers, facility managers and staff, government officials or Community-based Organisations CBOs).

1.2   Identify existing SW and PLHIV coordinating mechanism, e.g.; NAC, DCHO, NGOs and networks.

1.3   Identify other service providers in the area of HIV testing and counselling (HTC), care and treatment, Tuberculosis (TB), sexual and reproductive health/family planning (SRH/FP), sexual and gender based violence, drug and alcohol use and mental health services both in private public institutions to avoid duplication of efforts. Invite SWs, service providers and other stakeholders to take part in assessments and planning sessions.

2. Review existing data and additional/updated information: The data should be gathered through observations and mapping, in-depth interviews, focus groups, and short surveys.

2.1   Define location/ geographic scope. At minimum, identify the following:

2.1.1 Existing hotspots (locations with a concentrated presence and/or activities of SW, such as neighborhoods, streets, or bars, where SW meet or interact with clients);

2.1.2 Location and types of HIV and reproductive health services;

2.1.3 Existing resources/other interventions working with SWs;

2.1.4 Locations of potential barriers to implementation (e.g. police stations); and

2.1.5 Identify key stakeholders/gatekeepers critical for the achievement of intervention goals and objectives.

2.2   Define microsites within the larger intervention area: The ideal microsite should be concise geographical area that has one or more hot spots with between 30 to 60 enumerated SWs, to which one peer promoter (PP) will be assigned.

2.3   Identify key characteristics, risks and needs of SWs within the intervention area. Use recent behavioral and biological surveillance results as a guide. At minimum, document the following:

2.3.1 Characteristics (gender, age, ethnicity, marital status);

2.3.2 HIV risk behaviours (unprotected vaginal/anal/oral sex);

2.3.3 Typologies (e.g. for SW: brothel-based, bar based, street based, home-based);

2.3.4 Particular vulnerabilities (poverty, stigma, SGBV, that may facilitate HIV transmission);

2.3.5 Typical clients, partners;

2.3.6 Ability to access family planning and emergency contraceptive services;

2.3.7 Availability and use of condoms and lubricant;

2.3.8 Policy, legal and environmental factors; and

2.3.9 Psychosocial needs.

3. Use gathered data, develop an implementation/work plan.

Additional/ updated information and data should be gathered through observations and mapping, in-depth interviews, focus groups, and short surveys. (refer to SOP No. 1.2 on Mapping and size estimation of SWs)

3.1   Define location/ geographic scope. At minimum, identify the following:

3.1.1 Existing hotspots (locations with a concentrated presence and/or activities of SW, such as

neighbourhoods, streets, or bars, where SW meet or interact with clients);

3.1.2 Location and types of HIV and reproductive health services;

3.1.3 Existing resources/other interventions working with KP;

3.1.4 Locations of potential barriers to implementation (e.g. police stations); and

3.1.5 Identify key stakeholders/gatekeepers critical for the achievement of intervention goals and objectives.

3.2 Define microsites within the larger intervention area: The ideal microsite should be concise geographical area that has one or more hotspots with between 30 to 60 enumerated SW, to which one peer promoter (PP) will be assigned. For more information refer to SOP No 2.2 on Peer education and outreach strategy.

4. Define the project goal, objectives, activities and strategies.

4.1 A goal is the broad, long term result to which the intervention aims to contribute.

4.2 Objectives should be SMART:

4.2.1 Specific - specifies the characteristics of the target population;

4.2.2 Measurable - can be measured, using available methods and tools;

4.2.3 Attainable - can be realistically reached;

4.2.4 Relevant - relates to the overall program goal; and

4.2.5 Time-bound - includes an end date by which the objective is to be achieved.

Defining the goals and objectives with the active participation of SW, stakeholders and other service providers will ensure that they are appropriate, acceptable and well-coordinated.

4.3 Define activities and strategies. Although all SWs should be offered a complete package of services, the implementation of this package may differ depending on local needs, priorities and capacity of each implementing partner. It is not expected that every program should offer every component of the minimum package of services, for details refer to the Minimum package of services for SWs in Zambia.

4.3.1 Typical approaches for implementing HIV programmes among SW include, but are not limited to:

4.3.1.1 Behavioural interventions

4.3.1.2 Biomedical interventions

4.3.1.3 Structural interventions

4.3.2 Base the strategies and activities on findings from participatory assessments and planning activities.

4.3.3 Organize activities by objectives helps to ensure that the planned activities remain focused on the overall goal and objectives of the project.

4.3.4 Map out the sequence of activities along a timeline helps to ensure your plan is realistic within the given timeframe.

4.3.5 Illustrative work-plan template is available in the annexure section (Annexure A).

4.3.6 Develop a M&E plan.

4.3.6.1 The M&E plan should include: qualitative and quantitative indicators, data collection instruments and systems, timetables, responsible parties, reporting channels, etc. Set achievable targets and timelines for each activity.

4.3.6.2 Refer to SOP No 1.5 on Monitoring and evaluation (M&E) for more information.

5. Ensure adequate resources for implementation of each activity.

5.1 Identify financial and human resources needed to deliver program activities.

5.2 Identify available resources and try to fill gaps. Include resources that are obtainable (it could be from donor agencies or government or another NGO or CBO working with similar populations and interested in supporting the service) as well as existing gaps requiring attention.

5.3 Cost all needed resources to ensure that they are realistic within the available financial and human resources.

5.4 Refer to SOP No. 1.3 on Budgeting and ensuring adequate resources and SOP No 1.4 Human resources (HR) and capacity building.

6. Coordinate and establish linkages with other programs.

6.1 Establish multi-sectoral involvement with key stakeholders, partners, and other programs through joint programming, coordination, and linkages of activities.

6.2 Refer to SOP No 1.7 on Establish coordination mechanisms for further guidance.

7. Develop a plan for resource mobilization and sustainability.

Develop a plan for adequate and timely funding of program activities, along with a plan that fosters institutionalization, ownership, and other mechanisms to ensure that activities are sustained beyond the program's term.

SOP 1.2

MAPPING AND SIZE ESTIMATION OF SWs AT INTERVENTION LEVELS

Objective:

To provide guidelines for mapping and estimating size of SW population at intervention site levels.

Users:

Program managers, Site managers, BCCO, OWs, PPs, implementation teams

Context:

Often the size estimation are done through various indirect methods are meant for developing a sampling frame. These numbers are good start up for any intervention for prevention care. However, when the outreach team starts its work on the filed it is important for them to generate a date that could be used as denominator to assess their performance. This section makes and effort to generate a localized population size estimates which local implementers can use to set targets and to guide their programming. This will help the local, community level size estimates for SWs for use in planning purposes which also serves as a denominator against which achievements are compared. An extensive exercise involving the partners and the SWs should be planned using well accepted methodology for identifying and enumerating the SW size, which will help plan activities according to the newly developed SoPs for SWs.

Key Features:

- This exercise is conducted compulsorily with the involvement of SWs.

- To estimate size of SWs and map groups who have been identified as vulnerable to infection and transmission of HIV and other STIs.

- To identify and map Health Care Providers (HCPs) and facilities and Condom Depots available in close vicinity of the areas where the SWs are mapped.

- To list CSO/NGOs/CBOs (Community Based Organizations) working within the   mapped geographic locations of the selected area and services provided.

- Other service providers could include medical and non-medical services in the area. The service could include HIV testing and counseling (HTC), care and treatment, Tuberculosis (TB), sexual and reproductive health/family planning (SRH/FP), sexual and gender based violence (SGBV), drug and alcohol use and mental health services both in private and public institutions.

- This exercise will help to avoid duplication of efforts for providing services to SWs.

Material required for mapping:

- Maps of location where mapping exercise is being carried out.

- The only materials needed to conduct the group session are large flipchart papers and marker pens

- Data collator should carry sufficient number of broad mapping forms to fill out (immediately) after each broad mapping session

- Mapping teams should carry letters of introduction so that SWs and others who participate in the mapping exercise understand that the teams' work is legitimate, as well as to provide contact information if they would like to find out more about the project

- The mapping teams should also carry condoms, lubricant, and referral information to distribute upon request.

Procedures:

1. Define the SWs that being mapped by an organization.

2. Decide the scope of mapping including high-risk behavior of SWs can be accessed and mapping of services (health care, condom depots and NGOs/CBOs) available for them is the primary focus of the exercise.

3. Set up a team for conducting the mapping for each of the areas of the intervention. This could include one outreach member, one Sex worker and one local leader so that they have access to all the information needed to be completed as a part of this exercise.

<u>How to reach SW key informants</u>

Step 1: Identify the key hot spots using the potential key informants from the first section of the list above.

Step 2: Identify exact site location with more information on the site, including type of key informants available at the sites and the risk behavior of the SWs

Step 3: Use Delhpi method to discuss with the SW's key informants to understand the size of the SWs at that site, with all the other information requested in the format. Key informants at the site have to be SWs themselves. This will help to collect authentic information about the site.

Detailed approach is available in Annexure B

SOP 1.3

BUDGETING AND ENSURING ADEQUATE RESOURCES

Objective:

To provide standard guidelines to ensure adequate resources are available to effectively implement the SW interventions.

Users:

Program Managers, Site Managers, Program Team, HR Managers

Context:

All SW interventions require a range of resources available so that activities can be implemented efficiently, within a given time and with desired quality. Budgeting is a crucial step in project planning and management to develop a detailed budget to ensure that sufficient funds are available to implement the work-plan and ensure that the scope of work is realistic. The budget describes in detail the estimated cost of implementing the program. Based on the work and M&E plan, budgets should include costs for activities; commodities to be procured; printing and publications; computers and Information Technology (IT) support; and office support and rent. There should always be a clear, justifiable relationship between the proposed project and the budget. As a project moves forward, it is expected that the budget projections will change based on changing needs and realities of the project. It is critical, as the budget is adjusted, that you revise the project work-plan, scale of activities, target figures, and staffing plan accordingly. Subsequently, budgets should be used for planning, organizing and directing activities throughout the life of project as means of guiding day-to-day management decisions and a mark to measure and compare actual performance.

Key Features:

To provide standard guidelines to ensure adequate resources are available to effectively implement the SW interventions.

Procedures:

Based on the review, work plan and determine resources needed for intervention. Consider the following

1. Human resources/staffing:

    1.1 Will you need additional staff (full-time, facilitators, or consultants)

    1.2 Will existing or new staff need additional training?

    1.3 What duration do your need for each position?

    1.4 Cost out staff salaries, benefits, allowances and severance.

    Detailed guidelines concerning HR are covered in SOP No 1.4 on Human resources (HR) and capacity building.

2. Procurement.

    2.1 Equipment: Functional/standard equipment that facilitate efficient working environment (eg. computers, Wellness Center equipment etc.)

    2.2 Furniture: Standard office furniture that enhances /promotes effective work such as desks, chairs.

2.3 Means of transport: Appropriate and affordable means of transportation.

2.4 Communication tools: Access to office communication tools.

3. Identify a dedicated space for administrative/management needs.

    3.1 Identify space for service delivery, such as the Wellness Center. Remember that this space should be easily accessible and acceptable for the targeted SWs.

    3.2 Identify & cost secure space for storing equipment, files.

    3.3 Consider if space will need to be renovated, upgraded or adapted to meet the needs of the intervention. For example, a space that is intended for counseling services may need to be refurbished to ensure confidentiality.

4. Travel Cost:

    4.1 Planned travel for regular monitoring visits, meetings, and workshops. This includes per diem (accommodations, allowances for travel and transport -(T&T)

    4.2 Cost for transporting the supplies and utilities

5. Workshops/ trainings/ meetings:

    5.1 Consider the need to rent a venue?

    5.2 Do participants need accommodations?

    5.3 Will you provide for coffee breaks and/or lunches?

    5.4 What training materials do you need?

6. Identify existing available resources

    E.g. in-kind contributions or donations from community leaders, stakeholders, and share resources with partners.

7. Cost out all inputs that are unavailable and need to be covered by the project.

8. Illustrative budget format can be found in Annexure - C

SOP 1.4

HUMAN RESOURCES (HR) AND CAPACITY BUILDING

Objective:

To set standard guidelines to ensure appropriate and adequate HR to implement the intervention.

Users:

Program managers, Site Managers, implementation teams

Context:

Human resources are a valuable and essential component of any program. Successful programs require team members with a variety of skills. The particular composition (number and type of skills) of your team will depend on the types of services to be provided, the strategy for delivering those services, and the intended coverage of the program.

At minimum, each intervention should ensure adequate staffing (appropriate categories, level of effort, and numbers of staff) to assume responsibility for management, leadership, coordination, technical oversight, service delivery, outreach, M&E, finance and administration. It is important to define the necessary level of effort per position and to assign clear roles and responsibilities for different aspects of the intervention.

Procedures:

1.   Identify HR needs.

1.1   Refer to the relevant technical SOP for guidance on recommended staffing for HR needs for a particular intervention type or activity. Illustrative job categories include:

1.1.1   Program Manager: A trained individual who will lead the project team, design and manage the implementation of the program; will also ensure overall service delivery for the community and coordinate with other stakeholders for effective program implementation.

1.1.2   PP Supervisors/ Outreach Worker/Site Managers: A trained individual who supervises a number PPs within a defined geographical area.

1.1.3   Peer Promoter (PP): An individual trained to reach their peers with HIV information and services. They influence behaviour change among their peers. PPs can be engaged on a stipend or as fully paid staff basis depending on the financial capacity of the IP. It is recommended that one PP be assigned to 30 to 60 enumerated SWs to balance workload with quality.

1.1.4   BCCOs: A trained individual who coordinates all HIV continuum of prevention, care and support services.

1.1.5   M&E Officer: A trained individual who guides data collection, reviews collected data and collates them to generate periodic reports.

1.1.6   Finance, administrative and support staff: These are trained individuals who provide administrative, finance and logistical support to the program.

1.1.7   Ancillary (part time or voluntary staff) staff: These are human resources that are engaged to provide specialized services e.g. Nurses, Psychologists, etc.

1.2   Identify necessary level of effort (LOE) for each position.

2.   Develop job descriptions.

        Each job description should define at minimum:

2.1   Roles and responsibilities

2.2   Expected LOE

2.3   Minimum qualifications

2.4   Direct supervisor (reporting line)

3.   Develop an organogram

To illustrate the various positions and reporting lines of reporting and supervisory structure develop an organogram.

4.   Develop human resources plan.

4.1   Budget: Establish the cost of the human resources needs. Remember to include cost of advertising, interviewing and training, staff salaries, benefits, allowances and severance.

4.2   Recruitment

4.2.1   Criteria

4.2.2   Advertisement

4.2.3   Schedule

5.   Develop a capacity building plan.

5.1   Refer to the relevant SOP for recommendations for particular technical areas.

5.2   Trainings:

5.2.1   All PPs must undergo training using the National PP training manuals.

5.2.2   All project coordinators and field staff should receive an induction training covering all elements of the intervention that are already covered in the PP manuals with additional modules on MIS formats, data quality assessment, supportive supervision, advocacy and coordination with supporting agencies.

5.2.3   Field staff will receive quarterly updates and refresher training once a year.

5.2.4   PMs and SMs will be trained on mentoring of PPs and field staff, problem identification and solving based on MIS, coordination of outreach, DIC and clinical services, public relations and leadership skills.

5.2.5   All service providers and outreach workers should be trained on the linkages between HIV, gender and SGBV, incidence and risk factors associated with SGBV, and special considerations for working with SGBV survivors.

5.3   Meetings:

Convene monthly meeting of PPs with their field staff and project coordinator where additional reinforcement of training will be conducted on the basis of debriefing and feedback.

5.4   Supportive supervision and mentoring:

5.4.1   Peer Promoter: All the PPs will be regularly supervised by Field staff once a month. On site supportive supervision and/or mentoring will be provided using a checklist. Quarterly debriefing and training reinforcement will also be provided at the DIC.

5.4.2   Field staff will be mentored by project coordinators.

5.4.3   Project coordinators: Additional mentoring will be provided by Technical Support Unit (TSU) from the coordinating body (GAC) and Technical Support Agency staff during visits.

SOP 1.5

MONITORING AND EVALUATION (M&E)

Objective:

To harmonize M&E (MIS, DQA, feedback and reporting) systems among implementers of SW interventions.

Users:

Program Managers, Site Managers, M&E officers and stakeholders

Context:

A strong M&E system is based on robust health information system, skilled personnel, standardized tools and processes to collect, collate, analyze, disseminate and use information. Instituting an effective Management Information Systems (MIS) is a prerequisite for ensuring quality data at all levels of program intervention. The available quality data contributes to making informed decision to improve programming.

Routine data quality assurance (DQA) exercises ensure that collected and reported data are accurate, reliable, consistent and timely. DQA needs to be a participatory process involving program staff and or external assessors to verify the extent to which the reported data reflects the actual situations and their underlying M&E systems. Evidenced- based decision making depends further on a strong feedback system.

Experience has shown that data-driven programs achieve better results by being evidence- based and responsive to changing programmatic needs, more efficient and ultimately more effective. Routine reporting should be viewed as a management tool to ensure project objectives are being met as planned. It is an opportunity to regularly assess progress (monitoring) and improve activities through a reflection on challenges – what worked, what didn't and to reassess resource and capacity building needs. For purposes of uniformity and comparability between interventions, there is the need to have in place a standardized format to be used by all agencies to prepare status reports on SW interventions.

Establishing and implementing effective feedback mechanisms keeps service providers motivated when they see the results of their actions; maintains the interest and support of stakeholders and donors; provides information for program managers to re-strategize or re-organise activities if necessary; and ensures an opportunity for beneficiaries to identify what is and what is not working.

In the context of Zambia and SW programs, the NSF 2014-2016 provides the framework needed to produce data for making decisions on SW interventions. The indicators in the framework were derived from the National HIV M&E Plan, United Nations General Assembly Special Session on HIV/AIDS (UNGASS), UNAIDS and President Emergency Plan for AIDS Relief (PEPFAR) and they have been further broken down separately for each SW category.

SOP 1.5.1

MANAGEMENT INFORMATION SYSTEM (MIS)

Procedures:

1. Establish MIS

1.1 Indicators

1.1.1 Develop data entry and management system/dashboard.

1.1.2 Pilot test the system (Dashboard) and make necessary adjustments.

1.1.3 Build consensus on core indicators for MIS dashboard.

1.1.4 Indicators for SW programming can be found in Annexure D

1.2 Define levels of data reporting

1.3 Define the data reporting flow between the different levels

1.4 Ensure all levels have the tools required to collect and collate data at their level

2. Develop/ update tools and distribution. Use the standardized data collection and collation tools (refer to the Data Management Manual for SW programs).

2.1 MIS tools include:

2.1.1 PP daily activity sheet and referral forms

2.1.2 Wellness Centre attendance reporting forms

2.1.3 Summary report data collection forms

2.1.4 Indicator sheet

2.1.5 Counselling and testing forms;

2.1.6 SGBV screening and referral forms

2.1.7 Support group management

2.1.8 Defaulter tracing forms

2.2 Make data management system/software available

2.2.1 MIS software and data tools must be user-friendly at all levels.

3 Train staff in the use of the tools and MIS software - Country Response Information System [CRIS]

4 Launch data collection process.

4.1 Establish a schedule for routine data quality assessment.

4.2 Collect and collate data in a timely manner with standardized tools at all levels

4.3 Ascertain the quality of collated data e.g. through the DQA process (see SOP No 1.5.2 on Data Quality Assessment) at all levels

4.4 Generate reports and disseminate to project staff and stakeholders.

5   Ensure that data is analysed and used at all levels.

5.1   Generate reports and disseminate data obtained to all levels.

5.2   Every effort should be made to ensure that data is owned and used at the level of generation as well as at the higher levels such that the lower levels do not just serve as a source of data.

5.2.1 Establish medium and schedule for meetings where data is discussed and used in decision making.

5.2.2 Provide feedback to sources of data (see SOP No 1.5.3 on Developing feedback mechanisms)

5.2.3 Track implementation of decisions arising from MIS.

SOP 1.5.2

DATA QUALITY ASSURANCE

Procedures:

1. Prepare for DQA assessments.

1.1 Form DQA Team(s) comprising of at least 2 people, an M&E and program person. This can be implemented at various levels such that data at all levels is assessed.

1.2 Develop Terms of Reference for the DQA Team.

1.3 Develop tools for data collection, verification and reporting on the DQA conducted. Adapt to the specific situation if necessary.

1.4 Train the DQA Team and how to implement DQA.

1.5 Identify relevant sources of data.

1.6 Select indicators to verify, a rationale of selection of indicators should be specified e.g. indicators of greatest importance to the program need to be included in the selection, specific indicators that are linked to activities which receive a large investment (i.e. funding).

1.7 Select the period for which data will be reviewed.

1.8 Select sites to visit, agree on criteria for site selection. Where there are no specific reasons for selecting sites, random selection of sites can be applied covering priority and high volume sites.

1.9 Notify selected sites. These sites should be provided with advance notice and tools for DQA and sources of data to prepare for the exercise. However, the advance notice should not be such that implementers spend time to rectify errors before the arrival of the team such that the assessment is true picture of what occurred.

1.10 Ensure that all logistics for the visits are available.

2 Implement DQA.

2.1 Conduct briefing site meeting to orient the site staff on the purpose of the DQA.

2.2 Review source and secondary documents, these include relevant data collection tools and reporting or summarizing formats.

2.3 Onsite verification of data for the selected indicators.

2.4 Recalculate indicators using the primary source of data, numbers should be recalculated for each indicator being verified and then compared to what was reported

2.5 Undertake root cause analysis to identify the specific sources of identified errors e.g. errors may include calculation errors in totalling the results, transcription errors when entering data into computer data base.

2.6 Identify of areas of intervention: these are measures for correcting inaccuracies in data.

2.7 Develop an action plan and follow up: these are longer term measures taken to prevent the specified errors from recurring e.g. mentoring, TA, training, improved supervision and distribution of guidelines.

3   Analyse and follow up

3.1   Prioritize recommendations and develop a work plan

3.1.1   Findings from sites should be collated and the verification team should agree on recommendations.

3.1.2   Prioritize the most important and prepare a work plan with activities, responsibilities and timelines.

3.2   Develop a report indicating methodology, collective findings, recommendations

3.3   Communicate findings and recommendation – conduct exit briefing onsite with program staff, reviewing findings, recommendations and correction action points and share the DQA report with the program team when it is available.

Follow up with sites to ensure necessary corrections are made.

SOP 1.5.3

DEVELOPING FEEDBACK MECHANISM

Procedures:

1. Establish feedback, reporting & communication channels:

1.1 Peer Promoter to/from Implementing Partner;

1.2 Implementing Partners to/from intermediary principal recipient of funds

1.3 Principal recipient to/from funding/donor agency;

1.4 Various principal recipients to/from national coordinating body.

2. Define the mechanism for reviewing of reports to form basis of providing feedback

2.1 Review data quality assessment reports where available

2.2 Review narrative reports

2.3 Compare for trend analysis

3. Mode of providing feedback

3.1 One on one discussion, small group discussion and review meetings recommended at Peer Promoter and Implementing Partner level

3.2 Written feedback, shared and discussed recommended for intermediary recipient and implementing partners

4 Conduct follow up on the recommendations in the feedback

4.1 Agree on timelines/milestones to address weakness or improvement required and document them

4.2 Issues arising from the feedback should be acknowledged, addressed and documented

4.3 Agree on mode of reporting on the issues identified and addressed

4.4 Specify support that will be provided to the PP if needed, who should provide the support and at what time

SOP 1.5.4

PROGRAM REPORTS

Procedures:

1. Determine roles and responsibilities:

1.1 Who is responsible for collecting and verifying information;

1.2 Who will collate information and write report; and

1.3 Who submits reports and to whom.

1.4 At the implementation level, monthly qualitative and quantitative reports should be documented and collated quarterly and submitted to the donor.

1.5 At the regional level: all district reports should be compiled by the Provincial Officer and sent to the NAC.

1.6 At the national level: Lead implementing organizations should submit quarterly reports to the NAC.

2 Determine frequency for different types of reports

3 Prepare report

3.1 Reports should follow standard template (see Annex A) and include at minimum, the following information:

3.1.1 Activities implemented during the reporting period

3.1.2 Key results achieved

3.1.3 Challenges

3.1.4 Lessons learnt

3.1.5 Recommendations/ next steps

3.2 Compile and verify progress report information – quantitative and qualitative.

3.2.1 See SOP No 1.5.2 on Data Quality Assurance for more guidance.

3.3 Compare activities with work-plan for the reporting period.

3.4 Explain any variances between planned and actual activities.

3.5 Identify challenges and proposed measures to address them.

3.6 Highlight lessons learned, success stories, major achievements.

4 Submit both qualitative and quantitative, soft and hard copy reports to appropriate persons and copy relevant officials (including district and regional coordinating bodies).

5 Ensure confidentiality of sensitive information by keeping all reports in secure location.

6 Establish a feedback mechanism. See SOP No. 1.5.3 on Developing feedback mechanisms for more guidance.

SOP 1.6

QUALITY ASSURANCE AND QUALITY IMPROVEMENT (QAQI)

Objective:

To describes standard guidelines for instituting a quality assurance and quality improvement (QA/QI) system.

Users:

Program managers, coordinators, implementation teams

Context:

Quality assurance (QA) is a means of establishing standards—for example, clinical protocols and guidelines, program and administrative standard operating procedures (SOPs)—and consistently using them as a basis for assessing performance. It includes all the actions taken to improve health care and providing support that enables SW to achieve their maximum in physical and psychosocial health.

Results from QA monitoring lead to the quality improvement (QI) process. QI is a means of establishing and using a client-focused, problem-solving approach to test and implement solutions to problems that affect quality. QI is a continuous process that identifies where gaps exist between services actually provided and expectations for services and then lessens these gaps not only to meet client's needs and expectations, but to exceed them and attain exceptional levels of performance. This SOP describes the steps required in integrating quality improvement into designing and implementing programmes for SW.

Quality assurance/quality improvement tools should be based on national standards, and project implementation should use and improve existing health system structures.

Procedures:

1. Establish Quality Assurance and Improvement Provincial (QAIP) Teams

1.1 The personnel that will constitute the QAIP teams have training, expertise and interest in Quality Assurance and Improvement (QAI).

1.2 Identify QAIP teams and assign responsibility. For example:

1.2.1 Project director to assume overall responsibility

1.2.2 Program manager to act as the point person and oversee adherence to established SOPs for each activity

1.2.3 Other staff persons to assure implementation of specific activities according to SOPs

1.3 Conduct an orientation and training workshop to build the capacity of the QAIP teams to implement the SOPs, assess and monitor quality based on the QAIP teams framework, and to take appropriate measures to improve performance and achieve standards.

1.4 The team should meet quarterly to review reports using data quality and improvement tools.

2 Operationalize SOPs - Conduct workshops to disseminate SOPs to relevant implementation staff.

3 Quality assurance monitoring

3.1 Periodically review, assess and monitor activities for adherence to SOP, guidelines, and protocols.

Reviews may include various forms of communication channels such as E-mail; SMS and phone calls and site visits.

Develop a schedule for assessing the quality of interventions/services using checklists. To be most effective these meetings and field visits should be conducted regularly utilizing standardized mechanisms developed for the quality assurance specifically for SW.

3.2   Organize quarterly program review meetings.

3.3   Conduct site visits to verify reports presented at program review meetings and to ascertain the quality of services provided at different sites.

3.3.1   Select the site to be visited based on set criteria.

3.3.2   The site visited should be changed for each review, unless a specific site is of particular interest (e.g. Specific best practices or recurrent challenges are noted).

3.3.3   Develop a checklist (use NAC and R-NASF QA checklists where they exist) and use it during the visit to enable evaluators to easily describe the nature of the program/problem and location.

3.3.4   Start the process by preparing the scene (geographical site, exact location of activities).

3.3.5   Prepare a draft program review agenda and share with key partners for review and finalization.

3.3.6   Organize follow-up to the location of the visit to ensure that the necessary ground work has being successfully carried out. This includes courtesy call on key stakeholders and a write up on the geographical site, location of the activity, some previous and current work of clients being visited, etc.

3.3.7   Prepare the scene setting.

3.3.8   Share with team members to finalize action on other forms of communication in the form of E-mail, SMS that may be used as part of the review process.

3.4   Communicate achievements and shortfalls to all staff involved.

3.5   Develop action plans to ensure that findings and shortfalls from assessments are addressed.

3.6   Plan for subsequent programme/service review and assessments.

4   Quality Improvement system.

4.1   Identify explicit improvement aim and objectives.

4.2   Develop measurement system.

4.2.1   Identify national standards to be used as guideposts.

4.2.2   Identify a few indicators that will be collected on a regular basis.

4.2.3   Collect data from select sites.

4.2.4   Collate results.

4.3   Analyse results and generate ideas for change/ improvement.

4.4   Test and implement the system change.

SOP 1.7

ESTABLISH COORDINATIONG MECHANISMS

Objective:

To provide guidelines for coordination among different stakeholders and service providers of SW interventions.

Users:

Program managers, coordinators, implementation teams

Context:

Effective coordination between different stakeholders and service providers targeting SW with HIV services ensures cost effectiveness, reduces duplication, and encourages participation and representation by stakeholders at national, provincial and district level. Information sharing between partners at all levels strengthens the evidence base, reinforces SW monitoring systems and generates strategic information to improve programmes.

Regular meetings between the clinical and outreach teams are required to ensure coordination between them. These coordination meetings will help to improve the quality and coverage of services and also help implementers to review progress, innovate on their strategies and rethink their resource allocations. Regular clinical and outreach coordination meetings will ensure that activity reports are compiled and documented based upon information from both field and clinic perspective.

SOP 1.7.1

PARTNER COORDINATION

Procedures:

1. Define roles and responsibilities of the different partners.

1.1 Identify different agencies needed for the smooth functioning of an intervention.

1.2 Provide coordination guidelines among these agencies.

1.3 Form the group (total membership of the group, provinces and districts to be decided).

1.4 Nominate leaders.

2. Review work plans (goals, objectives, and activities) of each stakeholder to identify areas of collaboration and coordination.

3. Collate and disseminate the reports, minutes, service statistics and issues concerning SW from implementers.

4. Institute quarterly coordination meetings.

4.1 Specify the rational, agenda and objective of the coordination meeting.

4.2 Focus meeting discussions on the implementation of the SW HIV Prevention program.

4.3 Running effective meetings:

4.3.1 Fix day and time of the meeting.

4.3.2 Set the agenda for the meeting in advance.

4.3.3 Designate a person to take minutes and ensure registration of participants.

4.3.4 Read and confirm minutes of previous meetings. (Minutes of the previous meeting should be documented and circulated to members several days before the next meeting).

4.3.5 Discussion points:

4.3.5.1 Matters arising from the previous meeting.

4.3.5.2 Agenda for the day.

4.3.5.3 Any other topic on the agenda or requiring attention.

4.3.5.4 Next steps.

4.4 Assign follow up on the Action points to group members and ensure updates of these action points form part of the agenda for the next meeting.

5 Coordination at the National Level:

5.1 At the National level the National AIDS Council Zambia will be responsible for coordination. The coordination will be done under the SW Technical Working Group.

5.2 Participants should be drawn from NAC, governmental agencies and non-governmental agencies engaged in working with SWs; such as National AIDS/STI Control Program, Zambia Police Service, Zambia Prisons Services, Narcotic Control Board; stakeholders from Development Partners, , Faith-Based Organizations, Non-Governmental Organizations, Community Based Organizations,

Networks of People Living with HIV (NAP+).

5.3   Annually review terms of reference of SW TWG and amend if required to facilitate coordination of strategy.

5.4   Facilitate input from Provincial and District levels through representation through PAC and DAC.

5.5   Frequency of meeting should be at least bi-annually.

6   Coordination at the Regional Level:

6.1   Participation should be decided by the NAC. This should include governmental institutions, NGO, and provincial representatives of the participants at the national level as applicable.

6.2   Regional level or district level implementers should be invited to participate.

6.3   The meetings should focus on the implementation of the SW HIV prevention program the provincial level and the level of program implementation as well as achievements by stakeholders and implementers. It should provide a platform for stakeholder to present their achievements.

6.4   Quarterly meetings are recommended. However, these meetings can be linked to other meetings for HIV coordination at the provincial level. It should be ensured that SW interventions are fully discussed.

7   Coordination at the District Level

7.1   The meeting should be organised on a quarterly basis.

7.2   Participants: should be decided by the district coordinating body of NAC (i.e. DAC) if functional, the district coordinating council in conjunction with support from the district health management team.

7.3   The meetings should focus on the coordination of HIV activities focused on SW and the implementation of the SW HIV prevention program and progress towards achieving the objectives at the district level.

SOP 1.7.2

CLINICAL AND OUTREACH COORDINATION

Procedures:

1. Participants: The clinic team comprising of providers such as doctor/clinical officer, nurse, counsellor and laboratory technician and the outreach team, where each site is represented by either the field staff or the PP. The Program Manager should also participate when possible.

2. Frequency: Coordination meetings should be held once a month. Time and date should be fixed for the same time each month if possible.

3. Location: In the Wellness Centre, health facility or any other convenient location/site.

4. Purpose of the Meeting / Agenda:

4.1 To discuss if the service delivery site is strategically positioned to meet the needs of SWs.

4.2 To discuss follow up of SWs e.g. to provide treatment, to monitor compliance with treatment, to monitor progress of disease, to follow up on referrals made.

4.3 To answer medical queries coming up in the field that cannot be answered by the outreach staff.

4.4 To provide feedback to clinic as well as the outreach teams to improve services.

4.5 Acceptability and effectiveness of counselling messages.

4.6 To strategize for the forthcoming weeks to improve coverage and quality of services.

4.7 Updates on referrals should be made available for discussion during these meetings.

5. Prepare for the meeting:

5.1 Minutes of the previous meeting should be documented and circulated to members at least five days before the next meeting

5.2 Set the agenda for the meeting in advance.

5.3 Before the meeting, the clinic and the outreach teams should analyse their performance for the previous month and come prepared with data.

5.4 Designate an individual to ensure registration of participants and take minutes.

5.5 Matters arising from the previous meeting should be discussed first this and this followed by discussion of the agenda of the day.

5.6 At the end of the meeting, indicate the task that need to be done, who is responsible and timelines for actionable points.

5.7 Special situations should be referred to appropriate service provider.

5.8 Updates of referral services should be made available during these meetings.

PART - B
SOPs

SECTION 2 - BEHAVIOURAL INTERVENTIONS STANDARD OPERATING PROCEDURES

Behaviour change communication (BCC) strategies, approaches, and methods enable SW to play an active role in achieving, protecting and sustaining their own health, empowering them to make decisions, modify behaviour and change social conditions by transferring knowledge, skills and techniques. To be effective, BCC strategies must be community-centered and acceptable to the SW. Well-developed BCC materials play an important role in supporting BCC goals.

Peer education programs are a key component of the behavioural interventions. PP themselves trains SWs and offers direct outreach through one-to-one or small group communication sessions. These outreach sessions aim to assess specific risks and vulnerabilities including risk of SGBV; deliver correct information regarding transmission of HIV and means of prevention, including condoms and water-based lubricants; and provide referrals as appropriate. Wellness Centre provide safe places for SW to access information/ education, resources and services in the prevention of HIV/STIs, to offer compassionate support services for persons affected by HIV; and to support community building activities in a safe and confidential environment. Furthermore, Wellness Centre plays a pivotal role as part of the referral network to ensure that SWs are able to access necessary services.

List of SOPs:

SOP 2.1 Developing a BCC strategy

SOP 2.1.1 Developing BCC messages and materials

SOP 2.1.2 Advocacy/Sensitization

SOP 2.1.2.1 Establishing relationships with key focal point persons

SOP 2.1.2.2 Establishing and maintaining partnerships

SOP 2.2 Peer education and outreach strategy

SOP 2.2.1 Peer Promoter Selection

SOP 2.2.2 Peer Promoter capacity building

SOP 2.2.3 Peer Promoters retention and progression

SOP 2.3 Micro planning and individual tracking

SOP 2.4 Conducting BCC sessions

SOP 2.5 Condom and water –based lubricant demonstrations and promotion

SOP 2.5.1 Establishing & supporting condom outlets

SOP 2.6 Establishing and supporting a Wellness Centre

SOP 2.1

DEVELOPING A BCC STRATEGY

Objective:
To provide guidelines in the development of coordinated BCC strategy tailored to the specific needs of sex-worker sub-groups.

Users:
Program Managers, Site Managers, Clinic staff, OWs, Peer Promoters, Behavioral Change Communications Officers (BCCO)

Context:
This SOP aims to guide BCC practitioners and programs to develop and implement a BCC strategy that is participatory and in accordance with community customs and traditions. The communication strategy should promote the process of behaviour change at the individual, community and societal levels as well as support and encourage the maintenance of positive behaviours. Effective interventions must recognize that individual behaviour is influenced by many factors and thus, the development of a BCC strategy requires careful analysis of a problem situation at the individual, community, system and policy levels. Key steps to developing an effective BCC strategy include: identifying target audience, involving stakeholders, determining behavioural objectives, deciding what messages and materials are needed, distribution and dissemination of materials.

Procedures:

1.	Conduct situational assessments. Assess HIV prevention, care and treatment, and other health needs, barriers and identify all the components of a possible solution (e.g., communication as well as changes in policy, products, or services).

1.1	Identify the problem behaviours and circumstances in which they take place that affect your priority audience. Priority areas may include unsafe sexual behaviours that increase risk of HIV transmission or poor health seeking behaviours that affect access, utilisation of key HIV/FP products and services.

1.2	Identify barriers at the individual, community, system, or policy maker levels that need to be addressed for your priority audience. Barriers include low risk perception, lack of confidence and skills at the individual level, peer, partner, and family pressure, harmful cultural and gender norms, and stigma at the community, level, lack of friendly and accessible health products and services, or supportive, workplace policies and programs at the system level, and criminalization of SWs or lack of supportive policies, in place at the policy level.

1.3	Do a literature review through existing literature, formative assessment, surveys, and informal means to help identify knowledge, attitudes, and practices; specific needs of SW; and gaps in existing interventions, materials.

2.	Identify target audience(s). Define and learn about intended audiences. Segment the intended audience into homogeneous sub groups.

3.	Define BCC goal and objectives.

3.1	Set a broad statement of what you would like to accomplish with the target audience.

3.2	Establish behavioural objectives that will contribute to achieving the goal.

3.3   Conduct workshops to develop appropriate BCC messages that are tailored for SW using consultative and participatory process.

3.3.1 Mobilize target population.

3.3.2 Conduct formative assessment.

3.3.3 Design content of the curriculum for BCC messages workshop.

3.3.4 Pre-test and revise as appropriate.

3.3.5 Train in the use of the messages and the materials.

3.3.6 Deploy the messages and materials.

SOP 2.1.1

DEVELOP BCC MESSAGES AND MATERIALS

The design and production of BCC materials typically occurs after a behavioural communication strategy has been developed based on a formative assessment and in consultation with program stakeholders. A well-thought-out BCC strategy should segment the intended audiences, develop targeted messages and approaches using a variety of communication channels to promote positive behaviours; generate demand for and sustain individual, community and societal change; and support the maintenance of healthy behaviours.

Procedures:

1.   Use participatory approach to define messages and develop materials.

1.1   Discuss with stakeholders (at one-to-one meetings or in workshop settings) BCC materials development plan.

1.2   Involve SW in message and materials development at every phase.

2.   Determine messages

2.1   Identify factors inhibiting and enabling optimal behaviours through rapid assessment and utilization of existing behavioural data

2.2   Based on behavioural needs and intervention objectives, work with SWs to develop, test and finalize key behavioural messages.

3.   Determine appropriate BCC channels.

3.1   People access information in various ways, at different times of the day, and for different reasons. Explore settings, channels, and activities best suited to reach intended audiences.

3.2   Determine of what communication channels will most effectively reach the target audience based on messages selected. Match the needs of the target audience with the tools that best support the objectives and resources.

3.2.1   Examples of communication channels include: Print (Posters, billboards, leaflets), radio/TV, mobile phone, social media, one-on-one (e.g. peer education, Help Line counselling).

3.2.2   Decide what materials are needed based on assessments. It is helpful to do this with implementing partners and selected target audience who have had experience with the use of existing materials.

3.2.3   Choose materials that will best promote the objectives of the strategic behavioural communication strategy for the budget available and specific Sex worker segment.

3.2.4   Identify potentials partners, resources and other forms of support for the development of the BCC materials.

3.2.5   Using social media tools has become an effective way to expand reach, foster engagement and increase access to credible, science-based health messages. Social media and other emerging communication technologies can be used to facilitate and connect SW, especially the hidden SWs, to health and protection information and empower them to make safer and healthier decisions.

4.   Adapt or develop BCC materials.

4.1   Gather relevant existing BCC materials to adapt.

4.2   Modify materials as appropriate. While technical information and main ideas may remain unchanged, modifications in language and localization of images and styles may probably be necessary.

4.3   Design need materials as needed, based on the above steps.

4.4   Pre-test materials.

4.4.1   Chose appropriate method for pre-testing. For example, arrange for a two-person team: a facilitator and a note-taker. A two-person team can effectively interview 5-6 people a day or conduct 2 pre-testing focus group discussions per day.

4.4.2   Ensure that participants match the profile of the SWs as closely as possible. Make sure that the same respondents do not participate in more than one round of pre-testing.

4.4.3   Materials required: draft materials (e.g., pictures and text separately), audio recorder, pens, paper for taking notes.

4.4.4   If pre-testing in groups, for print materials, make a copy of messages/ materials for each participant.

4.4.5   Number all messages and images to be pre-tested for easy reference.

4.4.6   At least two rounds of pre-testing should be conducted: one for draft versions and one for almost-final versions.

4.4.7   Ensure privacy and confidentiality by conducting pre-tests in a secure environment and assuring participants of complete confidentiality. Discourage onlookers to facilitate the process free of interference.

4.4.8   Interviewers should ask questions measuring the following variables:

4.4.8.1 Comprehension: Do respondents understand messages?

4.4.8.2 Attractiveness: Do respondents find messages/materials/images appealing?

4.4.8.3 Acceptance: Do respondents find messages culturally/socially acceptable?

4.4.8.4 Involvement: Do respondents perceive materials to relate to people like them?

4.4.8.5 Inducement to action: Do respondents feel motivated to act after exposure to messages/ materials?

4.4.8.6 Ask open-ended questions that elicit detailed comments. Ensure that questions do not lead participants to specific answers.

4.4.9   Compile summary results. Once all parts of messages and materials have been pre-tested, compile a summary of results for the graphic artist and BCC team and make necessary revisions to the prototype.

4.4.10 Obtain approval from stakeholders and relevant staff. This includes collaborating institutions, organizations interested in using materials, agencies with authority to approve materials or stop them from circulating and donors.

5   Produce Materials.

5.1   Determine pictorial and textual messages as specifically as possible before contacting vendors.

5.2 Relevant staff should draft text or copy of print materials as appropriate and possible.

5.3 Contact three or more vendors to find the one most suitable for the intended production of materials.

5.4 Describe the proposed job and including a creative brief, a short paper outlining project needs to the vendors. The brief should include: expected graphic content, messages, colour, type of paper, number of copies and project background. Request creative and financial proposals by a certain date from prospective vendors. Request samples of past relevant work.

5.5 Hire appropriate creative vendors (e.g., graphic designers, writers, production vendors).

5.6 Make sure all selected vendors have the information needed to do their work. This may include technical information that they may not have access to, sample images, finalized messages, and donor/stakeholder logos.

5.7 Deliver requested changes to vendors after pre-testing.

5.8 Make sure production timing is clear to all parties concerned. Your contract with vendors should include penalties for delays in production.

5.9 Coordinate production schedules so that all materials are completed in time for a launch, intervention start or major event.

5.10 Monitor progress of vendors' work throughout the development process.

5.11 Always demand to see "proof" of products to sign off on before final production. For print materials, this may be the very first copy of an item right off the presses to review before the full print run is executed.

6 Distribution of materials:

6.1 Develop inventory for all available materials. It should include quantity, goal and objective, target population of each material. Check all materials regularly to ensure quantity and availability of materials.

6.2 Develop a distribution plan and share with all parties concerned (include the amount of space required for storage at facilities where materials will be stored).

6.3 Develop and use receipts/forms for recording distribution.

6.4 Train material users such as BCC practitioners, peer promoters, outreach workers or relevant staffs how to use materials, including goals and objectives, target audience, and content of the materials. Ensure that they are well prepared for using the materials. Conduct refresher training as possible.

7 Establish feedback mechanisms.

7.1 Incorporate channels through which SWs and stakeholders can share their views about the materials and make suggestions for improvement.

7.2 Plan and implement for M&E. Use appropriate M&E for different type of materials and target groups. Periodically, assess whether:

7.2.1 Activities are being completed at scheduled times;

7.2.2 Your intended audiences are being reached;

7.2.3   Certain activities or materials are more successful than others;

7.2.4   Certain aspects of the program need to be altered or eliminated; and

7.2.5   Your expenditures are within budget.

7.3   Use process evaluation to track the following (depending on focus of BCC strategy):

7.3.1   The functioning and quality of your BCC interventions

7.3.2   Partner/coalition involvement

7.3.3   The effectiveness of publicity, promotion, and other outreach efforts

7.3.4   Media response

7.3.5   Intended audience participation, inquiries, and other responses

7.3.6   Adherence to schedule

7.3.7   Expenditures and adherence to budget

7.4   The following are examples of ways to gather the information needed for process evaluation:

7.4.1   Use activity tracking forms.

7.4.2   Ask callers what prompted their call (e.g., for Help Line counselling).

7.4.3   Gather feedback cards from or make follow-up phone calls to television and radio stations.

7.4.4   Review telephone responses for accuracy.

7.4.5   Follow up with teachers, physicians, or other gatekeepers to check their preparedness and interest.

7.4.6   Gather regular status reports from staff, contractors, and partners.

7.4.7   Meet in person or by telephone with partners to review your program's progress.

7.4.8   Track traffic to project web sites.

7.4.9   Review publication requests and distribution

7.5   Refer to Annexure E for tips in producing successful materials.

SOP 2.1.2

ADVOCACY / SENSITIZATIONS

Procedures:

- Identify a team of individuals responsible for the planning and implementing the working with SW sensitization strategy.

- Conduct stakeholder mapping (including listing and categorization) which can include:
  - 2.1 Commission for Human Rights and Administrative Justice
  - 2.2 Zambia Police and Armed Services
  - 2.3 Civil Society Organisations including Organisations for SWs
  - 2.4 SW friendly political and opinion leaders
  - 2.5 Bar and Hotel owners and managers
  - 2.6 Law enforcement agencies
  - 2.7 Civil society groups
  - 2.8 Peer leaders
  - 2.9 Traditional Health Practitioners
  - 2.10 Bartenders/bar managers/owners/security guards in the bars,
  - 2.11 Truck/Taxi drivers and Helpers,
  - 2.12 Clients/regular partners,
  - 2.13 Queen Mothers/Brothel keepers/Managers,
  - 2.14 Pimps/non-paying partners,
  - 2.15 Lodge managers/owners

- Develop community mobilization/advocacy plan
  - 3.1 Analyse stakeholder information needs.
  - 3.2 Identify potential challenges that could be expected from each category of stakeholder.
  - 3.3 Plan strategies to minimize the challenges and gain support from stakeholders.
  - 3.4 Establish tailor-made sensitization and communication strategies.
  - 3.5 Package tailored messages for each "target" stakeholder.

- Sensitize stakeholders and gatekeepers.
  - 4.1 Initiate contact with stakeholders, maintain and monitoring contact.
  - 4.2 Dispatch messages through appropriate communication medium e.g. one-on-one, small group, etc.
  - 4.3 Conduct follow-up.
  - 4.4 Conduct regular stakeholder meetings to give project updates and get their inputs and support to resolve problem facing the project implementation.
  - 4.5 Invite stakeholders regularly to project activities and events and acknowledge their contributions to the project.

- Conduct stigma and discrimination reduction training for stakeholders and service providers.
  - 5.1 Training should include SGBV, legal issues, stigma and discrimination.
  - 5.2 The goal of training is to provide services that are acceptable to SW and that address the needs of the SW while respecting their health and human rights.

SOP 2.1.2.1

ESTABLISING RELATIONSHIPS WITH KEY PERSONS

Objective:

- To provide contextual clarity on the sensitization efforts needed with stakeholders and gatekeepers such as Queen Mothers, Bar/Brothel owners/ managers and other community gatekeepers while working with SWs.

- To provide essential requirements and detailed processes on the content and implementation of a sensitization strategy.

- This SOP will be complemented by the SOP on Networking and Linkages and Mechanisms for Community Management.

Users:

Program Managers, Site Managers, Clinic staff, OWs, Peer Promoters, Behavioral Change Communications Officers (BCCO)

Context:

Sex Work as a sector often operates at the periphery of the law. It is important to ensure that project activities do not lead to either tacit or implicit acceptance of any criminal activities/persons. Sensitization of gatekeepers and stakeholders while working with SWs is a crucial activity, as it serves two main purposes. In the short term, it creates opportunities for continuous access to the SWs for the provision of services. Long term benefits would be the creation of an enabling environment in which SWs can access services themselves. In this manner, SWs would be able to practice healthy behaviors and utilize health services, making these processes sustainable. SWs would be able to enjoy their fundamental rights and avail services without the stigma and discrimination associated with their profession.

In the context of SWs in HIV prevention projects, sensitization efforts with the gatekeepers and key stakeholders such as Queen mothers, Bar/Brothel owners/ managers and other community gatekeepers need a specific strategy, keeping in mind community dynamics and local conditions. These activities need to be conducted on a regular basis and should focus on building community linkages. It is expected that an open engagement with gatekeepers and stakeholders would not only increase the access of SWs to condoms and STI/HIV services but also lead to a norm where potential illegal activities could be eliminated.

Development of a Sensitization Strategy

1. Create a team of individuals (PM, SM, OWs, PPs and PP- Advocate) and experts responsible for the planning and implementation of the strategy

2. Conduct stakeholder mapping (including listing and categorization)

2.1 Gate Keepers: Individuals with whom rapport is needed to identify SWs as well as gain and maintain access to SWs. These are individuals who have direct and regular contact with the SWs and are instrumental while conducting project activities.

2.2 Key Stakeholders: individuals with whom rapport is needed to identify SWs and create an enabling and supportive environment, thereby making services accessible to the SWs. These are individuals who have direct and regular contact with the SWs and are instrumental while conducting project activities.

2.3 Other stakeholders: individuals with whom rapport is needed to create an enabling and supportive environment. These are individuals who are on the periphery but have contact with the SWs. These individuals are supportive while conducting project activities e.g. provide space to conduct health camps, serve as condom depots etc. These individuals are also potential/existing clients of the SWs.

Gatekeepers	**Key Stakeholders**	**Other Stakeholders**
• Queen Mothers/ Brothel Keepers/ managers • Pimps • Bar managers/owners • Lodge managers/ owners • Bouncers in the bars	• Local Police • Local Leaders • Local Mafia/goons • Waiters • Money lenders • Regular partners • Local Service Providers	• shopkeepers who sell cigarettes etc • bus and mini bus drivers • Truck/Taxi drivers • Clients

2.4 Identify areas where support is needed from the stakeholders

2.5 Develop a system for initiation of contact with stakeholders, maintaining contact and monitoring of the same

2.6 Develop a format for conducting a sensitization program (including frequency, content, resource persons etc)

2.7 Make project services such as condom distribution, HIV/AIDS and STI testing, health check-ups etc available for them. The frequency and the extent of services to be made available to be decided earlier by project staff.

2.8 Discuss the strategy with key community members and staff

2.9 Review strategy on a periodic basis – decide the time period with the team

Procedures:

1. Sensitization of Gate Keepers

1.1 Queen Mothers/Brothel keepers/managers, pimps, bar managers/owners, lodge managers/ owners, bouncers in the bars

1.1.1 Identify the gate keepers

1.1.2 Analyze the role played by each gate keeper in the program

1.1.3 Enlist the ways in which each gate keeper can contribute to the implementation and effectiveness of project activities

1.1.4 Highlight the potential threats that could be expected from the gate keepers

1.1.5 Plan strategies to minimize the threats and gain support from gate keepers

1.1.6 Conduct regular (monthly) visits and meetings to give project updates and also to discuss

difficulties faced in project implementation, thus get their inputs and support to resolve problems.

1.1.7   Invite them to participate in community and project events and acknowledge their contributions to the project.

2.   Sensitization of Key Stakeholders

2.1   Local Police

2.1.1   Build rapport with the Head of the police in the project district/zone (in the Zambian context, the Commissioner of Police and Police Officer in Charge). This is to be done by senior project officials. This is to gain permission to conduct sensitization programs with all the police stations in their jurisdiction.

2.1.2   Prepare a list of all the police stations and beats in the project area.

2.1.3   Inform the local police in advance regarding events and health camps on a regular basis. This helps develop rapport and builds trust.

2.1.4   PM and SM to lead exposure visits to local police stations in order to demonstrate the process of rapport building with police officials to the OWs.

2.1.5   Project staff to visit local police stations for individual meetings with the police station in-charge. These meetings need to involve facts and figures to help them understand issues related to HIV/AIDS, SWs and the incidence of HIV/AIDS among police staff.

2.1.6   Monthly visits are especially important as there are constant transfers of officials.

2.1.7   Obtain written approval from the police station in-charge to conduct a sensitization program on HIV/AIDS for their staff

2.1.8   Prepare power point presentations and develop resource material for the sensitization programs.

2.1.9   Conduct sensitization programs at police stations and facilitate training of project staff who will later conduct similar sessions at other police stations

2.1.10   During the sensitization visits/programs, the PPs and OWs sensitize the police personnel on:

2.1.10.1   Issues and information about HIV/AIDS

2.1.10.2   Modes of transmission

2.1.10.3   Myths and misconceptions

2.1.10.4   Methods of STI/HIV prevention

2.1.10.5   Information about project activities

2.1.10.6   Issues related to SWs

2.1.10.7   Incidence of HIV amongst police personnel and addressing risk perceptions

2.1.11   The sensitization program should include testimonials of SWs, sharing experiences of support received from the police which have further led to reducing his/her vulnerability. These SWs should be identified in advance and trained in public speaking.

2.1.12   Distribute some reading material on HIV/AIDS in the local language for participants to refer after the sessions

2.1.13 Project services such as condom distribution, STI testing and treatment etc to be made available for them at the time of the sensitization program to increase their interest and involvement.

3. Local Leaders

3.1 Identify the local leaders

3.2 Analyze the role played by each local leader in the program

3.3 Build rapport with district level Government representatives and those in change of government and municipal services of the area. This needs to be done by the PM and SMs.

3.4 On a regular basis, the project staff to visit the offices' of the local leaders to build rapport and give them information about the project and the role they can play in the implementation. The agenda of meetings with local leaders needs to include the following,

3.4.1 Information about HIV/AIDS

3.4.2 Information about HIV prevention project activities

3.4.3 Difficulties faced by the project team during project implementation.

3.5 Invite them to participate in community and project events and acknowledge their contributions to the project.

4. Local mafia/goons, Waiters, Money lenders,

4.1 Identify the stakeholders

4.2 Analyze the role played by each stakeholder in the program

4.3 Invite them to participate in community and project events and acknowledge their contributions to the project.

4.4 Build rapport through regular visits to their locations. This is to be done by OWs and PPs.

4.5 Project services, such as condom distribution, STI testing and treatment etc, to be made available for them at the time of the sensitization program to increase their interest and involvement.

5. Regular partners

5.1 Give them information about HIV/AIDS in order to encourage them to use condoms and undergo regular health check ups

5.2 All project services can be provided to a regular partner, other than AG membership

6. Other Stakeholders : Trucker/taxi drivers and clients

6.1 Give information about HIV/AIDS, thus reduce myths and misconceptions and their risk perceptions as potential/existing clients.

6.2 Conduct regular (monthly) visits and meetings. This is to be done by the PPs and OWs.

ESTABLISHING AND MAINTAINING PARTNERSHIPS

Objective:

- To provide contextual clarity on the establishing and maintaining partnerships and networking efforts needed with stakeholders while working with SWs.

- To provide essential requirements of networking and detailed processes for establishing linkages.

Users:

Program Managers, Site Managers, Clinic staff, OWs, Peer Promoters, Behavioral Change Communications Officers (BCCO)

Context:

Establishing and maintaining partnerships are an essential component of any intervention with SWs as they provide synergies for the project to build upon; from a point of challenge to advantage to a point of strength. Networking involves forming formal and informal partnerships and ties with various stakeholders with different/mutual areas of interest and/or benefits.

Any one project cannot provide every service needed/wanted by the beneficiaries. Therefore, establishing and maintaining linkages with stakeholders' brings the community closer to services needed that go beyond the scope of the project. It also supports the facilitation of the creation of an enabling environment, in which SWs would be able to practice healthy behaviors and utilize health services, making these processes sustainable. The networks work independently and together to ensure that SWs enjoy their fundamental rights and avail services without the stigma and discrimination associated with their profession.

In the context of SWs in HIV prevention project, networking with stakeholders and establishing linkages needs a specific strategy, keeping in mind community dynamics and local conditions. These activities need to be conducted on a regular basis and should focus on building community linkages.

Development of Networking Strategy

A. Create a team of individuals (PM, SM, BCCO, OW, PP-Advocate and PPs) and experts responsible for the planning and implementation of the strategy.

B. Assess the needs of the community, through minimum three group discussions conducted by the PC and SM. The number of group discussions will be dependent on the variances in typology, background of the SWs in the project area.

C. Prepare a document, enumerating the following:

    i.   Needs of the community being reached by the project

    ii.   Needs of the community outside the scope of the project, requiring linkages

D. Conduct mapping of potential linkages, to enable access to need-based services not being provided by the project (including listing and categorization). Listing should include services in (within a 15 – 30 minutes walking distance) and outside the project area (nearest possible location).

Government level	Local level
• Health post	• Local service providers (local private hospitals and clinics)
• Government hospitals for FP and other services	• Lawyers
• Anti Retroviral Centers (ART) Centers	• Local NGOs
	• Women Welfare Associations
	• Forums and community based groups

E. Develop a system for initiation of linkages with stakeholders and strengthening the same.

F. Develop a relationship building system to facilitate regular exchange of views and updates to sustain their interest in project activities and get feedback. This will ensure continuous support and access of services to the SWs.

G. Discuss the networking strategy with key community members and staff.

H. Review strategy on a periodic basis – decide the time period of the review with the team.

Procedures:

1. Networking at Government level

1.1 Health post, Government hospitals, ART Centers,

1.1.1 Identify the local Government functionaries and facilities as per the needs assessment (services not being provided by the project). Keep in mind the travel time as specified.

1.1.2 Build rapport with local Government representatives and those in charge of services for the area. This needs to be done by the PM and SMs.

1.1.3 On a regular basis, the project staff to visit the offices of the functionaries to build rapport and give them information about the project and the role they can play in the implementation. The agenda of meetings needs to include the following,

1.1.3.1 Information about HIV prevention project activities

1.1.3.2 Difficulties faced by the project team during project implementation.

1.1.2 Invite them to participate in community and project events and acknowledge them.

2. Networking at the Local level

2.1 Local hospitals and health care providers

2.1.1 Make a list of hospitals and health centers in the project area.

2.1.2 Regular visits to the identified hospitals and health centers to build rapport with health care providers

2.1.3 During the visits the PPs and OWs need to talk to the health care providers' about HIV prevention project activities. This makes it conducive for SWs to access health care services.

2.1.4   In partnership with the hospital/health care center, have a specified space in their premises for a staff member. This is to create an enabling environment in which SWs would be able to practice healthy behaviors and utilize health services, without stigma and discrimination.

2.1.5   Staff/key community members responsible for the linkages, to accompany SWs in need of services.

2.2   Lawyers

2.2.1   Each organization needs to appoint a Legal Resource Person (LRP).

2.2.2   The LRP is an expert lawyer (consultant to HIV prevention project) who trains the Core Group members (Refer in SOP No.5.4) on legal provisions for SWs.

2.2.3   The training conducted by the LRP needs to includes information about,

2.2.4   Fundamental rights

2.2.5   Procedure of filing a FIR

2.2.6   Rights at the time of arrest.

2.2.7   The LRP could also provide his/her legal services as and when required. Expenses to be borne by the SW/s.

2.3   Local NGOs, Women Welfare Associations, forums and community based groups.

2.3.1   Team to identify NGOs, forums and community based groups in the project area that provide services the SWs need and/or are interested in (especially those not provided by the project; e.g. day care services, psychiatric support etc)

2.3.2   Staff/community members to visit the NGOs, forums and community based groups on a regular basis to develop contact and strengthen the same. Two individuals to preferably focus on each relationship (to ensure continuation in the case of one individual not being available).

2.3.3   Visits to be made initially on a monthly basis. This can be reduced to once in a quarter as the relationship strengthens.

2.3.4   Staff/key community members responsible for the linkages, to accompany SWs in need of services.

SOP 2.2

PEER EDUCATION AND OUTREACH STRATEGY

Objective:

To provide a standardized guide to establishing and implementing an effective peer education programs.

Users:

Program Managers, Site Managers, BCCO, OWs, Peer Promoters

Context:

Greater involvement of SWs will ensure the sustainability of the HIV prevention efforts, It is a process which involves enhancing the ongoing role of SWs in project implementation as per their involvement and performance. Individuals with strong leadership skills were informally elected by the community members and project staff as peer leaders. These leaders need to be true peers and should be individuals from the same geographical community, speak the same language, belong to the same age group and work in the same profession. It is essential that a Peer Promoter (PP) needs to be a practicing sex worker (SW) so that she has regular access to other SWs, has active linkages and understands the present needs.

The OWs identify SWs as peer promoters on the basis of feedback from other SWs. SWs are appointed as peer leaders on the basis of their participation in the project activities and their interactions with other SWs, thus the peer leaders are not just selected but also elected individuals with strong leadership qualities. In a setting where community mobilization is at an advanced stage, a panel of PPs would select new PPs. The processes already in place have resulted in an increase in the confidence levels of the SWs involved in the project. Their involvement is not only as project participants but also as implementers.

Peer education is a structured, interpersonal form of communication where trained SWs peers influence their peers to maintain positive behaviours or undertake behaviour change to improve or protect their health. Peer education is often used to effect changes in knowledge, attitudes, beliefs, and behaviours at the individual and community level. They may also be involved in the protection of the rights of their peers and in linking peers to key health, protection and psychosocial services. Peer promoters are an essential link between the community and NGO and facility-based services, and are most effective when they maintain contact with peers over time. Peer promoters may interact with peers on a one-on-one or group setting.

Micro-planning is a crucial approach to ensure that planning, implementing and monitoring and strategizing service delivery for community outreach interventions is effective, relevant and efficient recognizing that each "hotspot" and each SW in every hotspot have unique risks and needs. Micro-planning enables a PP to do individual-level assessment, planning and tracking/ follow up on service uptake based on their individual risk, vulnerability and profiles; gives a visual picture of the site; and enables a PP to monitor and track individual SW to ensure that all services and follow-ups are provided.

Before individuals can reduce their level of risk or change their behaviours, they must first understand basic facts about HIV, adopt key attitudes, learn a set of skills, and be given access to appropriate products and services. This is often done through communication sessions led by a PP. Effective communication sessions facilitate and enhance participation of the peers to initiate dialogue with the community, enhance participation of SW to improve self-risk perception of STI/HIV transmission and to identify the ways and means to reduce the risk, improve skills and sense of self-efficacy and promote services for prevention, care and support. Communication sessions may be conducted one-on-one (one PP to one SW) or small group sessions (one PP to group of maximum four to eight SW).

Key features

- Effective strategy to ensure that project services are provided to all SWs through peers who can reach out to other SWs in situations beyond the reach of project staff.

- Greater involvement of SWs in project implementation through PPs as site managers.

- Sustainability of project activities by increasing ownership of SWs.

PEER PROMOTERS SELECTION

Objectives

- To provide contextual clarity on the strategy for selecting peers from among the SWs.

- To provide information about essential requirements and detailed processes for peer selection.

- This SOP will be complemented by SOPs on sex worker progression and micro-plan.

Key Features

- Effective strategy to ensure that project services are provided to all SWs through peers who can reach out to other SWs in situations beyond the reach of project staff.

- Greater involvement of SWs in project implementation through PPs as site managers.

- Sustainability of project activities by increasing ownership of SWs.

Advantages of selecting Peer Promoters

- Contact and sensitization of maximum number of SWs through interpersonal communication

- Peers effectively motivate other SWs to practice safer sex behavior and access health services through a credible and acceptable channel of communication based at the project's working area

- Peers increase project sustainability as they will remain in the area even after the project phases out.

Criteria for selecting peer promoters

- Individuals who are practicing SWs and are not retired from profession nor should they quit the profession just because they have become "social workers"

- SWs from the same geographical community

- SWs who speak the same language

- SWs of the same age group

- SWs with leadership qualities

- SWs belonging to the same typology

- SWs who show willingness to work for the community on a volunteer basis

- SWs who demonstrate self-confidence and show potential for leadership

- SWs who have good communication and interpersonal skills

- SWs who listen to other SWs and represent their voice at small and large forums

- SWs who understand cause and are committed to the goals of the project

- SWs who are knowledge of problems and difficulties of the community

- SWs who are recommended by other SWs for peer positions.

Pre-requisites for Peer Selection:

- Strong belief of all the members of the NGO staff in this philosophy and implementation of the strategy to ensure readiness and support.

- Geographical area of intervention to be divided into micro-sites of 50 SWs.

- Criteria for the selection of SWs as peers to be in place.

- Induction and training strategy to be developed and pre-tested.

- Monitoring mechanisms to be established

- SWs to be identified to become unpaid Community Volunteers and support OWs in implementing project activities in each site.

- SWs to have worked in a position for a minimum of three months as a Community Volunteer before being considered for a Peer Promoter position.

Role of Peer Promoter

- Peers are an interface between the SWs and the project team. As site managers, their main responsibilities are:

- To map SWs in their area of operation and regularly update this information

- To collect and analyze data related to the project to help in planning and implementation.

- To ensure that services are provided to SWs as per the Minimum Package of Services for SWs in Zambia

- To identify new SWs as soon as they come into their site and enroll them with the project

- To ensure that services are provided to new SWs within one week of enrollment

- To identify and ensure that services are provided with priority to those with a higher risk profile

- To prepare and regularly update the Micro-plan

- To support condom promotion activities undertaken

- To play an active role in the activities of community led committees

- To play an active role in the CBO activities

- To support OWs and project team in project activities.

- To provide support to SWs in their site in times of crisis within one hour.

- To act as eyes and ears of the project and keep it updated on developments in their site

- To provide feedback from the SWs to the project and voice their concerns.

Procedures:

1. Selection of Peer Promoters should be taken up as an intentional strategy to make the project sustainable and increase community ownership.

1.1 SWs to be inducted and trained to work as community volunteers with minimal responsibilities.

1.2 OWs and project staff to observe the performance of community volunteers in the project and identify SWs who have leadership qualities and commitment towards project activities.

1.3 OWs and project staff to observe the community volunteer's linkages within the community and level of respect received and given. A list of the existing network to be shared.

1.4 Unpaid community volunteers to be considered for promotion only after a minimum of three

months of performance.

1.5   In the initial stages, BCCO or senior representatives from the organization to interview each SW being considered and then appoint.

1.6   As the project develops, a panel of PPs to be formed to interview every potential PP and give recommendations. This panel is to include PPs who have been involved with the project since its inception or a defined minimum time period. The panelists to interview potential candidates for the post of PP on the basis of a selection criteria developed by them. The PPs in the selection panel to discuss job responsibilities, honorarium etc with the candidate and make the final decision about the appointment.

2.   Strengthening of Peer Promoters

2.1   PPs to be oriented to the mission, vision and objectives of the project.

2.2   PPs to be explained the commitment needed as well as the number of hours expected and outputs expected

2.3   A cadre of motivated PPs to be developed and encouraged.

2.4   An attempt should be made to form a community based organization (CBO) of this cadre in order to sustain project activities in the future.

2.5   PPs to be organized in formal or informal groups depending upon the context and most importantly based on the active participation of the peer promoters.

2.6   Training mechanisms to be in place with modules on the following topics:

2.6.1   Sex and sexuality

2.6.2   Sexual and reproductive health

2.6.3   STIs and peer role in STI management

2.6.4   Basics of HIV/AIDS

2.6.5   Providing Minimum package of services(MPS) to all registered SWs in the micro plan (Refer SOP No. 2.3) area

2.6.6   Condom promotion

2.6.7   Negotiation skills

2.6.8   Self esteem

2.6.9   Care for PLHIV

2.6.10 Peer-led monitoring and decision making

2.6.11 Advocacy

2.6.12 Community mobilization (Refer SOP No. 4.2 and 4.3)

2.7   Support to build additional networks amongst stakeholders, key individuals and points of assistance to be given.

2.8   PPs to be promoted to various peer positions depending on their potential, interest and performance.

2.9 Peer progression and career growth plan to be shared with all PPs

2.10 Recognition for performance plays a major role in the motivation of PPs. Therefore, appropriate recognition systems such as certificates, medals, special mentions, citations etc to be institutionalized.

2.11 Mechanisms for regular interactions amongst peers as well as between peers and key stakeholders, including government counterparts in order to facilitate their ownership to be established.

Phased transition of SWs in the peer promoter selection process is to be planned for and

implemented. The time period and conditions of this process is flexible and dependent on the prevailing local conditions, existing level of community ownership.

Phased Peer Selection

PHASE - I **Staff Driven Stage 1 Year**	**PHASE - II** **Transition Stage 6 months**	**PHASE - III** Community Driven Stage
• OWs identify SWs as Community volunteers • OWs identify CVs as potential PPs • BCCO / PM/ representative to interview & appoint PPs	• OWs and existing PPs to identify potential PPs from amongst CVs • A panel of PPs to interview potential PPs and appoint	• 1 year • Existing PPs to identify potential PPs from amongst CVs • CBO members to interview potential PPs and appoints

PEER PROMOTERS CAPACTIY BUILDING (TRAINING AND MENTORING)

Objectives:

- To provide contextual clarity on the strategy for carrying out training needs assessment for the development of need based training manual and programs.

- To provide information about essential requirements and detailed processes for assessing the training needs.

Context:

HIV Prevention programs aims to establish health seeking behavior among SWs. The sustainability of the project activities is achieved through the involvement of SWs as peer promoters. There is a high level of importance attached to performance. Programs should strives for proficiency through capacity building in the form of theoretical as well as on-job training. PP needs to achieve a set standard of performance. The gap between standard performance and actually performance helps to identify training needs. The process of analyzing the reasons for the gaps in performance facilitates training needs assessment.

Training needs assessment needs to be carried under the following conditions:

- New Recruitments - Induction and orientation to all new employees.

- If a new activity is included in the project.

- Difference between actual performance and standard performance.

- In case of attitudinal problems among the team members.

- If there is a need expressed by the project team.

Key Features:

- Identifying difference between standard performance and actually performance.

- Need based capacity building helps in reaching out to all staff and helps them to achieve high performance standards.

- The training needs is to be identified and training curriculum designed to impart knowledge, skills, practice and improve attitudes (KAPS) to PP and other staff through formal participatory trainings and mentoring during supervision visits.

- Training through on site demonstrations and supervision thus creating a cascading effect.

- Enhancing the confidence of the staff through feedback resulting in improved performance.

- PPs are illiterate or have low literacy working on an honorarium for four hours a day. Their attention span is low and they have low retention to improve their performance regular training and reorientation is needed. This will help them to retain the knowledge and practice and help them to improve their skills to improve the performance and effectivity of BCC sessions.

Procedures:

1. Capacity building through regular class room training

1.1 Creativity is an important requirement as the training should to be participatory and it needs to cater to participants who may be illiterate or semi-literate.

1.2 The training material and formats need to be pictorial and easy to use for all the participants.

1.3 The entry level behavior of the participants is to be documented and studied before designing the training.

1.4 The trainer to read the training and manual prior to the training

1.5 The trainer to come prepared and rehearse the sessions before conducting the training. This rehearsal needs to aim at overcoming inhibitions, if any.

1.6 The trainer needs to adopt a participatory approach to ensure involvement of all the participants.

1.7 The training needs to include energizers after every two hours to revive the mood of the participants and also to ensure everyone is attentive during the session

1.8 The venue, timing, temperature of the surroundings, food, toilet facilities, water etc need to be selected careful in keeping with the profile of the participants.

1.9 The trainer should eat with the participants and also stay with the participants if possible.

2. Capacity building through engaged mentoring

2.1 Engaged mentoring plan is to be made in keeping with the requirements of each type of SW.

2.2 Planning activities and rolling them out by achieving and maintaining speed.

2.3 Training through on site demonstrations and supervision thus creating a cascading effect.

2.4 Supportive supervision - demonstration and re-demonstration the activity to provide on-site training. (eg. if a PP is facing problems in conducting a group communication session, the supervisor needs to demonstrate the session to provide on-site training to the PP. The PP is to be encouraged to conduct group sessions under the supportive supervision of the OW. These sessions are to be observed by the OW and followed with feedback

2.5 Setting performance standards and stressing on uniformity.

2.6 Developing quality assessment tools and used at the time of supervision to assess performance standards.

2.7 In order to mentor the outreach staff, the process of training the PPs also needs to be demonstrated. The supervisor take over the role of engaged mentoring with the PPs.

SOP 2.2.3

PEER PROMOTERS RETENTION & PROGRESSION

Objectives:

- To provide contextual clarity on the strategy for PP retention

- To provide essential requirements and detailed processes of PP progression

- This SOP will be complemented by the SOP on Peer selection. (Refer SOP No.2.2.1)

Users:

Program Directors, Program Managers, BCCO, OWs, PPs

Context:

In order to achieve the vision of community involvement, it is necessary to have a specific strategy to involve the community in program implementation and management. Additionally, opportunities for community members to take on leadership and staff roles in the project should be available and advocated. This would lead to the gradual building of capacities of community members and an increased role of the community in defining the project direction, which is crucial for transfer of project activities to the community.

Aside from the regular involvement of SWs as PPs, Project should go beyond the generally understood concept of peer education and increased it from service delivery to site management.

For those with interest and skills, special peer positions such as peer counselors, peer trainers, peer nurses etc should be created. PPs, being considered for promotion to these positions, were provided with regular training and on-site technical guidance and performed additional responsibilities. SWs in HIV prevention projects currently hold many staff positions in the project e.g. Project MIS (Management Information System) Officer, OW etc. The peer progression strategy is part of the overall community involvement strategy of the project, which includes Self Help Groups (Refer SOP No - 4.2), CBO development (Refer SOP No. 4.3) etc and is part of the long term vision of transfer of ownership.

Key Features:

- Strategy to increase the involvement of the SW community in project implementation and management

- Specially created PP positions taking into consideration their skills and inclination, elevating the involvement of community members to beyond regular peer education.

- Strategy to involve SWs leading to sustainability and transfer of ownership.

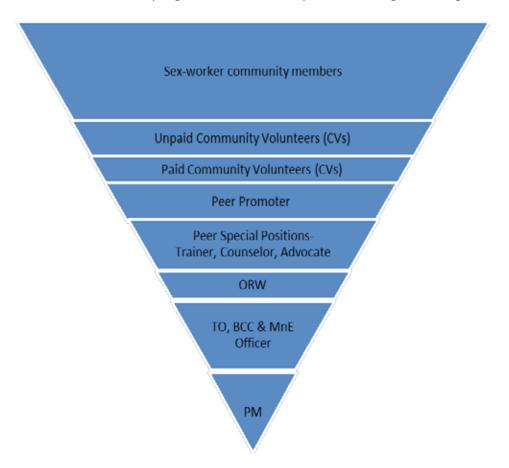**Pre-requisites of a SW Progression Strategy**

- Enrollment of all members of the NGO staff in this philosophy and implementation of the strategy to ensure readiness and support.

- Geographical area of intervention to be divided into micro-sites

- Responsibilities of PPs and special PP positions to be in place

- It is necessary for SWs to have worked in a position for a minimum time period (e.g. 6 months) before

they are to be considered for other position. This will provide an opportunity to the OWs to observe their performance, their skills levels and their leadership abilities.

- Having this kind of tier system in place ensures that migration of SWs does not affect the performance of the project. Should a SW holding a position leave the site, there are many on a lower rung who have been functioning for a while who are ready to be considered for promotion.

- These are honorary positions, receiving stipends, except for the staff positions.

- Monitoring and documentation formats to be created, keeping in mind the low literacy levels of the community.

- On-site guidance and training mechanisms in place to ensure regular support to those being elevated.

Procedures:

The procedures for vertical SW progression are best explained through the diagram:

Level 1: Unpaid Community Volunteers (CVs)

- SWs who show interest in the program and are willing to participate in delivering key project services.

- These should be SWs who are willing to give time to the project and have or are capable of developing strong networks amongst the community.

- This is a completely honorary position and the individual does not receive any compensation.

Responsibilities:

- Promote the safe sex practices and condom use;
- Motivate FSWs for treatment of STIs; and VCT
- Accompanied referral.

Level 2: Paid Community Volunteers

- To be chosen from amongst the unpaid CVs
- To have a minimum experience of 2 months as an unpaid CV
- To get an honorarium of K….only.
- No specific numbers of hours are fixed.

Responsibilities:

- Promote the safe sex practices and condom use;
- Ensure regular access to condoms among SWs;
- Educate and motivate FSWs for treatment of STIs; FP, VCT and
- Accompanied referral.

Level 3: Peer Promoters

- To be chosen from amongst the Paid CVs
- To have a minimum experience of 3 months as a Paid CV
- To get a monthly honorarium of K…… only and expected to work for 4 hours a day at a time that suits them.
- This individual to be someone who has shown constant dedication to the delivery of services to the community and an aptitude for people management.

Responsibilities:

- Develops the micro-plan and regularly updates it;
- Conduct SBC sessions with SWs regular distribution of condoms;
- Assist in forming self-help groups and conduct site events for FSWs;
- Extend support for visiting the project clinic and make referrals for STI treatment, VCT services; and
- Educate and motivate FSWs for treatment of STIs, FP and follow up.

Level 4: Special Peer Positions

- To be chosen from amongst the PPs
- To have a minimum experience of 6 months as a PP
- To get a monthly honorarium of K….. only and expected to work for 4 hours a day at a time that suits them and the project staff.

- This individual will be a site manager as well as will have specific responsibilities that make use of his/her unique skills. This individual will work along with a specific project staff member e.g. Peer counselor will work closely with the Project counselor, Peer nurse will work closely with the Project nurse and so on.

- This individual to have shown constant dedication to the delivery of services to the community and an aptitude for that specific job that he/she is being considered for. The list of qualities that each individual should have as per the position below, it is indicative and not exhaustive:

Peer Counselors: should be one who shows empathy towards others and is a good Listener

Responsibilities:

- Provide counseling to FSWs in zones, Wellness centers/clinics and sites;

- Meet vulnerable population and ensure treatment compliance;

- Motivate FSWs for female genital examinations in Wellness centers/clinics and

- Coordinate with self-help groups to mobilize FSWs for access services at clinic.

Peer nurse: should be interested in helping others, is not scared of the sight of blood and needles, has some basic literacy level and has a good memory.

Responsibilities:

- Provide on-site support to the health care provider at Wellness centers/ in health camps and satellite clinics;

- Prepare FSWs for female genital examinations;

- Giving first aid to FSWs; and

- Help staff nurse in sterilization of equipment and distribution of medicines.

Peer trainer: should be someone who has good oratory skills, likes to explain and teach others, is patient and has a good memory.

Responsibilities:

- Conduct trainings for new Peer Promoters and Community Volunteers at implementing partner level;

- Attend training programs conducted by principal recipient/donor;

- Identify vocational skill needs of FSWs and share with Project Advisory Group; and

- Provide support to Peer Promoter by conducting quality SBC session and self-help group meetings;

Peer Advocate: should be someone who has good networking skills, has an existing rapport with the stakeholders and has a history of supporting others in times of crisis.

Responsibilities:

- Provide legal literacy education to FSWs with Task Force Committee members;
- Provide rapid response to the FSWs in crisis; and
- Identify needs related to identity card, children's admission and opening of bank account.

Peer Supervisor: should be someone who has good management skills, has good people management skills, can multi task and is a leader amongst the PPs.

Responsibilities:

- Supervise the Peer Promoters in implementing field activities;
- Assist Peer Promoters to collect data for monthly, quarterly and annual progress reports;
- Organize coordination meetings with peers and other stakeholders; and
- Ensure all activities of the programs are implemented by the peers as per the work plan.

Level 5: OWs and other staff up the ladder
- The SW being considered for this position should undergo a test/detailed interview to ensure the necessary literacy level and knowledge level.
- Once hired as part of the staff, they are to be considered on par with all staff members and given opportunities accordingly.

MICRO-PLANNING AND INDIVIDUAL TRACKING

Objectives:

- To provide contextual clarity on the strategy for developing a micro plan for the effective implementation of an outreach program.
- To provide information about essential requirements and detailed processes for the development, implementation and monitoring of a micro plan.
- To understand ethical issues in implementation of micro plans

User:

Program Directors, Program Managers, Site Managers, BCCOs, OWs, PPs

Context:

A micro plan is a crucial tool in planning, implementing, monitoring and strategizing service delivery for community outreach interventions. Micro plan is a live tool that facilitates a Peer Promoter (PP) to do individual-level planning and follow up on prevention service uptake based on the individual risk, vulnerability, profiles of SWs and their partners. Micro-planning at each site is done by PPs. A micro plan gives a visual picture of the site that a PP is managing. It helps to understand the extent to which program services have reached the SWs and also helps to identify and monitor problem areas.

To ensure the effective execution of a micro plan, the outreach team prepares a plan by keeping in mind definite responsibilities of individuals involved in project implementation.

Key features:

- Planning activities to meet the needs of the SWs and the project
- Implementing the plan by executing the strategy planned at the micro level
- Regular monitoring at the site level (micro)

Pre-requisites for developing a Micro Plan:

- Project Staff at the implementation organization level – Program Manager (PM), Site Manager (FM), BCCOs, OWs and PPs.
- PM and OW to identify a team of PPs in their site area.
- One PP to have 20-60 SWs in his/her site area. Each PP to be responsible for two SHGs.
- PP training module
- A detailed site map of the area

Uses of Micro Plan:

- Defined area of operation by PP – This helps to avoid duplication of effort and diffusion of responsibility. Demarcation of a site responsibility for that site rests with an individual PP.
- Repeat visit for monthly screening- The PP is able to monitor clinic visits for monthly screening of the SWs in the given site.
- Risk-based segmentation of SW to provide appropriate service packages to each of them under their

micro-plan.

- Individual Tracking – PPs are able to track how many SWs are being reached out during a given month. This tracking is done by reviewing delivery of various HIV and FP related serviced such as, clinic/outreach (door to door) attendance, one to one sessions, contacts, group sessions, condom distribution and SHG membership.

- The PP is able to collect, analyze and act upon data – using the PP daily activity report.

- The PP is able to generate data and use it to provide minimum services to all SWs in her /his site.

- The PP becomes the site manager –PPs decide and budget for activities to be conducted in their site and take responsibility to ensure service provision to all SWs in their site.

- Community ownership – A sense of belongingness and ownership is cultivated by addressing felt needs of the community and encouraging active involvement and decision making by the SWs in all aspects of the program.

- Shift from delivering services (push) to meeting community's demand for services

- Ownership by the community leads to demand generated for services from the community (pull). The project services are then community driven than IP driven.

- The PP is effectively the managers of a site so they are best placed to track individuals and their service uptake.

- To aid the PPs, the program has developed a "Minimum Package of Services for SWs in Zambia" that should be offered to each SW. The package includes STI treatment, one to one BCC session, providing condoms every week and membership in Self Help Groups to each of the female sex workers in a site of a PP.
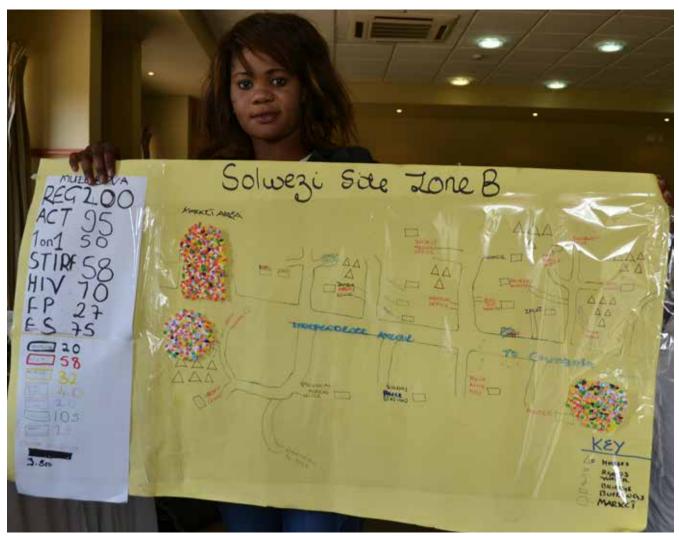
Institutionalization of Micro Plan:

It is important for the PPs to be able to develop their micro plans as it capacitates them as site managers and help them own the plan.

Micro Planning Competition: In order to institutionalize the concept of micro-planning, holding a competition was found useful. During this competition, each PP develops his/her own micro plan and presents the same to a panel of judges who selects the best micro plan. Each PP also needs to explain his/her micro-plan, the benefits and how he/she will use it for regular planning and monitoring. This creates healthy competition among the PPs as well as ensures that the process is ingrained.

Procedures:

1. The concept of micro planning is to be explained to the implementing organization under COH project, Zambia or any other projects implementing HIV prevention project for the Female Sex Workers.

2. The BCCO and Master Trainers to train the PPs to develop micro plans for their site area. These need to be updated on a monthly basis.

3. A Micro plan is developed in the following manner,

3.1 Geographical area of operation to be defined at the organizational level

3.2 Area demarcation is to be done at the site level. The site Micro-plan to consist of the areas of the PPs under the site.

3.3   PPs to be capacitated to make their specific area map, enroll and track registered SWs individually

3.4   Regular collection and action on data.

4.   PPs need to be equipped to be able to implement their micro plans.

5.   The implementation of the micro plan is to be monitored on a weekly basis.

6.   PPs need to put/ change appropriate color stickers for each SW based on risk assessment done.

7.   PPs need to record the services provided to each of the SW in that particular month.

8.   The implementation of micro plans is to be documented by the PP in the form of individual tracking sheets and weekly reports.

9.   Data is documented and is tracked through a smooth flow of various interconnected documents. Field data is to emerge from the micro-plan.

Micro Plan of a PP from Solwezi site

10.   Phased transition of micro planning from being staff driven to being community driven is to be planned for and implemented. The time period and conditions of transfer of ownership is flexible and dependent on the prevailing local conditions and existing level of community ownership in the program.

Phased transition of Micro Planning

PHASE - I
Staff Driven Stage 1 Year

- PM, SM and BCCO train PP to develop their site level micro plans
- OW & Master Trainer support PPs in preparing their micro plans
- OW & Master Trainer monitor the micro plans of the PPs

PHASE - II
Transition Stage 1 year

- PPs prepare their micro plans independently
- OW and Master Trainers monitor the implementation of the plans on a weekly basis

PHASE - III
Community Driven Stage 1 year

- PP trains SHG leaders to develop site level micro plans
- SHG leaders prepare micro plans along with the PPs

- Documentation of every micro plan and monitoring of the same is to be maintained.

CONDUCTING COMMUNICATION SESSIONS

Objective:

To provide contextual clarity on the strategy for conducting communication sessions with the SWs based on the risk based segmentation in the prevention project. To provide information about essential requirements and detailed processes for planning, conducting and evaluating communication sessions.

Users:

Program Directors, Program Managers, Site Managers, BCCOs, OWs, PPs

Context:

HIV prevention programs aims to develop health seeking behavior among SWs living in vulnerable circumstances and who face harassment and abuse by their partners, clients, police, local goons, brothel owners, bar owners etc. Effective BCC sessions with SWs are a very necessary strategy in the context of an STI/HIV prevention project as it is necessary to encourage SWs to register with the project, avail the services, participate in project activities and ultimately develop health seeking behavior.

The process of enrolling new SWs and improving health seeking behavior among them is carried out through communication sessions based on their existing knowledge, practices, behaviors and risk based segmentation.

- One to one communication sessions – one PP to one SW.
- One to group communication sessions – one PP to group of maximum four to five SWs.

Key Features:

- BCC sessions facilitate and enhance participation of the SW to initiate dialogue with them to improve self-risk perception of STI/HIV transmission and to identify the ways and mean to reduce the risk.
- BCC sessions serve as an effective strategy to provide on-site and grass root support to SWs
- BCC sessions build the capacity of community members as SWs who are trained as leaders.

Pre- requisites for BCC sessions

- Trained PPs to conduct the sessions
- A project team: PM, SM and OWs to provide supportive supervision to PPs.
- Technical team to develop and monitor the communication sessions within the program context.
- Relevant Training Manuals.
- A check list need to be developed to evaluate the performance of PPs. This needs to be used by the OWs to give feedback to the PPs.

Procedures:

Keys components of successful communication sessions:

1. The PP to build rapport with the SW before initiating a discussion on STI/HIV.

1.1 The PP to use appropriate language and dialect while communicating with the SW.

1.2   The PP to have appropriate body language and tone of voice during the sessions

1.3   The PP to respect the SWs and should be non-judgmental.

1.4   The PP to treat all SWs with equality.

2.   PP to conduct BCC sessions from appropriate SBC package based on risk based segmentation

2.1   The PP should take prior appointment to fix the session at a time convenient time to the SWs.

2.2   The PP is to identify appropriate place to conduct one to one/one to group session keeping in mind privacy and proper visibility and audibility.

2.3   The PP to listen to the current STI/HIV knowledge of the SWs.

2.4   The PP to address the myths and misconceptions of the SWs.

2.5   The PP to decide on the appropriate communication material or message to be discussed based on the prior session.

2.6   The PP to prepare speaking points for the session with the SWs.

2.7   The PP to use appropriate communication material in an interesting way.

2.8   The PP to give correct technical information related to STI/HIV and must remember the unanswered queries raised by SW.

2.9   The PP to initiate a dialogue with the SWs on risk reduction.

2.10   The PP to teach every SW three different ways to use a condom correctly with the help of a demonstration and re-demonstration on the penis model.

2.11   The PP to thank the SWs for their time and participation.

2.12   The PP to fix an appointment for the next session.

3.   Refer:

3.1   PP to refer the SW to the Wellness Center

3.2   PP should refer SWs to government health institutions to as per their needs as and when required.

3.3   The PP to refer SWs to other NGOs to as per their needs as and when required..

3.4   The PP to refer SWs to other government departments such as police etc to as per their needs as and when required.

3.5   The PP to refer SWs to financial institutions such as banks for opening saving accounts.

4. Key Messages: Behaviour change by a peer should be facilitated through the use of the BCC minimum package which includes provision of information/education on HIV/STI prevention (HIV/STI transmission and behaviours based on 10 key behaviours below), conducting a risk assessment based on behaviour and referring for the appropriate HIV/STI related service(s). Service includes STI, HTC, GBV and drug and alcohol counselling.

Ten Key behaviours:-

4.1   Use condoms consistently and correctly

4.2   Use non-oil-based lubricants correctly

4.3   Get tested and know HIV status

4.4   Disclose HIV status to regular partners

4.5   Promptly seek appropriate and effective treatment for STIs, HIV/AIDS and OIs

4.6   Adhere to treatment (STIs, OIs and ART)

4.7   Reduce number of multiple and concurrent sexual partners

4.8   Eat healthy

4.9   Protect against other infectious diseases such as TB, Malaria and diarrhoea

4.10 Get information on mitigating drug and alcohol use.

5.   Supportive Supervision to PPs:

5.1   A project team to provide supportive supervision to PPs.

5.2   BCCO to develop and monitor the communication sessions within the program context.

5.3   A check list to evaluate the performance of PPs. This needs to be used by the OWs to give feedback to the PPs.

Additional points:

•   Each PP to conduct minimum one, one to one session with maximum three SWs per day.

•   Each one to one session should not exceed more than 20 to 30 minutes

•   Each PP must conduct at least one, one to group session every day.

•   Every SW needs to get a minimum of a one to one session or a one to group session every month.

•   PP must report his/her activities on day to day and weekly basis.

SOP 2.5

CONDOM AND WATER BASED LUBRICATION PROMOTION

Objective:

To provide a standardized approach to the demonstration and promotion of male and female condoms, water-based lubricants and other commodities.

Users:

Program Directors, Program Managers, Site Managers, BCCOs, OWs, PPs

Context:

Correct and consistent condom use is one of the best methods for HIV prevention. Demonstrations and promotion of female and male condoms, as well as water-based lubricants and other commodities such as gels are important components of an HIV program among SW. Condoms, water-based lubricants and other commodities should be made available and accessible through SW focused programs. There needs to be a consistent and adequate supply of condoms and lubricant. PPs should demonstrate and encourage the correct and consistent use of condoms and water-based lubricants and provide SW with the skills to negotiate their use with clients and partners.

Key Features:

- Steps to be followed while correctly using a condom, thus ensuring protection from STIs/HIV.

- Innovative techniques to demonstrate the use of condoms in the dark or orally in keeping with the circumstances in which the SWs work

- Development of communication strategy for promotion of male and female condoms, water-based lubricants.

- Build capacity in condom use negotiation skills among SWs.

- Free distribute by PPs as per the need of SWs

- Establishing condom outlets for free distribution.

- Socially marketing of condoms and water-based lubricants

Procedures:

1. Demonstrate correct condom usage. PPs and clinical service providers must be trained to demonstrate the proper use of condoms and water-based lubricants.

1.1 Equip PP and outreach staff with a penis model.

1.2 Adequate supply of condoms and water-based lubricants with PPs and outreach staff for free distribution.

1.3 Flavoured condoms if doing the oral condom demonstration.

1.4 Train the PPs in innovative techniques to demonstrate the use condoms in the dark or orally in keeping with the circumstances in which the SWs work

2. Develop communication strategies to promote use of and create demand for condoms.

2.1 Demand creation for condoms can be done by PPs and through BCC materials including media outreaches.

2.2 Harness condom promotion with the existing electronic/folk/social media condom promotion campaign

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

3 Build capacity in condom use negotiation skills among SW. PEs and other service providers should provide SW with the skills in negotiating condom use with clients and partners.

4 Distribute/sell condoms and water-based lubricants.

4.1 Peer promoter to distribute freely/sell condoms and water-based lubricants whenever possible to SW during BCC sessions and contacts according to need of SW (to minimize wastage).

4.2 Condom and lubricant outlets should be opened in hotspots. These could include shops, bars, brothels, truck stops or guest houses.

4.3 Static, outreach and referral clinics need to distribute/sell condoms and water-based lubricants to SW.

4.4 Monitor quality of condoms (e.g. expiration dates, reports of breakage) and report problems to implementing partners and/or the National AIDS Council.

ESTABLSIHING AND SUPPORTING CONDOM OUTLETS

Objective:

- To provide conceptual clarity about the need to establish condom outlets involving maximum participation of SWs.

- To provide detailed information about the criteria to be followed while setting up condom outlets.

- To demonstrate the method and process of setting up condom depots.

Context:

Establishing and monitoring the performance of condom outlets is a challenge as the individual/s who operate condom outlet need to be sensitized and enrolled into the program. It is also a challenge to train them to maintain records of every transaction and to document the frequency of each transaction as most of them are not educated and are generally employed elsewhere.

Condom Outlets

Conventional	Non-conventional
• Local shops	• Public toilets
• Brothels	• Local doctors
• Bars	• Restaurants
• Alcohol shops/houses	• Hair salons
• Pimps	• Bus stops
• Lodges	• Home of Peer Promoters (PPs) or other community members
• Traditional healers	

It is also essential that condom outlets are community owned and managed to ensure that access is continuous and at the very site of sex work. Self Help Groups (Refer SOP No.) members are hence trained to do the same and can be involved in the selection of individuals/locations to become outlets.

Condom depots can also be manned or un-manned. An example of an un-manned condom depot is a public toilet (sex work site) where condoms are placed so that SWs can access as and when necessary. Manned condom depots are those which have an individual monitoring the supply and distributing the condoms, e.g. shop keeper, etc.

Calculating the unmet condom need

Assessing the condom requirement at any given site of intervention is critical in order to ensure condoms are not being "dumped" or stock-outs are not occurring. Ultimately, condom availability depends on the risk profile of the individual site and cannot be averaged or aggregated.

The following formula can be used to calculate condom requirement for SWs at a given site:

$$D = (S \times I \times N) - C$$

Where,
D is the condom requirement
S is the number of SWs operating in the area
I is the number of sex acts per day

N is the number of days a sex worker is "active" in a given month

C is the number of condoms brought by clients from other sources

S, I and N can be determined through the processes of site assessment and outreach planning. C, can be determined by local partner organizations, through special surveys of SWs. If such surveys have not yet been carried out, the NGO can estimate the proportion of condoms brought by the clients by polling a random sample of SWs. An additional question while talking to the SWs could be to know the brand of their preference

Once the condom demand has been fixed, there is a need to calculate with the PPs, the number of condoms they will distribute per SW in their micro-site in a month. This will form the thrust of condom distribution as condoms given directly to SWs are more likely to be used and less likely to be wasted. Additionally, condoms to be kept at the Wellness Centers and clinic need to be fixed, based on the attendance at the same. Condom demand minus the condoms distributed through outreach, Wellness Centre and clinic, will give an estimate of the condoms needed to be kept at the condom depots.

Procedures:

1. PP along with SWs to identify conventional and non-conventional condom outlets in their sites. Locations should be chosen carefully to minimize wastage or the chance of the condoms being sold.

2. The condom outlets to be established on the basis of the preference expressed by SWs. The SWs to decide the places and people they would prefer as condom depots.

3. It is necessary to build rapport and establish relationships with potential individual/s who serve as condom outlets or managers and to explain the purpose of setting up condom outlets.

4. Educate individual/s condom outlets to document and keep track of condoms being distributed.

5. Condom outlets managers to provide condoms to SWs as they ask for them and make note of the same.

6. The condom outlets to be visited by the PP on a daily basis to check on the stock. If the condom outlet manager is unable to maintain records, the PP to ask questions related to the condoms being taken and the details of the same.

7. The condom outlet stock is to be replenished on a weekly or monthly basis, as is decided between the PP and the condom outlet manager.

8. The unmet need to be calculated along with the SWs on a regular basis to ensure that the needs have not changed.

The phased transition of the condom outlets from being staff driven to being community driven is to be planned for and implemented. The time period and conditions of transfer of ownership is flexible and dependent on the prevailing local conditions and existing level of community ownership in the program.

ESTABLISHING WELLNESS CENTRES

Objective:

• To provide contextual clarity on the strategy for setting up and running a "Wellness Centre" for the effective implementation of an outreach programme.

• To provide information about essential requirements and detailed processes for setting up and running a Wellness Center.

The "Wellness Centre" as a strategy has the scope to reach out and mobilize SWs. The "Wellness Centre" needs be a place where the SWs would feel safe. The "Wellness Centre" is not to be restricted to being a 'service provider' place but a 'center to mobilize the SWs.' The "Wellness Centre" should be 'the most sought after place for the SWs.'

Users:

Program Directors, Program Managers, Site Managers, BCCOs, OWs, PPs

Context:

The "Wellness Centre" as a concept is to attract the SWs to a place which would be considered safe and a place to be used for the facilitation of project related activities. This place needs to be easily accessible with all the necessary facilities to conduct project activities in a non-threatening, clean and friendly environment with easy access to community. A "Wellness Centre" needs to be community centric and orientated to meet the project objectives. The "Wellness Centre" has to be a 'one stop' centre to address various needs of the SWs with flexibility in its implementation. This calls for creativity, innovation and needs to be strategized in keeping with the requirements of the SWs to make the "Wellness Centre" functional and meaningful. Apart from the project clinic the "Wellness Centre" is to provide entertainment in the form of 'infotainment'. This is the unique facility of providing key messages along with entertainment.

It provides strong linkages with referral centers need to include service providers from hospitals, legal help, police department, educational institutes, identity card authorities, etc. A good Wellness Center should be able to cater to the felt needs of the SWs by providing the services directly or by referring them to the referral centers. While setting up a "Wellness Centre" it is important to consider the requirements of each typology with sensitive towards hidden population who are spread across the area of operation.

Procedures:

1.   Conduct formative assessment and a participatory consultation

1.1   Assess specific needs of SWs through formative assessments or secondary data from previous surveys, and informal means. Make sure relevant representation of each typology of SWs is included in the assessment.

1.2   Identify possible locations for "Wellness Centre" based on mapping, available data and importantly, discussions with SWs.

1.3   Review relevant government policies and legislation that may impact on service establishment and operation.

1.4   Mobilize key stakeholders. Identify and bring together through a workshop various stakeholders to initiate a community dialogue, seek input on establishing the "Wellness Centre" and

generating "buy-in" for the activity. This stakeholder meeting should include representatives from Government/NGOs/CBOs working with SWS. Representatives from NAC in charge of HIV/STI service provision and other relevant health and welfare services in catchment area should be also invited as collaborative partners since the service will offer a referral.

1.5　　Actively involve SWs in the planning process so that their needs and preferences are identified and used to define the referral network.

2　　Develop "Wellness Centre" work plan.

2.1　　Identify the services to be provided:

2.1.1　　This will vary considerably, according to the availability of resources and the findings of the assessment.

2.1.2　　At a minimum you will need to implement the following key activities:

2.1.2.1　　Individual and group-level peer interventions

2.1.2.2　　Social activities/community mobilization activities

2.1.2.3　　Provision of relevant information/education (printed materials)

2.1.2.4　　Distribute/sell condoms and water-based lubricants.

2.1.2.5　　Assessment for HTC and STI service needs and referrals

2.1.3　　Other activities that may be provided at a "Wellness Centre" include:

2.1.3.1　　Support group meetings

2.1.3.2　　Counselling services (HIV counselling, psychosexual and psychosocial counselling)

2.1.3.3　　Community-based clinical services (HIV testing, STI clinic, family planning counselling and services, general health exams) or venue for hosting mobile clinic services

2.1.3.4　　Hot line or internet service

2.1.3.5　　Non-formal education, literacy/numeracy programs, language classes

2.1.3.6　　Classes on beauty tips, nutrition and self-care

2.1.3.7　　Showers and laundry facilities/lockers to store belongings while community members are working

2.1.3.8　　crèches (child care) for children of sex workers

2.2　　The "Wellness Centre" work plan should include site selection, hours of operation, minimum services to be offered, training plans, an advocacy and mobilization strategy, periodic meetings with the referral network, printed materials/tools development or adaptation, community involvement, and a monitoring and evaluation plan.

3　　Select site/venue

3.1　　Identify the criteria for site selection.

3.1.1　　The development of the site selection criteria should be informed by the community discussions and assessments, the type of the services/activities to be implemented, and the available resources.

3.1.2　　The list of criteria should be validated by SWs representatives and the staff.

3.1.3   The criteria should include structural safety & security such as availability (continuity of tenancy), accessibility, continuous electricity supply, exit issues in case of fire, potential for, or availability of multiple dedicated phone lines; cost of rental premises, flexibility to modify physical structure of premise, internet access, and, very importantly, proximity to the specific areas where SW live or gather.

3.1.4   Depending on the available resources, a "Wellness Centre" could be a venue either rented on specific daily or monthly basis integrated into the office of the NGO/CBOs or stand alone in another location/venue. Where possible, seek donated space.

3.2   Visit and assess potential sites. Document site selection criteria that are both acceptable and unacceptable at each potential location. Make the final selection in partnership with SW representatives.

3.3   Finalize rent agreements. Note in the agreements the site modifications will be required, if any. Ensure that funds are secured prior to sign the agreement and the duration of the lease should match with the duration of the contract with the donor to avoid interruption of service provision.

4   Prepare site including the development of "Wellness Centre" management procedures.

4.1   Ensure the functionality of the "Wellness Centre" (based on the services provided):

4.1.1   Required furniture and equipment

4.1.2   Decoration

4.1.3   Development of a "Wellness Centre" "membership" system and tools to monitor daily activities

4.1.4   Ensure sufficient telephone lines are available if a hotline service will be established

4.1.5   Ensure internet access is available, if relevant

4.1.6   If "face to face" counselling services are offered these should be conducted in rooms offering visual and auditory privacy to clients

4.2   Ensure building security and structural safety: exits, extinguishers, instructions in case of emergency such as fire or injury should be displayed and accessible for the beneficiaries and staff…Emergency telephone numbers (police, hospitals…) should also be displayed as well as 'SHG Leaders'.

4.3   Ensure the provision of materials and commodities, such as condoms and water-based lubricants, penis model for IEC materials, data collection tools etc. needed to support the implementation of the activities.

4.4   Ensure the "Wellness Centre" is integrated into a referral system. See SOP no. 4.1 Establishing and supporting referral networks.

4.5   Develop "Wellness Centre" management procedures. . The policy should clearly ensure that confidentiality and anonymity are respected and grievance procedures should be in place for beneficiaries who feel their confidentiality was breached. This aspect is crucial when working for example with SW when sex work is considered illegal, or when establishing community-based clinical services. The policy should be accessible for all the members and/or read to the members.

5   Recruit personnel.

5.1   Develop and agree upon selection criteria for recruitment or assignment.

5.1.1   Develop a list of criteria for selecting personnel to be trained to be staff (either full-time or part-time for the activities of the "Wellness Centre"). Volunteers, if any, could also be selected but under the mentoring of the assigned staff.

5.1.2   Advertise shortlist, interview and select applicants (external or internal).

5.1.3   Recruitment process must be transparent and free of coercion. A selection panel could be set up as well.

5.1.4   Standardized, interview questions should be drafted and applied to all recruitment interviews.

6   Train staff.

6.1   All staff, including volunteers, must agree to attend all training workshops and supervision sessions offered prior to, and after commencement on duty.

6.2   Each new employee should undergo a formal orientation to the DIC including the training of the "Wellness Centre" SOP, and basic peer support counselling, the internal policy and the basic training on HIV and STI outreach for peer educators/worker.

6.3   All staff should attend annual refresher training and other available and relevant training organized for the NGO/CBO.

7   Launch the "Wellness Centre": invite local authorities/stakeholders, beneficiaries, and partners for the launch of the "Wellness Centre".

8   Promote and implement services

8.1   Develop a strategy to promote the "Wellness Centre".

8.1.1   Identify ways to let SWs know about the service. This could include materials disseminated by peer promoters, through SMS or social media. Ensure promotion is conducted in a way which is discreet and targeted towards SWs and organizations working with SWs only.

8.1.2   A specific name and logo could be also designed (branding strategy).

8.1.3   Ensure that the promotion of the "Wellness Centre" is consistent and integrated in the other activities/interventions established by the CBO/NGO.

8.1.4   "Wellness Centre" can also be promoted by different partners such as social services of hospital, STI/HTC clinics, hotline, and any other services that are included in the 'referral system" (see SOP no 4.1 "Establishment of community-based referral system"), and specific entertainment venues.

8.1.5   Review the promotion/communication strategy every year based on the feedback from monitoring.

8.2   Develop a weekly or monthly agenda to plan "Wellness Centre" services.

8.2.1   The agenda should be available to the beneficiaries and peer educators/outreach workers to promote upcoming services during the outreach activities.

8.2.2   If the CBO/NGO or "Wellness Centre" has a website, the agenda could be also posted on their website.

8.2.3   Use SMS and social media to promote specific "Wellness Centre" activities or events.

8.3   Mobilize the communities/groups to use and support the services at the "Wellness Centre". Undertake intensive community mobilization and promotional activities to increase the demand of services.

9   Monitor the "Wellness Centre" activities (e.g., services offered, attendance) and use the findings to improve the system: strengthening/adapting the current services, and identifying new services.

9.1   The monitoring should include quantitative and qualitative data.

9.2   Feedback from the beneficiaries should be also regularly collected and monitored.

9.3   Organize periodic meetings with the staff and the beneficiaries using the "Wellness Centre". These meetings provide a venue for on-going communication, exchange of information about the services provided, discussion of challenges and gaps in terms of services and updating the service network directory.

9.4   Ensure compliance with program standards. Management staff needs to systematically monitor and assure compliance with standards and policy and initiate corrective action when shortfalls are identified. Refer to SOP no 1.6 Quality assurance and quality improvement (QA/QI) for further guidelines.

9.5   Use M&E for decision-making. Findings from timely reporting on program activities, as well as from any evaluation that takes place, should be used to make adjustments in program operations. Refer to SOP no 1.5 Monitoring and evaluation (M&E) for further guidelines.

SECTION 3

BIOMEDICAL INTERVENTIONS - STANDARD OPERATING PROCEDURES

Biomedical interventions (those that directly influence the biological systems through which the virus infects an individual, such as blocking, decreasing infectiousness, or reducing acquisition/infection risk) for SW specifically involve testing and diagnosis of infections, treatment, family planning and other clinical services that improve their health. Biomedical interventions for SW addressed in this section are STI management, HIV counselling and testing, and sexual and reproductive health.

Stigma and discrimination create barriers to SW access to clinical services. Effective clinical services (STI treatment, HTC) among SW is however an important strategy to reduce biomedical HIV transmission. Service providers and other social workers should be trained to provide friendly services to sex workers to promote uptake of STI/HIV and related services. Health workers' attitudes greatly influence the acceptability of services provided.

In addition, this section provides guidance on occupational infection control to minimize the spread of infection between patients, and between service providers, staff and patients (nosocomial infections).

List of SOPs:

SOP 3.1 Establishing SW-friendly clinical services

SOP 3.2.1 Facility based clinical services

SOP 3.2.2 Outreach clinical services

SOP 3.2 Provide SW- friendly services

SOP 3.2.1 STI management services

SOP 3.2.2 HIV testing and counselling

SOP 3.2.3 Sexual and reproductive health screening and services

SOP 3.3 Occupational infection

SOP 3.3.1 Infection Prevention

SOP 3.3.2 Bio-medical waste management

SOP 3.1

ESTABLISHING SW- FRIENDLY CLINICAL SERVICES

Objective:

To provide standard guidelines for establishing SW-friendly facility-based and outreach clinical services.

Users:

Service providers, Program Managers and Site Manager

Context:

SW face on-going challenges in accessing the health services they need, even when motivated to engage in healthier behaviours including seeking treatment for STIs and/or testing to know their HIV status. SW in Zambia tend to be highly stigmatized and discriminated against in their daily life due to cultural and legal prohibitions against commercial sex and homosexuality, and inadequate understanding of HIV transmission. Young SW are particularly vulnerable as they are further marginalised by health workers because of their age.

Health care providers have been known to stigmatize and discriminate against SW. Limited information about them, lack of requisite skills to work with them as well as limitation in the number of friendly facilities all contribute to this dilemma. This combined stigma leads to significant barriers to accessing comprehensive prevention, care and treatment services. Providing high quality, non-judgmental and supportive SW friendly clinical services (STIs, HTC) in both facility settings and through outreach clinics will help to increase uptake of clinical services by SW.

Procedures:

1.   All staff (clinical, outreach, assistants, receptionists, etc.) should be trained to be SW-friendly and have a non-judgmental attitude towards the sex workers served by the clinic.

1.1   Conduct stigma and discrimination reduction trainings for all staff and service providers using the SW and PLHIV stigma training guide for HIV testing and counselling and STI care providers (produced by the USAID Zambia COH Project).

1.2   Train providers on the linkages between SGBV and HIV, specifically how violence or the fear of violence can prevent women from assenting to HTC or returning for results; the importance of confidentiality; potential negative outcomes of disclosure, and incidence of anxiety, depression, and stress when learning about HIV status during pregnancy.

1.3   Identify the additional training needs of the staff and, if necessary, seek assistance for training.

2.   Plan for on-going technical support and supervision of staff.

3.   Establish strong linkages with referral network and all activities targeted at SW to create demand for the services and ensure diverse needs are met. See SOP no 4.1 Establishing and supporting referral networks.

SOP 3.1.1

FACILITY BASED CLINICAL SERVICES

Objective:

• To define a facility based clinical services

• To describe the process and essential requirements for facility based clinic

• To describe the minimum set of services that is given in a facility based clinic

Context:

SWs differ in their typologies, working hours, priority towards health and proximity of the clinic to their homes/work places. Therefore, the static clinic model of service delivery, which involves a fixed clinic providing services at fixed hours on all days, is not effective in providing clinical services to SWs.

To reach out maximally to SWs with clinical services, HIV prevention projects to design the facility based clinic model of service delivery. This model should be developed based discussion with SWs through PPs, focus group discussions and anecdotal evidence. In this model, clinical services are taken closer to the SWs when they are unable to access services at the clinic, common reasons for which being unsuitable clinic timings, distance of clinic from their homes/work place and low priority given to health. This model "Moonlight Model" has shown potential in increasing the reach to SWs with clinical services.

Procedures:

1.	Establish facility-based clinic team.

1.1	Refer to National HIV Counselling Guidelines and National STI Guidelines for detailed information.

1.2 T	eam Composition: Ideally, the team should be composed of a doctor/clinical officer, nurse, midwife and counsellor.

1.3 C	lear roles and responsibilities for each member of the clinic team should be outlined and followed.

2.	Sensitization/training. The Clinic should provide a SW friendly environment. The staff should be well trained and ensure that all SWs are cared for respectfully.

2.1	Train or otherwise sensitize management and key staff of the health facility on need to provide SW friendly services.

2.2	Team should have appropriate qualifications: training in the syndromic management of STIs, testing and counselling for HIV, provision of family planning services and detecting and managing cases of sexual violence to perform their assigned tasks. The staff should be well qualified and competent to carry out medical, nursing and laboratory procedures according to National guidelines

2.2.1	Ensure appropriate clinic structure, equipment and supplies. Full description of needed infrastructure, equipment supplies is described in the National HIV Counselling Guidelines and National STI Guidelines.

2.2.1.1.	Clinic buildings and rooms should be properly maintained to ensure a comfortable, safe and hygienic environment.

2.2.1.2	Clinic space must provide and ensure privacy and confidentiality for history taking, physical

examination including internal examination, individual, couple and group counselling and record keeping.

2.2.1.3   The internal structure of the clinic should include the following:

2.2.1.3.1   Waiting and registration area

2.2.1.3.2   Consultation and examination room

2.2.1.3.3   Laboratory area (if available)

2.2.1.3.4   Counselling room.

2.2.1.4   Ensure availability of occupational infection control materials. See SOP 3.3 Occupational infection for detailed guidance.

2.2.2   A client flow chart should be developed and clearly followed for the clinic.

2.2.3   Establish participation in referral network. See SOP No 4.1 Establishing and supporting referral networks for more information.

2.2.4   Provide a mechanism for SW feedback regarding the quality of clinical services.

SOP 3.1.2

OUTREACH CLINICAL SERVICES

Objective:

• To define an outreach clinic.

• To describe the process and essential requirements for conducting an outreach clinic.

• To describe the minimum set of services that is given in an outreach clinic.

Context:

As stated in SOP 3.1,1 Facility Based Clinical Services, SWs differ in their typologies, working hours, priority towards health and proximity of the clinic to their homes/work places. Therefore, the static clinic model of service delivery, which involves a fixed clinic providing services at fixed hours on all days, is not effective in providing clinical services to SWs.

To reach out maximally to SWs with clinical services, the HIV prevention projects should design the outreach clinic model of service delivery. This model should be developed after discussing with SWs through PPs, focus group discussions and anecdotal evidence. In this model, clinical services are taken to the doorstep of the SWs when they are unable to access services at the static clinic, common reasons for which being unsuitable clinic timings, distance of clinic from their homes/work place and low priority given to health. This model has shown great potential in reaching out maximally to SWs with clinical services.

Procedures:

1. Outreach Clinic

1.1   Establish outreach clinic team:

1.1.1   Clinic Team comprising of a health care provider who is SW friendly. Build the capacity of the health workers to be SW friendly at the HTC/STI/ART/SRH service, if necessary.

1.1.2   Outreach Team comprising of the PP and community volunteers (peers, bar or spot owner), OWs of the site/s.

1.2   Clinic structure is not fixed and can be held at any convenient and suitable place at the site e.g. brothel, lodge, home of a PP/SW, or bar.

1.3   The day and timing of the clinic is again not fixed and is decided jointly by the outreach service team and leadership of the SW in the community.

1.3.1   The outreach team informs the SW well in advance about the day, place and timing of the outreach service.

1.3.2   On the day of the service, the outreach team will visit the site a few hours before the outreach service begins and motivate the SW to access clinical services.

2   Determine and plan for services to be provided.

2.1   HIV testing and counselling.

2.2   Individual or group STI counselling.

2.3   Thorough history taking and physical examination. Internal examination, if the clinic facility allows.

2.4   Syndromic case management for symptomatic STIs.

2.5   Treatment for asymptomatic STIs, if first visit.

2.6   Screen for family planning, pregnancy and other SRH needs.

2.7   Screening and care for SGBV.

2.8   Treatment of general ailments.

2.9   Referrals for higher STI services or services not provided at the outreach clinic. Referrals for ART, SRH and other services.

2.10   Syphilis screening may be added

2.11   Verbal or signs and symptom screening for TB could also be done.

3   Ensure necessary resources:

3.1   Equipment required for physical examination of the patients as well as for internal examination, wherever the clinic facility is conducive for it.

3.2   Infection control materials such as soap for hand washing, disposable gloves, and bleach solution for disinfection of gloves and speculums and garbage bags for infectious and non-infectious waste. See SOP 3.3 Occupational infection for detailed guidance.

3.3   Counselling/teaching aids such as BCC material, speculum, penis model and condoms and water-based lubricants.

3.4   Documentation material such as HTC Forms, Referral and Registration forms.

3.5   Space that will provide facility for history taking, general examination, group counselling at the minimum. Ideally it should provide auditory and visual privacy for internal examination and individual counselling too.

3.6   Commodities/supplies: adequate supply of test kits, condoms and lubricants.

SOP 3.2

PROVIDE SW FRIENDLY CLINICAL SERVICES

Objective:

To provide standard guidelines for providing SW-friendly clinical services.

Users:

Doctor/clinical officer, nurse, counsellor, laboratory technician, outreach workers, program manager

Context:

Whether at the facility, at Wellness Centre or during outreaches, clinical services for SW focus mainly on the prevention and management of sexually transmitted infections; HIV testing and counselling; and sexual and reproductive health; This SOP focuses mainly on these services and does not focus on the more general clinical care that SWs may require.

Please note that the full package of clinical services (including internal examination and treatment) should only be provided in facilities designated for such services. These are public health facilities and private health facilities and health workers certified by the Zambia Health Council and Nursing Council of Zambia. All the services should thus have strong referral networks with other health facilities that provide specific clinical and other psychosocial services as required.

STI MANAGEMENT

Procedures:

1. Syndromic Management: In Zambia, syndromic management approach is used for the management and treatment of STI for SWs. Clinics should use the revised National STI Guidelines for STI management. This includes the following key components:

1.1 Sexual health history-taking.

1.2 Adequate and appropriate physical examination, including a speculum and bimanual examination of the genital tract for all female SWs and rectal examination (including proctoscopy, if indicated) for all SWs practicing receptive anal sex.

1.3 Treatment of syndromes: For the management of symptomatic sexually transmitted infections use the flow charts in the national STI guidelines and the treatment regimen.

1.4 Education and Counselling.

1.5 Partner Management.

2. Laboratory testing: In specialized clinics where laboratory services are available, the following can be performed:

2.1 Basic microscopy (Gram stain for vaginal and cervical specimens and wet-mount slide preparation for vaginal specimens): this is performed for women with vaginal discharge. This can also be conducted for men with urethral discharge.

2.2 Vaginal pH testing: for women with vaginal discharge when bacterial vaginosis is suspected.

2.3 Syphilis serology: testing on-site RDTs syphilis screening and or RPR or VDRL and referral for TPHA for positive syphilis serology where possible.

2.4 HIV testing. HTC will be offered to all SW visiting the clinic for management of STI as is recommended in the national STI guideline.

2.5 It should be noted that since most laboratories are not equipped to provide testing for all STI for a particular syndrome, positive tests for one condition does not exclude other aetiologies for the same syndrome. Therefore for various syndromes it is still recommended that all drugs for the specific syndrome is used in treatment of the condition despite the laboratory results.

2.6 Biennial syphilis screening: Where funds and test kits are available SWs should benefit from regular HIV and syphilis screening. Implementing partners should link-up with the laboratory for the provision of these services where available. However, this is not a national policy at this time.

3. Regular medical check-ups: This check-up should be on general health and well-being and be done so as to promote health seeking behaviour, reinforce preventive messages.

3.1 At each check-up:

3.1.2 3.1.1 Provide educational information. Take general health history and sexual history.

3.1.3 Conduct general and internal examination (proctoscopy/ speculum examination) to screen for asymptomatic STI.

3.1.4 Provide opportunity for syphilis and HIV testing.

3.1.5 Include screening for anaemia (looking out for pallor).

3.1.6   Monitor weight gain or weight loss.

3.1.7   Screen for TB (cough for more than 3 weeks, weight loss, night sweats etc.) and/or malaria.

3.1.8   Screen for Hep B vaccination and provide services as needed

3.1.9   Screen for family planning needs, pregnancy or fertility concerns and other SRH issues including screening for SGBV.

3.1.10   Where feasible, provide hepatitis B vaccine.

3.1.11   Screen for HIV and STI. During regular check-ups HTC will be discussed with the clients to determine whether specific risk behaviour occurred after the last test warrant HIV testing.

3.2   Depending on the type of service being provided and sources of funding half yearly check-up should be adequate.

3.3   All SWs should be referred for routine examinations on a regular basis through active outreach.

3.4   Presumptive or Epidemiologic approach to management of STIs among SW could be used. This is an approach once informed and supported by aetiological and prevalence study is used to treat for common STIs. In the Zambian context the common STIs are Syphilis, gonorrhoea, chlamydia and trichomonas vaginalis. Periodicall SW could be treated covering the common STIs.

SOP 3.2.2

HIV TESTING AND COUNSELLING

Procedures:

1. For detailed guidelines on HTC, refer to the National Guidelines for HIV Counselling and Testing in Zambia.

2. HTC can be done in clinics as well as in outreach settings as long as the provider has been trained and certified by the Zambia Counselling Council/Zambia Ministry of Health

2.1 Depending on the availability, tests could be offered on site or the client will be referred to a nearby HTC centre.

3. During outreach or when offering HTC at DICs, clients who require additional services will be referred to nearest STI clinic/HTC/ART/FP sites as per their need. For more details, refer to SOP No 4.1 Establishing and supporting referral networks

4. Integrate SGBV screening, care and support into HTC services.

4.1 Train and support HTC providers to understand the link between HIV and SGBV; to identify possible survivors of SGBV and those who fear there will be possible violence meted out to them as a result of testing or disclosure and how to counsel them on how to address these fears.

4.2 Refer to SOP 4.2 Establishing and sustaining a Community Rapid Response System for more information.

SOP 3.2.3

SEXUAL AND REPRODUCTIVE HEALTH SCREENING SERVICES

Procedures:

1.   Provide family planning and contraceptive counselling, including short and long-term methods. Dual protection: While condoms used consistently and correctly, are the best prevention against transmission of STIs, they are less effective in pregnancy prevention. Dual protection can be achieved by using a highly effective contraceptive method for pregnancy prevention, and the male or female condom for STI/HIV prevention.

1.1   Provide information on the variety, use and side-effects of contraceptives to all SW, tailored to their individual needs, motivation and barriers to dual protection.

1.2   Provide contraceptive counselling to determine pregnancy intention of sex worker and discuss available methods.

1.3   Determine medical eligibility for desired family planning method.

1.4   Refer for family planning method. If female sex worker is also HIV-positive, refer them to their ART clinic for further counselling on family planning options.

1.5   Promote and provide condoms.

1.6   Emergency contraception (EC) can be provided to a woman who has had unprotected vaginal sex is not currently using a contraceptive method and is not pregnant.

1.6.1   It should be provided as soon as possible after unprotected sex, ideally within 72 hours, with a limit of 120 hours (5 days).

1.6.2   EC should be accessible to sex workers, and frequency of EC use should be monitored.

1.6.3   However, since EC is not completely effective in preventing pregnancy and might not be efficient if used frequently, it is important to encourage sex workers to use a long-term family planning method.

2.   Provide abortion and post-abortion care. In Zambia, abortion is legal when conducted by a qualified doctor in a registered public or private health facility and hence linkages to safe abortion services should be established.

2.1   Appropriate referrals should be made utilizing the Illustrative DIC Screening tool.

2.2   Sex workers should have access to appropriate post-abortion care to reduce morbidity and mortality related to abortion.

2.3   Post-abortion complication care should be ensured.

2.4   SW should be counselled on family planning to prevent future unwanted pregnancies.

3.   Provide cervical cancer screening. Human papilloma virus (HPV) is an STI and leads to cervical cancer. Cervical cancer screening leads to early detection of pre-cancerous and cancerous cervical lesions and can prevent serious morbidity and mortality.

3.1   Information on cervical cancer screening should be provided using the Illustrative DIC Screening tool. It is recommended that cervical screening be performed for every woman 30-49 years of age. Screening can be done through visual inspection with acetic acid, conventional Pap smear or HPV testing.

3.2   Women who are HIV-positive should be screened for cervical cancer regardless of age.

3.3   Priority for screening should be given to maximizing coverage of the risk target age group and to assure complete follow-up of women with abnormal screening test results.

3.4   Effective referrals should be provided in appropriate cases. Ensure immediate referral and treatment of pre-cancerous and cancerous lesions.

3.5   FSW should be referred to health facilities where these services are available.

4.   Provide Sexual and Gender based violence (SGBV) screening.

4.1   It is recommended that Gender Based Violence Screening should be done for all SW visiting the service delivery points.

4.2   Universal Screening tool should be used for the screening process and appropriate referrals should be made.

4.2.1   Refer to SOP No 4.2 Establishing and sustaining a Community Rapid Response System for more information.

OCCUPATIONAL INFECTION PREVENTION

Objective:

To provide guidelines on basic standards of occupational infection prevention.

Users:

Clinical service providers, Program managers, Site managers

Context:

Standards for occupational infection control should be in place for all healthcare settings at all levels- in hospitals, clinics, health posts, mobile/outreach clinics, and community health centres. Infection control principles can be adopted in all healthcare settings, even in settings where water and electricity supply is not constant. Every healthcare setting should adopt a set of practices to minimize the spread of infection between patients and between staff and patients (nosocomial infections).

Standard precautions are designed for use by all people (patients, health workers, ancillary staff, and laboratory staff), regardless of whether or not they are infected. These include good hygiene practices such as washing hands before and after patient contact, wearing gloves and other protective devices, following aseptic techniques, safe handling of sharps, cleaning treatment and care areas, and disposing of medical waste. Precautions should be implemented in the context of creating a safe work environment and provision of on-going prevention education for all employees. Precautions should always be applied when handling blood (including dried blood), all other bodily fluids, secretions, and excretions (excluding sweat), regardless of visible blood.

Hazardous bio-medical waste as may be produced from clinical procedures must be disposed safely, in a manner that eliminates any possibility of infecting clinic staff or community members. Proper waste management begins in the clinic with safe handling of waste and continues until its safe final disposal. It is the responsibility of the clinic to dispose of waste in a safe manner. In most cases, this means contracting with a commercial waste-disposal service or making an arrangement with a nearby hospital facility. In either case, it is the responsibility of the clinic staff to know the disposal procedures of the commercial service or hospital and to use only those services that follow recommended procedures.

SOP 3.3.1

INFECTION PREVENTION

Procedures:

1. Hand washing is the single most effective form of infection prevention. (Policy and Guidelines for Infection Prevention and Control in Healthcare Facilities, Ministry of Health, Zambia).

2. Wash hands:

2.1 Before and after direct contact with clients and potential infected bio-hazardous material.

2.2 After touching blood, bodily fluids, secretions, excretions, and contaminated items

2.3 Before and immediately after removing gloves; and before contact with next patient.

3. Use personal protective material when at risk of contact with bio-hazardous material.

3.1 Gloves: For contact with blood, bodily fluids, secretions, and contaminated items; and for contact with mucous membranes and non-intact skin.

3.2 Masks, goggles, face masks: Protect mucous membranes of eyes, nose, and mouth when contact with blood and bodily fluids are anticipated.

3.3 Gowns: Protect skin from blood or bodily fluid contact; and prevent soiling of clothing during procedures that may involve contact with blood or bodily fluids.

3.4 Linen: Handle soiled linens so that they do not touch skin/mucous membranes; and do not pre-rinse soiled linen.

4. Patient Care Equipment:

4.1 Handle soiled equipment in a manner to prevent contact with skin or mucous membranes and to prevent contamination of clothing or the environment; and

4.2 Disinfect reusable equipment before reusing it.

5. Environmental Cleaning: Routine care, cleaning, and disinfection of equipment and furnishings in patient care areas.

6. Usage of Equipment:

6.1 Sharps : Avoid recapping used needles

6.1.1 Avoid removing used needles from disposable syringes;

6.1.2 Avoid bending, breaking, or manipulating used needles by hand; and

6.1.3 Place used sharps in puncture-resistant containers.

6.2 Patient Resuscitation: Use mouthpieces, resuscitation bags, or other ventilation devices to avoid mouth-to-mouth contact during resuscitation.

7 Protective barriers are used to minimize the risk of transfer of bodily fluids and microorganisms from patient to staff member and from staff member to patient. Barriers include gloves, face masks, protective gowns, caps, aprons, and eye goggles.

7.1 Gloves are not required for all patient procedures, only for those procedures where it is likely that the health worker or clients will come in contact with mucous membranes or bodily fluids such as blood, urine, faeces, or other fluids.

7.2 Standard gloves should be worn when:

7.2.1   Examining mucous membranes or non-intact skin (e.g., genital examination);

7.2.2   Drawing blood (phlebotomy), finger sticks/heel sticks or establishing intravenous access, but not required for giving IM injections;

7.2.3   Handling soiled instruments, equipment, or linens; and

7.2.4   Disposing of contaminated medical waste (e.g., cotton, gauze or dressings).

7.2.5   Health staff should change gloves between patients and between procedures on the same patient. Health staff should wash hands with soap and free-flowing water immediately after removing their gloves (after each patient) and before touching anything else.

7.2.6   Gloves should be worn for all genital examinations.

7.2.6.1.1   Two types of gloves should be available:

7.2.6.1.1.1   Examination gloves to wear when coming in contact with bodily fluids or mucous membranes.

7.2.6.1.1.2   Heavy-duty utility gloves to wear when cleaning equipment or handling hospital waste.

8. S   afe handling of needles and other sharp instruments. Healthcare staff can be exposed to viruses such as hepatitis B or HIV through accidental cuts from sharp instruments or through needle-stick injuries (although the risk is very small). Small amounts of blood and other bodily substances can remain on used instruments or in the hole inside the needle. All healthcare settings should have in place a system for the safe use and disposal of sharp instruments, including needles.

8.1   Sharp instruments should not be passed directly from one staff member to another; that is, a safe zone should be used (e.g., place the sharps in a tray and allow the other staff member to pick them up from the tray);

8.2   Needles should be used once only;

8.3   Best practice is that needles are not re-capped;

8.4   Puncture-proof containers should be placed in all areas where needles are used. Used needles and syringes should be placed in the containers whether or not a needle destroyer is used;

8.5   If specially manufactured sharps containers are not available, other puncture-proof buckets or containers with lids should be used;

8.6   The sharps container should be sealed and removed when it is three quarters full; and

8.7   Containers should be disposed of by incineration.

9.   Processing instruments and equipment. All instruments that are involved in invasive procedures (i.e., those that cut or pierce the skin or touch the mucous membrane) have the potential to transmit microorganisms and infections. A three-step method is used to process instruments and equipment:

Step 1: Decontamination

Step 2: Cleaning/washing

Step 3: Sterilization and high-level disinfection (HLD) to remove any blood or bodily fluids and ecretions and to prevent microorganisms from passing from one patient to another.

A   All reusable items should be decontaminated, cleaned, and either sterilized or disinfected using high-level disinfection techniques. This applies to re-usable gloves, surgical instruments, and any re-usable equipment that comes in contact with tissue under the patient's skin or with mucous membranes.

B   Instruments that come into contact with intact mucous membranes may be either steam-sterilized (if possible), undergo HLD, or be processed under low temperature automated chemical sterilization systems.

C   Maintain separate bench space for clean equipment and dirty equipment.

D   Store sterilized instruments in a dry, clean, dust-free and covered space until next use and sterilization.

10.   Aseptic techniques are designed to reduce the chances of microorganisms entering the body during surgery, when dressing wounds, when using catheterization, or during any other procedures that involve breaking the skin or mucous membrane. Any health worker performing surgery, carrying out a procedure that breaks the patient's skin or enters the patient's body, or dressing a wound should use aseptic techniques.

10.1   Surgical scrub hand washing;

10.2   Using instruments and dressings that have been sterilized or undergone high-level disinfection;

10.3   Wearing a mask and sterile gloves;

10.4   Setting up and maintaining a sterile field; and

10.5   Properly preparing the patient's skin or the area involved in the procedure by using antiseptic and sterile gauze to disinfect.

BIOMEDICAL WASTE MANAGEMENT

Procedures:

1.   The waste management must comply with Policy and Guidelines for Infection Prevention and Control in Healthcare Facilities, Ministry of Health, Zambia.

2.   There are various types of hazardous waste generated at the clinic level. These wastes should be segregated and disposed of in a manner that does not cause risk of infection or injury to clinic staff or the general public. The types of hazardous waste generated at the clinic level include sharps, infectious medical waste, and pharmaceutical waste and other hazardous waste.

2.1   Sharps waste: Single-use disposable needles, needles from auto-disable syringes, scalpel blades, disposable trocars, sharp instruments requiring disposal and sharps waste from laboratory procedures.

2.2   Other infectious medical waste: Waste contaminated with blood and other bodily fluids, including gloves, cotton, dressings, linens, disposable intravenous sets, catheters and so on. This also includes infectious laboratory wastes such as waste from laboratory tests and other items that were in contact with the specimens, such as gloves.

2.3   Pharmaceutical waste: Expired, damaged or otherwise unusable medicines and items contaminated by or containing medicinal substances.

2.4   General waste: Waste that is not infectious, sharp or toxic can be handled like domestic refuse for disposal.

3.   Waste segregation and storage. Waste segregation reduces the volume of waste that requires special handling.

3.1   Segregation is the responsibility of the waste producer and should take place at the first disposal point.

3.2   Under no circumstances should clinic staff attempt to sort waste or correct waste segregation after it has been placed in disposal containers.

3.3   If hazardous waste is accidentally thrown into a non-hazardous container, treat the entire container as hazardous waste.

3.4   Waste should be segregated and placed in color-coded bags according to National guidelines and labelled with the biohazard symbol.

3.5   Appropriate containers with plastic bag liners should be placed at all locations where particular categories of waste are generated.

3.6   Containers should be emptied when they are three-quarters full. Waste bags should be tightly sealed, either by tying the neck or by using a self-locking bag; waste bags should not be stapled.

3.7   Replacement plastic bags should be available at all locations where waste is produced.

4.   Storage of waste. A separate area or room should be designated for storage of full waste bags. The storage area should be:

4.1   Easy to clean and disinfect; and have a hard, impermeable floor;

4.2   Have readily available cleaning supplies and protective clothing;

4.3   Locked to prevent access by unauthorized persons;

4.4   Inaccessible to animals, insects and birds;

4.5   Protected from the sun; and

4.6   Easily accessible to waste collection vehicles.

5.   Disposal of Sharps.

5.1   Use sharps disposal containers. Sharps disposal containers are puncture and water-resistant impermeable containers. When used correctly, they reduce the risk of skin-puncture injuries that potentially can spread disease. Sharps disposal containers can be commercial or can be home-made of strong plastic or metal.

5.2   Do not recap syringes before disposal;

5.3   Place the syringes and needles in the sharps box immediately after use;

5.4   Keep the sharps container where the injections are given;

5.5   Do not overfill the sharps containers (maximum about ¾ full);

5.6   close and seal the container when the container is ¾ full;

5.7   Store the container in a safe and secure location until ready for final disposal;

5.8   Do not empty and refill sharps boxes. Fill once and discard immediately; and

5.9   Place filled and sealed sharps disposal containers in disposal bags that are labelled or color-coded for highly infectious waste.

6.   Pharmaceutical waste. Improper disposal of pharmaceutical waste can result in contaminated water supplies and the use and resale of expired or inactive medicines, or improperly incinerated products, which can result in releasing toxic pollutants into the air.

6.1   Small quantities of pharmaceutical waste can be incinerated (if < 1% of total waste), encapsulated, disposed of in a secure landfill, or buried.

6.2   It is not acceptable to dispose of even small quantities of pharmaceutical waste into slow-moving or stagnant water bodies. Antibiotics should never be disposed of in slow-moving or stagnant water.

6.3   The following should be considered in selecting options for waste treatment and disposal at the clinic:

6.3.1   The quantities of waste produced daily in the clinic;

6.3.2   Availability of appropriate sites for waste treatment and disposal:

6.3.3   Space for pit burials;

6.3.4   Distance from water source, residential areas;

6.3.5   Presence of available legally recognized central facility for waste treatment within a reasonable distance; and

6.3.6   Availability of resources (human, financial and material).

7.   Other infectious medical waste. Infectious medical waste should be sterilized by autoclaving, microwaving, or incinerating, and then buried or disposed of in a secure landfill.

SECTION 4.

STRUCTURAL INTERVENTIONS

The vulnerabilities faced by SW relate not only to their individual risk behaviours but also to the broader societal and community factors, which include 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 the structural and policy barriers, gender economic and power inequalities, cultural norms, sexual and gender based violence (SGBV), and mobility are some of the factors that increase SW vulnerability to HIV.

Structural interventions aim to address social, cultural, political, economic, and legal or policy aspects of the environment that increase the vulnerability of SW and contribute to the spread of HIV. Structural interventions should focus on creating an enabling and abuse free environment that supports improved access to health services and commodities and the protection of rights. For HIV prevention, an enabling environment includes the social, economic, and legal determinants that facilitate the behaviour change process and encourage SW to participate in all levels of the response to the epidemic and increase access to appropriate, affordable, acceptable and assessable health services.

Since programs are rarely designed to provide all components of the HIV/STI package, service providers need to establish an effective collaboration to ensure each SW has access to each component of the HIV/STI package. A strong referral network is needed to ensure that programs effectively collaborate to deliver the package of services. Establishing a community based rapid response system helps SW to seek re-dress for human rights abuses and GBV and helps to create an abuse-free environment.

List of SOPs:

SOP 4.1 Establishing and supporting referral networks

SOP 4.2 Establishing and sustaining a Community Rapid Response System

SOP 4.3 Volunteer support systems/strategies

SOP 4.4 Literacy empowerment for beneficiaries

SOP 4.1

ESTABLISHING AND SUPPORTING REFERRAL NETWORKS

Objective:

To provide standard procedures for establishing effective referral networks.

Users:

Program managers, Site managers and Clinical service providers.

Context:

Since a single project, facility, agency or community group can rarely deliver all of the services needed by SW, a well-established referral network is vital to link the different organizations providing prevention care, treatment, support and protection services. Meeting the needs of SW requires the collective effort of many facilities and organizations, both clinic- and community-based. Strengthening access to a comprehensive package of HIV-related services for SW in need and promoting communication among service providers requires a formalized referral network, e.g. from the drop in centres to health facilities. In the context of HIV, a referral is the process by which immediate client needs for comprehensive HIV care and supportive services are assessed and clients are helped to gain access to services. Referral should include reasonable efforts at follow-up.

A referral system entails a process of coordinating service delivery to ensure that:

- Access to needed services is expedited;

- Confidentiality is maintained;

- Referrals between organizations can be tracked;

- Referrals and their outcomes are documented; and

- Gaps in services can be identified and steps taken to address identified gaps.

- Follow up to ensure SW has received the service(s)

Procedures:

1.   Plan for the establishment of the referral networks.

1.1 Identify a team of service providers (program, clinical, community) responsible for the planning and implementation of the referral network. Usually this will include members of the Wellness Centre as well as health facilities and SW representatives.

1.2 Mobilize key stakeholders. Identify and bring together through a workshop various stakeholders to initiate a community dialogue, seek input on establishing a referral network and generating "buy-in" for the activity. Other NGOs/CBOs working with SWs in the same catchment area should be also invited as collaborative partners since the referral network could also serve their populations and also because some populations have cross-cutting issues e.g., SW who inject drugs.

1.3 Ensure active participation of key population. Actively involve sex-workers in the planning process so that their needs and preferences are identified and used to define the referral network.

2.   Conduct a participatory mapping exercise.

2.1 List services in (within a 15 – 30 minutes walking distance) and outside the project area (nearest possible location) including: health posts/centres; government hospitals (STI, ART, HTC, FP services);

NGOs/CBOs; and other support systems. Services may include any or all of the following:

Health care (STI, HTC, FP, ART and general health)	Nutrition and food security	Economic support/ employment
Mental health	PLHIV support group	Child support
Recreation and leisure	Transportation	Legal assistance
Psycho-social & spiritual support	Material support, linkage to social welfare	Home-based care/palliative care

2.2   Develop and agree upon selection criteria for services. The criteria should include availability, accessibility, attitudes of health care providers, supportive staff and counsellors, acceptability by sex workers, previous experience in serving specific populations, confidentiality, privacy, existing protocol, cost of the provided services, and other characteristics deemed relevant for the referral system.

2.3   Develop topic guides for the interview of the services and tools to map the identified services: A range of questions should be developed to assess the service as per the criteria developed in the above section. A map could be drawn to pin the identified services. Note that the mapping is not intended to assess the quality of the services provided by the identified and visited agency. This activity required a more sophisticated and specific assessment.

2.4   Identify the team to conduct the mapping exercise. The team should be diversified as much as possible and should include GO/NGO/CBO workers, beneficiaries and health care providers. Avoid large team when visiting a service.

2.5   Organize training for the mapping team, explaining to them the objectives of the referral network, criteria, and a set of question for the interview of the services.

2.6   Implement the mapping exercise during a short timeline.

2.7   Documenting the findings of the mapping exercise.

3.   Establish the Referral Network.

3.1   Organize workshop with key stakeholders to disseminate the findings, to map the referral network, to identify key contact(s) of each identified service, and determine role and responsibilities of each organization in the network.

3.2   Develop an official document such as meeting minute, letter of agreement, or Memorandum of Understanding (MOU) between organizations. It should include the role and responsibilities identified in the previous step. It is also important to address the issue of confidentiality and shared confidentiality within the referral network in this MOU.

3.3   Identify a unit or organization to coordinate and oversee the referral network. This could be the Wellness Centre or health facility or an NGO.

3.4   Adapt standardized forms, tools and procedure that will ease the referral procedures and also help for the monitoring of the referral network, including referral forms and client tracking forms.

3.5   Develop/adapt a referral directory of facilities providing a list of facilities that provide clinical care and non-clinical services for PLHIV including the details of the type of services provided in each facility.

3.6   Outline an appropriate mechanism to document the process for the referrals and follow-up.

3.7 Hold sensitizing meeting with each agency to explain the referral network and the tools, to approve the MOU, and identify key contact (focal point) representing the agency for the referral network.

3.8 Train key contacts of the concerned services on the procedures for the referral system, utilization of documents, monitoring, and also sensitize them on specific issues of the served populations.

3.9 Establish a system to update the list of services. Services could be added or removed as per the needs of the population served, the availability of these services in the catchment area, and the evolution of public health and social policies in the country.

4. Implement referral process.

4.1 Screen all clients during their Wellness Centre visits to identify their need for specific services using checklist for referrals. Refer to the Wellness Centre SOP No 2.6 for checklist.

4.2 Develop individualized service plans: The referring staff and the SW should jointly develop a service plan that defines his/her needs and the steps to meet those needs. The plan should be updated in accordance with progress made and new needs identified.

4.3 Refer clients: The referring staff will make referrals and coordinate delivery of services, track referral requests and follow-up to ensure that the needs are met.

4.4 Clinical follow-up should be according to the National Guidelines. However, the referral facility will continue to have regular contact with the SW.

4.5 When a SW is tested and is positive, s/he is referred to government health centres which provide comprehensive ART care and support.

4.6 If a SW is on ART, the referral staff should monitor ART adherence and also assist the SW+ in managing side effects. The same information should be provided to the Government clinic staff.

4.7 The facility staff should provide information about existing PLHIV support groups and in turn assist to join the support groups.

4.8 If needed, provide accompanied referrals (peer led) to SW for other services like nutrition support, legal assistance, economic support, skill development activities, PMTCT services, getting admission in school and hostels for their children etc.

4.9 The referral staff should assist the SW and the adherence monitor in determining needs and will also provide referrals to other SWs in need of services. For further details on adherence monitor, refer to the Guidelines for Antiretroviral Therapy in Zambia.

4.10 The clinical care team should send back information on the action taken for the SW clients to the referring staff at the Wellness Centre. It could include the date certain tests (e.g. CD4 counts are done) and the date for the next test. The clinical care team should also state whether the SW living with HIV is on OI or ART medication. There is no need to state the details of the medication or the test results.

5. Record keeping:

5.1 The referral staff will maintain a record of meetings with the SW living with HIV, the referrals made for the SW, and the outcomes of the referrals. This documentation will be maintained in the SW referral record.

6. Ensure confidentiality:

6.1 All referrals and records should be kept under lock and key and made available only to authorized persons to maintain privacy and confidentiality.

6.2 Clients' HIV test results must be kept confidential. However, there are circumstances when other professionals, such as counsellors and health staff at organizations where the client is being referred, might also need to know the person's HIV status in order to provide appropriate care. Approval must be sought from the client before status is shared with a professional. This shared confidentiality is encouraged. Shared confidentiality also refers to confidentiality that is shared with others at the discretion of the person who will be tested. These might include family members, loved ones, health and social service providers, caregivers and trusted friends.

7. Monitor and sustain the referral network

7.1 Mobilize the communities/groups to use and support the network. Undertake intensive community mobilization and promotional activities to increase the demand of services.

7.2 Maintain and update tools and forms as needed. This includes the referral directory, referral forms, Referral tracking forms and referral register.

7.3 Monitor the network's activities and use the findings to improve the system. The monitoring should include quantitative and qualitative data. Feedback from the beneficiaries but also from service providers of the referral network should be also monitored.

7.4 Organize periodic meetings with the key contacts and the beneficiaries of the network. These meetings provide a venue for on-going communication, exchange of information about the referral process, discussion of challenges and gaps in terms of services and updating the service network directory.

7.5 Ensure compliance with program standards. Management staff (internal and/or external) need to systematically monitor and assure compliance with standards (as per the MOU) and initiate corrective action when shortfalls are identified.

7.6 Use M&E for decision-making. Findings from timely reporting on program activities, as well as from any evaluation that takes place, should be used to make adjustments in program operations.

8. Forge linkages with non-health facilities at government and local levels.

8.1 Identify stakeholders and service providers in the community: Health facilities, legal and human rights services, local NGOs, women welfare associations, forums and community based groups, faith based groups including prayer and spiritual camps.

8.2 Establish linkages with existing human rights and sexual/gender based violence (HR & SGBV) reduction services providers and networks: Develop mutually reinforcing partnerships and referral networks among HIV-service and HR & GBV organizations and promote bidirectional integration of HIV and HR & GBV prevention and response efforts. Make sure SWs are aware of the human rights violation reporting system through the Commission on Human Rights and Administrative Justice.

8.3 Build rapport with the organizations through regular visits. Recognize their importance in HIV care and support. Keep them updated on key activities of the SW intervention. It is recommended that two individuals be appointed to focus on each relationship (to ensure continuation in case one individual is not available.

\8.4 Invite key staff or representatives from each organization to attend regular stakeholder meetings as members of the referral network.

8.5 Identify staff/key community members responsible for linkages to accompany SW in need of services.

SOP 4.2

FORMATION OF SEX-WORKER'S SELF HELP GROUPS

Objective:

• To provide contextual clarity on the formation and working of the Sex-worker's SHGs.

• To provide essential requirements and detailed processes on the functioning of the SHGs.

• This SOP will be complemented by SOPs on Community Based Organizations (CBOs), Fedration of Sex-worker CBOs, CRRS and Mechanisms of Community Management.

Users:
Program Managers, Site Managers, BCCOs, OWs, PPs, Peer Advocates, SHG leaders

Context:

SWs rarely come together, generally seeing each other as rivals. Being isolated, they tend to get marginalized and vulnerable to abuse, violence, arrests and coercion. It is imperative to bring SWs together to help them recognize and address their problems and use their collective strength to derive solutions and reduce exploitation. Being together also gives them a group identity, leading to increased self-esteem and therefore improved negotiation skills, health seeking behavior and safer sex practices.

SHGs, the site- level support groups formed as part of the HIV prevention interventions, take on a proactive role in solving personal as well as community problems of the SWs. This includes problems with police, regular partners, local leaders, goons etc. The true success of SHGs is achieved when every member of the group understands the importance of being self-dependent and working for each other, along with each other.

Procedures:

1.   Essential Elements of SHGs

1.1   All SHG members to be SWs only.

1.2   All the SHG members to imbibe the HIV prevention project core values and vision in community mobilization:

1.2.1   HIV prevention project core values

1.2.1.1 To come together (unity)

1.2.1.2 To solve difficulties

1.2.1.3 To give respect and dignity to all

1.2.2   HIV prevention project vision

1.2.2.1 Every enrolled sex worker to lead a healthy life

1.2.2.2 Every enrolled sex worker to be a member of the SHG

1.3   Each SHG needs to have three leaders: a President, a Secretary and a Treasurer.

1.4   The PP to be a member of any one of his/her SHG but cannot hold any post.

1.5   SHGs to have monthly meetings

1.6   Minutes of every monthly meeting to be documented in a register

1.7   Leaders of all SHGs in the NGO to have quarterly meetings in order to increase interaction and build the foundation for the formation of the CBO.

1.8   An event for all the SHGs at the NGO level to be organized once in a quarter to provide a common platform for interaction.

2.   Roles and responsibility of the SHGs

2.1   SHGs to motivate their members to access prevention services.

2.2   Issues of SWs to be discussed in SHG meetings to find viable solutions.

2.3   Responsibilities and follow up plans to be reviewed

2.4   Problem solving responsibilities and crisis support to be delegated among SHG members. Issues not solved or resolved by the SHGs to be taken up by the respective legal resource person in the operational area

2.5   SHG to open a bank account. This is optional and is dependent on the role of the SHG; e.g. if the SHG becomes a micro-credit group, receives donations etc.

2.6   SHG to provide support during other needs e.g. school admissions, providing food which a member is sick, opening an individual's bank account etc.

3.   Formation and strengthening of the SW's SHG

3.1   Community events to be organized at the PP site level to bring the SWs together and build rapport.

3.2   During the events, build awareness related to common needs e.g. the need to provide support in times of crises, the need to be self-dependent and the effectiveness of collective action.

3.3   OW and PPs to form SHGs of SWs in their operational area and take the support of the Peer Advocate as needed.

3.4   Each PP to have 50 SWs under them, therefore the size of an SHG should not exceed 20 SWs.

3.5   Each PP to have all registered SWs under him/her in a SHG. There could be up to two –three SHGs under each PP.

3.6   Each SHG to democratically elect three leaders during an SHG meeting: President, Secretary and Treasurer. If any post holder leaves the SHG, a new election for that post is to be held immediately.

3.7   The PP to conduct at least one monthly meeting with their respective SHGs with support from their OW.

3.8   Regular exposure visits to police stations, relevant government offices, hospitals, banks to be organized for the SHG members to familiarize them with the personnel and services available.

3.9   SHG to open a bank account

4.   Roles and responsibility of SHG leaders- President, Secretary and Treasurer

4.1   SHG leaders to ensure monthly meetings of the group take place with maximum attendance.

4.2   SHG leaders across all sites to meet every quarter to discuss the formation of the CBO (Refer SOP No. 4.3) at the organizational level

4.3 SHG leaders to be involved in designing the program activities and strategies, their feedback to be incorporated in the project.

4.4 President:

4.4.1 The President will preside at, conduct and regulate all meetings of the SHG.

4.4.2 The President in addition to his/her right to vote as an SHG member shall have a casting vote in the case of a tie.

4.4.3 The President's decision on any point of order shall be final and conclusive.

4.4.4 The President has the authority to act as per the rules and regulations of the SHG.

4.5 Secretary:

4.5.1 To maintain a register with the names of the SHG members and their addresses.

4.5.2 To convene the meeting of the SHG.

4.5.3 To keep detailed minutes of the proceedings of the SHG meetings

4.5.4 To conduct the correspondence on resolutions passed by the SHG.

4.5.5 To supervise the activities of the SHG on a day-to-day basis.

4.5.6 To issue notices as and when required.

4.6 Treasurer:

4.6.1 To handle financial transactions and maintain accounts.

4.6.2 S/He to operate the SHG bank account jointly with the President or Secretary. In case of her/his absence, the Secretary to manage the responsibilities of the Treasurer.

5 Procedures for conducting a SHG meeting

5.1 Introduction:

5.1.1 Each meeting to start with an introduction session, where all the members introduce themselves.

5.1.2 The introduction is to be repeated if there are any new members.

5.1.3 A song to be sung by the group, to create a feeling of togetherness, cohesiveness and empowerment among the members.

5.2 Issues taken up by the SHG:

5.2.1 Last meeting minutes to be read and follow up action to be discussed.

5.2.2 Discussions about any issue that the SHG wants to take up.

5.2.3 Information related to HIV prevention project services to be shared

5.2.4 SHG members, PP and OW to plan and prepare in advance for a session on the issue of discussion.

5.3 Entertainment:

5.3.1 Games, songs or other activities as per the interest of the SWs to be conducted in order to facilitate interaction among the members.

5.4 Planning for the next meeting:

5.4.1 Date, time, place and issues to be discussed to be finalized before the close of the meeting.

6.   Procedure for conducting an exposure visits

6.1   OW/PP/PA to identify and list the site level-key service providers and stakeholders and build rapport.

6.2   SHG leaders to be taken to visit the service providers and stakeholders in order to build rapport and increase awareness related to existing services. The OW/PP/PA to accompany.

6.3   SHG leaders to share their observations and experiences with other SHG members in the next SHG meeting

6.4   SHG members to be taken to visit the service providers and stakeholders in small groups (two – five members) depending on their availability and the space at the stakeholder site. SHG leaders to lead these visits with support from the PP/PA.

6.5   All SHG members to visit each service provider and stakeholder once every six months, keeping in mind possible transfers of personnel, changes in services and registration of new SWs in the SHG.

SOP 4.3

FORMATION OF COMMUNITY BASED ORGANIZATION

Objective:

- To provide contextual clarity on the formation and working of the CBOs.
- To provide essential requirements and detailed processes on the functioning of the CBOs.
- This SOP will be complemented by SOPs on Self Help Groups and the Federation of CBOs

Users:

Program Managers, Site Managers, BCCOs, OWs, PPs, Peer Advocates, SHG leaders

Context:

SWs are marginalized and their rights get violated as they are unable to assert themselves or unite. Organizing them into small groups can unite those living/working in close proximity; however, for SWs who are mobile, scattered or in order to bring about change/awareness of broader level issues, it is necessary to have a larger body to ensure impact. While self help groups (Refer SOP No. 4.2) work towards change at a local/site level, organizing SWs into CBOs ensures interventions at a systemic level; while also giving the movement, size and legitimacy; e.g. approaching a Minister to bring to his/her notice the problems related to getting identity cards.

An organization formed and led by the SWs themselves would be able to address all need based issues, in addition to health, for e.g. problems of women, domestic violence, education for the girl child, discrimination faced by sexual minorities etc. The CBO would also serve as a common forum to capacitate SW leaders to guide and implement project interventions in their geographical area. This is an effective strategy towards ultimate sustainability and empowerment.

The HIV prevention project intends to transfer project implementation to the CBOs and the Federation of CBO (Refer SOP No.4.4) by the end of the current project period.

Procedures:

1.   Pre-requisites

1.1   SHGs to be formed by PPs in their project area.

1.2   All the SHGs to elect leaders: President, Secretary and a Treasurer.

1.3   SHG leaders across all sites to meet once in every quarter to share program activities and progress.

1.4   Guidelines and constitution for CBOs to be developed by the NGO staff and shared with all SHGs for their feedback. Their feedback to be incorporated.

1.5   By- Laws, Memorandum of Association (MOA), guidelines and constitution of CBO to be drafted by the NGO staff to be shared with the CBO Governing Body once elected.

2.   Formation of CBO

2.1   The three SHG leaders from each SHG to come together to form the General Body (e.g. in the case of an NGO that has fifty SHGs, three leaders from each SHG to come together to form the General Body of 150 leaders)

2.2   Members from the General Body to elect 20 members from among themselves to form the Governing Body (e.g. 150 members of the General Body to elect 20 members from among themselves).

2.3   The Governing Body to also include five additional members from amongst the PPs and any Community positions; such as Peer Nurse, Peer Counselor, Peer Trainer and Peer Advocate. These five members should be from the community.

2.4   The Governing Body members to elect the Managing Committee members from amongst themselves by means of an election; e.g. Seven members of the Managing Committee to be elected from amongst the twenty-five members of the Governing Body with the following posts:

2.4.1   President

2.4.2   Vice President

2.4.3   Secretary

2.4.4   Joint Secretary

2.4.5   Treasurer

2.4.6   Member

2.4.7   Member

2.5   The Governing Body members to select a name for their CBO.

2.6   By-laws and Memorandum of Association (MOA) to be formulated and shared with all the Governing Body members.

2.7   Governing Body members to meet every month for a minimum of three months to discuss the by-laws

2.8   Registration process of the CBO to be initiated.

2.9   The name of the CBO and names of Managing Committee members to be shared with all SHGs during their meetings.

2.10   A logo for the CBO to be developed through a drawing competition among the SHG members, thus ensuring participation from the entire community.

2.11   The final logo to be shared with all SHGs during their meetings.

2.12   A CBO letter head, identity cards, visiting cards and receipt booklets to be printed.

2.13   A Bank Account to be opened in the name of the CBO.

2.14   The President, Secretary and Treasurer of the CBO to be registered as signatories for all bank transactions.

2.15   All bank transactions should have the provision of two signatories to sign cheques and important documents. Secretary to be a compulsory signatory. The other signatory could be either the President or the Treasurer)

2.16   A post box number to be obtained in the local post office.

2.17   An Advisory Committee of the CBO is to be formed. Members could be from the NGO or any other external individual who has interest and is willing to devote time to the CBO.

2.18   A letter head comprising of the name and designation of major members of advisory committee

and Managing Committee of the CBO should be designed and printed.

2.19   Meetings registers, stock registers, membership registers, accounts, assets, correspondence and other related documents should be prepared.

3.   Post formation support

3.1   Build the capacity of the Managing Committee members through regular training programs on:

3.1.1   Management skills

3.1.2   Finance management

3.1.3   Program implementation

3.1.4   Administration

3.1.5   Team work

3.1.6   Documentation

3.1.7   Organizational Processes - Communication, Conflict Resolution, Decision Making, Leadership, Participation, Vision Building of CBO, Linkages with other institution.

3.2   Build the capacities of the Managing Committee members in Networking and support to establish their linkages with:

3.2.1   Local Police Station

3.2.2   Local Administration and Municipal Corporation

3.2.3   Local Health Service providers

3.2.4   Local NGO and NGO forum or networks

3.2.5   Training institutions

3.2.6   District AIDS control committees

3.2.7   Media

3.2.8   Other donors

3.2.9   Postal department

3.2.10   Banks

3.2.11   Local leaders and other stakeholders

3.3   Integration of HIV prevention project activities and transition of responsibility

3.3.1   Gradual transfer of project activities in partnership with the NGO as per a plan jointly decided

3.3.2   NGO to provide technical support and monitor progress

4.   Roles and responsibilities of the CBO Leaders

4.1   President

4.1.1   The President of the Managing Committee to be the President of the CBO and to preside at, conduct and regulate all meetings of the Managing Committee

4.1.2   His/her rulings on any point of order and decisions as to the result of voting to be final and conclusive.

4.1.3   The President in addition to his/her right to vote as a member; to have the casting vote in case of a tie.

4.1.4   The President at the Governing Body Meeting shall have the authority to interpret the provisions of the rules and regulations of the by-laws for the purpose of conducting and regulating the meeting and deciding any issues/questions.

4.2   Vice President

4.2.1   In the absence or vacancy of the President, the Vice President to perform the ordinary duties of the President.

4.2.2   He/she is to convene the Governing Body Meeting within a period of three months and in the case of a vacancy, to ensure the election of the President.

4.2.3   In the absence of both the President and the Vice-President at any meeting, the members present at the meeting to appoint any member amongst them to be the President for the specific meeting.

4.3   Secretary

4.3.1   The Secretary to look after the affairs of the CBO under the directions and in accordance with the resolutions passed by the Managing Committee from time to time.

4.3.2   To keep and maintain a register of the members of the CBO along with their addresses.

4.3.3   To convene the meeting of the Managing Committee with previous approval or intimation to the President.

4.3.4   To keep detailed minutes of the proceedings of the Annual Governing Body Meeting/ Extra Ordinary Governing Body Meeting, Ordinary Governing Body meeting of the CBO and the Managing Committee meetings and give effect to the resolutions passed.

4.3.5   To conduct the correspondence of the CBO on resolutions passed by the Managing Committee and the Annual Governing Body Meeting and to keep proper records and place before the Managing Committee and the Governing Body Meeting such materials and information as may be necessary or as may be required by the Managing Committee.

4.3.6   To keep or cause to be kept all records of the CBO at a specific place as determined by the Managing Committee.

4.3.7   To supervise the working of the Managing Committee and the activities of the CBO on a day-to-day basis.

4.3.8   To issue notices of the Governing Body Meeting as and when required.

4.4   Joint Secretary

4.4.1   In the absence of the Secretary, the Joint Secretary shall exercise all powers of the Secretary as above and also assist the Secretary in discharge of his/her duties under the guidance of the President.

4.5   Treasurer

4.5.1   The Treasurer is to act under the directions and as per the resolutions passed by the Managing Committee. He/she is responsible to the Managing Committee for all accounts.

4.5.2   To collect CBO membership fees, to receive donations and to keep accurate accounts of such donations that may be marked for any special purpose by the donor.

4.5.3   To deposit any amount exceeding K 500/- which is not required for immediate use in the bank account of the CBO.

4.5.4   To receive all payments made to the CBO and to pass all necessary receipts and to maintain proper books of accounts under the supervision and direction of the Managing Committee.

4.5.5   To exercise all such powers and do all such acts as may be required for the proper conduct of ordinary business administration of the properties, movable and immovable, of the CBO under the general supervision of the President or Vice President.

4.5.6   He/she shall operate the bank account jointly with the President or the Secretary. In case of her/his absence, the Secretary shall look after the affairs of the Treasurer.

5.   Procedure related to CBO related meetings

5.1   Governing Body Meeting

5.1.1   The Governing Body meeting of the CBO shall be called four times (quarterly) on any date of every year, as may be decided by the CBO.

5.1.2   The term of the Governing Body will be one year.

5.1.3   The Governing Body members shall be entitled to vote at the Governing Body Meeting and elect the Managing Committee

5.1.4   The intimation of the Governing Body Meeting along with all necessary documents such as statement of accounts, balance sheet etc. as per agenda shall be intimated in writing to all the members of the Governing Body not less than 15 days prior to the date of the said Governing Body Meeting. The Managing Committee shall convene the Governing Body Meeting of the CBO through the Secretary to conduct the following business:

5.1.4.1 To receive and adopt the audited statements of Accounts and annual report from the Managing Committee.

5.1.4.2 To elect the Managing Committee of the CBO.

5.1.4.3 To vote for the formation of the new Managing Committee

5.1.4.4 To appoint auditors or Auditor and to fix their or his/her remuneration.

5.1.4.5 To appoint an Advocate, Legal Advisor of the CBO and fix their remuneration.

5.1.4.6 To look after and check the activities of the CBO.

5.1.4.7 To appoint an auditor for accounting and audit of the CBO and fix his remuneration.

5.1.4.8 To approve the Annual financial Reports and Annual Budget.

5.1.4.9 To approve the annual report & progress report of the CBO for previous year.

5.1.4.10 To consider and decide matters put for the approval by the Managing Committee.

5.1.4.11 To transact any other issue/matter/business, which may be forwarded by any member of the Managing Committee or the CBO with the prior permission of the President.

5.2   Extra Ordinary Governing Body Meeting

5.2.1   An Extra Ordinary Governing Body Meeting may be convened by the Managing Committee of its own motion or upon requisition made in writing by not less than 1/10th of the total members of the CBO who are entitled to vote.

5.2.2 Such requisition shall specify the objects of the meeting proposed to be called and must be signed by the members and shall be delivered or sent to Registered Office of the CBO.

5.2.3 If no such meeting is convened by the Managing Committee within a month of the date of delivery of the requisition, the members may thereafter convene such meeting after one month from the date of delivery of such requisition and any resolution adopted by a majority of 2/3rd of the total members of the CBO present and voting in the said meeting, shall be final and binding on the Governing Body and Managing Committee as well as the members of the CBO.

5.3 Quorum of the meeting

5.3.1 Three fourth (3/4th) of the total members of the CBO who are entitled to vote shall form a quorum at the General and Governing Body Meeting.

5.3.2 If no quorum assembles within 30 minutes from the time appointed/fixed for the said meeting, then the meeting shall stand adjourned for another 30 minutes on the expiry of which; the persons so present shall be the quorum and the meeting shall be proceeded with and any decision/resolution adopted therein shall be valid and binding on all members of the CBO.

5.4 Managing Committee Meeting

5.4.1 The Chairperson of the Managing Committee shall be the President.

5.4.2 If h/she is not available the Vice-President presides over the meeting.

5.4.3 The quorum of the meeting of the Managing Committee is 3/4th members.

5.4.4 Questions arising in the Meeting shall be decided upon by the majority voted either by voice (Show of Hands) or by the polls and if needed the President has a second or casting vote.

SOP 4.4

FORMATION OF FEDERATION OF SW-CBOs

Objective:

• To provide contextual clarity on the democratic process of electing leaders for the Federation of SW-CBOs..

• To provide essential requirements and detailed procedures to be followed during the Federation elections.

• This SOP will be complemented by SOPs on Self Help Group: Self Help Groups, CBOs, and Federation of CBOs.

Users:

Program Managers, Site Managers, BCCOs, OWs, PPs, Peer Advocates, SHG leaders

Context:

It is essential to have the meaningful involvement of SWs in programs in order to ensure that they are need-based and sustainable. One clear strategy would be to include the SWs themselves in the planning and implementing of programs in order to increase ownership.

These CBOs formed in different district can come together to form a federation of SW CBOs (Refer SOP No 4.4) at the national level. This federation enabled SWs to voice their opinions regardless of religion, race, background, geography, language or sexual orientation and to band together to ensure that their needs were met. A unique aspect of the formation of the federation of CBOs was the democratic election that took place, including the building of voting booths, presence of voting officers etc. The true spirit of democracy could be seen and has been repeated every year.

Procedures:

1.   Pre- requisites

1.1   Self-help groups to come together to form CBOs.

1.2   CBOs to come together to form - a federation of CBOs at the national level.

1.3   Consent letter for persons involved in the election process

1.3.1   Observation Committee – SWs from each CBO who will observe the election process and vouch for the integrity and accuracy

1.3.2   Governing Body members – to vouch for the authenticity of the process as well as provide their approval

1.4   Nomination form for individuals contesting the elections.

1.5   Appoint an Election Committee, Voter Management Committee, Security Committee, Observation Committee, Crisis Management Committee and Vote counting Committee.

1.5.1   Responsibilities of the Election Committee

1.5.1.1   To be overall in charge of the election process and provide support whenever needed

1.5.1.2   To coordinate with all the other committees and activities in the election process

1.5.2   Responsibilities of the Voter Management Committee

1.5.2.1   To give the voters the necessary instructions

1.5.2.2   To ensure that the voters come to the right booths

1.5.2.3   To ensure that the voters maintain a queue

1.5.3   Responsibilities of the Security Committee

1.5.3.1   To overall ensure that proceedings take place smoothly.

1.5.3.2   Members to be placed at different points of the venue, specifically at the entry and exit to the voting area.

1.5.3.3   To manage any altercations/ protests that take place as a result of the election results of the process itself.

1.5.4   Responsibilities of the Observation Committee

1.5.4.1   To ensure integrity in the election process

1.5.4.2   To ratify that the ballot boxes have not been tampered with and have been opened in front of them.

1.5.4.3   To ratify all invalid votes.

1.5.4.4   To confirm that counting of the votes were fair and that the results are accurate.

1.5.4.5   Responsibilities of the Crisis Management Committee

1.5.4.6   To manage any emergency cases

1.5.6   Responsibilities of the Vote counting Committee

1.5.6.1   To open the ballot box and verify the votes for validity/invalidity

1.5.6.2   To highlight the invalid votes so that they do not get counted.

1.5.6.3   To do data entry in a previously prepared excel sheet

1.5.6.4   To do cross verification of votes

1.5.7   Responsibilities of the Voting Officer

1.5.7.1   To check the voter ID

1.5.7.2   To check the CBO ID card

1.5.7.3   To take the signature of each voter on a list, indicating the individual's name and CBO

1.5.7.4 To take the voter slip from the voter

1.5.7.5   To put ink mark across the end of the nail and the finger

1.5.7.6   To allow the voter to enter the polling booth.

1.5.8   Responsibilities of the Booth Officer

1.5.8.1   To provide the ballot paper to each voter

1.5.8.2   To give proper instructions regarding the voting and what constitutes an invalid vote or invalid ballot paper.

1.5.8.3   To seal and sign the ballot box once all voters on the list have voted or the time period has ended.

1.5.8.4 To ensure that no one leaves the counting premises till the vote counting is completed and the results are finalized.

1.5.8.5 To ensure that no unauthorized person is allowed to come into the counting premises.

1.6 Appoint Voting and Booth Officers

2 Preparation of election:

2.1 One representative to be elected from the Managing Committee of all the CBOs to contest elections. Therefore, one representative to be elected from each CBO to contest for election of the Managing Committee of Federation of CBO.

2.2 The 7 members (President, Vice President, Secretary, Joint Secretary, Treasurer and two other members) of the Managing Committee of the CBOs to exercise their right to vote in the Federation election.

2.3 All the voters to hold a valid identity card (I- Card) and voter slip of their respective CBO. Any voter without I-Card and voter slip to not be allowed to vote in the election.

2.4 One representatives from each CBO to meet to know each other

2.5 The representatives to be oriented about the election process and prepared for campaigning

2.6 Speeches of all the representatives to be video recorded.

2.7 All the representatives contesting for the election to get an election symbol.

2.9 Ballot papers to be prepared once all the symbols are finalized

2.10 Voting slips with the following information to be prepared and given to all CBO Managing Committee members:

2.10.1 Voting Booth Number

2.10.2 Name of Individual

2.10.3 Name of CBO

2.10.4 Name of geographical area

2.11 All contestants to get approximately one month for the election campaign. The campaign to be supported by the Project Managers and Site Managers.

2.12 Phone numbers of the members of all the CBOs to be given to those contesting elections.

2.13 Election campaigns to be conducted through:

2.13.1 Video recordings – speeches to be recorded focusing on the representatives' vision, strengths. This would be an opportunity to canvass votes.

2.13.2 Video conferencing - Each representative to fix a time with each CBO and through the web camera address the CBO members

2.13.3 Telephone calls

2.13.4 Posters - to contain the photograph of the contestant with their election symbol, name of their CBO and their mobile number

2.13.5 Cross visits to every CBO

2.13.6 Mass awareness meetings conducted specifically for the purpose of campaigning

2.14   The election campaign to stop 24 hrs before the date of election.

3.   Elections

3.1   Every voter to be allowed seven votes. The voter to stamp against the symbol of desired contestants on the ballot paper.

3.2   If the voter stamps or elects more than 7 contestants, the vote is to be treated as cancelled/null/void/invalid.

3.3   If the voter stamps against 7 or less than 7 contestants, the vote is to be treated as valid.

3.4   Any stamp found on the line of the ballot paper is not to be considered while counting the votes.

3.5   All the voters need to show their valid voter slip and CBO Identity Cards and sign the attendance sheet.

3.6   A non-removable ink mark should be made on the index finger of his/her left hand by the Voting Officer before the voter enters the polling booth to vote.

3.7   The duration of the voting needs to be for two hours and 10 minutes (if there are four booths working simultaneously with 105 voters to vote).

3.8   Any voter wanting to vote after the stipulated time of voting should not be allowed to vote. The entrance of the voting booth should close immediately after 2 hrs and 10 minutes. Individuals already waiting in the queue within the stipulated time should be allowed to vote. Voters who reach the polling area after 2 hrs and 10 minutes should not be allowed to enter and join the queue.

3.9   Maximum time for a voter should not exceed 5 minutes. This is to include:

3.9.1   Identity verification

3.9.2   Signature

3.9.3   Marking on the index finger by the Voting Officer

3.9.4   Taking voting instructions

3.9.5   Taking the ballot paper

3.9.6   Voting

3.10   There needs to be a sufficient number of polling booths for the voters.

3.11   Voting at all the booths should be undertaken simultaneously.

3.12   The voters to cast their votes in the booths assigned to them. No voter to be allowed to vote in a booth not assigned against their name.

4.   Counting

4.1   Crisis Management Committee and Security Committee members to ensure that, nobody is allowed to enter the counting premise while the counting is in progress. This security needs to be maintained till the results are declared.

4.2   All the ballot boxes to be sealed and signed by the respective Booth (Returning) Officer after the voting is over and to be handed over to the Vote Counting Committee.

4.3   There will be two Vote counting Committee and will count the votes simultaneously as per the number of (two each) ballot boxes assigned.

4.4   All the ballot boxes to be opened in front of the Observation Committee and signatures to be taken for ratification.

4.5   Counting to be done in a sequence of the first ballot box 1; second ballot box 2; third ballot box 3 and fourth ballot box 4.

4.6   Appoint an individual from the Election Committee to segregate all the valid votes and invalid votes. All the invalid votes need to be shown to the observation Committee. The invalid votes to be highlighted so that they are not counted.

4.7   All the ballot papers to be given fresh numbers and handed over to a member of the Vote counting committee.

4.8   Appoint an individual to dictate all the votes for counting. The votes to be entered into the computer.

4.9   As a counter check, each vote to be dictated again to the individual entering the votes by a different person.

4.10   Appoint an individual to manually enter the votes in the counting sheet developed simultaneously.

4.11   The individual appointed to enter votes manually has to enter the votes as per the numbers assigned to each ballot paper. (Fresh numbers to be assigned to each the ballot paper and should match with the number of row in excel).

4.12   Results to be displayed on a screen after every ballot box is counted.

4.13   Once the counting is concluded members of the Observation Committee to sign a consent letter to certify that the counting of votes was fair and that they agree with the results.

4.14   Additionally, members of the Governing Body to certify the results of the voting and accept the newly elected Managing Committee in writing.

SOP 4.5

ESTABLISHING AND SUSTAINING A CRISIS RAPID RESPONSE SYSTEM

Objective:

To provide standards for establishing and sustaining a Crisis Rapid Response System (CRRS) to address human rights abuses and sexual/gender-based violence.

Users:

Program Managers, Site Managers, BCCOs, OWs, PPs, Peer Advocates, SHG leaders

Context:

SW face discrimination, harassment, violence, human rights abuses, sexual and gender based violence and coercion which directly affect their health seeking behaviours. This ultimately makes them vulnerable to HIV. In many instances, abused sex workers cannot easily access help to address the abuse that is inflicted on them. To partly address the problem, Peer Advocates, Peer Promoters and SHG Leaders will be trained across the intervention sites to set up a community based networking system called the CRRS to identify and direct abused SWs to seek services (health, legal, psychosocial).

An Peer Advocate is a trained peer promoter who has received further training in how to identify and assist abused SW to seek immediate redress. An SHG leaders is a sex-worker within the site, who has been trained to build connections with service providers and decision makers (e.g. lawyers, doctors, police officers, traditional authorities).

Procedures:

1.   Creation of a supportive environment

1.1   Linkages to be developed between the Self Help Group (Refer SOP No 4.2 to ensure their understanding of the project objectives and establish the SWs direct interface with the stakeholders.

1.2   Legal awareness to be regularly generated to SWs through community-level legal literacy sessions. The agency would appoint Legal Resource Person (LRP) as consultants, who would conduct legal literacy sessions with the community and advises the SWs on legal issues. A Legal literacy module should be developed by the project in the local language. The module should have information related to the rights of the individual and all laws related that have any bearing on them. With respect to SWs, the information that is essential is their Fundamental Rights, Fundamental responsibilities, FIR related rights, Rights during arrest and detention, Rights during police interrogation, free legal support rights and the Right to get bail. Need based training on the decided curriculum is to be given on a regular basis to a Core Group, selected at each IP, consisting of OWs, PPs, selected SHG members, active stakeholders and peer advocates. This core group further is to conduct training at every site.

1.3   Networking with local gatekeepers and stakeholders through regular sensitization programs, visits and events to ensure their timely support in times of crisis.

2.   Pre-requisites/Essential elements of the CRRS

2.1   All sites to have PPs

2.2   Each PP site to have one member of the SHG and would be the first point of contact for the SWs in times of crisis.

2.3   One PA to be trained in legal issues and motivated to support SWs in crises

2.4   A Core Group for legal literacy to be established.

2.5   SM to have a Mobile phone

2.6   LRP to be enlisted who should immediately respond when called

2.7.   Police stations and hospitals to be visited once a month

2.8   Major stakeholders to be met once in two months

2.9   All PPs to have ID cards

3.   When a crisis incident takes place, the SW to approach the following individuals/groups in the suggested order:

3.1   First loop of support - Community members:

3.1.1   The SW in crisis to contact other SWs for immediate support

3.1.2   The SW in crisis or other SWs to contact the SHG members for immediate support.

3.1.3   The SW in crisis or other SWs to contact to contact PP and PA for immediate support

3.2   Second loop of support - Staff:

3.2.1   The SW in crisis or the other individual/s intimated to contact the ORW for support.

3.2.2   The SW in crisis or the other individual/s intimated to contact the SM for support.

3.3   Third loop of support - External support:

3.3.1   The SW in crisis or the other individual/s intimated to contact the Legal Resource Person for support

4.   The loops of support as mentioned above are from the point of sustainability of the community systems. If the community members are not available or feel that they need additional assistance; then staff members and lastly the LRPs are to be contacted. This will ensure that assistance reaches the SW from some source or the other even if some people fail to act in time or appropriately. This can be implemented flexibly as per the prevailing local situation.

5.   Instant support is to be provided by those contacted, within 30 minutes from the time of intimation

6.   The PP to follow up with the SW within 24 hours to ensure the quality of support and provide guidance, if necessary

7.   The project to decide the extent of support that they are willing to provide in every situation before hand and communicate to the SWs.

8.   Keeping sustainability in mind, any financial support that a SW in crisis might need, could be borne by community members, as per their discretion, and not the project.

9.   The following procedures are to be followed once intimated of crisis:

9.1   Harassment emergency

9.1.1   n the case of a situation of harassment, the individual/s contacted need to provide the necessary support, including visiting the family, police station and location of harassment (e.g. if from clients, pimps, goons etc.).

9.2   Arrest

9.2.1   In the case of police arrest, the individual/s contacted needs to visit the SW/s in question at the police station or place of arrest.

9.2.2   If the arrested SW/s is in contention with the law, only emotional support is to be provided and it should be ensured that he/she receives a fair trial.

9.2.3   If the charges are false or can be refuted, the individual/s contacted to provide support and evidence as necessary

9.3   Medical emergency

9.3.1   In the case of a medical emergency, the SW to be taken to the nearest hospital or medical center

9.3.2   If the emergency is of a minor nature (e.g. minor cuts, bruises etc) and takes places during the project clinic timings, the SW can be taken there.

9.4   Other emergencies

9.4.1   The individual/s contacted to provide support for any emergency, including settling disputes amongst SWs, settling disputes amongst family members, support in times of death of a loved one etc.

ESTABLISHING VOLUNTEER SUPPORT SYSTEM & STRATEGIES

Objective:

• To provide contextual clarity on develop and establishing volunteer support system

• To provide essential requirements and detailed processes on the functioning of the volunteer support system.

Users:

Program Managers, Site Managers, BCCOs and OWs

Context:

Volunteer support system is an important component of any intervention with key population as they provide synergies for the project to build upon; from a point of challenge to a point of strength. Volunteers can be full time, part time or on a need based. Any one intervention cannot have resource and expertise to handle various issues related to SWs HIV prevention intervention. Therefore, volunteer support system brings friends and sympathizers of the community closer to the community that go beyond the scope of the project. It also supports the facilitation of the creation of a volunteer support system for the illiterate/low literate community members makes the SW empowerment processes sustainable. The volunteers work independently and together to ensure that Key Population enjoy their fundamental rights without the stigma and discrimination associated with their profession. In the context of Volunteer support systems for HIV prevention for SW needs a specific strategy, keeping in mind stigma attached to the profession, community dynamics and local conditions. The selected volunteers need to be oriented properly and scope of work for each of the volunteer need to developed with time line and deliverables and should focus on building community empowerment.

Procedures:

Development of national/site level volunteer support strategy

1. Create a team of individuals (COP, STOs/SPM, PM, SM & OW) and experts responsible for the planning and implementation of the strategy at the project level.

2. Develop a list of all work items in which volunteers are needed. The list accounts for every work item, including items that are rarely (or never) completed. The list is dynamic document in which work items are updated regularly with additions, edits, and deletions by core team.

3. Each item listed is given a priority 1, 2, or 3. Priority 1 activities are those critical to the project and would hamper project activities if not completed.

4. Based on the each listed work items identify the education, qualification, experience and time required completing the work.

5. Volunteers can be minors, the elderly, handicapped, employed or unemployed, any nationality, race, or just the person next door.

6. Identification of volunteers at the site level.

7. Demand for volunteers may not meet the supply of volunteers. A plan in which to recruit new volunteers is critical to complete certain work listed.

8. A comprehensive, organized, and well managed volunteer program demonstrates the commitment

the HIV prevention program has towards its volunteers. The program itself would attract volunteers looking for an opportunity to work for HIV prevention program that effectively utilizes and appreciates its volunteers.

9. Word of mouth: The least costly method of recruitment would be word of mouth. Not only Program staff visiting with potential volunteers, but current volunteers visiting with potential volunteers. To achieve the later, a positive volunteer experience is essential. The positive volunteer experience is dependent on every HIV prevention staff member and their individual commitment to volunteers.

10. Development of the scope of work and work plan for volunteer for example; documentation of success stories, helping CBO in accounting, conducting English speaking/ literacy classes for the SWs or helping SWs/SHGs in opening bank account or writing the monthly meeting minutes.

11. Volunteers should be oriented on one to one basis or a group of volunteers by PM/SM.

12. Developing a reporting format for the volunteer as per the SOW and work-plan.

13. Reimbursement for incidental expenses to volunteers is authorized, but not mandatory.

14. Evaluations of the volunteers to be done to aid communication between the volunteer and the program.

15. An award is one of the few tangible incentives for volunteering. Appreciation of a volunteer's time and effort has been stated time and time again as the best way to keep volunteers coming back and attract new volunteers.

16. Maintaining a pool of past and new volunteers with various expertize, experiences, education qualification and time commitment for future needs.

SOP 4.7

LEGAL LITERACY AND EMPOWERMENT OF SEX_WORKERS

Objective:

- To provide contextual clarity on the legal literacy component for SWs

- To provide essential requirements and detailed processes on the functioning of the legal literacy component.

- This SOP will be complemented by SOPs on Self Help Group and CRRS.

Users:

Program Managers, Site Managers, BCCOs, Legal Resource persons, OWs, PPs, Peer Advocates, SHG leaders.

Context:

Due to the nature of their profession, SWs face harassment, violence and coercion. They are stigmatized and marginalized, which prevents them from seeking legal redress against discrimination, non payment, abuse, rape etc. It is difficult for them to access services and their rights, which are not only denied but also violated. Arrests and punishment on false pretexts due to lack of awareness about the legal system and their rights as women/sexual minorities worsen their situation. Legal literacy works as a tool to build the capacity of SWs to protect themselves. It is a tool that brings about qualitative change at the grass root level. While devising the project's advocacy strategy, a need was felt for generating awareness of legal rights and increased information about pertinent laws as knowledge is a source of power.

The legal literacy component was developed to prevent exploitation of SWs and does not imply that the project supports crime. The component keeps in mind the country's legal framework and the focus of the legal support provided by the project is to ensure that legal rights are upheld and justice is served. This component complements the crisis intervention components; such as the Crisis rapid response system CRRS (Refer SOP No.4.5)

Procedures:

Development of a Legal Literacy Strategy

1. Development of a Legal Literacy Strategy

1.1 Create a team of individuals (PM, SM, OW and PA) and experts responsible for the planning and implementation of the strategy at the project level.

2. Appointment of Legal Resource Person

2.1 Appoint LRP; lawyer; as consultants who would conduct two legal literacy sessions a month with the Core Group.

2.2 The LRPs should be sensitive, be comfortable working in the NGO set up and be familiar with the laws related to SWs and their rights.

2.3 The LRPs should be willing to commit to two sessions per month at the NGO site

2.4 It is necessary to keep a list of possible LRPs on hand who could be contacted at a short notice.

3.   Core Group: consist of OWs, POs, SHG members, active stakeholders and PAs.

3.1   The Core Group is responsible to share legal information gained during the sessions with the LRPs, with other SWs during SHG meetings (Refer SOP No. 4.2), DIC meetings (Refer SOP No. 2.6), special events etc.

3.2   The Core Group is to conduct sessions on a monthly basis with as many SWs as possible.

3.3   Coverage plans to be made along with the outreach team to ensure that all SWs are covered within a quarter.

4.   Legal Literacy Module

4.1   Develop a Legal Literacy module in the local language used everyday, based on the local context and citing local examples or anecdotes.

4.2   The module should include information on fundamental rights granted by the country's constitution, fundamental responsibilities, First Information Report (FIR; process of filing a police complaint) related rights, rights during the time of arrest and detention, rights during police interrogation, free legal support rights and right to get bail.

4.3   Additional laws pertaining to SWs and the various typologies need to be included e.g. laws related to begging, immoral sex acts, solicitation in public etc. These laws have to be listed and shared with the LRPs before they conduct the sessions.

4.4   It is important to clarify that while legal information is being shared, legal cases that arise would need to be handled directly by the SW. The LRPs could be contacted for support but is not mandated to take the case. The NGO would also not be liable for legal fees. However support can be provided to the SW under the CRRS as per the situation.

5.   The LRPs should impart legal literacy to the core group. Two sessions are to be conducted every month.

6.   The Core Group members are to be capacitated as trainers and should be able to educate all other SWs and answer relevant questions.

7.   The Core Group members to conduct legal literacy sessions at the project sites in order to ensure that all the SWs have complete legal knowledge. Repeat sessions to be conducted as per the need.

ANNEXURE

ANNEXURE A

ILLUSTRATIVE WORKPLAN TEMPLATE

Geographic location:
Program dates:
Program goal:
OBJECTIVE: 1. To support increased access and improved coverage of HIV prevention, treatment, care and related services for key populations.

S/No	Activity Title	Activity details	Responsible	Timeline	Targets	Inputs (Resources)
1	*Limit this to one sentence.	In responding to this column, always apply the 5 "Ws" (What, why, who, when and where) and 1 "H" (how)	This column should provide information on specific persons, institutions or partners responsible for a particular task.	This column should provide information on month, phase etc. Number of days required to complete each tasks.	This column should provide information on number of people to be reached and deliverables.	This column should provide information on staff time, consultants, procurement, operational expenses,
2.	Example: Conduct training for clinical staff	Example: Train staff at 8 clinics to provide KP friendly services	Example: STI specialist and training consultant	Example: To be completed during month 2 of the project. : 1 week, residential training	Example: 5 staff per clinic trained. Total 40 persons trained.	Example: 2 months staff time. 2 weeks local consultant time. Venue, food, per diem, travels, training materials, etc.

ANNEXURE A

Sex Worker Mapping Methodology

Methodology

The interviewer will introduce him/herself and explain the purpose for which they have approached the participants. The consent of the respondent will be taken before commencing the interview. The tool is to be administered to the participants in the manner that is taught during the field staff training.

Steps for Mapping

Key informant discussions at the region, district, city and town level were held to get leads and contacts to understand the presence of the groups and locations where they could be accessed.

How to reach key population key informants

Step 1:

Identify the key hot spots using the potential key informants from the first section of the list above

Step 2:

Identify exact site location with more information on the site, including type of key informants available at the sites and the risk behavior of the Sex-workers

Step 3:

Use Delhpi method to discuss with the sex-worker key informants to understand the size of the sex-worker population at that site, with all the other information requested in the format. Key informants at the site have to be sex-worker themselves. This will help to collect authentic information about the site.

Categories of key informants approached at different levels of data collection

Levels	Suggested Categories of Key Informants
District/Regional Headquarter	Regional units, District health facilities, NGOs, Research Organizations, NGO networks, PLHIV networks, LGBT networks Local people, Taxi drivers, Transport workers, Police, any other knowledgeable individuals
City/Town level	NGOs, cart pushers, petty shop owners, individuals in the vicinity of the site/spot, bar owners, Police, health care providers, NGO volunteers, restaurant owners/managers, Bar owners, Hotel staff, brothel managers, DIC staff, Taxi Drivers , local persons etc.
At site/spots	Primary key informant for Sex Worker: Taxi Drivers, intimate partners, sex workers, Truck drivers, migrant workers, and those visiting the weekly markets, local traders, any other informed individual, health workers, bar and restaurant owners, Bar Attenders.

Process of Mapping

How do we begin?

- Each mapping session should start with an icebreaker to put the participants at ease.

- Individual introduction by the mappers and participants to take place

- Brief introduction about the mapping exercise should be given (AIDS prevention program, mapping for targeted intervention, etc.)

- Inform the group about what they would do during the mapping exercise; and that the mapping would take about 20-60 minutes to complete.

- Participants should be told that they are not obligated to stay until the end of the session if they do not wish to.

- Mapping team members should not ask to take photographs of participants during the mapping, unless a process for informed consent has been established prior to the mapping.

Who draws on the charts and what?

- Decide who among the participants would draw on the chart – someone who knows how to read and write.

- Anybody from the area (including sex-workers) who is familiar with the sex-workers and with the area can be involved in drawing the map.

- Mapping teams must ask permission from the sex-workers groups before recording information on charts, maps, and drawings. These documents should be carefully labelled to include Site name; Hotspot name; Number of people in the group; Names of mapping team facilitators.

- The names of sex-worker participants must not be recorded

- Spread the chart paper on the ground, hand out sketch pens, and request the participants to draw the geographical outline of the area. Mapping team members should take the initiative to draw on the charts if participants are not literate or hesitant to draw. However, they should be encouraged to have a say in how the maps are being drawn. Since people tend to have opinions on what others draw, having drawing charts helps to motivate group members to become active participants.

- Request participants to mark the important landmarks in the area. Whilst marking landmarks, services such as government hospitals, popular dispensaries, and NGOs can also be marked on the emerging map.

- Next, ask participants to mark the specific locations or hotspots where sex-workers tend to congregate.

- Ask specifically about the mobility patterns of sex-workers —migration to and from the site as well as within the site. Obtain information on who migrates from where, which places they come from, which places they go, why they do so, when they do so, and in what numbers.

What questions to ask during the mapping?

- Whilst the participants draw the map, ask them probing questions to generate information on categories of sex-workers at different hotspots. Note the key information in a field diary.

- Methods used in mapping should be dialogue-based, and very participatory

- Whilst facilitating the methods, let participants discuss among them to reach a consensus, especially when estimating numbers. Note any differences in participants' points of view.

What question to ask –

- What are the in site where sex-workers can be found taking high risk?

- Can you provide landmarks (street name, etc.) where we can find these groups?

- What are their estimated numbers? Please discuss if you think the numbers are different from what others are saying.

- Please tell me more about these groups (any sub-groups, mobility pattern of sex-workers, if any; active during certain hours)?

- During the mapping, the teams need to be very careful to keep information secure and confidential. They must also take care not to make false promises or raise unrealistic expectations about what will happen after the mapping.

How to conclude the mapping meeting?

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

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

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

- The mapping teams should stop accessing groups and individuals when no new information is being offered.

The field team will contact the key informants at the district level to seek information on the presence of identified high-risk behavior groups and their locations in the district. Further key informants will be spoken to at the city/block/town level for further identifying new links and verifying the information collected at the district level. Key informant log sheets will be maintained at each level of data collection; district/region, city/town, and at the identified site. The following information will be collected through the key informant log sheets:

- Name of the key informant- Optional

- Name of the organization/institution/department that she/he is affiliated with

- List of groups present in the district

- Types of sites where the identified groups reside, aggregate, work, or network for any other reason

- Names of the location and sites where these groups can be accessed

- Any other useful link at tehsil, block, city, or town level to seek information about the groups

The team will cover both urban and rural area in the district based on the leads received at the district level (Step 1) using snowballing and key informant discussions to seek information about the presence of these groups in the district.

Estimation of size of Sex-Worker

The following methods/techniques will be applied simultaneously to arrive at an estimate of number of units/households and individuals at each location identified.

1. Direct questioning of 'gatekeepers' and other knowledgeable persons.

2. Interviewing of key informants from various segment of population in the identified geographical community.

3. Delphi method to arrive at consensus on the estimate of high-risk behaviour groups from the key informants.

To the extent possible, direct questioning of individuals at the site will be used for obtaining the number of individuals at the site and seasonal variations at various hours of the day, on different days of the week and during different seasons. Where there is a refusal /reluctance others such as clients / `knowledgeable persons' will be approached.

Seasonal variations in the high-risk activity at locations and sites and in congregation of high-risk behavior groups will be also captured through the data collection format.

Delphi Method : The Delphi method will be used to arrive at the number of individuals from high-risk behavior groups. Three key informants including the community consultants from each area will be asked to mention the number of individuals of high-risk behavior group residing/aggregating at each site in their respective areas. A consensus will be arrived by cross feeding the information to the three key informants. In case of 3 varied responses, a few more informants will be asked to arrive at a consensus figure.

Mapping of relevant services HTCs/Facilities, CSOs, NGOs, CBOs

After identification of the site; the health care providers and shops selling and not selling condoms, NGOs/CBOs in the vicinity of the sites/spots, will be mapped:

• Services within 250-500 meters on either side of the identified site/spot.

• If the identified site is a dead end with one approach road, HCPs, shops selling and not selling condoms, and NGOs/CBOs will be mapped within 250-500 meters from the identified site.

For Health care providers in the vicinity, following information will be collected:
• Qualification
• Type of service providers
• Average number of patients in a day/week
• Does he/she treat STI patients?
• If yes, number of patients treated on an average in a week

For shops selling and free distribution of condoms in the vicinity, following information will be collected:
• Type of outlet
• Whether stocks condoms
• Sale/distribution per day/per week
• Most selling/distribution brand

For NGOs/CBOs following information will be collected:
• Address
• Area of operation
• Number of years that they are functional
• Target groups that they work with
• Type of services provided

ANNEXURE C

Illustrative budget format

Title of Activity:
Venue:
Period of Activity:

Budget

Description	Qty.	# of Days	Rate (GH¢)	Total Cost (GH¢)	Comments
T&T					
Sub total					
Materials					
Sub total					
Accommodation					
Sub total					
Sub total					
Total Amount					

Prepared by: _____

Reviewed by: _____

Approved by: _____

ANNEXURE D

Indicators for Sex Workers

Below is the list of indicators that should be measured based on the minimum package of services.

|	
Achievement of Goal	• Reduction of new HIV infections among female sex workers by 50% by 2015
Achievement of objectives	• % of FSW who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission • Number of FSW reached by interventions disaggregated by i) prevention, ii) treatment, care and support, iii) psycho-social • Number of FSW referred to other services (illustrative examples include: STI, HTC, ARV, Care and Support, PMTCT, Family Planning/ Reproductive Health (FP/RH), Antenatal Care (ANC), Life Skills, Drug Treatment)/total number of individuals receiving intervention • Total number of referrals/total number of referred • Number of prevention commodities distributed (condoms, water-based lubricants, needles) • Number of targeted condom service outlets, disaggregated by new and continuing sites • Number of dedicated FSW drop-in centers • Number of peer support groups formed • Number of healthcare workers trained as FSW-friendly • Number of peer educators recruited and trained
Achievement of strategies	• % of FSW surveyed reporting the use of a condom with most recent client, by age • % of FSW surveyed reporting use of condom with every client in the last month • % of FSW (by age) surveyed who received an HIV test in the last 12 months and know results • % of FSW reporting the use of a condom with NPP at last sex-act • % of HIV positive FSW surveyed by age • % of HIV positive FSW surveyed receiving care services • % of HIV positive FSW surveyed receiving ARV treatment
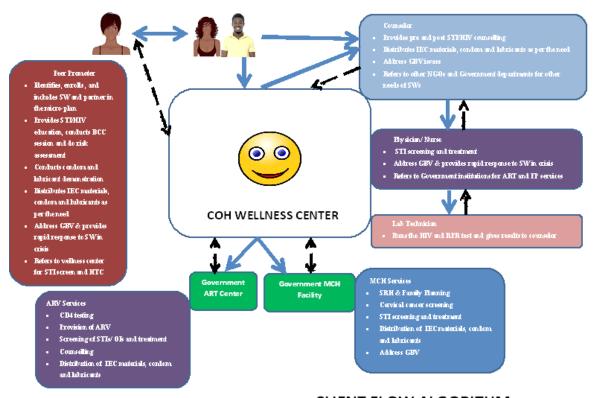
ANNEXURE E

KEYS TO PRODUCING SUCCESSFUL MATERIALS

1. The lower the literacy level of key populations, the more emphasis should be placed on pictorial images and the less on text. Use short and simple text.

2. Messages should be positive, not fear-based, and discriminated.

3. If the materials feature a source, ensure that the source is authoritative and credible for the key population (doctors, celebrities, officials, traditional healers.)

4. Make sure the main message is repeated within a single material for maximum effect.

5. Limit the number of messages to avoid confusion.

6. Be careful not to use language or images that could stigmatize specific population. Include target audience in the design and review process.

7. Concern about copy right of the text and picture.

8. Get approval from key organizations such as Broadcasting Committee, Ministry of Culture, etc.

9. Establish feedback mechanisms if there is sensitive issue in the materials.

10. Materials should be visually appealing and eye-catching.

11. Messages should be presented in a way that is both logical and rational and emotionally compelling.

12. Materials should clearly reflect the reality of everyday lives of key populations. Use familiar faces, buildings, streetscapes, etc.It should be clear who the key population is when looking at the materials.

13. Include a call to action.

14. Present one message per illustration/page/graphics. The more white space on a page, the more inviting it is to the eye. The simpler the TV/radio messages, the more likely they will be remembered.

15. Ensure that materials are free of confusing and culturally inappropriate messages and images.

16. Don't be too abstract. Avoid overly sophisticated messages.

17. Ensure quantity and availability of materials.

18. Think about where to distribute materials

ANNEXURE F

Client Flow Algorithm SW HIV Prevention Projects in Zambia

CLIENT FLOW ALGORITHM
SW HIV PREVENTION PROJECTS IN ZAMBIA

PHOTO GALLERY

Republic of Zambia