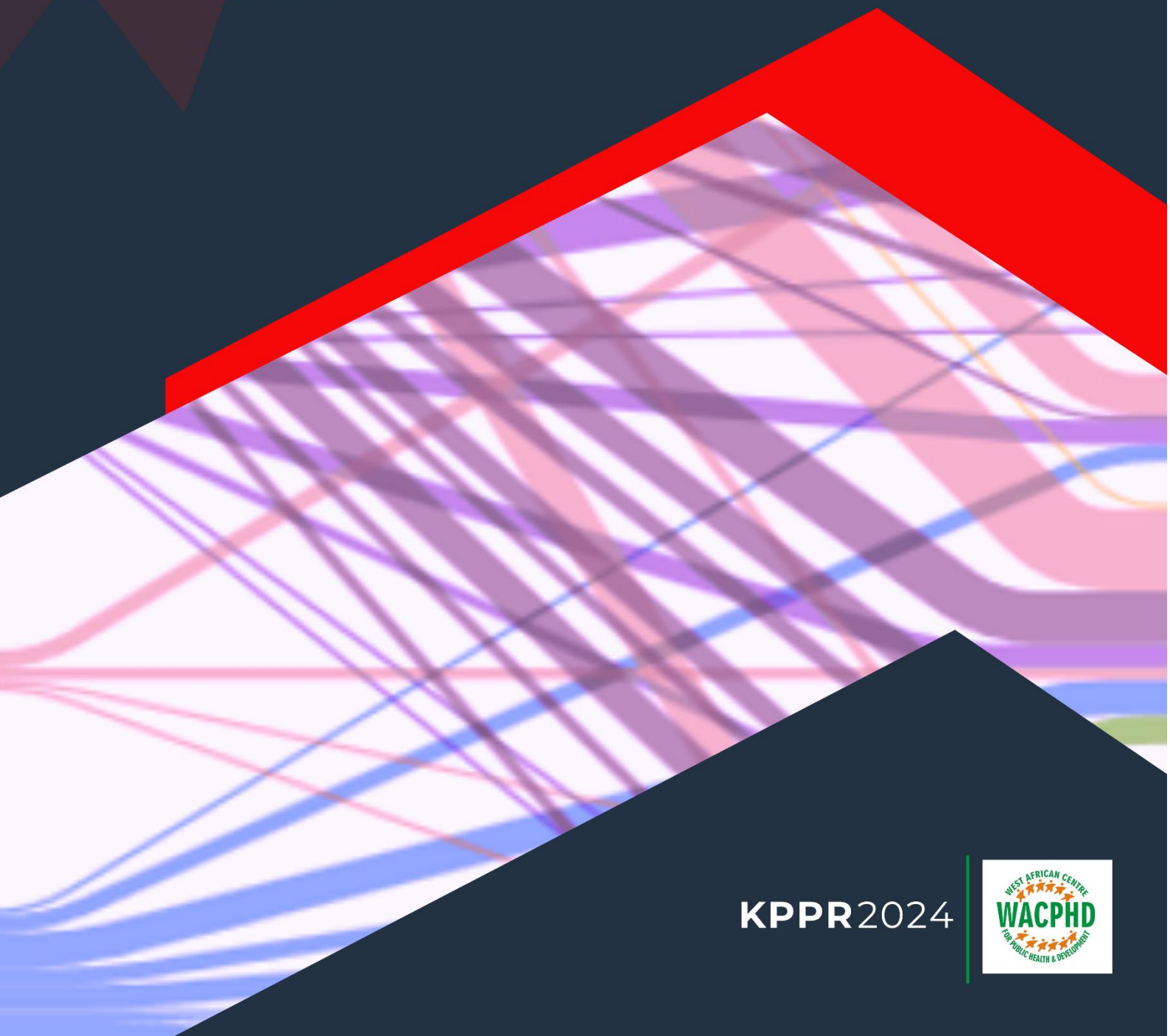
KEY POPULATION PROGRAMME REVIEW REPORT



KPPR2024

REPORT OF THE KEY POPULATION PROGRAMME REVIEW IN NIGERIA

July 2024

FOREWORD

I am pleased to present the findings of the Key Population Programme Review (KPPR) in Nigeria, a comprehensive evaluation of our efforts in addressing the HIV prevention and care needs of key populations. The report provides a detailed analysis of our strategies, implementation approaches, barriers, and good practices to enhance the reach and impact of our programmes.

Through an in-depth review of data from various sources across the six (6) geopolitical zones in the country using the Polling Booth Survey (PBS), Prevention Self-Assessment Tool - Lite (PSAT Lite), Focus Group Discussions (FGDs), In-depth Interviews (IDIs), and the One-Stop Shop (OSS) Assessments, we have gained valuable insights into the successes and challenges of our key population programmes. These insights offer a roadmap for scaling up and strengthening our interventions to achieve better outcomes.

From understanding the key population programme strategy to identifying barriers contributing to gaps in service availability, this report highlights the importance of community engagement, tailored service delivery, data-driven programming, capacity building, and sustainable funding. It underscores the need for a multifaceted approach to ensure effective coverage and population-level impact.

I commend the dedication and commitment of the Research, Monitoring and Evaluation (RM&E) department of the agency, partners, all stakeholders, partners, and key population members who have contributed to the success of our programmes. Their perseverance and collaboration have been instrumental in advancing our HIV response in Nigeria. I encourage all stakeholders to leverage the recommendations outlined in this report and continue working together to improve the health outcomes of key populations in Nigeria.

As we look to the future, let us build on the strengths identified in the KPPR and proactively address the gaps and challenges. By embracing evidence-based practices, fostering community participation, and advocating for supportive policies, we can strive towards a more inclusive and effective approach to HIV prevention and care for key populations in Nigeria.

I extend my gratitude to the Global Fund (GFATM) for the continuous financial support and to everyone involved in this review. Together, we can make a significant impact and progress towards ending the HIV epidemic in Nigeria by 2030.

DR TEMITOPE ILORI

Director General

National Agency for the Control of AIDS

ACKNOWLEDGEMENTS

On behalf of the Research, Monitoring, and Evaluation Department (RM&E) of the National Agency for the Control of AIDS (NACA), I wish to acknowledge the efforts of stakeholders and individuals who significantly contributed to the success of the Key Population Programme Review (KPPR) across 18 states in Nigeria in 2024.

I would like to express our appreciation to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) for the funding support. I also extend my commendation to the team from the West African Centre for Public Health and Development (WACPHD), an affiliate of the Institute for Global Public Health, University of Manitoba (IGPH) for providing technical guidance. My gratitude also goes to our stakeholders who participated and provided technical support throughout the study. In particular, I recognize the invaluable support from the Federal Ministry of Health and Social Welfare, members of the Key Population Secretariat, and all other stakeholders who contributed to the success of the KPP Review in Nigeria.

I acknowledge the contributions of the Director General NACA, Dr Temitope Ilori, for her unwavering leadership throughout the conduct of the Review process. Additionally, I appreciate my fellow directors from various departments of NACA who took time out of their busy schedules to provide the necessary information for the successful implementation of this Review, as well as the focal persons from various departments and the staff of the RM&E department for their commitment and dedication that led to this significant achievement.

I look forward to continued collaboration and support for proper coordination of the Key Population programme in Nigeria.

Francis Agbo

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Director, Research, Monitoring and Evaluation

National Agency for the Control of AIDS (NACA)

EXECUTIVE SUMMARY

The National Agency for the Control of AIDS (NACA), in collaboration with stakeholders, and with funding support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) conducted the maiden Key Population Programme Review (KPPR) in Nigeria in 2024. The West African Centre for Public Health and Development, the regional affiliate of the Institute for Global Public Health, University of Manitoba was engaged as the technical support partner in charge of implementation. The KPPR was conducted in 18 states, representing 49.5 % national coverage. These states include Abia, Adamawa, Akwa Ibom, Anambra, Bayelsa, Delta, Edo, Enugu, Gombe, Imo, Kaduna, Kano, Kogi, Lagos, Niger, Oyo, Rivers, and Taraba. These states comprise GFATM programme states and those with available KP data necessary for the review assessments.

The thrust of the review efforts was to (a) examine the progress of KP programmes and its contribution to HIV epidemic control, (b) identify replicable good practices to accelerate the progress, including opportunities for GF grant reprogramming,(c) set targets and define strategies for PEPFAR's Country Operational Plan (COP), (d) Identify challenges and bottlenecks that hamper implementation of KP programmes, (e) review how the result of the Integrated Behavioural and Biological Surveillance Survey(IBBSS) 2020 have been incorporated in the current design of KP programme in Nigeria, (f) provide recommendations from the review that will foster improvement and learnings for KP programme, and (g) make recommendations for the KP programme priorities for the next 2 years. Ultimately, the exercise was also geared towards fast-tracking the achievement of epidemic control amongst key populations : female sex workers, men who have sex with men, transgender people and people who inject drugs, who bear a disproportionate burden of the epidemic compared to persons in the general population.

In line with the study protocol, relevant research questions were developed to address these objectives, aligning with the effective coverage framework. As addressed in the discussion section, these questions were subsumed in the underlisted sub-thematic objectives:

- Understanding the Key Population Programme Strategy
- Assessing the implementation of the KP programme Strategy
- Understanding barriers contributing to gaps in service availability, contact, and utilisation amongst Key Population
- Identifying good practices for scaling up to address coverage gaps

- Providing recommendations for effective coverage

During implementation, the Key Population Programme review employed various quantitative and qualitative data collection approaches –Prevention Self-Assessment Tool (PSAT)-Lite, Polling Booth Surveys (PBS), OSS Assessment, Desk Reviews, Focus Group Discussions(FGDs) and In-depth interviews(IDIs) to elicit diverse responses from study participants, ranging from direct KP community members, implementing partners, funders, and other critical stakeholders involved in the HIV response at different levels over the years. Operationally, the participants for inclusion into the study were defined as thus: **Female Sex Workers (FSW)**: Any female, acknowledging to have received money or gifts in exchange for sexual intercourse with an assigned male at birth at least once. **Men who have Sex with Men (MSM)**: Assigned male at birth, reporting at least one anal sex act (insertive or receptive) with another assigned male at birth. **People Who Inject Drugs (PWID)**: Any person, who injects drugs (illicit, non-prescribed or illegal) recreationally irrespective of the type of drug injected. **Transgender People (TG)**: Any person who has a gender identity or gender expression that differs from the sex they had at birth. Both trans women and trans men were included in this exercise. **Programme implementers**: Personnel or staff from KP-focused and/or KP-led organisations who were involved in implementing programmes for key populations across the 18 study states during the period under review. **Policymakers**: Persons who were involved in developing policies for key population programming during the period under review. These include officials from the Ministry of Health (MoH), NACA, National Council for Health, UNAID and other UN organisations. **Funders and Donor Agencies**: Organisations who were involved in the funding of key population programmes during the period under review. These include officials from GFATM, PEPFAR, USAID, The World Bank, BMGF, CHAI and other donors.

The Prevention Self-Assessment Tool-Lite (PSAT Lite) was used to assess the context of the programme, understand strengths and gaps, and to identify best practices that has impacted service optimization for key population. The Polling Booth Survey (PBS) was used to collect quantitative data on programme outcomes from the service users. This data helped in understanding the programme coverage cascades from users' perspective, OSS assessment was done in designated health facilities to explore the extent and quality of prevention services delivery for Key Population under the Required, Availability, Contact and Utilisation cascades. In-depth interview (IDI) was conducted among stakeholders at the national and state levels to understand the programme strategy adopted at the national and state levels and assess how

effective those strategies have been in meeting the healthcare needs of the Key Population. Focus Group Discussion (FGD) was carried out among service users or beneficiaries to understand their perception of barriers to accessing and utilisation services. Desk review was conducted for the period between 2016 and 2021. Documents reviewed included the National Strategic Plan, the National Prevention Plan, survey reports like IBBSS, and Routine Programme Monitoring Reports etc. The Desk Review examined documents, policy instruments, service protocols and other guideline manuals that have shaped prevention programme delivery for Key Populations in Nigeria.

To enhance coordination during implementation, structures were put in place for optimum delivery of the study mandate across the 18 states, The National Technical Committee (NTC) and the Project Implementation Team coordinated and supervised operations across the 18 states while the respective State Technical Team (STT) and State Study Field Team supervised field operations in each of the participating states. The field data collection exercise lasted for a total of 60 days. To ensure ethical compliance, the study protocol was approved by Nigeria's National Health Research Ethics Committee (NHREC). Only persons 18 years and above were interviewed.

KEY FINDINGS:

Across all the data collection methods deployed during the Key Population Programme Review (KPPR), a total of 668 interview sessions (PBS: 299, PSAT-Lite: 18, FGDs: 144, IDIs: 166 and OSS:41) engagement, involving about 5433 respondents/participants were conducted. Specifically, a total of 18 PSAT Lite sessions were held across the states (i.e. one per state) The PSAT Lite was designed to enable rapid self-assessment within each HIV prevention pillar under the following thematic areas: Leadership/Coordination and Programme Implementation. The tool was used to review the programmes for Female Sex workers, Men who have Sex with Men, People Who Inject Drugs and Transgender People. The PSAT-Lite was used to assess KP programmes using a 5-point scoring scale while exploring the factors that influenced strengths and gaps within the context of each state programme.

Polling Booth Survey (PBS), a group interview method, assessed individuals by KP typology who provide responses through a ballot box. The individual responses were anonymized and unlinked. The anonymity of the respondents has been shown to increase the sense of confidentiality among respondents hence their accurate reporting on sensitive and personal information, thereby increasing objectivity in assessment. During the study, potential

respondents were selected using a probability sampling procedure and organised into small homogenous groups of 12 people per group. Being a group interview, questions were brief, short, simple and dichotomized for ease of response. The review conducted PBS at sub-national level to generate measurable outcome indicators. Given the scope of this review and considering that PBS method has been tested and implemented in multiple contexts and countries with the assurance of replicability, it was used quantitatively for FSW, MSM, PWID and TG people.

Across 144 LGAs in 13 states, a total number of 299 PBS was conducted during this review spread across all the KP typologies of FSW, MSM, PWID and TG . 13 PBS sessions were conducted for each key population typology in each selected state. In summary, 78 PBS sessions with 936 FSW, 78 PBS sessions with 936 MSM, 78 PBS sessions with 936 PWID and 65 PBS sessions with 780 TG were conducted. Adamawa, Lagos, Niger state had PBS sessions across 3 different KP typologies, Akwa Ibom, Anambra, Kogi, Kaduna, had 2 typology PBS sessions, while Abia, Bayelsa, Delta, Kano and Rivers had 1 PBS each. TG PBS was conducted in 5 states: Adamawa, Bayelsa, Delta, Kogi and, Niger. Within each region, based on the programmatic mapping and 3-source capture-recapture data, the states with the highest number of KP of the respective typology were selected for the conduct of PBS to enable national-level representativeness and inferences. Hence, Edo, Enugu, Oyo, Imo and Taraba had no PBS sessions carried out in them.

A total of 166 In-depth interviews (IDIs) was conducted with stakeholders using a structured interview guide (Target: 175). Key informants were identified and interviewed at the state level (SASCP, SACA: Lead, CMO and M&E, KP secretariat Lead/KP CBO, State implementing partners), and at the national level (Government agencies, Implementing partners, Funders/Donor agencies, NGO). The purpose of the IDI was to understand the key population programme context and strategy adopted by the country and the states. IDI provided information in other areas of advocacy, community engagement and resource mobilization. Furthermore, IDI identified best practices that can be replicated. A total of 158 in-depth interviews were conducted at the state level and 8 interviews were conducted at the national level.

Eight sessions of Focus Group Discussions (FGDs) were held per state, two each with FSW, MSM, PWID and Transgender people, with an aggregated national total of 144 FGD sessions conducted across the 18 states. The FGD sessions sought to understand the challenges experienced by key populations in accessing and using HIV/STI prevention and treatment

services, as well as other covert and overt factors influencing HIV response amongst designated Key Population typologies in Nigeria. A Focus Group Discussion (FGD) tool was developed to guide discussion with participants. Each FGD had approximately 10 respondents (range 8-12 participants) and was facilitated by a trained qualitative researcher (moderator) and a research assistant (note-taker)

One Stop Shop (OSS) assessment utilised a mixed method, including the effective coverage approach, in accessing 41 out of 44 sample One-Stop-Shops (OSS) facilities for HIV Prevention and Treatment across the 18 selected KPPR states and the FCT. The OSS assessment addressed the unique challenges faced by KPs, including the gap in equitable access to quality HIV services. During the course of the assessment, many of the sample facilities were undergoing partner transitions.

The desk review process of the key population programme focused on the collection of documents, selection of relevant data and information resources, review of data collected, data analysis and results. Instructively Desk Review highlighted the recency in programming and interventions for Transgender people in Nigeria, which gained wider traction following the 2020 Integrated Behavioural and Biological Surveillance Survey. The desk review was conducted at the national level

Through a thorough review of data from various sources, the use of Polling Booth Survey (PBS), Prevention Self-Assessment Tool - Lite (PSAT Lite), Focus Group Discussions (FGDs), In-depth Interviews (IDIs), and the One-Stop Shop (OSS) Assessments, the review gives valuable insights into the successes and challenges of our key population programmes. Amongst others, these insights include greater involvement of Key Population, continuous capacity building and mentoring efforts, adequate resource mobilization, strengthening HIV response structures, especially at the LGAs, eliminating all forms of legal and cultural barriers impinging on service uptake, scaling up access to OSS facilities, strengthening learning, accountability monitoring and evaluation systems ,integration of HIV prevention services, provision of essential commodities, including ARTs and PrEP/PEP, investment in research, advocacy, etc , all of which offer a roadmap for optimization of interventions outcomes within the confines of Nigeria's multi-sectoral response.

As the push towards population-level epidemic control by 2030 intensifies, the result of the KPPR will consolidate on the gains made thus far while expanding the frontiers of evidence available to stakeholders for informed policy and programme decisions.

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ACRONYMS/ABBREVIATION

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
BCC	Behavioural Change Communication
BMGF	Bill and Melinda Gates Foundation
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
CHAI	Clinton Health Access Initiatives
CBO	Community Based Organisations
CRRF	Combined Report and Requisition Form
CSS	Community System Strengthening
DIC	Drop In Centres
DHIS	District Health Information System
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FSW	Female Sex Worker
GBV	Gender Based Violence
GENPOP	General Population
GF	Global Fund
GoN	Government of Nigeria
HEAP	HIV/AIDS Emergency Action Plan
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IBBSS	Integrated Behavioural and Biological Surveillance Survey
IDI	In-Depth Interview
KP	Key Population

KPPR	Key Population Programme Review
LACA	Lagos State Agency for the Control of AIDs
MARPs	Most -At-Risk-Population
MHPSS	Mental Health and Psychosocial Support
MoU	Memorandum of Understanding
MPPI	Minimum Prevention Package Intervention
MSM	Men who have Sex with Men
NACA	National Agency for the Control of AIDS
NASA	National AIDs Spending Assessment
NASCP	National AIDS and STIs Control Programme
NAIIS	Nigeria HIV/AIDS Indicator and Impact Survey
NDLEA	National Drug Law Enforcement Agency
NDR	National Data Repository
NEPHAK	National Empowerment Network of People Living with HIV/AIDs in Kenya
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NGO	Non-governmental Organisation
NSF	National HIV/AIDs Strategic Framework
NSP	National HIV/AIDs Strategic Plan
NTC	National Technical Committee
OSS	One-Stop Shop
OST	Opioid Substitution Therapy
PBS	Polling Booth Survey
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-Child Transmission

PrEP	Pre-Exposure Prophylaxis
PEP	Post Exposure Prophylaxis
PPE	Personal Protective Equipment
PWID	People Who Inject Drugs
SASCP	State AIDS, STIs and Viral Hepatitis Control Programme
SACA	State Agency for the Control of AIDS
SBCC	Social Behavioural Change Communication
SDP	Service Delivery Point
SOP	Standard Operating Procedure
SRHR	Sexual and Reproductive Health and Right
STI	Sexually Transmitted Infection
STT	State Technical Team
TACA	Taraba State Agency for the Control of AIDs
TB	Tuberculosis
TasP	Treatment as Prevention
TG	Transgender
TSO	Technical Support Organisation
TSU	Technical Support Unit
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations
USD	United States Dollar
USG	United States Government
USAID	United States Agency for International Development
WACPHD	West African Centre for Public Health and Development

CHAPTER 1

INTRODUCTION

1.1 GLOBAL OVERVIEW OF HIV AND KEY POPULATION

HIV remains a significant global health challenge, with data showing that there were 39 million people globally living with HIV, 1.5 million new infections, and 650,000 AIDS-related deaths in 2022. This shows that every day, 4000 people including 1100 young people (aged 15 to 24), become infected with HIV. If current trends continue, 1.2 million people will be newly infected with HIV in 2025, three times more than the projected 2025 target of 370,000 new infections[1].

Key populations (KP), as defined by UNAIDS, are groups of people who are at higher risk of HIV infection due to their behaviours, identities, or social contexts. They include Female Sex Workers (FSW), Men who have Sex with Men (MSM), People Who Inject Drugs (PWID), Transgender People (TG) and People in Prisons and closed settings. These groups face multiple barriers to accessing HIV prevention, treatment, and care services, such as stigma, discrimination, violence, criminalization, and marginalization. Globally, Key populations are highly vulnerable to HIV acquisition and transmission. Their mobility alongside other factors plays a critical role in the spread of HIV and other sexually transmitted infections. Though Key populations constitute less than 5% of the global population, they and their sexual partners accounted for 70% of new HIV infections in 2021[2]. The global median HIV prevalence among Female Sex Workers is 2.5%, 7.7% among Men who have Sex with Men, 5.0% among People Who Inject Drugs and 10.3% among Transgender Persons[3]. Despite notable progress in expanding access to antiretroviral therapy (ART) and scaling up prevention efforts, Key populations continue to experience higher HIV prevalence rates than the general population. The global response to HIV has emphasized tailored interventions and programmes to address the unique vulnerabilities and needs of these Key population groups.

[1] UNAIDS, 2023
[2] UNAIDS, 2023
[3] UNAIDS, 2023

1.2 HIV AND KEY POPULATION IN NIGERIA

Nigeria with a population of over 211 million is the seventh most populous country in the world and the most populous country in Africa[4]. Nigeria is characterized as having a mixed HIV epidemic with high HIV prevalence among key population members and low prevalence in the general population. The annual incidence rate was estimated at 0.13%, which translates to about 130,000 new infections per year. The 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) revealed that the prevalence of HIV among adults aged 15-64 was 1.4%, with a higher prevalence in females (1.9%) compared to males (0.9%). For children aged 0-14 years, the prevalence was significantly lower at 0.2%. A closer look at the data shows that females aged 35-39 had a higher prevalence rate of 3.3%. while male prevalence was highest among those aged 50 – 54 at 2.3%. The HIV prevalence gender disparity between females and males was greatest among younger adults, with females aged 20-24 having four times the prevalence of males in the same age group[5].

In Nigeria, Key populations (FSW, MSM, and PWID) make up only 3.4% of the population, yet account for 11% of new HIV infection[6]. They continue to face discrimination, limited access to healthcare, information and prevention services which further exacerbate their vulnerability to acquiring and transmitting HIV. HIV transmission and acquisition risk factors (drivers of the epidemic) include; personal behaviour, and lifestyles, environmental exposures and innate characteristics (high-risk sexual practices, high-risk groups, prevalence of other sexually transmitted infections (STIs), low use of condoms, poverty and poor health status, low status of women, stigma and denial, high-risk drug use) which are so widespread and account for the increase of HIV epidemic at the population level in Nigeria, The National Strategic Plan 2023-2027 in alignment with the Global AIDS Strategy 2022, recommends equitable and equal access to HIV services, breakdown of barriers and fully funded HIV response to all including KPs. This specifically, underscores the need to expand and promote equitable, affordable access to high-quality medicines, health commodities, science, technology, innovations, and solutions for PLHIV, KPs, and other priority populations[7]. Implementation of comprehensive prevention programmes, promotion of condom use, expansion of HIV testing, counselling

[4] National Population Commission (NPC), 2021.
[5] Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS), 2018
[6] UNAIDS & NACA, (2020). Modes of HIV Transmission in Nigeria (MOT): Application of the Incidence Patterns Model.
[7] UNAIDS & NACA, (2023). National HIV and AIDS Strategic Plan (NSP) 2023-2027

services, and provision of antiretroviral therapy are among the strategies employed to combat the epidemic.

HIV Prevalence Among Key Population

HIV prevalence and incidence rates among key populations in Nigeria are higher than the general population. In 2020, the national HIV prevalence among adults aged 15-49 years was 1.3%[8]. However, within the same year, the prevalence among key populations such as FSW was 15.5%, among MSM was 25%, and among PWID was 10.9%[9].

The trends in HIV prevalence and incidence among key populations over time show that there has been a fluctuation in HIV prevalence among some key populations in Nigeria. For example, the HIV prevalence among FSWs decreased from 24.5% in 2007 to 19.4% in 2014 and decreased to 15.5% in 2020 amongst brothel-based FSWs. The HIV prevalence among MSM increased from 13.5% in 2007 to 22.9% in 2014 and increased further to 25% in 2020[10, 11]. Among people who Inject drugs, the HIV prevalence increased from 3.4% in 2014[12] to 10.9% in 2020[13].

Critical to ensuring that the HIV programme response is appropriate for the local context and that resources are allocated to interventions that will have the greatest efficiency and impact at the population level, NACA put out a Request for Proposals to review the key population programme implemented over the last 3 to 5 five years (January 2016 to December 2021) through support from GF, PEPFAR, GoN and other partners.

Key Population Size: Several empirical methods are used globally for estimating the size of key populations. These include; Census and Enumeration methods, Population Survey, Multiplier Methods, Capture-Recapture Methods, Nomination Methods, Respondent Driven Sampling and Programmatic Mapping Methods. In Nigeria, the following methods have been applied in estimating the size and characterization of the Key Population:

- Programmatic Mapping and Size Estimation in 2012 (8 States), 2018 (10 States) and 2022 (20 States).

[8] Statista, 2021
[9] HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS), 2020
[10] Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS), 2018
[11] HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS), 2020
[12] HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS), 2014
[13] HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS), 2020

- Multiple Source Capture-Recapture Method in 2018 (6+1 States).
- Network Scale-up Method 2018 (36+1 States).

The findings from the size estimation have given a better insight into the population size and characteristics of KP in Nigeria. The table below shows the population size estimation by KP subpopulations.

Table 1: KP Estimates by States and KP Typology

Type of Estimate (year)	State	FSW	MSM	PWID	TG
Programmatic Mapping (2023)[14]	Adamawa	9,747	3,050	6,794	1,821
	Bauchi	9,778	7,274	20,143	2,290
	Bayelsa	6,284	3,924	2,483	2,906
	Borno	23,282	5,149	19,351	5,929
	Delta	33,995	7,674	9,446	2,212
	Ebonyi	4,896	4,848	5,825	2,440
	Ekiti	4,633	3,586	9,703	2,492
	Jigawa	6,808	5,697	4,364	3,895
	Katsina	22,518	14,023	15,243	11,604
	Kebbi	12,381	2,130	11,776	1,794
	Kogi	10,366	3,482	8,804	1,947
	Kwara	5,342	3,922	4,249	1,129
	Niger	13,022	7,619	7,661	3,682
	Ogun	19,229	4,028	9,611	2,653
	Ondo	18,109	10,031	12,418	1,894
	Osun	7,336	2,721	7,160	1,746
	Plateau	14,571	3,243	3,461	1,493

[14] Key Population Programmatic Mapping and Size Estimation Study in 20 States (KPSE), 2023

Type of Estimate (year)	State	FSW	MSM	PWID	TG
	Sokoto	17,373	8,533	9,860	6,297
	Yobe	5,984	939	12,810	1,343
	Zamfara	8,958	7,114	20,798	4,588
Programmatic Mapping (2018)[15]	Abia	8,869	2,282	4,398	N/A
	Anambra	40,894	4,333	4,012	N/A
	Edo	10,592	1,377	727	N/A
	Enugu	5,089	2,032	1,395	N/A
	Gombe	5,657	2,200	8,268	N/A
	Imo	5,690	963	3,409	N/A
	Kaduna	27,770	10,117	11,343	N/A
	Kano	14,372	24,119	8,880	N/A
	Oyo	12,929	4,889	17,882	N/A
	Taraba	5,069	849	1,342	N/A
Capture-recapture (2018)[16]	Akwa-Ibom	84,900	72,400	31,300	N/A
	Benue	113,900	13,100	82,800	N/A
	Cross River	20,000	3,600	24,400	N/A
	FCT	56,700	10,700	3,200	N/A
	Lagos	76,100	127,400	51,600	N/A
	Nasarawa	73,700	6,400	7,600	N/A
	Rivers	15,200	61,800	43,100	N/A

N/A=Not available

[15] Key Population Geographic Mapping and Size Estimation-Nigeria, 2018
[16] Mapping and Size Estimation of Key Populations in Nigeria: Six States and the Federal Capital Territory, 2018

Response to HIV among Key Population in Nigeria

Nigeria faces significant challenges in addressing the HIV epidemic, particularly among key populations who are disproportionately affected by HIV due to a confluence of social, economic, and legal factors. Effective response to HIV among these populations is critical for the country's overall public health strategy, as these groups often exhibit higher prevalence rates and face substantial barriers to accessing healthcare services.

The Nigerian government's response to HIV has evolved over the years, incorporating a mix of prevention, treatment, and care strategies tailored to the needs of key populations. Initiatives such as the National HIV/AIDS Strategic Framework and the implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) have been pivotal in mobilizing resources and shaping policies aimed at curbing the epidemic. These efforts have included targeted interventions like harm reduction programmes for PWID, condom distribution, safer sex education for sex workers and MSM, and advocacy for the rights and health needs of transgender individuals. However, significant challenges remain. Stigma, discrimination, and criminalization of certain behaviours continue to hinder the effectiveness of HIV responses among key populations. . Moreover, there is a persistent gap in data and research specific to these groups, which hampers the development of fully informed and effective health policies.

Addressing HIV among key populations in Nigeria requires a multifaceted approach that includes legal reform, community engagement, and the provision of culturally competent healthcare services. It also demands the active involvement of key populations in designing and implementing interventions, ensuring that their voices and experiences shape the response. By focusing on these areas, Nigeria can make significant strides in reducing HIV transmission, improving health outcomes for key populations, and advancing towards its goal of ending the HIV epidemic.

Programme Coverage of Key Populations

Effective public health interventions rely heavily on the comprehensive coverage of key population groups disproportionately affected by issues due to a combination of behavioural, structural, and social factors. These key populations often face unique challenges and barriers to accessing healthcare. Ensuring that health programmes effectively reach these groups is essential for controlling and mitigating the spread of diseases like HIV/AIDS, hepatitis, and other infectious diseases, as well as addressing broader health disparities.

Programme coverage refers to the extent to which health services are available, accessible, and utilised by the target populations. High coverage ensures that a significant portion of the key population receives the necessary preventive, diagnostic, and treatment services. This is critical not only for the health of individuals within the key populations but also for the health of the broader community, as these groups often play a pivotal role in the epidemiology of infectious diseases. Examining the strategies and outcomes of programme coverage for key popuis imperative. It offers insights into successful interventions, identifies gaps in service delivery, and underscores the importance of inclusive and equitable health policies. This exploration is essential for informing future public health strategies and ensuring that no one is left behind in the pursuit of global health equity.

1.3 STUDY JUSTIFICATION

Notably, while important investments and progress have been made to provide Key Populations with services, the IBBSS 2020 results highlighted the need for Key Populations programme review.

Findings from the IBBSS 2020 show:

- Increasing HIV prevalence among MSM, FSW and PWID.
- Low consistent condom use among all KP groups - FSWs, MSM, PWIDs and TGs.
- Inconsistent knowledge among KPs about places to receive key prevention and treatment services.
- Low contact with peer educators among key populations in several locations.
- High experience of violence against key populations.
- Low achievement of the 95-95-95 cascade spectrum.

Hence, it became imperative to review the key population programme implemented in Nigeria over the last 3 to 5 five years (January 2016 to December 2021) through support from GF, PEPFAR, GoN and other partners to understand the issues and set out a practical plan of action as the country work towards comprehensive epidemic control by 2030.

1.4 STUDY OBJECTIVES

Developing appropriate HIV prevention strategies and policies at a national or sub-national level is critical to ensure that the prevention response is appropriate for the local context and that resources are allocated to interventions that will have the greatest efficiency and impact at the population level. A review of the key population programme seeks to determine the gaps

in effective coverage of the programme and if, and by how much, programme activities are achieving their intended effects in the target population.

The key objectives of conducting this review include:

1. Examine the progress of KP programmes and its contribution to HIV epidemic control.
2. Identify replicable good practices to accelerate the progress, including opportunities for GF grant reprogramming, and the use of data for reprogramming within PEPFAR's Country Operational Plan (COP).
3. Identify challenges and bottlenecks that hamper the implementation of KP programmes.
4. Review how the results of the IBBSS 2020 have been incorporated into the current design of the KP programmes in Nigeria.
5. Provide recommendations from the review that will foster improvement and learnings for KP Programmes.
6. Make recommendations for KP programme priorities for the next two (2) years.

1.5 RESEARCH QUESTIONS

The following research questions were addressed in the course of the study:

- What is the design, strategy and implementation arrangements of the key population programme in Nigeria?
- How were the KP typologies as well as target areas prioritized? Are the design and services packages aligned to international guidelines and do they address the gaps stated in IBBSS 2020?
- What is the level of HIV prevention and treatment programme availability, accessibility and utilisation coverage as well as strengths and gaps among key populations (by typology)?
- What are the factors that have facilitated these strengths and gaps at the end-user and programme level?
- How can these gaps be addressed to ensure effective coverage is achieved?
- What are the monitoring systems that measure coverage of KP programmes? Were data generated regularly used for decision-making?
- How can the strength and good practices of the current programme be replicated and scaled up?

1.6 CONCEPTUAL FRAMEWORK

The effective programme coverage framework is a programme measurement cascade that considers health service at the population-level by measuring contact coverage, quality-adjusted coverage, user-adjusted coverage, and outcome-adjusted coverage. The KPPR adopted the effective coverage framework to measure coverage within the different priority intervention areas of HIV programmes. This is in addition to the available crude coverage measured by programme interventions on the availability and accessibility of services for key populations during the review period. Effective coverage assessed both the quality of services provided and the levels of community or user behaviours. The cascade identified coverage gaps, quantified coverage at the different intervention areas, determined gaps within the cascade and identified actions required for future implementation. The schematic is as represented underneath:

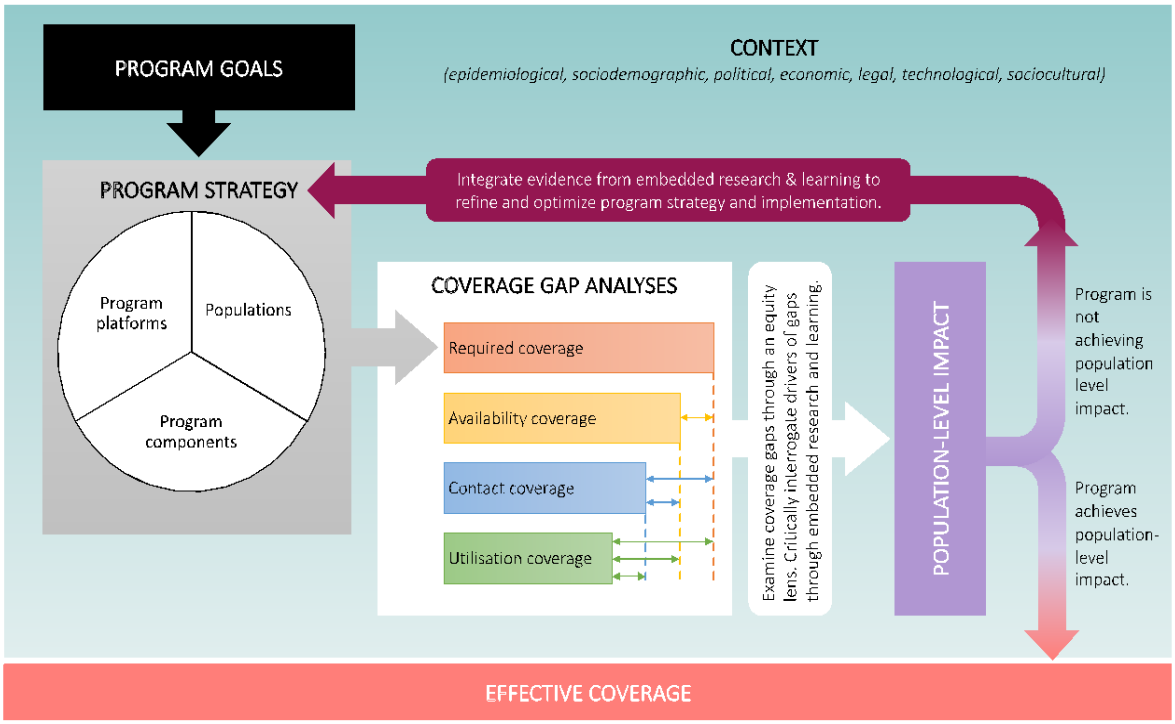

Figure 1: Effective Coverage Framework

The framework explores gaps in 'contact coverage' among the Key population who do not access HIV testing or treatment services, because of sub-optimal distribution in the availability or access to services or the lack of community awareness as to what exists, where and at what cost,

Quality-adjusted coverage is the proportion of individuals who receive HIV services as per standards.

User-adjusted coverage represents how and what specific drivers of community behaviours related to health-seeking or treatment adherence impact overall coverage.

For the OSS assessment, coverage for each of the programme's component interventions was reviewed using a cascade model that measures indicators for four dimensions of coverage: Required, Availability, Contact, and Utilisation.

Coverage gap analyses were simultaneously performed with the programme team, end users, programme implementers and policymakers through embedded research processes to identify, quantify, and understand the gaps in the coverage cascade.

Achieving effective coverage is essential for combating the HIV/AIDS epidemic. Effective coverage ascertains the extent to which the programme successfully reaches and benefits its target population (FSW, TG MSM and PWID) within the review period. It provides insight into the outcomes related to HIV prevention, treatment, care, and support. Here are some key components and strategies for achieving effective coverage that were reviewed across the HIV programme implementation: Service Access, Prevention and Education, HIV Testing and Counselling, Antiretroviral Therapy (ART), Retention in Care, Pre-Exposure Prophylaxis (PrEP), Engaging Key Populations, Integration of Services, Data and Monitoring, Community Involvement, Resource Allocation, Policy and Legal Frameworks, and Health Worker Training.

The following indicators guided the review of effective coverage across the various levels of programme implementation within the states.

Table 2: Indicators for KP Programme Review

	Indicator	Relevance	Rationale	Disaggregation	Data Source /Mode of Verification
1	The percentage reporting condom use with a most recent client	Reflects prevention Interventions in key population groups	Condom use with non-regular client (key interventions that can be consistently measured)	key population group	Survey data

	Indicator	Relevance	Rationale	Disaggregation	Data Source /Mode of Verification
2	Percentage reporting condom use at last anal sex with a non-regular partner		High-risk sexual Partners (key interventions that can be consistently measured)	key population group	Survey data
3	Percentage of PWID who used new (unused) needles and syringes the last time they injected		Use of new (unused) needles and syringes among PWID	PWID	Programme data
4	Percentage of Key population living with HIV who have been diagnosed	Diagnosis and awareness of HIV-positive status is a precursor to care and treatment.	HIV testing is key to effective responses to HIV.	Sex, age, key Population group	Programme data and survey data
5	Percentage of Key population living with HIV who are receiving ART	Measures the extent to which needs for ART are	Tracks trends in ART coverage nationally and globally.	Sex, age, key population, regimen (if available).	ART Monthly Summary Form (MSF),

	Indicator	Relevance	Rationale	Disaggregation	Data Source /Mode of Verification
		met.			Programme data
6	Percentage of Key population living with HIV and on ART who are retained on ART 12 months after initiation	Once on ART, Treatment is lifelong. Retention on ART is important to achieve the desired outcomes of the HIV care cascade.	Indicates quality of services and continuing engagement of people living with HIV on ART.	Sex, age, key population group.	ART Monthly Summary Form (MSF)
7	Percentage of Key population on ART who have suppressed viral load	Gauges the proportion of people on ART who have suppressed viral load. Viral load suppression among a cohort 12 months after ART initiation should also	Viral suppression is an indicator of treatment success and reduced potential for transmission	Sex, age, key population group	ART Monthly Summary Form (MSF)

	Indicator	Relevance	Rationale	Disaggregation	Data Source /Mode of Verification
		be monitored			
8	Number of individuals who received PrEP	Reflects the effect of PrEP among key populations	Monitors the use of PrEP as a prevention approach	Sex, Age, Key population typologies	Programme data

CHAPTER 2

METHODOLOGY

A retrospective review of the programme was carried out from 2016 to 2021 using a mix of quantitative and qualitative research approaches. The quantitative methods were; a) HIV Prevention Self-Assessment Tool Lite (PSAT Lite), b) Polling Booth Survey, and c) One-Stop Shop (OSS). While qualitative methods were; a) Focus Group Discussions (FGD), b) In-depth interviews (IDI), and c) Desk review.

2.1 QUANTITATIVE METHODS

a) Prevention Self-Assessment Tool-Lite (PSAT Lite) was used to assess the context of the programme, understand strengths and gaps, and identify best practices. This helped to understand the different areas of programme interventions and their current status.
b) Polling Booth Survey (PBS) was used to collect quantitative data on programme outcomes from the service users. This data helped in understanding the programme coverage cascades from the users' perspective.
c) One Stop Shop(OSS) assessment was done in designated Health Facilities.

2.2 QUALITATIVE METHODS

a) In-depth interview (IDI): This was conducted among stakeholders at the national and state levels to understand the programme strategy adopted at the national and state levels and assess how effective those strategies have been.
b) Focus Group Discussion (FGD): This was carried out among service users to understand their perception of barriers to accessing and utilisating services.
c) Desk review was conducted for the period between 2016 and 2021. The documents reviewed included the National Strategic Plan, the National Prevention Plan, survey reports like IBBSS, and Routine Programme Monitoring Reports etc.

2.3 STUDY AREA

The Review covered 18 states implementing the KP programme in the country which are as follows:

a) North Central: Niger; Kogi
b) North East: Adamawa; Taraba; Gombe
c) North West: Kaduna; Kano
d) South East: Abia; Anambra; Enugu; Imo
e) South West: Lagos; Oyo
f) South South: Akwa-Ibom; Bayelsa; Delta; Edo; Rivers

2.4 STUDY POPULATION

The study population include:

1. Intervention beneficiaries (End users) of the key population programme
    a. **Female Sex Workers (FSW)**: Any female, acknowledging having received money or gifts in exchange for sexual intercourse with an assigned male at birth at least once.
    b. **Men who have Sex with Men (MSM)**: Assigned male at birth, reporting at least one anal sex act (insertive or receptive) with another assigned male at birth.
    c. **People Who Inject Drugs (PWID)**: Any person, who injects drugs (illicit, non-prescribed or illegal) recreationally irrespective of the type of drug injected.
    d. **Transgender People (TG)**: Any person who has a gender identity or gender expression that differs from the sex they had at birth. Both trans women and trans men were included in this exercise.
2. Programme implementers: implementing programmes for key populations during the period under review. Implementers include staff of organisations implementing the KP programme in the 18 states.
3. Policymakers: Who were developing policies for key population programming during the period under review. These include officials from MoH, NACA, National Council for Health, UNAIDS and other UN organisations.

4. Funders and Donor Agencies: Who were funding of key population programmes during the period under review. These include officials from GFATM, PEPFAR, USAID, The World Bank, BMGF, CHAI and other donors.

***For ethical considerations, only persons 18 years and above in these groups were included as study participants during the KP programme review.**

2.5 DATA COLLECTION METHODS

The KPPR was implemented using a mixed study approach involving quantitative and qualitative methods. The study utilised the following methods:

Desk Review

The desk review process of the key population programme entailed the collection of documents, selection of relevant data and information resources, review of data collected, data analysis and results. The review of the key population programmes sought to determine the gaps in effective coverage of the programmes and if, and by how much, programme activities are achieving their intended effects in the target population. The activities included a review of the following data sets and reports; a) national routine KP monitoring data for the review year (2016-2021); b) IBBSS 2020 c) Key Population Size estimation, and d) KP facility registers in OSS only In addition, the study also reviewed existing key population guidelines such as; a) National HIV policy 2020, b) National strategic framework 2017-2021, c) KP programme implementation guideline 2021, and d) 2021 consolidated service delivery guideline for HIV and STI for key population in Nigeria. annual key population reports, the global fund G7 application/ proposal and PEPFAR COP. Checklists were developed for the measurement of behavioural, structural and biomedical indicators from these documents. This exercise was conducted to:

- Review existing data and studies on HIV prevalence and risk factors among key populations in Nigeria.
- Identify the specific challenges faced by each key population group, including legal, social, and healthcare barriers.
- Understand the existing interventions and services available for key populations using the effective programme coverage framework.

Prevention Self-Assessment Tool Lite (PSAT Lite)

The HIV Prevention Self-Assessment Tool (PSAT) Lite developed by the Global Prevention Coalition (GPC) is an easy-to-use tool for country-led review of national HIV programmes against a global standardized set of programmatic components. The PSAT Lite was designed to enable rapid self-assessment within each HIV prevention pillar. The tool was used to review the programmes for Female Sex workers, Men who have Sex with Men, People Who Inject Drugs and Transgender People.

A 2-day stakeholder workshop was conducted in each of the 18 states under review where the PSAT-Lite was used to assess KP programmes using a 5-point scoring scale and explored the reasons for strengths and gaps.

Polling Booth Survey:

Polling Booth Survey (PBS), a group interview method, assessed individuals by KP typology who provide responses through a ballot box. The individual responses were anonymous and unlinked. The anonymity of the respondents has been shown to increase the sense of confidentiality among respondents hence their accurate reporting on sensitive and personal information, thereby increasing objectivity in assessment. During the study, potential respondents were selected using a probability sampling procedure and organised into small homogenous groups of 12 people per group. Being a group interview, questions were brief, short, simple and dichotomized for ease of response. The review was conducted by PBS at the sub-national level to generate measurable outcome indicators. Given the scope of this review and considering that the PBS method has been tested and implemented in multiple contexts and countries with the assurance of replicability, it was used quantitatively for FSW, MSM, PWID and TG individuals.

PBS Sample Size

The overall sample size calculated at the national level was **936** for FSW, MSM and PWID and **780** for TG (including 10% non-response) which has to account for an indicator value of 50% (maximum sample size), desired precision level of ±5%, and a design effect of 2 at 95% confidence. Further, the design equally allocated the sample into the six geopolitical zones to represent each typology. It had 12 participants per PBS session: a total of **78** PBS sessions for FSW, MSM, PWID and **65** sessions for TG. The sample size was calculated using the formulae below:

$$n = \frac{Z\alpha^2 * p * (1 - \mathrm{p})}{d^2} * D$$

Where n= sample size;

p= (50%) is the value of the prevalence indicator;

d = the precision,

D = design effect and

$Z\alpha$=1.96.

The sample size was further adjusted with the finite population correction factor taken into account estimate of KP.

Therefore, the adjusted sample size with the estimated population using a finite population correction factor as $\boldsymbol{n_f}$ **= n*fpc**

i.e., $n_f = n * (n*N)/(n+(N-1)$,

where n_f = the adjusted sample size,

n = the unadjusted sample size for fpc,

N = the estimated KP.

A total number of 299 PBS was conducted during this review spread across all the KP typologies of FSW, MSM, PWID and TG: 78 PBS sessions with 936 FSW, 78 PBS sessions with 936 MSM, 78 PBS sessions with 936 PWID and 65 PBS sessions with 780 TG.

FSW, MSM and PWID PBS sessions were conducted in 6 states each and TG PBS was conducted in 5 states. 13 PBS sessions were conducted for each population in each selected state. Within each region, the state with the highest number of KP of the respective typology (highlighted states) was selected for the conduct of PBS to enable national-level representativeness and inferences.

Table 3: States/Sessions highlighted in Yellow

State	FSW	FSW PBS	MSM	MSM-PBS	PWID	PWID PBS	TG	TG PBS
Kogi	10,366		3,482		8,804	13	1,947	13
Niger	13,022	13	7,619	13	7,661		3,682	13
Adamawa	9,747	13	3,050	13	6,794		1,821	13
Gombe	5,657		2,200		8,268	13		
Taraba	5,069		849		1,342			
Kaduna	27,770	13	10,117		11,343	13		

State	FSW	FSW PBS	MSM	MSM-PBS	PWID	PWID PBS	TG	TG PBS
Kano	14,372		24,119	13	8,880			
Abia	8,869		2,282		4,398	13		
Anambra	40,894	13	4,333	13	4,012			
Enugu	5,089		2,032		1,395			
Imo	5,690		963		3,409			
Akwa-Ibom	84,900	13	72,400	13	31,300			
Bayelsa	6,284		3,924		2,483		2,906	13
Delta	33,995		7,674		9,446		2,212	13
Edo	10,592		1,377		727			
Rivers	15,200		61,800		43,100	13		
Lagos	76,100	13	127,400	13	51,600	13		
Oyo	12,929		4,889		17,882			
Total		**78**		**78**		**78**		**65**

Focus Group Discussion

The FGD sessions sought to understand the challenges experienced by key populations in accessing and using HIV/STI prevention and treatment services, as well as other covert and overt factors influencing HIV response amongst Key Populations in Nigeria.

- Small groups of key population members were mobilized to discuss specific topics related to the KP Programme Review.
- Focus groups allowed participants to share experiences, interact, and generate insights collectively.

A FGD tool was developed to guide discussion with the participants and provide direction for FGD facilitators. Each FGD had approximately 10 respondents (range 8-12 participants) and was facilitated by a trained qualitative researcher (moderator) and a research assistant (note taker). Each FGD was recorded; informed consent was sought for participation and recording.

Eight sessions of Focus Group Discussions (FGD) were held per state, two each with FSW, MSM, PWID and Transgender people. A total of 36 FGD per typology and an aggregated total of 144 FGD was conducted across the 18 states.

In-depth Interviews

An in-depth interview (IDI) was conducted with stakeholders using a structured interview guide. Key informants were identified and interviewed at the state level (SASCP, SACA: Lead, CMO and M&E, KP secretariat Lead/KP CBO, State implementing partners), and at the national level (Government agencies, Donor agencies, NGO). The purpose of the IDI was to understand the key population programme context and strategy adopted by the country and the states. IDI provided rich information in other areas of the response including advocacy and resource mobilization. Furthermore, IDI identified best practices that can be replicated. 158 interviews were conducted at the state level and 8 interviews were conducted at the national level. The IDI involved engagements with:

- Community leaders, healthcare providers, or experts who have insights into the specific challenges and needs of key populations.
- One-on-one interviews to explore individual experiences, perspectives, and narratives related to the KP Programme prevention and care. This method provides rich qualitative data.

One Stop Shop Assessment:

One Stop Shop (OSS) assessment utilised a mixed method, including the effective coverage approach, in accessing 41 out of 44 One-Stop-Shops (OSS) facilities for HIV Prevention and Treatment across the 18 selected KPPR states and the FCT. OSS represents an innovative and integrated approach to delivering HIV services to Key Populations, offering a wide range of services including HIV testing, prevention, treatment, and support in a non-discriminatory and community-friendly environment. This model aims to address the unique challenges faced by KPs, ensuring equitable access to quality HIV services. The assessment informs evidence-based, decision-making and programmatic interventions by identifying gaps, strengths, and areas for improvement.

A comprehensive One Stop Shop (OSS) KP HIV Programme Coverage Gap Assessment Tool was developed. This tool incorporated structured approaches for identifying gaps, making recommendations for improvement, assigning responsibilities, and emphasizing monitoring and evaluation. An explanatory guide manual was also developed along with the tool for enumerators to understand and administer the tool smoothly. Data collection was carried out using the developed assessment tool which contained a mix of quantitative and qualitative questions. The assessment tool was administered to OSS facility managers and key staff.

Table 4: Summary of Methods

Effective Coverage Framework	Data Collection Method					
	Desk Review	**PBS**	**PSAT**	**FGD**	**IDI**	**OSS**
To understand the key population programme strategy (population, programme platform and programme components) adopted and implemented by Nigeria	Yes		Yes (Every State)	Yes	Yes (Every state)	
To assess the implementation of the KP programme strategy to achieve effective programme coverage of the key population and population-level impact	Yes	Yes (Selected States where there are programmes running consistently for the last 5 years – review period)		Yes (Selected States where there are programmes running consistently for the last 5 years – review period)		Yes
To understand the barriers contributing to gaps in availability,				Yes Yes	Yes (state) Govt	Yes

Effective Coverage Framework	Data Collection Method					
	Desk Review	**PBS**	**PSAT**	**FGD**	**IDI**	**OSS**
contact and utilisation of services among key populations at end-user and programme level				(Selected States where there are programmes running consistently for the last 5 years – review period)	IP KP networks	
To identify good practices that can be scaled up to address coverage gaps	Yes		Yes		Yes	
To provide recommendations that will ensure effective coverage of key populations for population level impact		Yes	Yes	Yes	Yes	Yes

Table 5: Methods and Research Questions

Data Collection Method	Research Questions
Desk Review	● What is the programme strategy (population, programme components or service package and programme delivery platforms) adopted by the Nigeria KP programme? ● What is the programme context within which the Nigeria KP programme is being implemented? ● What has been the progress of the key population programme in Nigeria? What are the strengths and weaknesses of the programme? ● What are the good practices related to key population programmes in Nigeria that can be replicated
PBS	● What are the coverage gaps experienced by the end users and what are the reasons for those gaps?
PSAT	● What has been the progress of the key population programme in Nigeria in the last 5 years? What are the strengths and weaknesses of the programme? ● What are the good practices related to key population programmes in Nigeria that can be replicated?
Focus Group Discussions	● What are the coverage gaps experienced by the end users and what are the reasons for those gaps? ● What are the recommendations for programme improvement?
In-Depth Interviews	● What is the programme strategy (population, programme components or service package and programme delivery platforms) adopted by the Nigeria KP programme? ● What is the programme context within which the Nigeria KP programme is being implemented? ● What has been the progress of the key population programme in Nigeria? What are the strengths and weaknesses of the programme? ● What are the good practices related to key population programmes in Nigeria that can be replicated? ● What should be the priority for Nigeria to strengthen its KP programme?

Table 6: Qualitative Interview Distribution

KP Review Data Collection/Interview State Distribution Table						
S/N	**Method**	**Level**	**Target Population**	**# Of Sessions/ Interviews**	**Per State**	**Overall Total**
1	FGD	State	All KP Typology (FSW, MSM, TG, PWID)	2	8	**144**
2	**IDI**	State	SACA (Lead, CMO/ M&E)	3	6	**108**
			SASCP Focal Persons	1		
			State KP Secretariat Lead/KP CBO	2		
		State	State KP Lead Partner	1	3	**54**
			KP implementing partners and service providers (Community and facility level)	2		
		National	Donor Agencies (USG: PEPFAR, DOD, CDC), NACA (3), GF	8	13	**13**
		NGO	APIN, FHI360, SFH, ECEWS & HALG	5		
3	**PSAT - lite**	State	PACA/NDLEA	1	1	**18**
			M&E SACA	1		
			CMO	1		
			KP Implementing Partner	1		
			KP Rep	4		
4	**PBS**	State	FSW, MSM, PWID	39	6	234
			TG	13	5	65
						299

KP Review Data Collection/Interview State Distribution Table						
S/N	**Method**	**Level**	**Target Population**	**# Of Sessions/ Interviews**	**Per State**	**Overall Total**
5	**Desk Reviews**		FSW, MSM, PWID & TG	National Level		

All the methods were used synergistically to respond to the programme objectives, identify good practices, define priorities as well as generate national recommendations.

2.6 SAMPLING PROCEDURE

Sampling

A simple random probability sampling approach was used to select KP participants for the FGDs. This was done at the state level across the respective KP typology, working together with the KP community.

For the PBS sampling, a multi-stage sampling approach was adopted. Firstly, LGAs with the highest number of key populations (KP) estimates were identified in the selected states for PBS. The hotspots were categorized by typology, and the selection of respondents to participate in PBS was based on the proportionate population allotment to each hotspot typology.

2.7 FIELD PREPARATION

Prior to field implementation, the National Technical Team, comprising representative stakeholders from NACA, NASCP, GF, PEPFAR, KP Community, and WACPHD, participated in two meetings to finalize the scopes, agree on the field plan, and define the specific roles of each stakeholder during the implementation.

Recruitment

Implementing a successful KP programme review required the recruitment of competent, skilled, and adequate mix of human resources necessary to execute a study of this scale. Officers were recruited at the national level to support implementation at the field office. At the states, WACPHD utilised a team of field data collectors/supervisors as well as qualitative transcribers who have had extensive experience in the conduct of similar surveys. Recruited

field team members were individuals who are well-versed in various research methodologies and are comfortable working with key population communities.

The selection process for field workers was based on the following criteria:

- Possession of relevant skill set (core and technical).
- Prior experience working with WACPHD/UOM was taken into consideration.
- Willingness and availability to participate within the designated timeframe for the KP Review activity.
- Proven experience and familiarity with the target population.

Recruited field workers were trained on the data collection methods and tools for 3 days before the commencement of field data collection (see training section below). The field workers were compensated for their time according to the contract terms established on engagement.

Training

At the national level, a 4-day training session was held between 27th - 30th November 2023 for Master trainers for NACA and the TSO. The master trainers cascaded the training down across the 18 states, the training was tailored in content to build the capacity of field officers at the sub-national level to be able to carry out a successful field operation. At the state level, training was held for 5 days; Three (3) days for the technical training of recruited state officers and 2 days for the filling of the PSAT-Lite tool. Trainings were enabled through; technical slide presentations, group works, role Plays, etc. See the Appendix for the list of states with dates and venues of training.

2.8 STAKEHOLDER ENGAGEMENT

WACPHD identified and involved relevant stakeholders, including government agencies, NGOs, healthcare providers, community-based organisations, and key population representatives both at the National and State level. State entry meetings established partnerships and collaborations which ensured a comprehensive and coordinated response within the 18 project states, as the success of the KP review depended on strong commitment, collaboration, and sustained involvement of all stakeholders in the HIV response for Key Population. Post-field implementation, exit meetings were also held to debrief relevant stakeholders on the outcome of the exercise in their respective domains. See the appendix for the dates of the state entry and exit meetings across the 18 states.

2.9 STUDY INSTRUMENTS

Study instruments refer to the tools or materials used to collect data in research studies. Quantitative and qualitative instruments were used to gather relevant information. The following tools were used:

Quantitative Tool

- Structured questionnaires with closed-ended responses were used for the PBS method, (Appendix 2). Analysed PBS responses guided the development of recommendations for KP programmes in the country.
- PSAT lite tool was used to solicit stakeholder responses.

The OSS assessment tool was used to collect data at the OSS facilities (Appendix 3) to assess the quality of services received by the Key population.

Qualitative Tool

- In-depth interview guides with open-ended responses, were used to explore experiences, perceptions, and challenges related to KP Programmes for the period under review.
- FGD guides (Appendix 4) were also used to gather information from KP.

2.10 FIELD STUDY TEAMS/ DATA COLLECTION TEAMS

The state field team was responsible for collecting data. The field team comprised of supervisors, qualitative interviewers, quantitative interviewers, transcribers, coders, and social mobilizers. Each state had a team of 4-13 individuals depending on the volume of work to be done in the state, with each member being assigned to either the qualitative or quantitative component of the study, team supervisors provided oversight of daily operations. Moderators and note-takers for the qualitative focus group discussion sessions were selected from within the team based on their skills and competencies. Checklists, recorders, FGD guides, and semi-structured questionnaires were developed and utilised during field implementation for data collection.

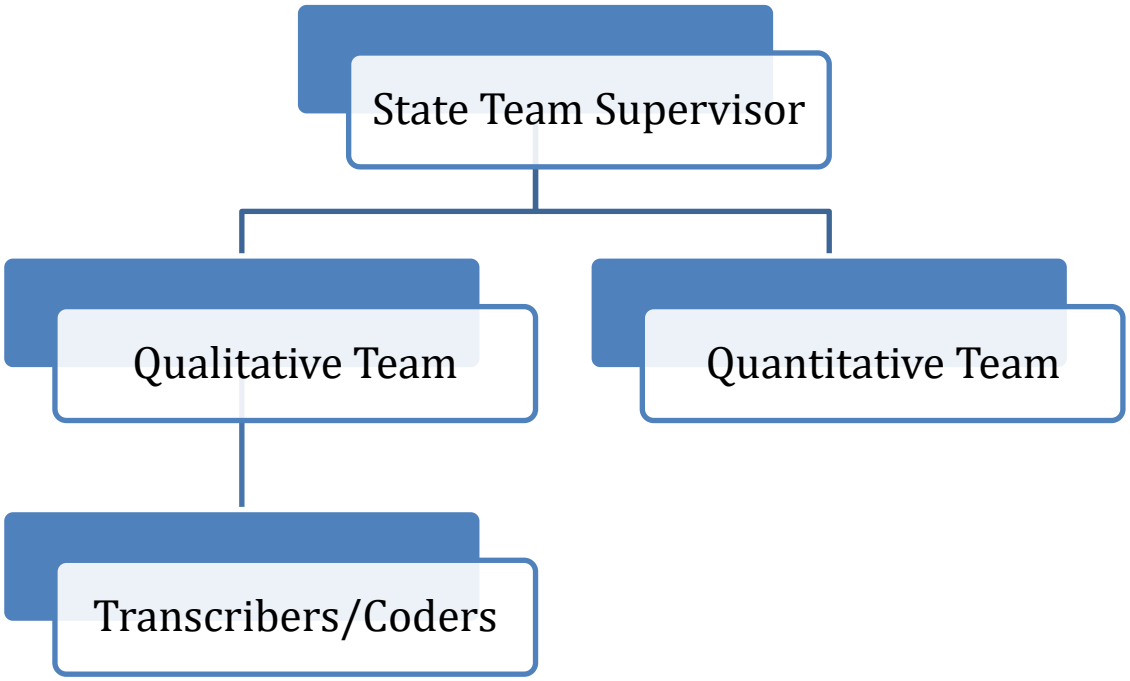

Figure 2: State Field Team Organogram

Field Team Training

Before the commencement of fieldwork, data collectors were trained at the respective states for three days on the various components of the study. For ease and efficiency in the management of training, and to engender learning and understanding of modules, a minimum of 36 master trainers (2 NACA officers, 1 KP representative, 1 WACPHD staff per state) were trained at the central level and deployed for step-down training to the different study state within a week.

Trainings were facilitated by competent master trainers using a slide deck that was developed centrally to ensure uniform messaging. Training included theoretical and practical aspects relevant to the conduct of a research review. The theoretical aspect emphasized the objectives of the review, its importance, the definition of key concepts, the role of the team members, the procedure of data collection, conducting FGDs/IDIs, administration of checklist, PBS and the filling of the various tools including PSAT Lite. The practical aspects consisted of simulating interview scenarios with interviewers and interviewees in an imaginary field setting as well as adapting role plays and group work for team-building exercises. Training slides were used for presentations during the training. The number of persons trained varied per state based on workload, however, 2 extra persons were added per state to make allowance for contingency. This allowed for seamless replacement of field officers in instances of human resource attrition.

Supervision

During implementation, team supervisors were in charge of managing daily field operations reviews. They were recruited based on core and technical competencies, including the ability to demonstrate team leadership and problem-solving ability. Team supervisors managed the daily pre-field and post-field debriefing, as well as ensuring that logistics arrangements were foolproof to foreclose unnecessary delays in review activities. Furthermore, for continuous quality assurance purposes and to ensure that every aspect of the review was implemented in line with the protocol specifications, monitoring and supportive supervisory activities were conducted during the review.

External monitory/supervisorys teams at both national and sub-national levels were given orientation on the use of checklists and other monitoring tools, before field supervisory activities. All aspects of the review, including recruitment, training and data collection were supervised/monitored.

There were two rounds of supportive supervisory visits per state by national teams during implementation. The supportive supervisory visits gave field teams the opportunity to be guided by visiting technical personnel in areas of field support, which increased quality assurance and achievement of set targets. Field supportive supervision activities were documented and reports were produced upon completion of the assignment.

2.11 ETHICAL CONSIDERATIONS

Ethical standards were deployed maximally during the implementation of the KP review exercise. Fundamentally, ethical approval was obtained from the National Health and Ethics Review Committee (NHREC) of the Federal Ministry of Health, through the National Agency for the Control of AIDs (NACA).

Study implementation was conducted with high regard to ethical guidelines as provided in the protocol. These included:

- Informed Consent: This was obtained freely and voluntarily from each respondent before the commencement of the interview/data collection. To facilitate comprehension, the consent tool was read audibly to respective respondents in a location that strengthens their individual right to information privacy and confidentiality. During FGD, the consent tool was read out to the group. The consent tool was configured on electronic tablets. Data collectors checked the relevant box upon

receiving oral consent from individual respondents. The principle of informed consent is underpinned by the recognition of every person (i.e., Respondent) as a moral free agent who has the right to determine their own course of action (Autonomy).

- Veracity: Truthfulness in the sharing of information was central in the effort towards obtaining informed consent and every other information on the study tools throughout the review. Interviewers must divulge all relevant information in truth to elicit respondent's understanding of the study's objectives as well as potential harms and benefits.
- Respect: Especially for vulnerable persons/groups, including members of the Key Population, was ensured during the study on the grounds of human dignity and the need for special protection from abuse, discrimination and exploitation.
- Privacy and Confidentiality: As enshrined in the Data Protection Act (1998), the privacy and confidentiality of all study respondents, which are critical ethical standards, were maintained throughout the implementation of the 2023 18-state KP programme review.

Potential Harm and Measures to Mitigate Harm

The analysis, balance and distribution of potential study harms and benefits are central to the research. As an important ethical parameter, measures were put in place during the study to minimize harm (non-maleficence) and maximize benefits (Beneficence). The principles of non-maleficence demand that research participants be protected from all harm while the principle of beneficence imposes the duty on researchers to ensure the even/balanced distribution of research gains to participants.

Adverse Incidents

Unanticipated events may occur during fieldwork. Measures were put in place to avert such occurrences. In occasions where they do occur, the field team were trained to respond using appropriate measures. Such measures included the use of an incidence form for proper documentation and proffering of remedial mitigation actions. Also, with regards to security breaches during implementation, the study team liaised routinely with security agencies in the respective states/communities to forestall possible adverse events through the sharing of intelligence.

Data Security, Privacy and Protocol Adherence

While the subject matter of this review is not unduly sensitive, it is crucial, based on ethical standards, that qualitative research methods, e.g., In-Depth interviews, PBS and focus group discussions are conducted in an area that strengthens respondent's privacy so that respondents feel comfortable responding honestly and unreservedly to the questions. Before commencing such interview processes, the review team requested that the responsible persons assign them a private area for these interviews. Under no circumstances was confidential information passed on to third parties.

For the electronic data processes, all collected data and entries were encrypted and password-protected to maintain data/information security. There was no point in the survey, where information freely provided by a designated respondent linked back to him/her in such a manner that a third party would track it. Results were provided in aggregate summaries in line with protocol guidelines.

Data Management and Quality Assurance Measures

The Quality measures in the management of the Key Populations Programme Review, led by the West African Centre for Public Health and Development (WACPHD), were structured to ensure the systematic and ethical collection, analysis, and reporting of highly valid and reliable data. These measures and management protocols are vital to maintain the integrity, security, and ethical handling of the collected data. Below, a detailed explanation of each of these data quality measures and management is provided:

Informed Consent

The primary objective of this measure was to ensure that all participants fully comprehend the study's nature, their roles, and the confidentiality of their responses. This was achieved through the acquisition of signed consent forms from each participant, demonstrating their voluntary participation and their understanding of the study's objectives, thus confirming their fully informed and voluntary participation.

Data Collection

Quality data is the unit for evidence-based programme decision-making, and as such the method of data collection for the KP review is critical. Data was collected quantitatively and qualitatively. Primary data was collected quantitatively using the PBS and the PSAT Lite methods, while qualitative data was collected using FGD and IDI.

This measure encompasses a variety of data sources, including qualitative interviews (IDI) with key stakeholders, Focus Group Discussions (FGDs) with participants, PSAT Lite and PBS, and supplementary data (Reports). PBS collation was done using an electronic data collation form, aggregated data was uploaded to the cloud server. To guarantee high-quality data collection, multiple steps were taken. This includes pilot testing of qualitative instruments to enhance clarity, comprehensibility, and cultural sensitivity, as well as the deployment of well-trained data collectors. Additionally, audio recordings of qualitative interviews (FGDs and IDIs) ensured accurate transcription and analysis.

OSS Data Collection was done using a checklist guide/ questionnaire that elicited responses from stakeholders involved in the management of the OSS facilities across the 18 study states.

The management flowchart gives a sequential account of how the PBS data was collated and analysed to yield timely and reliable information for policy recommendations and future programme decisions.

Figure 3: Data Management Flow Chart

Data Storage and Security

Data has been stored across multiple locations, including local servers, cloud-based storage, and encrypted offline devices to ensure redundancy and security. Original recordings, both audio and written, are securely stored in a central location, and regular backups have been performed to prevent data loss. To safeguard the data, encryption and password protection have been employed, and access is restricted to authorized personnel only. Further, data was de-identified to ensure participant confidentiality.

Data Ownership

Data *will* remain the property of the Federal Government of Nigeria. Co-lead investigators will have access to the study data and will be involved in the analysis process at the National level. State-specific data will be shared with the respective states. Data sharing will be done between NACA (Data Provider) and other institutions including WACPHD (Data Recipient). Data retrieval will be subject to authorization by NACA. Data will also be stored in the cloud server as a backup for a minimum of at least 2 years post-review. Electronic data sets will be transferred to NACA for storage and archiving.

Data Quality Assurance

Data quality was maintained through continuous checks and validation. Trained data officers performed data cleaning to identify and rectify errors, while data validation checks were implemented during data entry to maintain accuracy. Quality control checks were conducted periodically to ensure data collectors followed established guidelines and protocols.

Data Analysis

Qualitative data was systematically analysed through thematic analysis, which identified, coded, and categorized themes within the data. A coding framework based on these themes was developed for consistent and reliable coding. Data saturation was achieved during data collection, ensuring that no new themes or patterns emerged, and that key insights are captured. Data analysis tools, including software such as Excel/Stata for quantitative data and /ATLAS Ti for qualitative data were utilised, and the analysed data was summarised and presented in this report.

Privacy and Confidentiality

To protect participant privacy and confidentiality, respondents' identities were anonymized in this report, a measure which will be maintained in future publications, in line with protocol guidelines. Additionally, any data that could potentially reveal individual participant identities were removed from the dataset to maintain confidentiality. Analysis was done as aggregate summaries.

Data Retention Policy

KPPR electronic data will be retained for a minimum of two years post-review, and original recordings will be securely stored for future reference.

Reporting and Dissemination

KPPR findings have been reported and disseminated through stakeholder meetings, technical working group meetings, and national dissemination events, fostering and strengthening data-use culture, collaboration and peer-learning amongst stakeholders.

WACPHD's rigorous adherence to these quality data measures and comprehensive data management processes for the Key Population Programme Review ensured the ethical collection, secure storage, systematic analysis, and rigorous reporting of data. This robust data management framework upholds the integrity of the data and the confidentiality of participants,

ultimately contributing to enhanced programme planning and design through the inclusion of valid and meaningful qualitative insights.

2.12 PLAN FOR COMMUNICATING FINDINGS OF THE STUDY

This report has been developed alongside stakeholders, including government, partner representatives and the WACPHD technical team in a report writing workshop. The national dissemination activity was done in Abuja in a one-day event that had critical stakeholders in attendance.

Furthermore, results from the exercise will be communicated to a wider audience and expanded members of the Science Community through abstract and manuscript publications in regional and international conferences and reputable peer-reviewed journals. Also, Evidence Briefs, Policy Briefs, Advocacy kits and Factsheets will be developed and used to communicate different aspects of the 2016-2021 KP review results. In quarterly government-hosted TWG meetings and other partner meetings, presentations and excerpts from the review findings will be shared to ensure that stakeholders in the national response are abreast with data and use such for regular programme planning, especially as it regards Key Population response.

2.13 MANAGEMENT AND ORGANISATION OF THE REVIEW

The KP programme review was conducted in close collaboration with the NACA, FMOH (NASCP), SACA, SASCP, and implementing partners including donor organisations and involved four phases:

- Preliminary planning and preparation;
- Fieldwork;
- Data analysis and report production;
- Report Dissemination

WACPHD, working together with NACA and other stakeholders led the review process and was responsible for technical leadership and overall coordination.

NACA set up a core team composed of key partners (including USG, UN, GF, KP groups, and NEPWHAN) who were involved in the design, implementation, analysis, finalization and dissemination of findings and recommendations. The review national team comprised of the National Technical Team (NTT) and was chaired by the Director of NACA's Research, Monitoring and Evaluation Department.

2.14 STUDY LIMITATION

- Some data sources were not readily accessible for desk review or a retrospective review, the potential effect of recall by participants may have limited response coverage
- Limited timeline for the implementation of the review.
- Security challenges limited access in some states especially in the north-east.
- Unanticipated environmental threats, (e.g.Flooding) limited field teams' ability to implement field activities in all places.

CHAPTER 3

RESULTS

This chapter presents the results of various methodologies used for the KPPR survey such as desk reviews, and quantitative and qualitative analysis. Categorical variables were summarised using bar charts and percentages, qualitative data were presented using diagrams and quotations and the mean was used to summarise continuous variables. Variations of self-reported HIV risk among KPs were determined using Analysis of Variance (ANOVA) and Post Hoc tests. All reported P-values < 0.05 were taken as statistically significant.

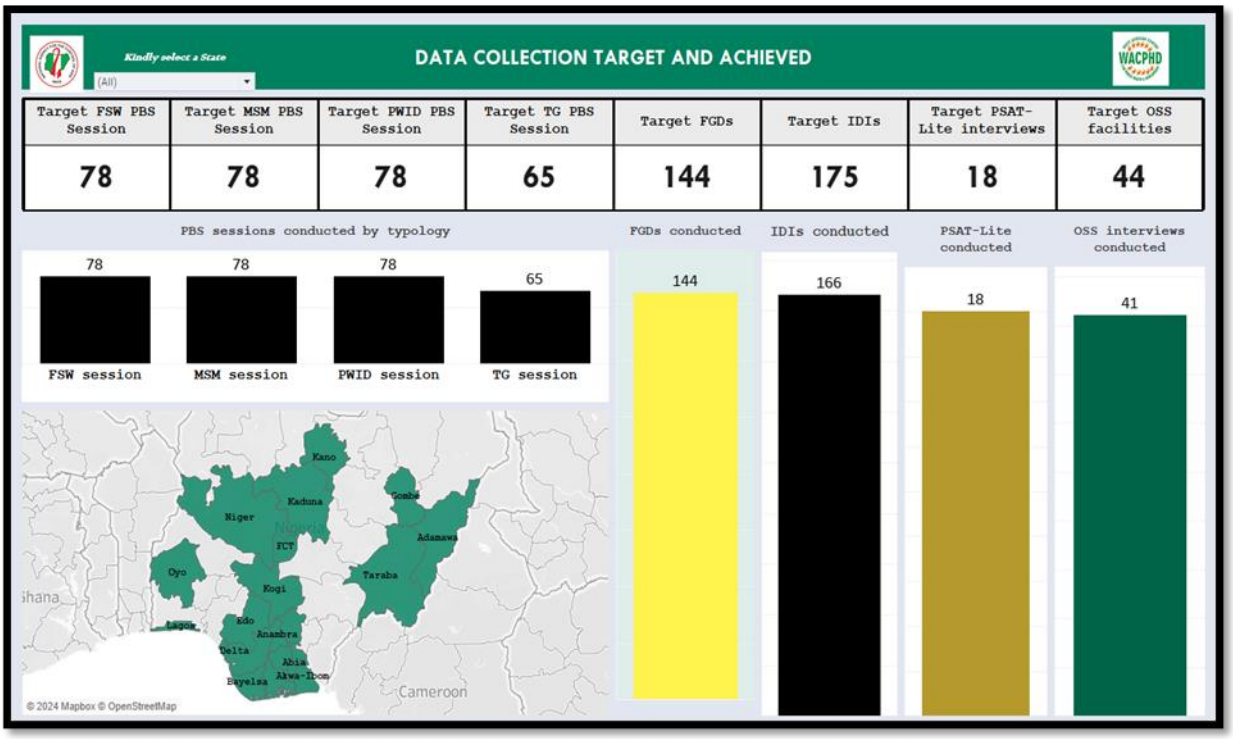

Figure 4: Data Collection Target and Achieved

Figure 4 shows a summary of data collection targets and data collection achieved during the KPPR study. A total of 166 In-depth Interviews were conducted while 144 FGDs, 41 OSS assessments, 18 PSAT-lite and 299 PBS sessions were carried out across the 18 states of the study.

3.1 FINDINGS OF THE DESK REVIEW

HIV & AIDS Policy and Strategic Frameworks

Policy and strategic frameworks provide guidelines for the planning, implementation and evaluation of key population programmes in Nigeria. The Federal Ministry of Health included key populations for the first time in the second IBBSS 2007. In this same year, the **National Action Committee on AIDS** became a full-fledged government agency -the **National Agency for the Control of AIDS (NACA).** In 2008, the NACA Board was constituted and after that, the National Policy on HIV 2009 was formulated and provided the foundation upon which KP programmes were developed[17]. Domestic Resource Mobilization Strategy 2012 was developed to facilitate and enhance greater resource mobilization domestically in the fight against HIV/AIDS.

National HIV Policies

The first national policy for HIV/AIDS 2005-2009 had its guiding principles as follows

- Commitment to scale up prevention among the general population as well as among high-risk and other groups vulnerable to HIV infection.
- Commitment to promote and protect rights and reduce the vulnerability of women, children, young people, and marginalized groups to HIV infection.
- Mainstreaming gender into all policy-related and programming activities and related structures to ensure that all interventions and programmes are gender-sensitive and gender-responsive, appropriately meeting the separate as well as related needs of females and males.

This policy did not provide specific actions for key population groups, it however recognized them as high-risk groups generally.

The National HIV/AIDS Policy 2020 succeeded the 2009 and further built on its framework underscoring national and international conventions for providing HIV services to all persons irrespective of their sexual orientation or gender. The rationale for the 2020 policy was to 'eliminate HIV and AIDS' in Nigeria as a significant public health threat and mitigate its social and economic impact[18].

The 2020 policy thrust had seven strategies and importantly included (1) Elimination of new infections of HIV and it prescribed the implementation of 'Combination prevention'

[17] NACA, (2009). National Policy on HIV/AIDS 2009
[18] NACA, (2020). National Policy on HIV/AIDS 2020

programmes. The combination programmes had strong community empowerment elements with specific efforts to address legal and policy barriers including strengthening of health and social systems while addressing gender inequality, stigma and discrimination[19]. The key objective for the 'elimination of new infections by 2023 was to promote safer behaviours that would eliminate new infections through Behavioural Change Communication (BCC) interventions targeting PLHIV; KPs; vulnerable and marginalized groups as well as the general population in the country. This strategic thrust and its objective became a major impetus for programming and service provision for KPs in the country as it also prescribed that ALL KPs and other vulnerable groups should have access to combination prevention intervention by 2030 and all Adolescents, young persons and KPs, infected and affected populations should have age-appropriate comprehensive knowledge of HIV, Sexual Reproductive Health and Rights and access to services.

Among the seven strategic thrusts of the 2020 policy that impacted KPs was also the Treatment of HIV and AIDS and other related health conditions. The focus of this strategy was to address immediate and comprehensive access challenges to efficacious anti-retroviral drugs, TB/HIV collaborative activities and prevention and management of opportunistic infections for ALL persons diagnosed as HIV positive. This dimension aligned with WHO Guidelines of Test and Treat predicated on the effectiveness of the Treatment as Prevention (TasP) strategy that employs increasing testing and coverage of treatment. TasP strategy was found to be effective as a patient-specific strategy and was adopted as a public health strategy as it reduced new infections and also resulted in the decrease of community viral load (average viral load among certain populations). Key populations and other vulnerable groups had a major challenge with access to TasP due to Human rights issues, stigma and discrimination.

The 'Same Sex Marriage Prohibition Act' was enacted in 2014 and this act posed a severe challenge to the provision of HIV/AIDS services to KPs and resulted in a lull in service delivery and uptake by KPs nationwide although the enactment of the National HIV Anti-discrimination Act in the same year protects HIV-positive people from any form of discrimination[20,21].

[19] UNAIDS, 2015
[20] GoN, (2014). Same-Sex Marriage Prohibition Act, 2014
[21] GoN, (2014). HIV and AIDS (Anti-Discrimination) Act, 2014

National Strategic Frameworks and Plans

National Strategic Frameworks and Plans are designed by governments to guide action, and often the allocation of resources, over a specified period and towards the fulfilment of a policy objective. These plans and strategic frameworks contain the following:

- Define HIV/AIDS vision for the national response drawing from the Policy document
- Assess where the HIV/AIDS programme is
- Determine HIV/AIDS priorities and objectives.
- Define responsibilities for the implementation of the policy directions.
- Measure and evaluate results following implementation.

HIV/AIDS programmes in the country have been guided in implementation by serial national strategic frameworks and plans over the years, The first National HIV/AIDS Strategic Action Plan (HEAP- HIV/AIDS Emergency Action Plan 2001-2003) mainly addressed the issues of creating public awareness, at a time when the epidemic was beginning to spread in the country and the HEAP was reviewed in 2004/2005.

The first National HIV Strategic Framework for Action tagged NSF 2005-2009 was developed in 2005 alongside the National workplace policy that was later revised in 2013 (35 years after the Nigerian Response to HIV/AIDS). All stakeholders within the response were expected to draw and derive their implementation plans from it. The expiration of the NSF 2005-2009 provided another opportunity to review the national response to deploy new strategies to ensure the attainment of national development goals and objectives such as the vision 20/20/20, MDGs, 7-point agenda, etc. Thus, the National Strategic Framework 2010-2015 (NSF) was developed with consideration for international and regional declarations on HIV/AIDS[22].

NSF 2010-2015 and NSP 1 2010-2015

The overall goal of the NSF 2010-2015 was to advance the multi-sectoral response to the epidemic in Nigeria to achieve effective control of the disease by reducing the number of new infections, providing equitable care and support, and mitigating the impact of the infection. The first National Strategic Plan (NSP 1 2010-2015) was developed from the NSF 2010-2015.

The overarching priority of the NSP 1 2010-15 was to reposition HIV prevention as the centrepiece of the National HIV/AIDS response, consequently, the thrust of the National HIV/AIDS Strategic Plan (NSP 1 2010-15) included Behaviour Change and Prevention of new

[22] FMoH, (2009). National Strategic Framework (NSF), 2010-2015

infections while sustaining the momentum in HIV/AIDS treatment, care and support for adults and children infected and affected by the epidemic. The Most-At-Risk-Populations (MARPs); including Female Sex Workers (FSWs), Intravenous Drug Users (IDUs), and Men who have Sex with Men (MSM) (Key Populations), were a major consideration of this plan with 'enhanced focus' on the MARPs within the guiding principles and commitments of the plan. This was in the era of 'Universal Access' and several broad interventions were identified as critical for the success of the NSP. These interventions included gender mainstreaming, advocacy at all levels, and capacity building including training and skills development, increased access to material goods, technical assistance, and sustainable funding.

NSF 2017-2021 and NSP II 2017-2021

The NSF 2017-2021 succeeded the NSF 2010-2015 and has its goal to "Fast-Track the national response towards ending AIDS in Nigeria by 2030." This framework incorporated the 90-90-90 strategy, Test and Treat, Sustainable Development Goals (SDGs) and the Option B+ model for the elimination of Mother-To-Child Transmission (e-MTCT). The National HIV and AIDS Strategic Framework (2017-2021) was the fourth national strategic document on HIV/AIDS. It was designed to guide the national response to HIV and AIDS, building on the achievements of the previous Frameworks.

The NSF 2017-2021 also recognized the efficacy of HIV combination prevention approaches by the application of a mix of evidence-based behavioural, biomedical and structural interventions to prevent new HIV infections based on the needs of, and its relevance for the target population. It recognized HIV testing services (HTS) as the bridge between prevention interventions and treatment efforts. The Framework further acknowledged that implementation of harm reduction strategies for PWID, promotion of access to Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), Treatment as Prevention (TasP) and effective treatment of sexually transmitted infections are critical elements of HIV prevention programmes. The National Strategic Plan II (2017-2021) was developed to guide the implementation of the NSF 2017-2021.

The NSP II served as a roadmap for programme implementation to achieve a future where HIV, TB and STIs are no longer public health problems. The plan set out goals and established landmarks in the form of specific measurable objectives to be achieved.

The National Strategic Plan II (2017-2021) is the focus guide for the period of KP Programme Review 2024. It had 5 core thematic areas: (i) Prevention of HIV among General and Key

Populations; (ii) HIV Testing Services; (iii) Elimination of Mother-to-Child transmission of HIV (e-MTCT); (iv) HIV Treatment; and, (v) Care, Support and Adherence. These thematic areas shored up by six cross-cutting issues and programme enablers (i) Gender and human rights; (ii) Health systems and community systems strengthening, and service integration; (iii) Coordination and institutional arrangement; (iv) Policy, advocacy and resource mobilization; (v) Monitoring and evaluation; and, (vi) Leadership, ownership and sustainability provided vastly for KPs specifically and was the largest thrust for key population programmes implementation in Nigeria.

The NSP II set targets and identified strategic interventions for implementation by KP programmes as shown:

Thematic Area 1: Prevention of HIV among General and Key Populations

- Target 2: 90% of key and vulnerable populations adopt HIV risk reduction behaviours by 2021.
- Target 3: 90% of key and vulnerable populations have access to desired HIV prophylaxis by 2021
- Target 5: 90% of the general, key and vulnerable populations access safe injection practices by 2021

Strategic Interventions

1. Foster an enabling environment that facilitates access of adolescents, young people and other vulnerable populations to a combination of appropriate HIV prevention strategies.
2. Strengthen community structures for the provision of equitable HIV prevention interventions.
3. Strengthen targeted strategic behaviour change communication for general, key and vulnerable populations.
4. Enhance the access of general, key and vulnerable populations to condoms and lubricants.
5. Facilitate access of PWID to harm reduction strategies.
6. Identify and strengthen service delivery model(s) that can provide a combination of quality HIV prevention services to key and vulnerable populations.
7. Expand access to populations at substantial risk of HIV-to-HIV prevention prophylaxis.
8. Strengthen referral and linkages between HIV prevention and other health and social services.

9. Conduct appropriate research to identify strategies that support improved access to HIV prevention services.

Thematic Area 2: HIV Testing Services

Strategic Objective: To increase access to HIV testing services to enable 90% of people living with HIV to know their status and be linked to relevant services.

- Target 1: 100% of key populations, 100% of children (age 1 to 9 years) of HIV-positive mothers, 80% of vulnerable populations and 60% of general population access HTS by 2021.
- Target 3: 90% of people tested for HIV screened for tuberculosis (TB), syphilis, hepatitis B and hepatitis C by 2021.
- Target 4: 90% of HTS sites establish and maintain quality control measures by 2021.

Strategic Interventions

1. Foster an enabling environment for improved access to HTS and screening services for HIV co-infections.
2. Expand coverage of HTS services and screening for HIV co-infections.
3. Strengthen community systems to support testing and re-testing of key populations, vulnerable populations and pregnant women.
4. Strengthen targeted HTS demand generation programmes.
5. Promote integration of, and strengthen referrals and linkages systems between HTS, other HIV management services, blood transfusion services and other health-related services.
6. Integrate screening for HIV co-infections into HTS.
7. Institute and strengthen the quality management systems for all HTS sites.
8. Improve the logistics and supply chain management for all testing commodities.
9. Conduct appropriate research to identify strategies that support improved access to HTS.

National Strategic Plan II-Targets and Indicators

Table 7: 90% of key and vulnerable populations adopt HIV risk reduction behaviour by 2021

INDICATORS	BASELINE	TARGET	% ACHIEVED
% Of FSW who used condoms at the last sex act	91.8% (2014)	98%	53.4 (IBBSS 2020)
% Of MSM who used condom at last anal sex with male partner	82% (2014)	98%	71.2 (IBBSS 2020)
% Of PWID who used condom at last sexual intercourse	83.2% (2014)	98%	51.1 (IBBSS 2020)
Target 3: 90% of the key and vulnerable populations have access to desired HIV prophylaxis by 2021			
% Of key population using PrEP in priority population	Not available	90%	
Target 5: 90% of the general, key and vulnerable populations access safe injection practices by 2021.			
Proportion of health care facilities using reuse-prevention (auto disable) injection equipment for therapeutic purposes	Not available	95%	
Proportion of health care facilities with no stock-out of reuse prevention injection	Not available	95%	

INDICATORS	BASELINE	TARGET	% ACHIEVED
equipment (auto-disable) in the last three months			
Proportion of health care facilities where used injection equipment can be observed in places where they expose health care workers to needle stick injuries	Not available	<5%	
Proportion of health care facilities with safety boxes in all injection areas	Not available	95%	

These specific targets set in the thematic areas of the NSF and prescribed interventions to be carried out by KP programmes are the subject of this Key Population Programme review.

Key Population Programmes in Nigeria

KP Programme Implementation Guidelines

Key populations in Nigeria include Female Sex workers (FSWs), Men who have Sex with Men (MSM), Transgender people (TG), and People Who Inject Drugs (PWID). They are disproportionately affected by HIV/AIDS. Stigma, discrimination, and the threat of criminal prosecution faced by key populations around the world pose serious barriers to their ability to access high-quality, and rights-based healthcare. (FHI, 2017).

HIV prevention programmes are developed using an investment approach that facilitates access of those disproportionately affected by HIV transmission to targeted and effective HIV prevention services. The Key Population Programmes are designed to provide client-centred services and the principles guiding the Design and Implementation of HIV Programmes for Key populations in the country include:

Evidence-based principles that emphasize research, evidence, and innovation as critical for effective programme development, including addressing various barriers and strategic

expansion of services towards universal coverage. All programmes implemented for KPs are expected to have clearly defined monitoring and evaluations that will facilitate continuous improvement.

***Quality-focused and result-oriented*:** The design and implementation of HIV programmes for KPs must meet defined outcomes that are in accord with the objectives of the national HIV strategic frameworks and implementation plans. Programmes and services must be implemented with a commitment to high quality and cost efficiency.

Rights-based approach principles are inculcated in KP programmes as All KP have the inalienable right to quality HIV services in synergy with other education and development opportunities that contribute to their general health and well-being. KP should have the right to participate in the development/review, implementation, monitoring and evaluation of policies and programmes that address their HIV risk.

People-centred approach recognises that KP have diverse needs and KP programmes should promote access to integrated people-centred HIV services, wherein people and communities, not diseases, are the centre of planning and implementation. KP programmes and interventions should focus on empowering KP including those who are young and those living with disability, through education and support to take charge of their HIV prevention and risks, rather than being passive recipients of services.

***Cost-effective**:* The programmes should be cost-effective to ensure value for all allocated resources invested in achieving set objectives.

Integrated services delivery: HIV programmes for KP advocate a combination prevention approach that consists of behavioural, biomedical, and structural interventions that address vulnerability to violence, stigma, and discrimination. HIV prevention services should be delivered in ways that ensure that KP receive a continuum of care delivered at the facility and community sites (public and private) according to their needs.

Context-specific: Interventions for KP should respond effectively to the local HIV epidemic and the needs of local KP communities. Cultural needs and values of the communities where the programmes will be implemented should inform the design of programmes. This awareness will foster practices that make the service-delivery environment safe, supportive, and protective for KP recipients.

The national response programmes for KP advocate the adaptation of the minimum package of interventions approach as prescribed in the guidelines for KP programmes. This approach is an

effort to ensure that key populations receive a combination of appropriate interventions at a dose and intensity that can lead to behaviour change and outcomes that reduce the transmission and acquisition of HIV/AIDS among KP. The implementation guidelines further stipulate that all KP programmes should ensure that the location of the community service site is acceptable to the target population and that the package of services and the mode of providing services are acceptable too. Also, programmes and projects should ensure that effective referral and linkage systems are in place to facilitate the use of the services by KP.

Nigeria has had several KP programme implementation guidelines in the past. The first implementation guideline provided for three KP typologies. These typologies evolved over time to now include the following: FSW, MSM, PWID, TG and People in Custodial Centres and Closed Settings.

Key Population programmes implementation guidelines further state that all programmes/projects should include activities that prevent and address violence, harassment and human rights abuse due to legal, social and cultural barriers that predispose KP to stigma and discrimination. These barriers may include exclusion from health and social services; economic vulnerability; low self-esteem; difficulty in contributing to community decision-making; and limited access to social entitlements. HIV projects that target KP should plan for legal aid to help seek redress and protect KP's rights. Human rights education and information should be included in the peer-education curriculum to enable learning about the prevention and management of intra-community violations and alternative mechanisms of dispute resolution.

Package of Services for Key Population

The national HIV response advocates a combination prevention approach that consists of behavioural, biomedical, and structural intervention.

Behavioural interventions are offered directly to KP by peer educators through outreach programmes and education sessions. These activities promote access to male and female condoms, lubricants, sexually transmitted infections and HIV prevention information and education, referral services, human rights education and community-based and gender-based violence prevention, care and treatment response activities. Outreaches include both physical and virtual activities and should be used to make initial contact with KP.

Biomedical interventions: These include testing and diagnosis of infections, HIV treatment, access to Pre- and Post-exposure prophylaxis, retention in care, management of sexually

transmitted infections, promoting access to Pre-Exposure Prophylaxis (PrEP), viral hepatitis screening, tuberculosis screening and management. Others include access to Prevention of Mother-Child Transmission services (PMTCT) and other clinical services that improve the sexual and reproductive health of KP including post-gender-based violence care. For KP that use drugs, harm reduction and drug overdose management services should be offered.

Structural interventions that address social, political, and environmental systems and beliefs that increase the vulnerability of KP. These include law and policy advocacy, provision of legal aids including alternative dispute resolution mechanisms, litigation, and human rights education. Other structural interventions include economic empowerment, supporting access to mental health care when needed, provision of safe spaces and vocational skills development including psychosocial support for life-long care. Interventions that address stigma in the community, and mitigate its impact on KP are critical for effective community response including community-led organisational development and individual capacity strengthening.

The 2013 implementation guideline emphasized the provision of services for KPs using the Minimum Prevention Package Intervention (MPPI). The interventions provided were behavioural, biomedical, and structural interventions for KPs with activities under the guidelines:

- Behavioural: Outreach, Peer Education, condom and lubricant programming
- Biomedical: STI Control and Management, HIV Counselling and Testing, PMTCT, Reproductive and allied health services FP, ANC, and postpartum/natal care.
- Structural: Community Dialogue, Advocacy and Income Generating Activities.

In alignment with the National Strategic Plan 2017-2021 and implementation guidelines for KP programmes, Prevention, HIV Testing Services, PMTCT, Treatment, Care, and Support services were provided for all key populations in Nigeria during the period of review and the targets were to facilitate 90% of key populations knowing their HIV status, ensure that 90% of them are on treatment and that 90% of those on treatment achieve viral suppression[23].

The 2021 Consolidated Service Delivery Guideline for HIV and STI for Key Populations in Nigeria, further improved on the implementation guideline for selected key populations. It brought all interventions for key populations into a document including the WHO Harm Reduction package for persons who inject drugs as well as prevention of HIV transmission in

[23] NACA, (2017). National Strategic Plan 2017-2021

health care settings[24]. Under its HTS programme, it included self-testing, recency-testing, social network testing, and community-based testing. Under the linkage and enrolment into Care and related services, it provided for community and facility referral systems as well as accompanied and non-accompanied referral and linkage systems. The Test and Treat policy under HIV treatment and care had the most impactful change in the KP programmes as it advocated for everyone who tested positive in care irrespective of the viral load to be treated. Also, the guidelines provided for mental health services in addition to TB and viral hepatitis programming. Last but not least is the inclusion of sexual and reproductive health and rights (SRHR) as well as nutrition as key components of the cross-cutting component of the guideline (NACA, 2021).

At the time of this review, detailed data specific to individual comprehensive coverage of these services was not accessible. However, the end-term review of the NSP 2017 provides some data for some of the services provided i.e., PrEP, PEP, SRH, Condom Programming, etc. A review of the implementation of the NSP 2017-2021 highlighted the following results for the National KP Programme:

- During the NSP implementation, there was a slight decline in condom use among key populations [FSW (1%) MSM (3%), and PWID (3%)].
- Use of PrEP among key populations remains low (<30%), particularly among PWID (11%).
- Post-Exposure Prophylaxis - 7,099 exposed people received prophylaxis but performance could not be assessed as these are actual figures and not a percentage.
- The proportion of key populations who tested for HIV and received their test results was much higher compared to the general population. Figures varied between 37% for PWID 59% among MSMs and 69% among FSW.
- About 93% of PLHIV is currently on ART. This surpassed the target set of 90% from a baseline of 28% in 2017 and an added improvement on the 61% captured in 2019. This result coupled with the results for HIV testing and results for viral suppression (which increased from 81% at baseline to 89% currently) gives the impression that Nigeria has now reached the point where it has been able to bring the HIV epidemic in the country under epidemiological control. However, sub-national disaggregation

[24] NACA, (2021). Consolidated Service Delivery guideline for HIV and STI for Key Population in Nigeria, 2021

suggests otherwise whilst treatment data for Key Population was not readily available at the time of the review.

- Only 8 out of the 36 + 1 states in the country reported domesticating the Anti-Stigma and Discrimination law. It appears the states did not get the necessary support to continue with and conclude this process and instances of stigma and discrimination remain rife across the nation, especially concerning key populations[25].

3.2 FINDINGS OF THE PREVENTION SELF-ASSESSMENT TOOL (PSAT-LITE)

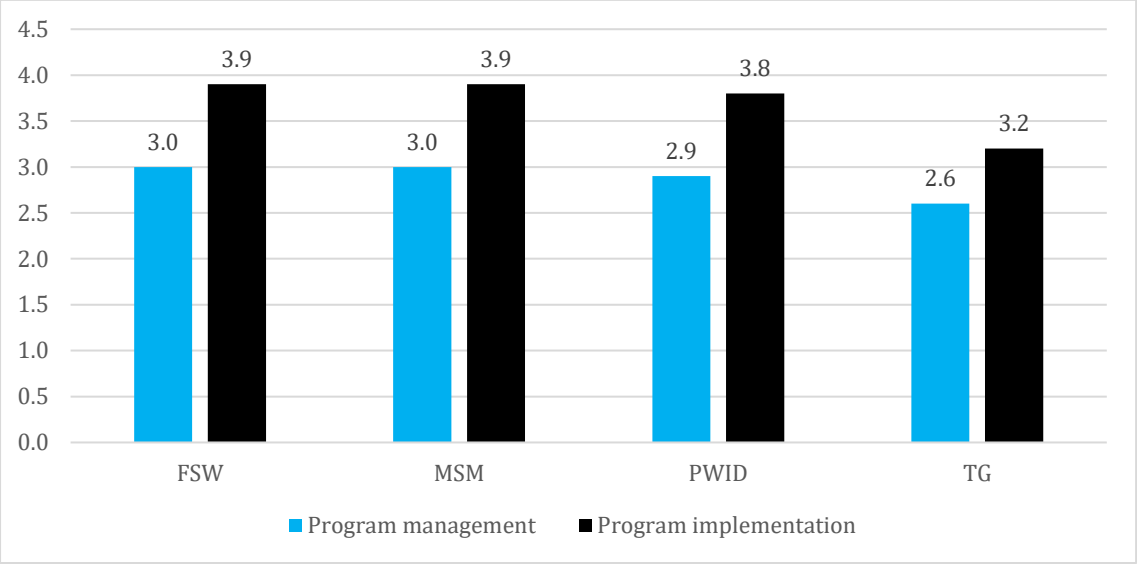

Figure 5: Summary Score of PSAT-Lite by Typology

Figure 5 illustrates the summary scores of the PSAT-lite across two pillars, programme management, and programme implementation, categorized by typology. The tool scores performance with 1 indicating the least performance or absence and 5 indicating the highest performance, or fully present and working well. FSW and MSM obtained the highest score of 3.0 for programme management, which means all the elements assessed were majorly present but not optimal, while TG received the lowest score of 2.6, which means the elements were partially present. Additionally, for programme implementation, FSW and MSM achieved the highest score of 3.9, while TG obtained the lowest score of 3.2.

[25] NACA, (2023). Factsheet

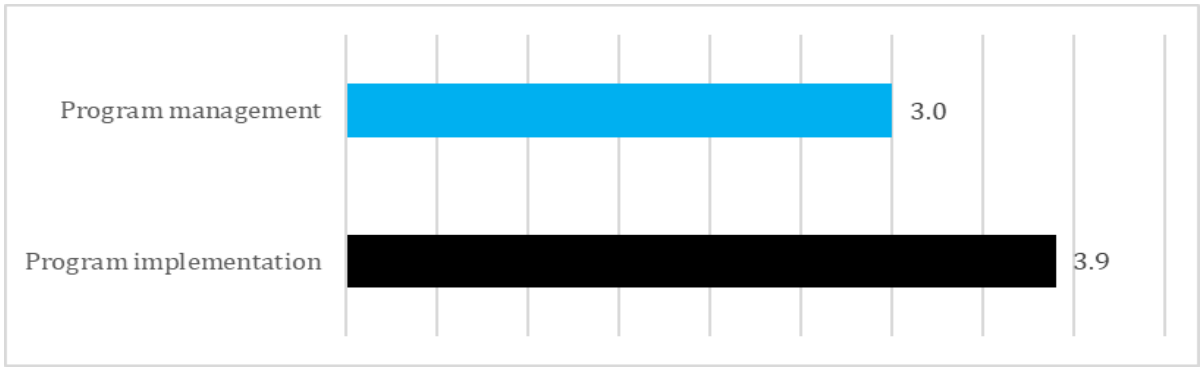

Figure 6: FSW Programme Score per Pillar

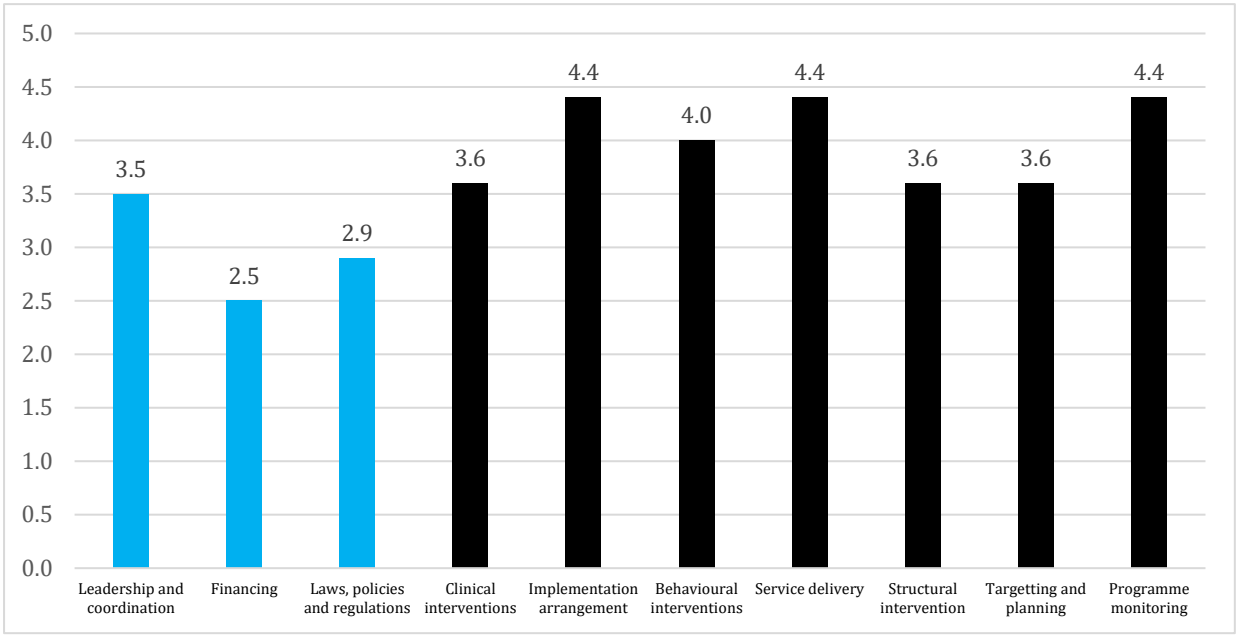

Figure 7: FSW Score per Function per Domain

programme management, scores per function fluctuate between 2.5 and 3.5 with leadership and coordination having the highest score of 3.5, while laws, policies, and regulations have a score of 2.9, and financing has the lowest score at 2.5. Furthermore, in FSW programme implementation, scores range from 3.6 to 4.4, indicating majorly to fully present but not optimal performance in implementation arrangements, service delivery, and programme monitoring.

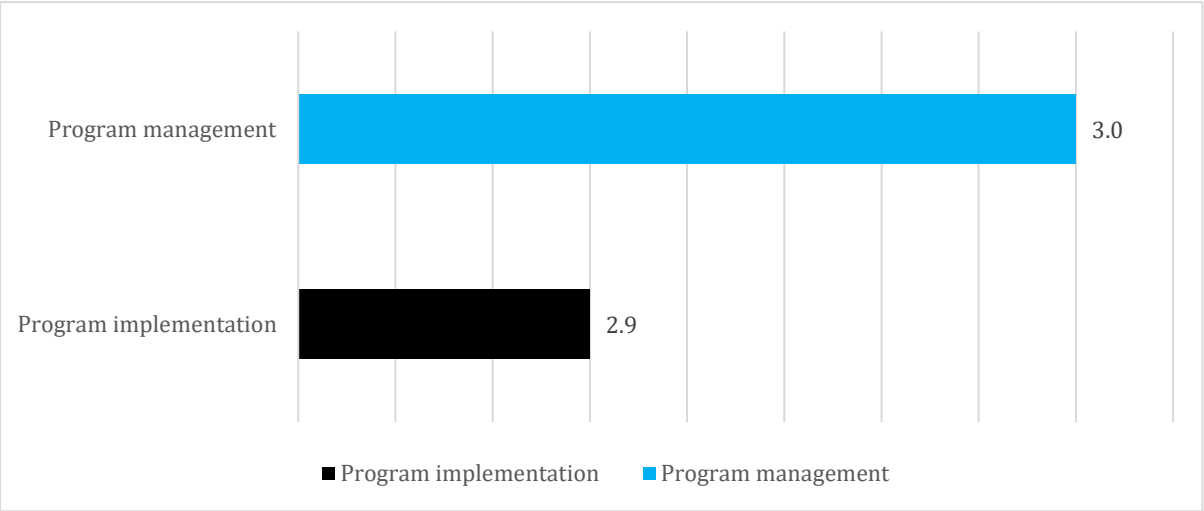

Figure 8: MSM Programme Score per Pillar

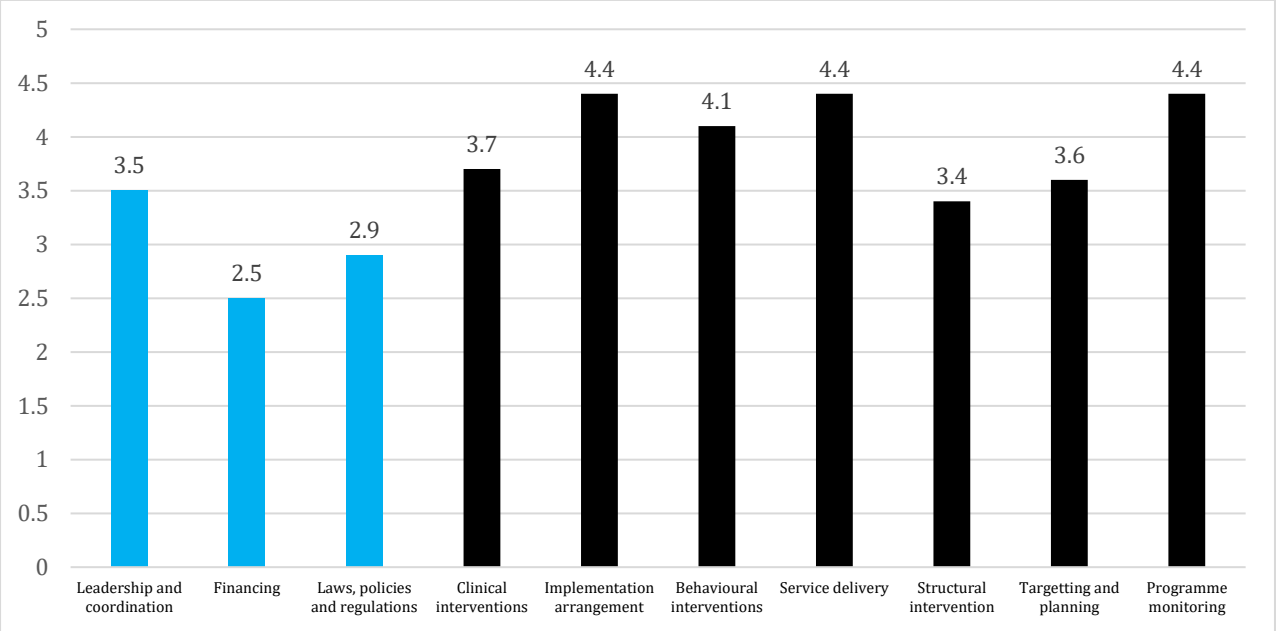

Figure 9: MSM Score per Function per Domain

MSM programme management domain scores span from 2.5 to 3.5, with leadership and coordination having the highest score of 3.5, which indicates the elements assessed were majorly present but not optimal, while financing had the lowest score of 2.5, which indicates the elements were partially present. Within the MSM programme implementation pillar, scores range from 3.4 to 4.4, which indicates the elements assessed were majorly to fully present but not optimal. Notably, implementation arrangement, service delivery, and programme monitoring domains performed well with the highest score of 4.4, indicating fully present and working well, whereas structural intervention had the lowest at 3.4, indicating fully present but not optimal.

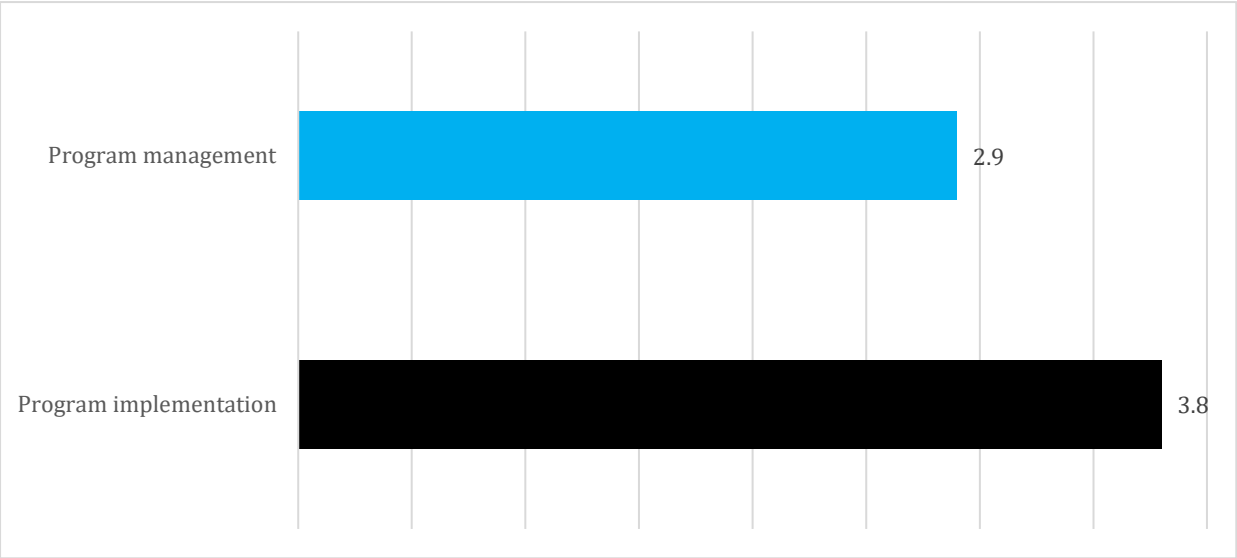

Figure 10: PWID Programme Score per Pillar

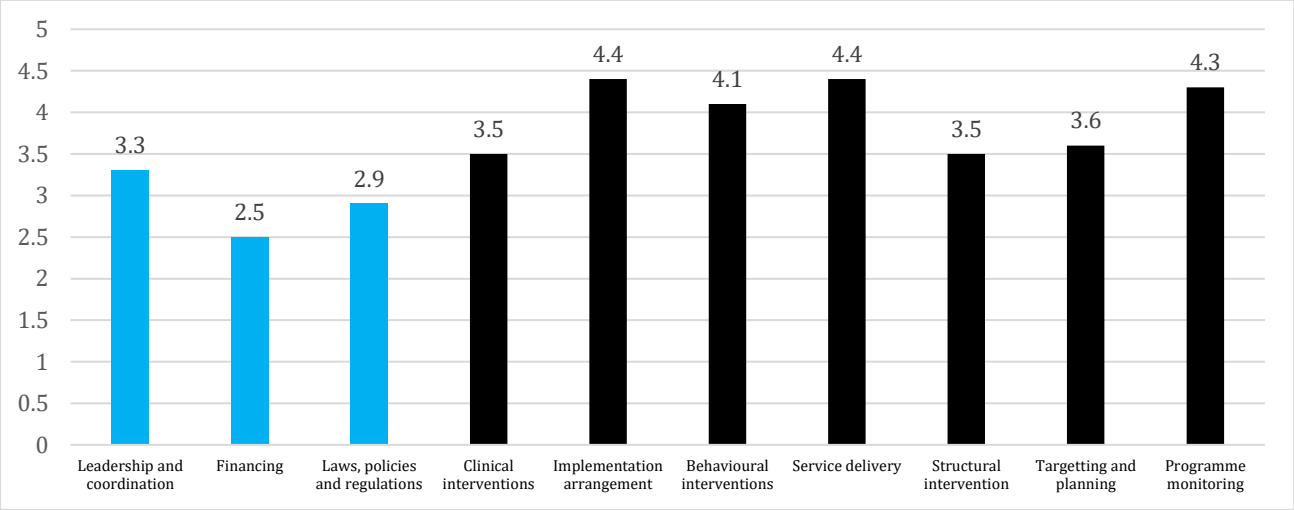

Figure 11: PWID Score per Function per Domain

Figure 10 and Figure 11 show summary scores for the PWID programme. PWID programme management domain scores span from 2.5 to 3.3 with leadership and coordination attaining the highest score at 3.3, which indicates the elements assessed were majorly present but not optimal, while financing had the lowest score of 2.5, which indicates the elements assessed were partially present. As for PWID programme implementation, implementation arrangement and service delivery garnered the highest score of 4.4, which indicates the elements assessed were fully present but not optimal, while clinical intervention and structural intervention achieved a score of 3.5 being the lowest, indicating elements assessed were majorly present but not optimal.

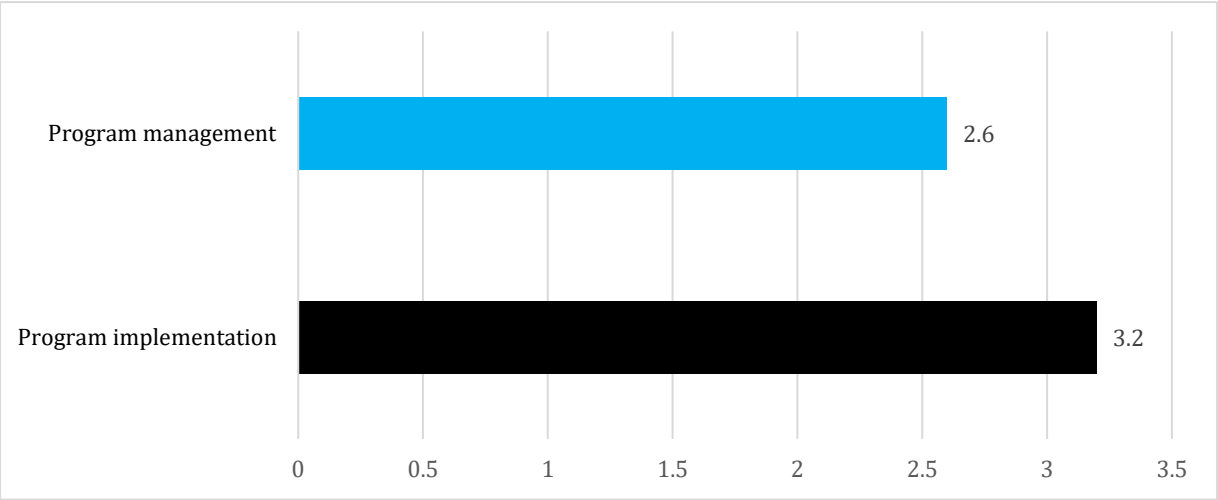

Figure 12: TG Score per Function

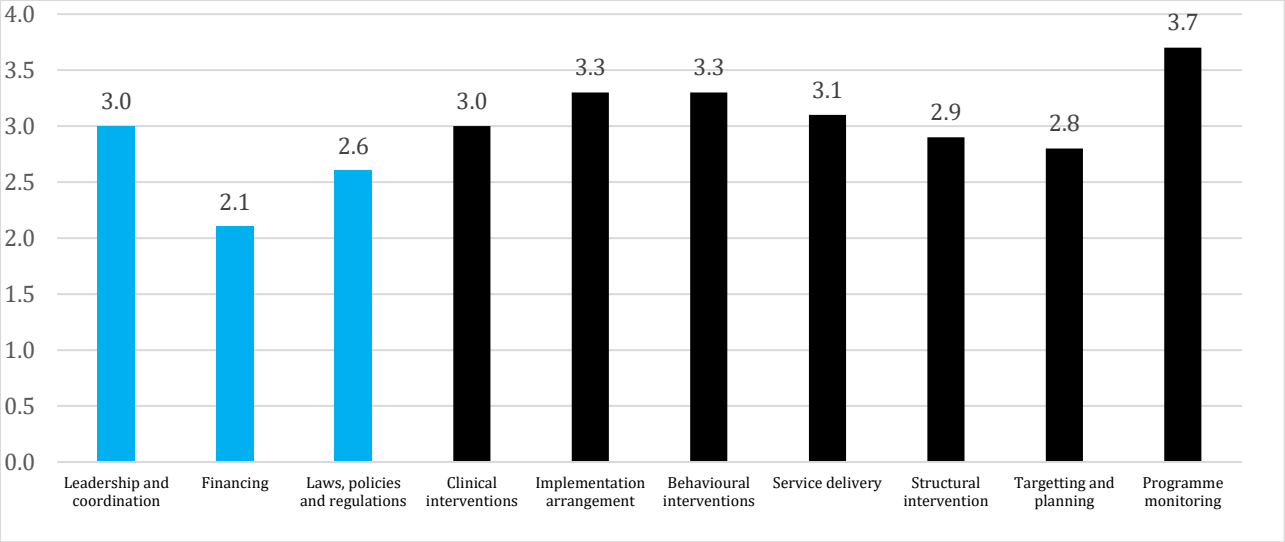

Figure 13: TG Score per Function per Domain

The TG programme management exhibits an average score of 2.1 to 3.0, indicating that the elements assessed were partial to majorly present but not optimal. Leadership and coordination achieved the highest score of 3.0, indicating majorly present but not optimal, while financing obtained the lowest score of 2.1, indicating partially present. Regarding TG programme implementation, scores range from 2.8 to 3.7, indicating majorly to fully present but not optimal, with programme monitoring having the highest score of 3.7 (majorly to fully present but not optimal) while targeting and planning had the lowest score of 2.8 indicating partially present.

Figure 14: National PSAT Summary Scores

Figure 14 presents the national PSAT summary scores. The colour codes are as stated below.

Absent: An element has not been put in place or is not functional

Partially present: Less than half of the element aspects are implemented.

Majority present, but not optimal: More than half of the element aspects are implemented

Fully present, but not optimal: All element aspects are implemented, but the element aspects may have poor coverage, poor quality, require further stakeholder buy-in etc

Fully present and working well: All elements' aspects are in place and implemented correctly.

3.3 FINDINGS OF THE POLLING BOOTH SURVEY (PBS)

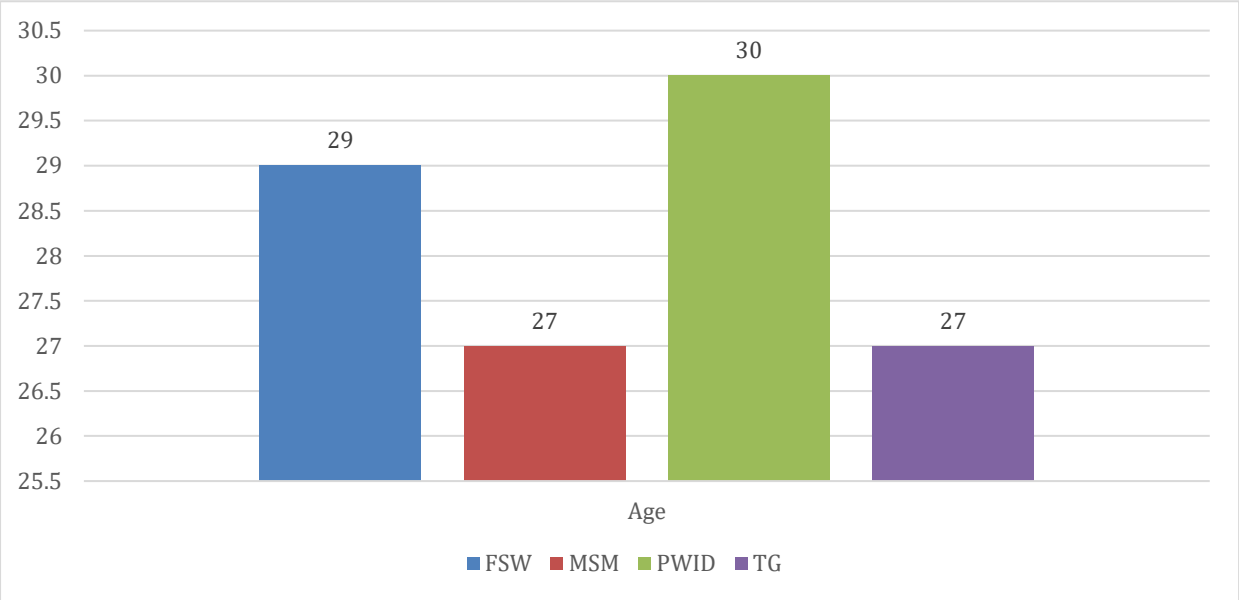

Figure 15: Mean Age of KPs by Typology in Years

Figure 15 shows the average age of PBS participants. The mean age of KPs across all typologies ranges between 27- 30 years with the MSM and TG having the youngest population while the PWID had the oldest population.

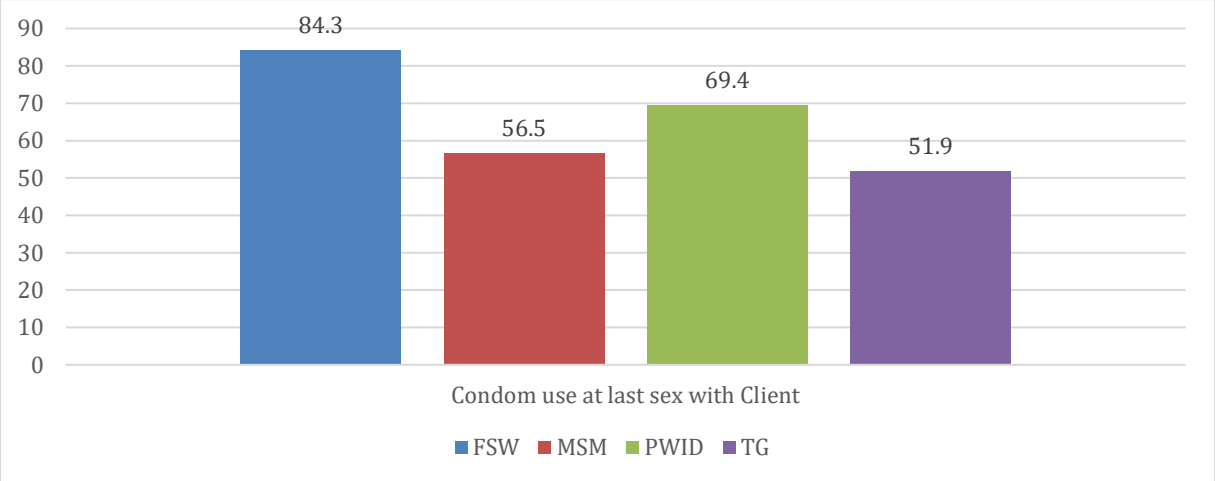

Figure 16: Condom Use at Last Sex with Client by KP Typology (%)

Figure 16 shows the percentage of PBS participants within each typology who reported using condoms during their last sexual encounter with a client. Eighty-four per cent (84%) of Female Sex Workers (FSW) reported using condoms at their last sexual encounter with a client, 57%

of Men who have Sex with Men (MSM) reported condom use, 69% of People Who Inject Drugs (PWID) reported condom use, and 52% of Transgender persons (TG) reported using condoms at their last sex with a client.

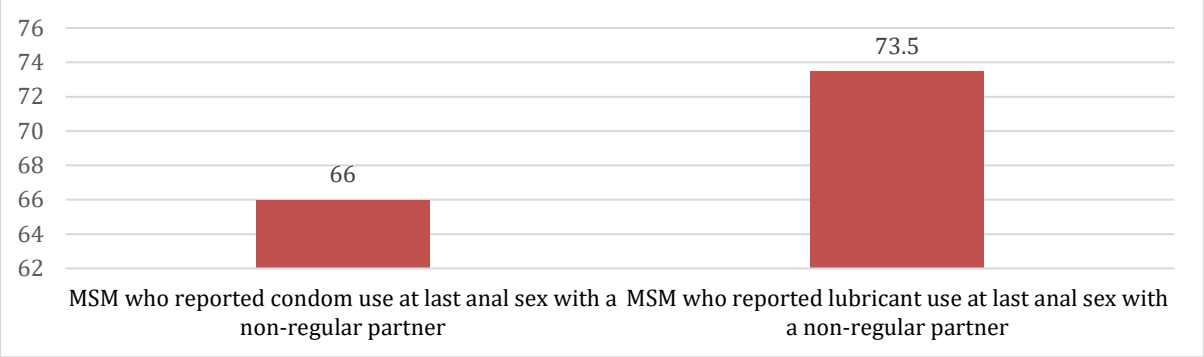

Figure 17: MSM who reported Condom and Lubricant Use at last Anal Sex with a non-regular Partner (%)

Figure 17 shows the percentage of MSM who reported condom and lubricant use at last anal sex with a non-regular partner. 66% of MSM reported condom use at last anal sex with a non-regular partner while 73.5% of them reported use of lubricant at last anal sex with a non-regular partner.

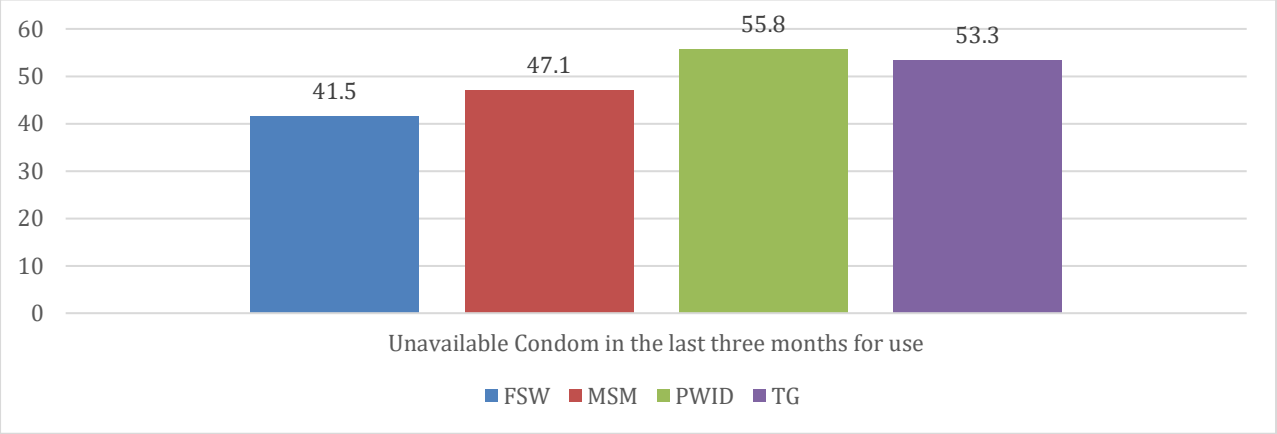

Figure 18: KP who wanted to use a Condom at a Time in the past 3 Months but could not due to Condom Unavailability at that time and place (%)

Figure 18 shows the percentage of PBS participants within each typology who reported unavailability of condoms for use at a time they wanted to use it in the last three months preceeding this study. Forty-two percent (42%) of Female Sex Workers (FSW) reported that condoms were unavailable for use at a time they wanted to use it in the last three months. 47% of Men who have Sex with Men (MSM) reported condom unavailability, 56% of People Who Inject Drugs (PWID) reported unavailability of the condom, and 53% of Transgender persons

(TG) reported unavailability of condoms at a time they want to use it in the last three months preceeding the KPPR study.

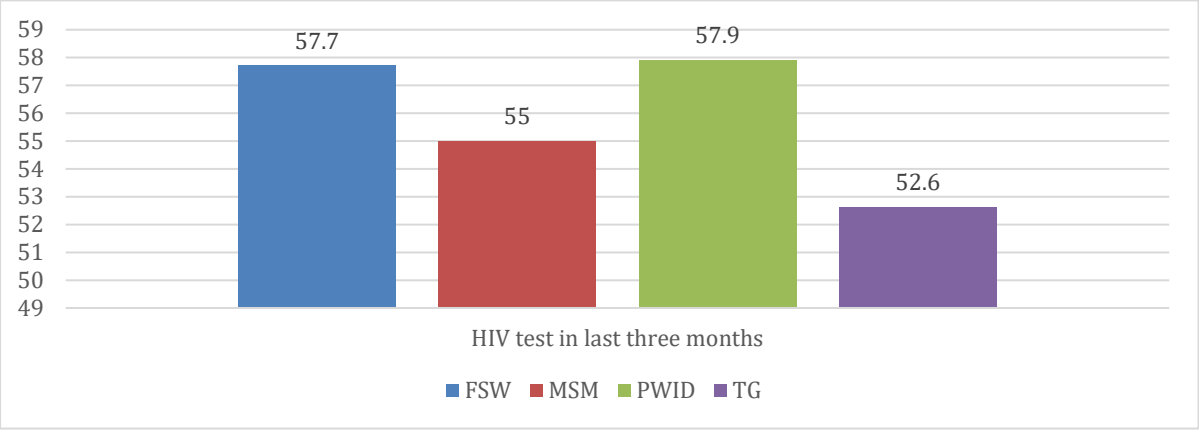

Figure 19: KP who have taken HIV Test in the past 3 Months (%)

Figure 19 shows the percentage of PBS participants within each typology who reported taking an HIV test within the last three months. 58% of Female Sex Workers (FSW) reported they took an HIV test in the last three months. 55% of Men who have Sex with Men (MSM) reported they took an HIV test, 58% of People Who Inject Drugs (PWID) reported they took an HIV test, and 53% of Transgender persons (TG) reported they took an HIV test in the last three months.

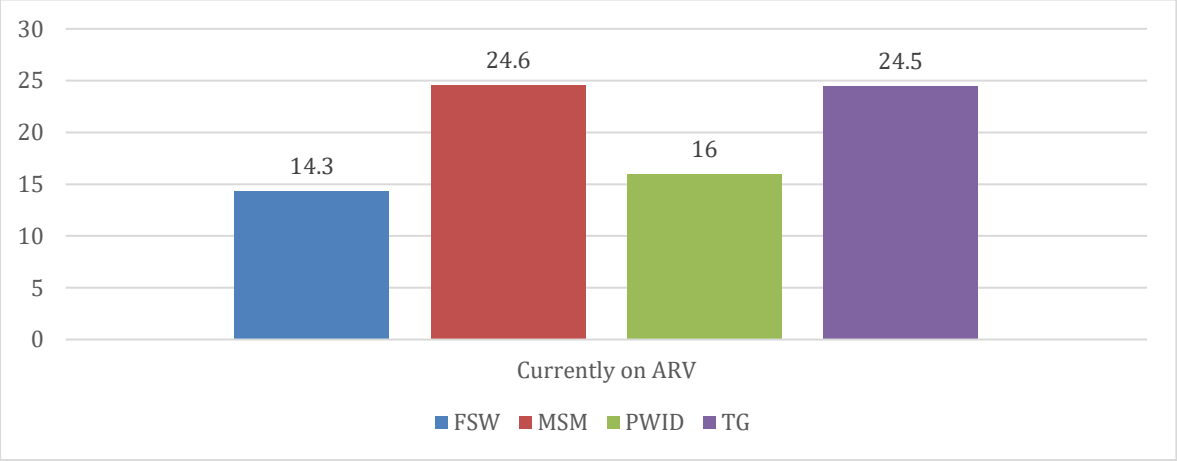

Figure 20: KPs who reported being on Antiretroviral Therapy (ART)

Figure 20 shows the percentage of PBS participants within each typology who reported currently being on Antiretroviral Therapy (ART). 14% of Female Sex Workers (FSW) reported currently being on ART. 25% of Men who have Sex with Men (MSM) are on ART, 16% of People Who Inject Drugs (PWID) are on ART, and 25% of Transgender persons (TG) reported currently being on ART.

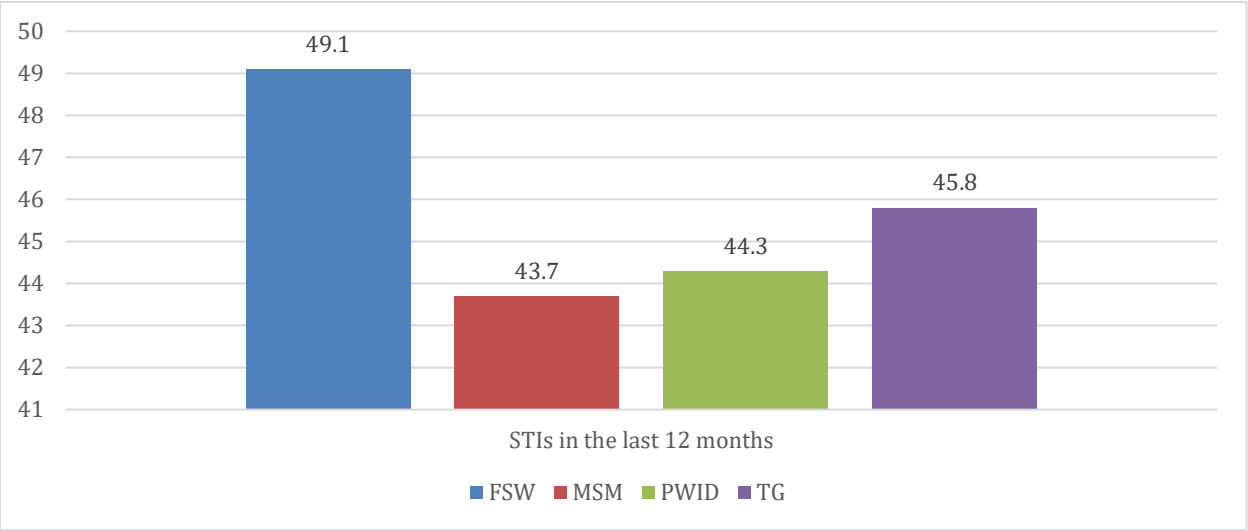

Figure 21: KP that are diagnosed with STIs in the last 12 Months (%)

Figure 21 shows the percentage of PBS participants within each typology who reported that they were diagnosed with Sexually Transmitted Infections (STIs) in the last 12 months. 49% of Female Sex Workers (FSW) reported they were diagnosed with STIs in the last 12 months before this survey. 44% of Men who have Sex with Men (MSM) reported they were diagnosed with STIs, 44% of People Who Inject Drugs (PWID) were diagnosed with STIs in the last 3 months, and 46% of Transgender persons (TG) reported they were diagnosed with STIs in the last 12 months.

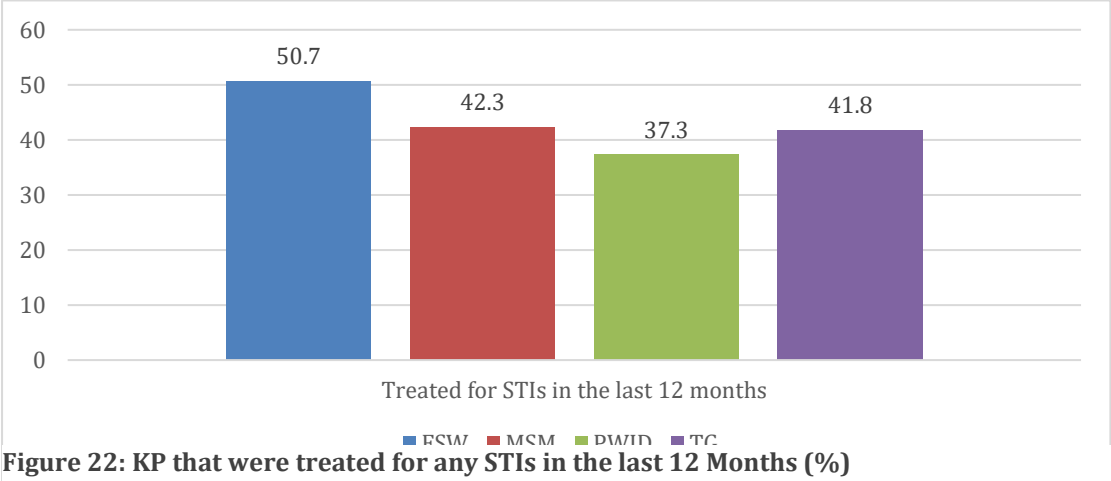

Figure 22: KP that were treated for any STIs in the last 12 Months (%)

Figure 22 shows the percentage of PBS participants who reported to have been treated for Sexually Transmitted Infections (STIs) in the last 12 months prior to this study. 51% of Female Sex Workers (FSW) reported STI treatment in the last 12 months. 42% of Men who have Sex with Men (MSM) reported STI treatment, 37% of People Who Inject Drugs (PWID) reported

STI treatment, and 42% of Transgender persons (TG) reported being treated for STI in the last 12 months previous to this study.

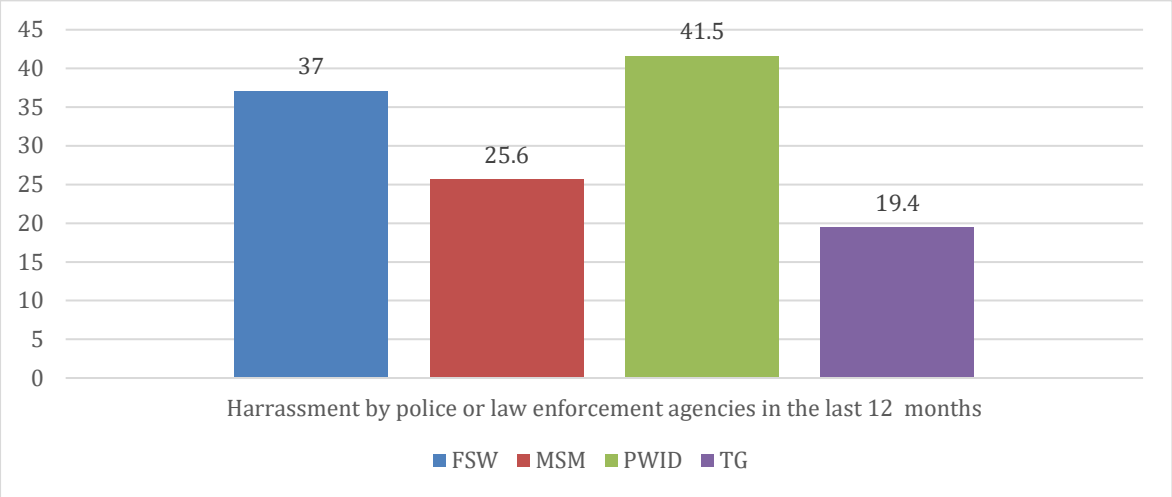

Figure 23: KPs that were beaten up by Police or arrested by Law Enforcement Agencies 6 - 12 Months prior to the Study (%)

Figure 23 shows the percentage of PBS participants within each typology who reported having experienced harassment by police or law enforcement agencies in the last 12 months. 37% of Female Sex Workers (FSW) reported experiencing harassment by police or law enforcement agencies in the last 12 months. 26% of Men who have Sex with Men (MSM) reported harassment, 42% of People Who Inject Drugs (PWID) reported experiencing harassment, and 19% of Transgender persons (TG) reported experiencing harassment by police or law enforcement agencies in the last 12 months prior to this study.

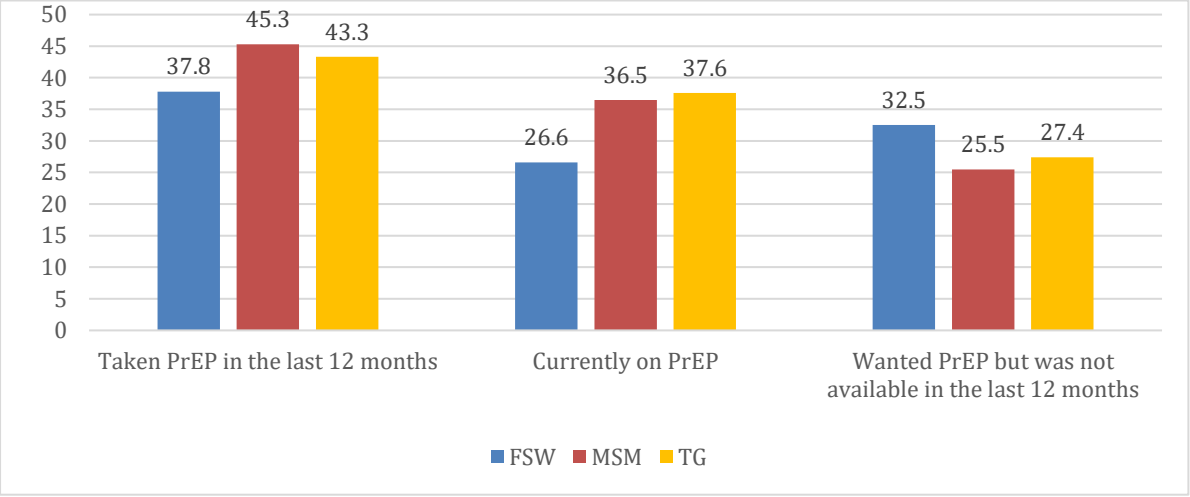

Figure 24: Use of PrEP among FSW, MSM and TG (%)

Figure 24 shows the proportion of participants who have taken PrEP in the last 12 months, currently on PrEP, and those who wanted to take PrEP but couldn't because it was not available.

38% of Female Sex Workers (FSW) took PrEP in the last 12 months, 27% are currently on PrEP, and 33% wanted to take PrEP in the last 12 months but it was not available. 45% of Men who have Sex with Men (MSM) took PrEP in the last twelve months, 37% of MSM are currently on PrEP, and 26% of MSM wanted to take PrEP in the last 12 months but it was not available. 43% of Transgender persons (TG) took PrEP in the last 12 months, 38% of TG are currently on PrEP, and 27% of TG wanted to take PrEP in the last 12 months but it was not available.

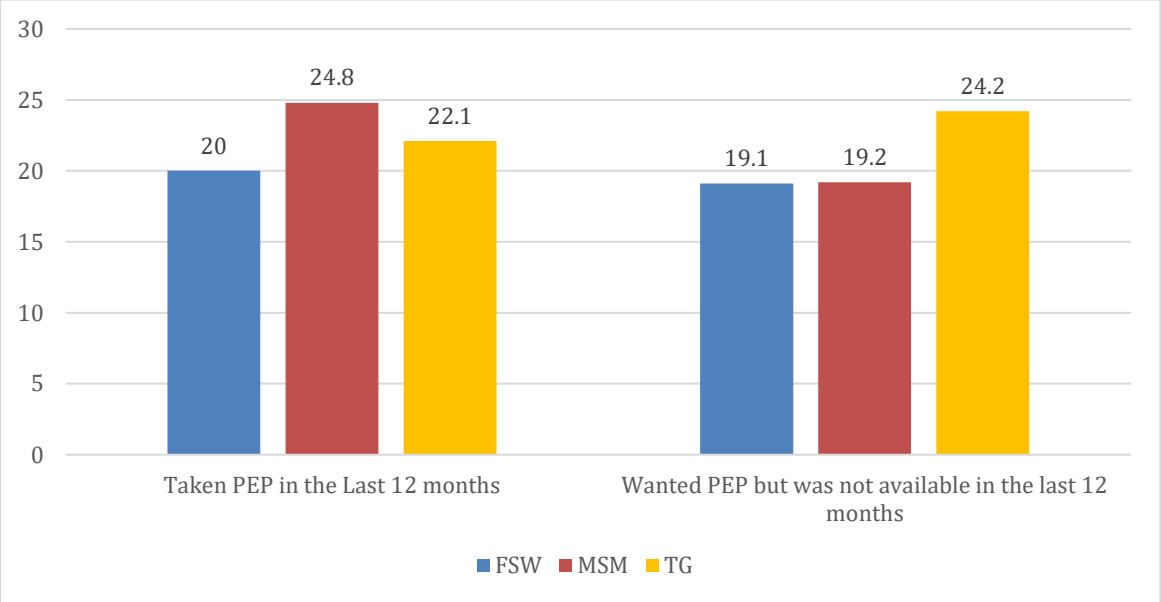

Figure 25: Use of PEP among FSW, MSM and TG (%)

Figure 25 shows the percentage use of PEP among KPs in the last 12 months prior to this survey and the percentage of those who wanted to use PEP but were not due to the non-availability of PEP in the last 12 months prior to the survey. Twenty per cent (20%) of Female Sex Workers took PEP, and 19% wanted PEP but couldn't access it, 25% of Men who have Sex with Men took PEP, and 19% wanted to take PEP but it was not available, while 22% of Transgender persons (TG) took PEP, and 24.2% wanted PEP but it was not available 12 months prior to the survey.

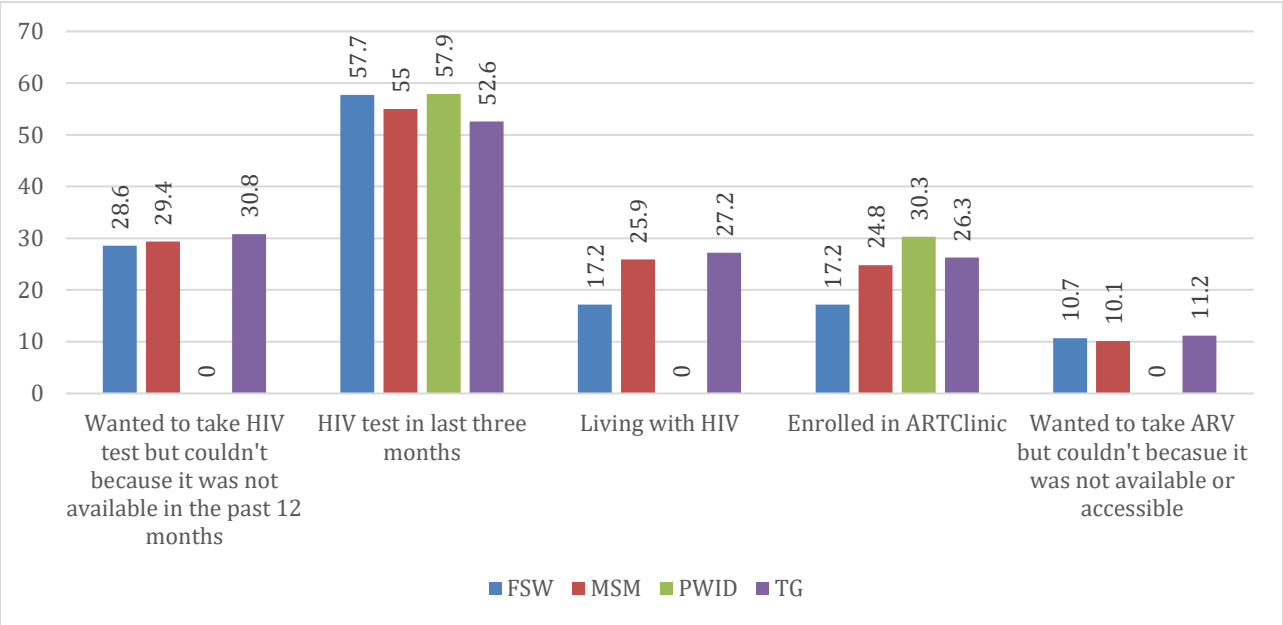

Figure 26: HIV testing and treatment among FSW (%)

Figure 26 shows that 29%, 29% and 31% of FSW, MSM and TG participants respectively wanted to take an HIV test but couldn't because it was not available. 58%, 55%, 58%, and 53% of FSW, MSM, PWID and TG participants respectively reported they took HIV test in the last 3 months. 17%, 26% and 27% of FSW, MSM, and TG participants respectively reported they are living with HIV. 17%, 25%, 30% and 26% of FSW, MSM, PWID and TG respectively are enrolled in ART Clinic, 10%, 20% and 11% of FSW, MSM, and TG participants wanted to take ARV medication but couldn't because it was not available or accessible.

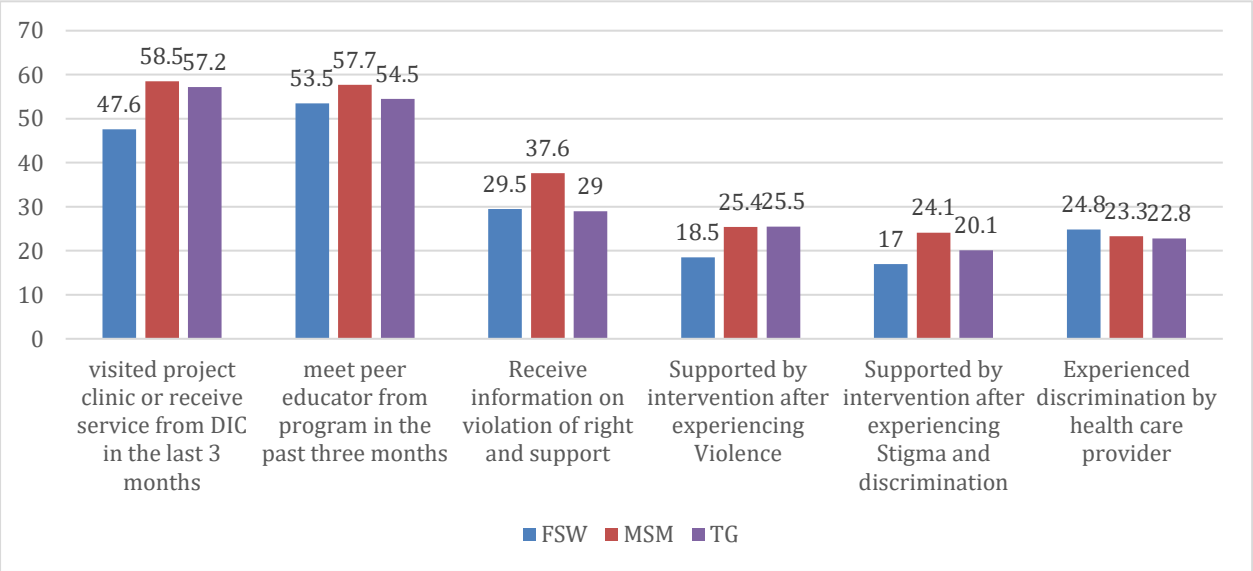

Figure 27: Experience and support of intervention among FSW

Figure 27 shows the proportion of Female sex workers, Men who have sex with men and transgender who have visited or have received service from Drop-In Centres (DIC), met peer

educators, received support and those who experienced discrimination by health care providers. 48% of FSW, 59% of MSM and 57% of TG visited a project clinic or received services from DIC in the last 3 months prior to this study. 54% of FSW, 58% of MSM and 55% of TG met a peer educator from the programme in the past three months. Thirty percent (30%) of FSW, 38% of MSM and 29% of TG received information on the violation of rights and support. Also 19% of FSW, 25% of MSM and 26% of TG were supported by intervention after experiencing violence. In addition, 17% of FSW, 24% of MSM and 20% of TG were supported by intervention after experiencing stigma and discrimination. 25% of FSW, 23% of MSM and 23% of TG experienced discrimination by a healthcare provider.

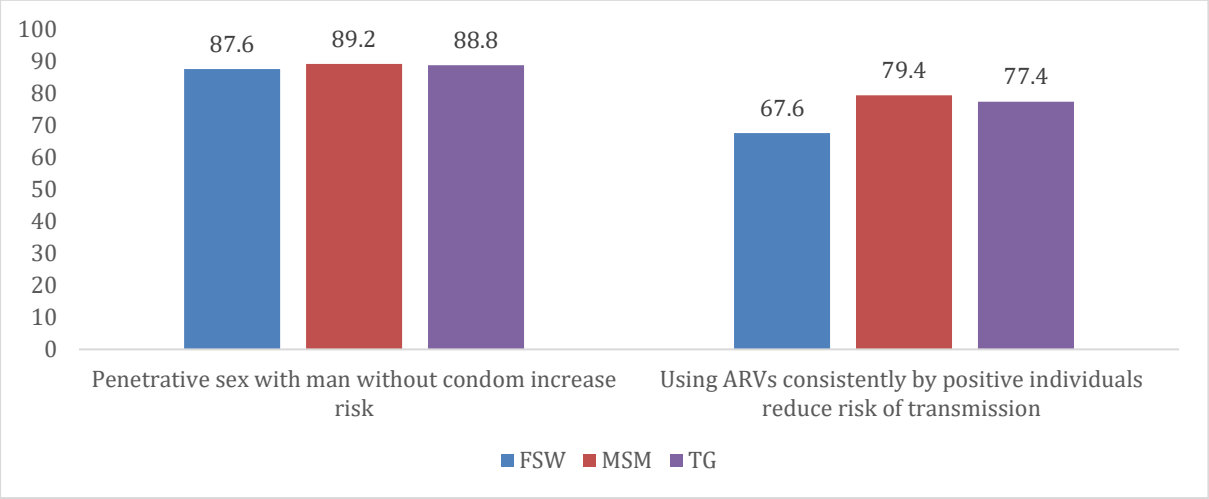

Figure 28: Knowledge perception of risk (%)

Figure 28 shows that 88% of Female Sex Workers (FSW), 89% of Men who have Sex with Men (MSM), and 89% of Transgender persons (TG) know that engaging in penetrative sex without a condom increases the risk of HIV. While 68% of Female Sex Workers (FSW), 79% of Men who have Sex with Men (MSM), and 77% of Transgender persons (TG) believed that consistent use of ARVs by HIV-positive individuals reduces the risk of transmission.

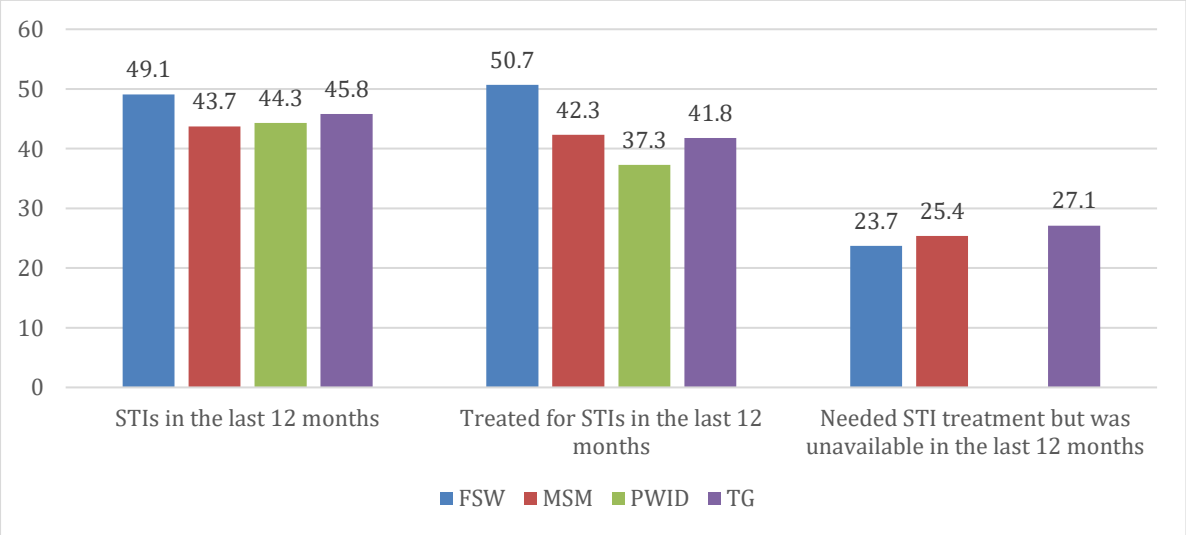

Figure 29: STIs treatment and availability (%)

Figure 29 shows that 49% of FSW, 44% of MSM, 44% of PWID and 46% of TG reported they had STIs in the last 12 months prior to the survey. Fifty-one per cent (51%) of FSW, 42% of MSM, 37% of PWID and 42% of TG reported having received treatment for STIs in the last 12 months, while 24%, 25% and 27% of FSW, MSM and TG participants reported they needed STI treatment but faced unavailability in the last 12 months prior to the survey.

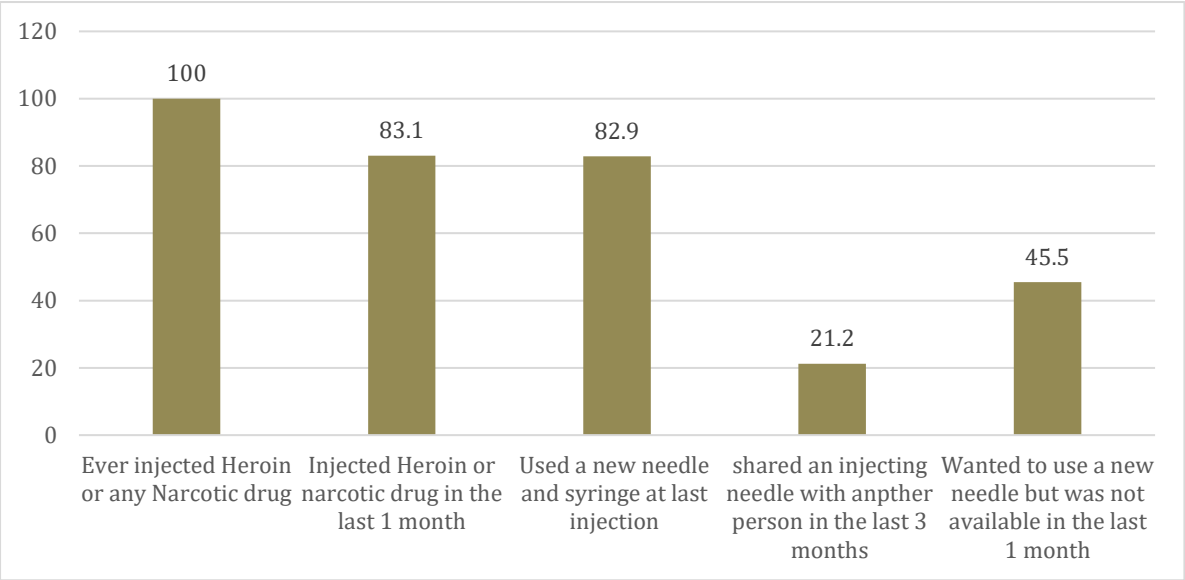

Figure 30: Heroin and other narcotic drug use among PWID (%)

Figure 30 shows that all (100%) of PWID reported they ever injected heroin or any narcotic drug prior to the survey. 83% reported having injected heroin or a narcotic drug in the last 1 month prior to the survey. 83% reported using a new needle and syringe at their last injection. 21% reported sharing an injecting needle with another person in the last 3 months. 46% reported wanting to use a new needle but were unable to do so because it was not available in the last 1 month prior to the survey.

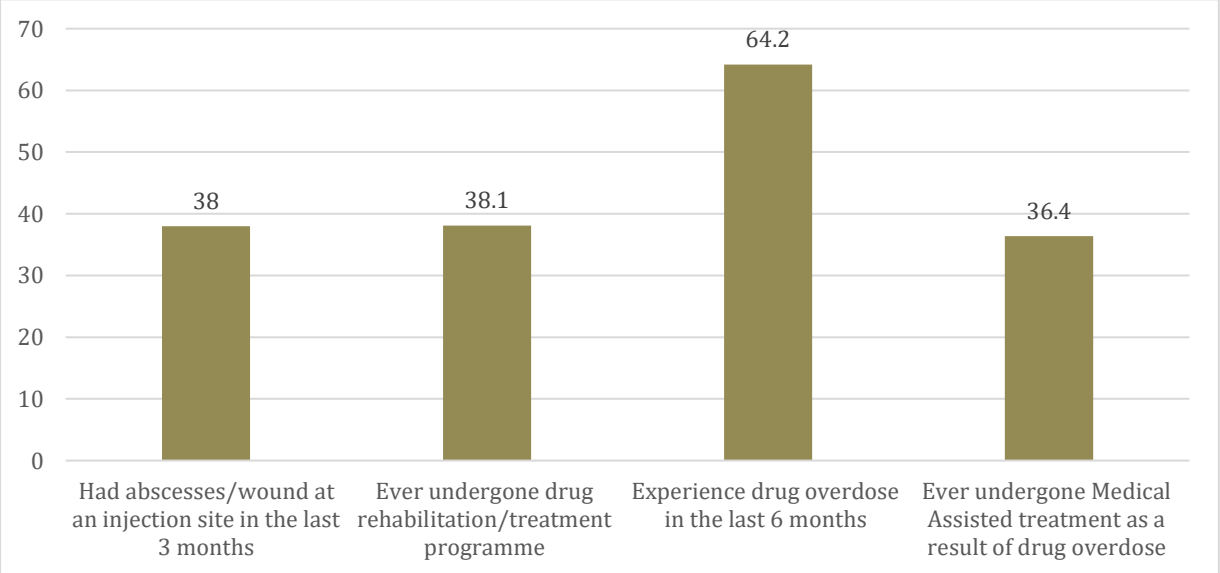

Figure 31: PWID that have undergone drug rehabilitation and medical assisted treatment (%)

Figure 31 shows that 38% of PWID reported they had abscesses or wounds at an injection site in the last 3 months. 38% of them had ever undergone drug rehabilitation or treatment programmes. 64% of the PWID reported to have experienced a drug overdose in the last 6 months while 36% of them reported ever undergone Medical Assisted treatment as a result of a drug overdose.

Table 8: Self-reported HIV risk among KPs

	Key population (%)				Significant Difference among Key Population						
	FSW (%)	MSM (%)	PWID (%)	TG (%)	All KPs (P-value)	FSW and MSM (P-value)	FSW and PWID (P-value)	FSW vs. TG (P-value)	MSM and PWID (P-value)	MSM and TG (P-value)	PWID and TG (P-value)
Condom use											
Condom use at last sex with any paying client	84.3	56.5	68.8	51.9	0.000	0.000	0.000	0.000	0.002	0.600	0.000
Condom not available at a time of sex in the past 3 months	41.5	47.1	55.8	53.3	0.001	0.439	0.001	0.015	0.102	0.397	0.927
HIV Testing											
HIV test during the past 3 months	57.7	55.0	58.0	52.6	0.562	0.915	1.000	0.632	0.896	0.941	0.601
HIV positive and currently taking ARVs	18.2	24.6	16.4	24.5	0.022	0.226	0.920	0.277	0.055	1.000	0.079
HIV knowledge											
Having penetrating sex with a man without a condom will increase the risk of contracting HIV	87.6	89.2	-	88.8	0.731	0.728	-	0.841	-	0.985	-
Using ARVs consistently by HIV positive individuals reduce the risk of transmitting HIV	67.8	79.4	-	77.4	0.025	1.000	-	0.045	-	0.045	-
Needle and syringe usage											
Used new needle and syringe when injecting drug last time	-	-	82.9	-	-	-	-	-	-	-	-

Clean needle not available in the past month	-	-	45.5	-	-	-	-	-	-	-	-

Significant = P < 0.05

Table 8 shows percentages of various indicators and significant differences among key populations, 84% of FSW reported using a condom at last sex with a paying client when compared to MSM (56.5%), PWID (68.8%) and TG (51.9%), and these differences were statistically significant ($P < 0.05$). Nevertheless, 59% of PWID, 42% of FSW, 47% of MSM and 53% of TG reported the non-availability of condom at a time of sex in the past 3 months prior to the study, these variations were also statistically significant for the entire group (P-value < 0.05).

The percentage of KPs who reported HIV testing in the past 3 months prior to the survey by typologies are similar (FSW – 58%, MSM -55%, PWID- 58% and TG-52.6%). The results show that there is no significant difference in the proportion of KPs who reported HIV testing across typologies ($P > 0.05$). KPs (FSW-87.6%, MSM-89.2% and TG-88.8%) know that having penetrative sex with a man without the use of condom will increase the risk of contracting HIV and there is no significant difference among the groups. 83% of the PWID reported usage of new needles and syringes when injecting drugs last time. Meanwhile, 46% reported that clean needles were not available in the previous month prior to this survey

3.4 COMPARISON OF FINDINGS OF POLLING BOOTH SURVEY (PBS) AND INTEGRATED BIOLOGICAL AND BEHAVIORAL SURVEILLANCE SURVEY (IBBSS 2020)

Table 9: Mean age of the KPs (in years)

KP typology	PBS 2024	IBBSS 2020
FSW	29 years	28 years
MSM	27 years	25 years
PWID	30 years	30 years
TG	27 years	24 years

PBS study shows the mean age of KPs across all typologies ranges between 27 and 30 years with the MSM and TG groups having the lowest mean age while the PWID have the highest

mean age. This result is slightly different from the IBBSS 2020 study where the mean age of respondents ranges between 24 and 30 years with the TG and PWID groups having the youngest and older populations.

Table 10: Condom use at last sex with paying client (%)

KP typology	PBS 2024 condom use at last sex with paying client	IBBSS 2020 condom use at last sex with paying client
FSW	84.3	91.0
MSM	56.5	82.9
PWID	69.4	79.8
TG	51.9	79.1

Table 10 above shows that FSW (84.3%), MSM (56.5%), PWID (69.4%) and TG (51.9%) reported condom use at last sex with paying clients, compared with the IBBSS 2020, which shows a higher rate in condom use at last sex with a paying client.

Table 11: Diagnosed with STIs in the last 12 months (%)

KP typology	PBS 2024 Diagnosed with STIs (%)	IBBSS 2020 STI occurrence (%)
FSW	49.1	55.6
MSM	43.7	30.2
PWID	44.3	34.0
TG	45.8	30.9

Table 11 shows that FSW (49.1%), MSM (43.7%), PWID (44.3%) and TG (45.8%) reported being diagnosed with STIs, compared with the IBBSS 2020 which showed a higher rate in STI occurrence among the FSW, while MSM, PWID and TG shows a reduced rate in STI occurrence).

Table 12: Tested for HIV in the past 12 months (%)

KP typology	PBS 2024 Tested for HIV in the past 12 months	IBBSS 2020 Tested for HIV in the past 12 months
FSW	81.1	84.3
MSM	73.7	77.1
PWID	Not Available	41.7
TG	70.9	77.1

Table 12 above shows that FSW-81%, MSM-74%, and TG-71% reported being tested for HIV in the past 12 months prior to the study, compared to IBBSS 2020 which reported slightly higher figures with FSW-84%, MSM-77%, PWID-42% and TG-77% tested for HIV in the past 12 months prior to the study.

Table 13: Harassment Rate by Typology (%)

KP typology	PBS 2024 Harassment in the past 12 months	IBBSS 2020 Harassment in the past 12 months
FSW	37.0	37.5
MSM	25.6	16.5
PWID	41.5	51.1
TG	19.4	32.1

Table 13 above shows that 42% of PWID, 37% of FSW, 26% of MSM and 19% of TG have experienced harassment in the last 12 months prior to the study, compared with IBBSS 2020 which shows higher figures except among MSM with 51%, 37%, 17%, and 32% of PWID, FSW, MSM and TG had experienced harassment in the last 12 month prior to the study.

3.4 FINDINGS OF FOCUS GROUP DISCUSSION AND IN-DEPTH INTERVIEW

Acces to HIV Programme

Figure 32: Accessibility to the HIV Programme

Figure 32 **above shows Access to programmes by KP across the state,** the intensity of the lines indicates the frequency of mention of accessibility or non-accessibility of HIV programmes across the states

Preventive methods used by KPs

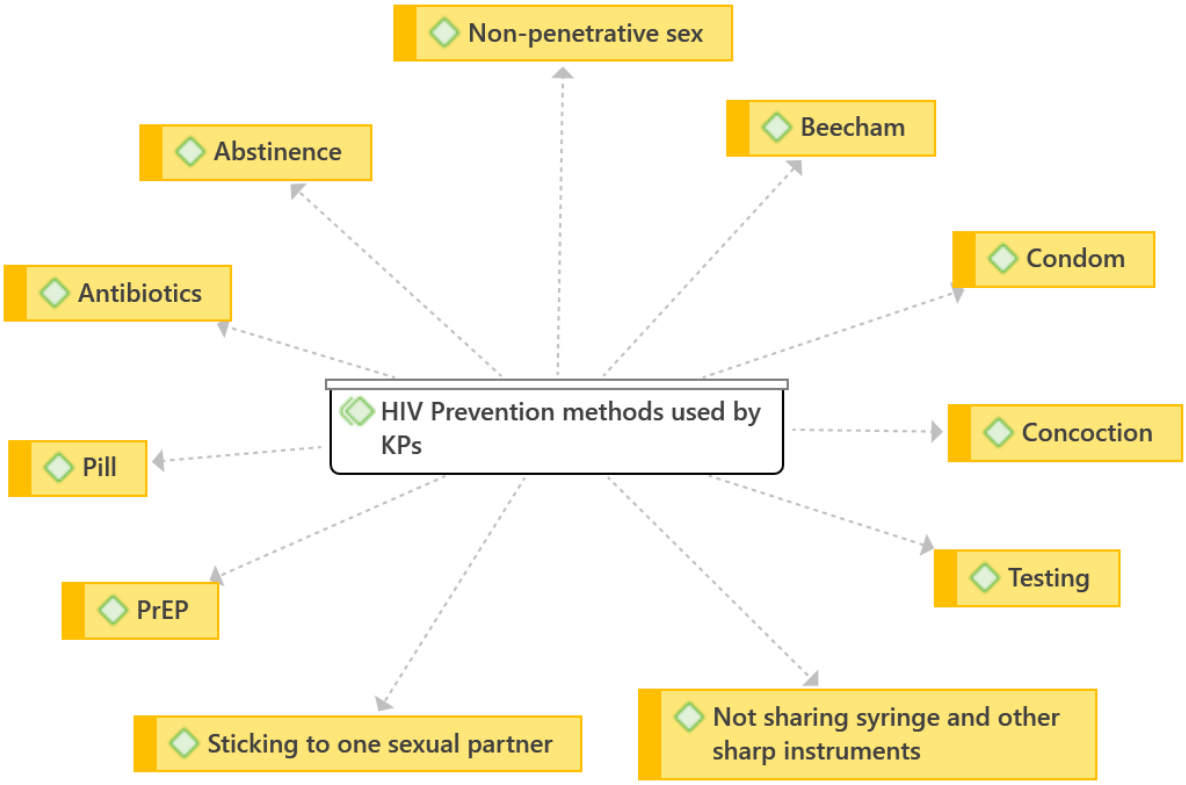

Figure 33: Preventive Methods Used by the Key Populations

The decisions of the KP to use a particular preventive method are influenced by a number of factors among which are: dislike for medicines, availability and accessibility, individual and partner preferences, quest for healthy living, prevention from diseases, safety, securing sexual relationship etc.

Adopted HIV Programmes

The informants alluded to several HIV programmes they adopted, which included: community outreach, distribution of preventive materials, harm reduction programme, HTS, MPPI model, one-stop-shop (OSS), peer education, referrals, stigma reduction, training etc.

Factors facilitating the delivery of services to KP

KP services delivery and uptake, according to the informants, were aided by some factors which include: the involvement of KPs, Provision of friendly facilities for KP, Training of health workers on how to relate with KPs, Drop-in-centres, Constant ARV supply, Anti-stigmatization and discrimination campaigns etc.

Direct involvement of the KP's to be service champions is one element that cannot be overemphasized in ensuring adequate service provision to KP's. If you have KP's reaching out to their own, you will have more of them covered than against when you have KP's wanting to provide services to KP's. FSW would know how best to talk to a fellow FSW to obtain service than a conventional normal female individual outside might not know how to do, the FSW will tell you ah my fellow sister come on you see this thing they say e good for us make we warm me and you we know what's involved you know how many man we carry, we know that a regular female outside might not be able to communicate in that time or in that way KPPR_TARABA_IDI_IP2_09_TRANSCRIPTION

Alright, thank you. When we talk of these facilitators, I think, let me start with speaking for SFH, who are, we have in the state as an implementing partner right now for the KP project, KP K2 project. They have designed under structural and OSS, which is a KP-friendly space, where they go there and receive all the necessary educations they really want, orientation, treatments, prevention, and all other services they want. And another facilitator I can talk about is the Adamawa state stakeholders. KPPR_ADAMAWA_IDI_KP STATE KP SEC (LEAD) 01

Modifications to enhance programme implementation

In enhancing programme implementation, the programme implementers and policymakers suggested some modifications in their services which include: capacity building, creation of more OSS/DICs, engaging stakeholders from the start of the project, funding, scale-up etc.

And another one is there should be a steady training for the field workers. Education now is you learn you relearn and you unlearn the one that you got. So that reason, if you look at dictionary, dictionary normally have several editions. As time goes on, it's increasing. But you can't tell someone that is being trained last three years or last two years, oga, enter the field and start giving information to these people. When the person enters the field and start giving information to these people, those it's not working that way. ANAMBRA, __IDI_KP REVIEW_CBO

Actually, in the programme department what we actually need right now is more funding, yeah, it's not like funding the same project, another funder will come and fund

the same project, no. We look at it, cost of living is now high. How do you think it is to take somebody out from that neighbourhood and tell him this is your full-time job right now, to be doing this, and this person is married or have kids or have family, or have responsibility, or an MSM has a boyfriend has things that he is he is doing, and you expect this person to take care of his rent, transportation and all the whole thing under how much? And they expect this person to deliver, with the crazy stress of Lagos State KPPR_LAGOS_IDI_KP_SEC

Programme replication to scale up good practices across KP programmes

According to policymakers, certain practices could be replicated in scaling up KP programmes, practices such as capacity building, creating more OSS, training and re-training of stakeholders, a strong synergy between SACA, SASCP, and IPs, strengthening LACAs involvement, sharing idea forums, policy review across states, monitoring and evaluation, involving the KP community in developing a national strategic plan, HIV testing services, collecting data of different topologies, equitable and qualitative service, creating KPs friendly facilities/programmes, continuous funding, collaboration among states, advocacy, address loopholes etc.

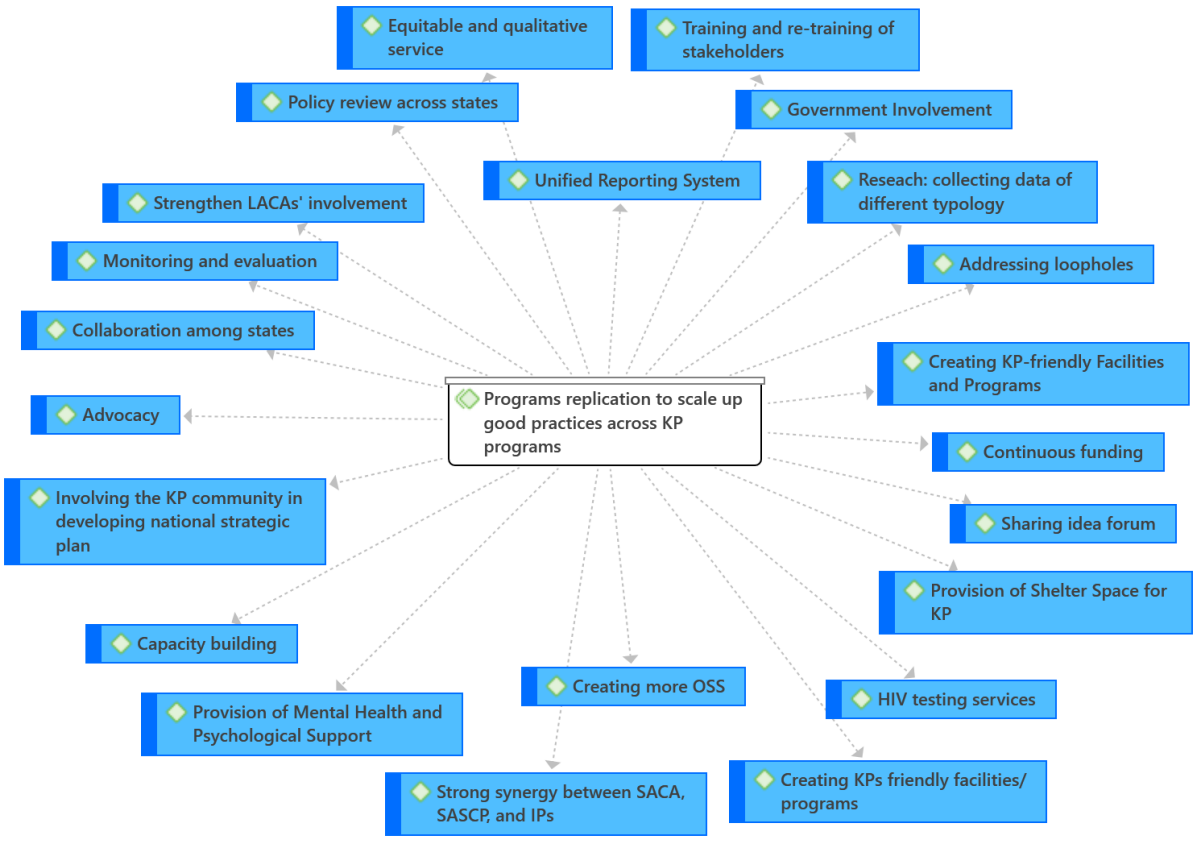

Figure 34: Programme replication to scale up good practices across KP programmes

Barriers to accessing available services by the KPs

The informants alluded to certain barriers which they opined hinder KPs' access to HIV programmes. These barriers include the attitude of health personnel toward KPs, lack of funds/incentives, harassment by law enforcement agencies, insufficient OSS, proximity, access and cost of transportation to OSS, stigmatization, state law/cultural norms etc.

> *Issue of the legislation which we know the law is against them, so is also another barrier then the issue of security agencies sometimes they arrest the members of the key population and as a result of that, some of them go into hiding.* KPPR_TARABA_IDI__TACA_LEAD_04

> *The only thing is the issue of OSS whereby we only have one in the state. So, wherever you are in the 26 local government in Kaduna, you still have to come down to the OSS here in Kaduna or you go to the one in Kafanchan that is the drop-in centre. I think they are not efficient for or they are not for the KPs and they are even far away from*

KPs. I just think more of such structures should be provided KPPR_Kaduna_IDI_KP Secretariat Lead 04

Barriers to delivering available services to KP

The informants further opined that the attitude of KPs, clamp down of KPs by law enforcement agents, cultural-religious factors, cultural/societal constraints, funding, government laws against KPs, inadequate commodities, stigma and discrimination etc. are some of the bottlenecks they faced in delivering available services to KPs.

Another thing is, of course, you will see people have ART in there bag and the police stop and search and the police and they claim that the drug it's unlicensed, that they don't know this drug that is hard drugs and you see clients calling us and say police catch me with ART, you know even with condom, police catch people with condom, you know some people will have sex are they will not want to discard the condom and say they will discard later and coming out they wear the cloth and police catch them and see used condom, you are a ritualist those the things that hinder the programme and you see us running to police all the time to bail people out, DELTA_IDI_KPREVIEW_KP CBO_01

Some of the barriers we looked, I am thinking of now. You know the policy of this country, the rules, the law in the land, you know, against KPs makes it difficult for them to identify themselves in the first place. So ermm they are always in hiding. So, what we are looking at as ermm ermm as a barrier. KPPR_Akwa Ibom_IDI_KPPR_SASCAP

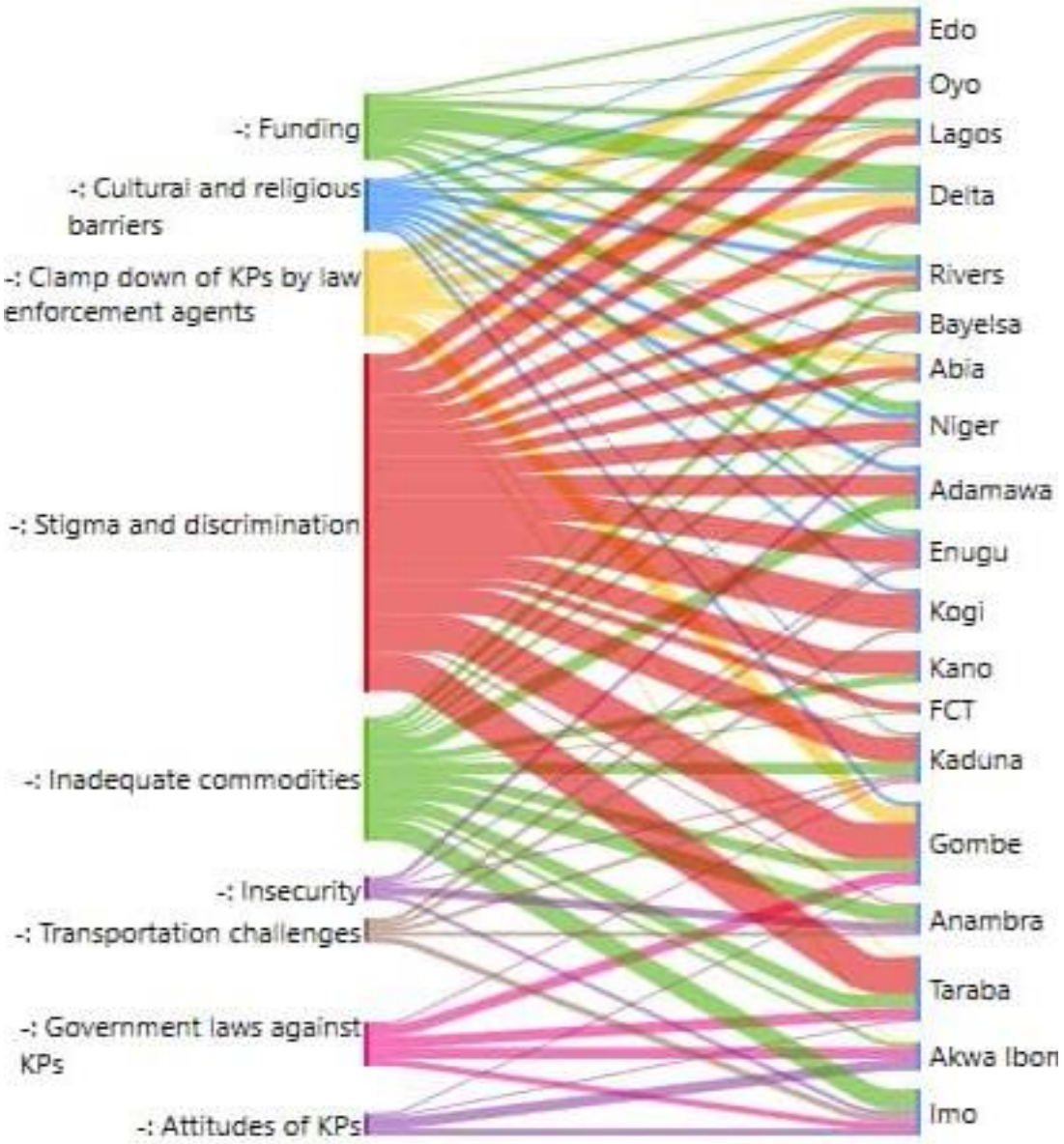

Figure 35: Barriers to delivering available services to KP

Note: The thickness of the lines indicates the number of times each factor was mentioned in each of the states

Challenges in the Key Population Programme

Key population programmes are facing certain challenges across the states. The informants alluded to some of the challenges which are: commodities running out of stock, discrimination of KPs, lack of funding from the government, lack of personnel, lack of anti-stigmatization law, stigmatization of KPs, people's lack of awareness regarding KPs, insecurity etc.

Sometimes there are stock out for commodities like condoms, lubricant, determine, test kits, but for now I would say the only stock out is condom even SFH which is the OSS have a stock out for it, KPPR-GOMBE-IDI- SACA CMO

Yes, is the stigma, the stigma & the discrimination in KP programmes, even ARV, I don't think there is issue of drugs or test kit major challenges for them especially at the community is the stigma & discrimination. ok, ye KPPR_KADUNA_IDI_SASCP Focal Person_03

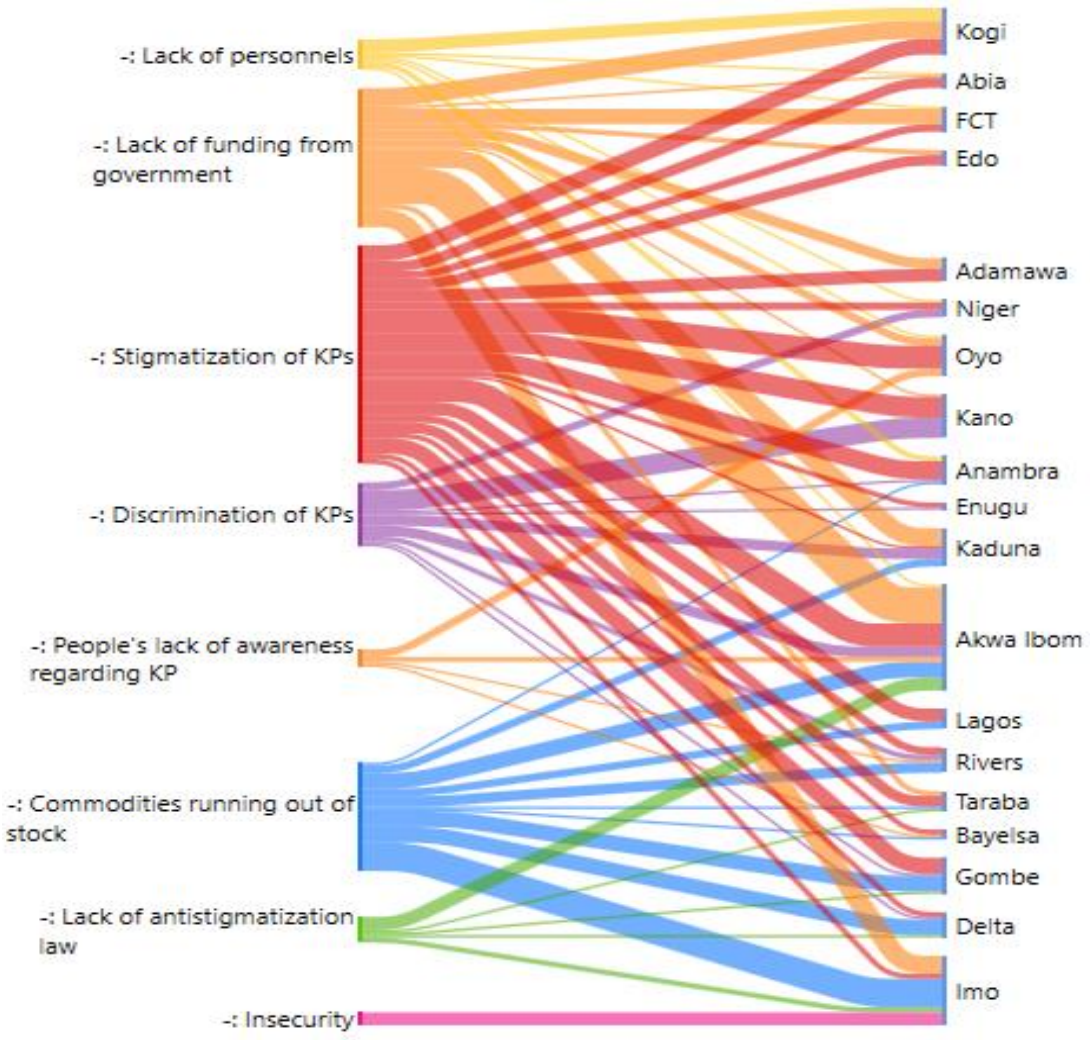

Figure 36: Challenges in key population programme

Changes to be made to the prevention

The KPs advocated for access to commodities, consistency in the programme, convenient time, decentralisation, locally accessible services, additional facilities, HIV vaccine, home delivery, improving female condoms, injectable PrEPs, and provision of quality products etc.

> *Respondent M6: what I will want them to change is bad staff, number one, when they say give the product free, some kind of people, Delta State people, they will tell it's for sale, but, instead of you to give them free for protection, and you don't know whether they need that thing at that aid, you will tell them to buy, as they don't have money so, we will use our spit o* KPPR_DELTA_FGD_MSM 01

> *R1: The support we need specifically pertains to transportation cost. For instance, some people do not have means to travel to the OSS, and without transportation, they cannot visit to obtain more supplies like condoms. If we could receive assistance with transportation costs, then those who lack supplies would be able to visit and access the necessary supplies and services. I think, this strategy would encourage more people to visit and access the prevention supplies.* KPPR_Kano_FGD_TG_01

Services Offered through NGOs/CBOs

Participants commented on the services that they were offered through Non-Governmental Organisations (NGOs) and Community-Based Organisations (CBOs). The services include testing and prevention services, treatment services, sensitization and training services. Participants mentioned that they were tested for HIV, hepatitis, syphilis, and other STIs and directed to the appropriate quarters for the right care.

> *They do test for HIV, and if you are found positive, they will refer you to their office in there they will still test you again.* ***KPPR-GOMBE-FGD-TG1-01***

> *like I bin tell you all those things wey I bin dey always do na there women plenty because the organisation them dey always take care of women wey dey do drugs, so I go just call them say today I go gather my people say today this people say them go come carry us go health centre, go do test, sometimes I go commot enter another bong wey I dey friendly with still gather everybody so na how me I dey take dey gather people up be that for them.* ***KPPR_AKWA IBOM_FGD_PWID_001***

Furthermore, participants commented on some of the treatments that they receive through NGOs. Among them is the treatment for anal warts, malaria, and typhoid. According to KPs, they have also accessed hepatitis vaccination as well as other prevention services through some of the NGOs/CBOs. There was a particular mention of HIV prevention services including the provision of condoms as one of the main services provided by NGOs and CBOs to key population.

> ***RES 11:*** *HIV preventive, Hepatitis, Tuberculosis and sometimes a touch of malaria but though is not part of the criteria of the service they offer, but a big part of it.* ***KPPR-KOGI-FGD-PWID 01***
>
> ***Respondent TG2:*** *ok ehmmmm speaking as regards the services we give in this facility, uhm, we have a number of services ehm we do GBV cases we do HIVSTs whereby we do testing using determine or HIVST whereby we take home and test other persons that are not in the space, yes, we do cases that are like ehm sexual related cases like uhm anal warts and stuff, treatment in general, we do malaria testing, HIV testing, hepatitis testing, syphilis testing and uhn equally screen for GBV cases like I said earlier and uh what further questions like?* ***KPPR_DELTA_FGD_TG 01***

Participants also indicated that they attended training and counselling sessions on how to avoid infection or re-infection. Also, counselling is offered as a part of the testing and treatment process, particularly for KPs living dangerously, or who have tested positive for some STIs or HIV. Furthermore, participants mentioned that they benefitted from psychosocial support from the NGOs/CBOs. Participants also indicated that they accessed paralegal services, particularly for cases of GBV suffered by KPs.

> ***P7:*** *like I said before, we just dey our community 1-day na him some group of people came and they started doing orientation and doing HIV sensitization and all, so na so how me I take know about these services be that, HIV services and prevention whatever, yeah.* ***KPPR-KOGI-FGD-FSW 02***
>
> ***Respondent TG2:*** *ok ehmmmm speaking as regards the services we give in this facility, uhm, we have a number of services ehm we do GBV cases we do HIVSTs whereby we do testing using determine or HIVST whereby we take home and test other persons that are not in the space, yes, we do cases that are like ehm sexual related cases like uhm anal warts and stuff, treatment in general, we do malaria testing, HIV testing, hepatitis*

testing, syphilis testing and uhn equally screen for GBV cases like I said earlier and uh what further questions like? ***KPPR_DELTA_FGD_TG 01***

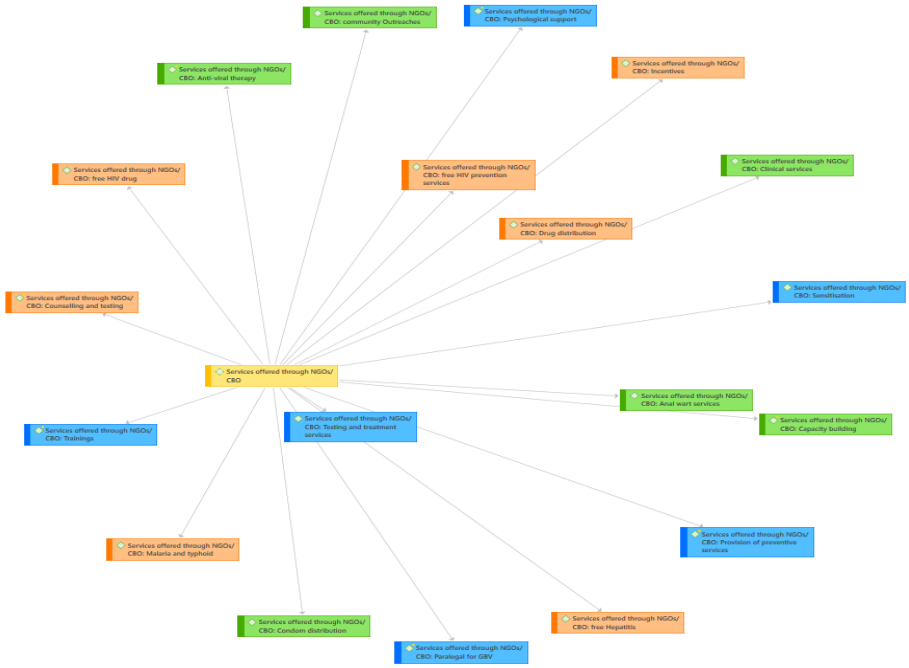

Figure 37: Network showing Services Offered through NGOs/CBOs

Perception about the attitude/behaviour of service providers

Participants commented on the attitudes/behaviour of the service providers. Some of the KPs perceived that service providers were friendly and understanding when they were approached.

Okay I do notice say those people way de those CBOs way they attend to us they just be like us too. So, they understand us well well unlike some people way no understand watin we de do. So far, for the services way I de access dey okay and then de make things much easier for us. ***KPPR_ENUGU_FGD_PWID 01***

Despite the good words, some of the respondents noted that there were still some behavioural lapses in the attitudes of the service providers that they met. In most cases, the participants indicated that the service providers were mixed with a section being friendly and hostile.

I will rate the case manager for TG there hundred per cent. But others working there have their biases. Okay. But the case manager for TG is awesomely doing well. ***KPPR_ENUGU_FGD_TG 01***

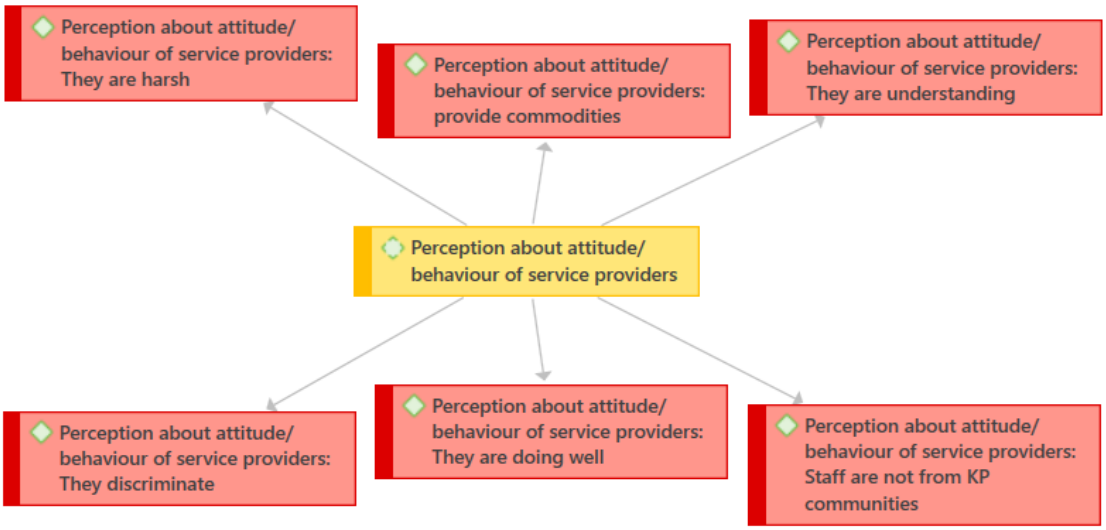

Figure 38: Network showing the codes under Perception and attitude/behaviour of service providers

Organisations Participants are Associated With

Participants commented on the organisations that they were associated with. The organisations include development partners within the country, international associations organised by the KPs, local NGOs, health development organisations, to local associations. A minority of the participants indicated that they were not associated with any organisation at the time of the interview. However, such people may find it difficult to access services directly, or are unable to enjoy the full benefits of the associations.

> *R7: Not only him, but I also don't have any association with those organisations. However, when I need prevention supplies, I will meet with my friend and he will give them to me.* ***KPPR_Kano_FGD_TG_01***
>
> *I am not if there's an opportunity, I would love to join them but I have been hearing about them because that's where I take my treatment drugs, I am not working with them, I am brothel base.* ***KPPR_ENUGU_FGD_FSW 01***

Figure 39: Network showing Associations KPs are Associated with

Suggestion to help improve KP programme implementation

The informants also suggested ways through which KP programmes across the states can be improved, these suggestions are availability/accessibility of commodities, capacity building, collaboration with key stakeholders, creating awareness on HIV/AIDS, engaging the KPs, funding for KP programmes, government funding for CBOs, government taking ownership of KP programmes, the pro, government acceptance and decriminalisation of KPs, involving SACA in CBO programmes, having KP friendly facilities and services, improving the skill capacity of CBOs, operational guideline/policy reform, scale-up/expansion, skill acquisition programmes for KPs, survey/mapping of risk population, adopting moonlight method, adopting WHO revised guideline, sensitization and awareness for GENPOP, integrating OSS into regular health services etc.

> *Well, suggestion is that, well they have come to, you know, I'm just talking from programme aspect. But not from moral aspect, now I'm talking as a programmer. I think there's need for the state to have to have an act, institution against discriminating them. There's it. I'm talking like a programmer. Okay. But when, when you talk about the moral aspects and my own personal disposition, such thing should not exist.* KPPR_ENUGU_IDI_SACA LEAD 05

Also, maybe try and see how they can do more of continuous awareness creation. Because there are some places you go to, some people feel it's not true, and some people have not really heard of HIV, they feel it is a spiritual thing. So, I think continuous awareness creation. KPPR_RIV_IDI_STATE KP LEAD PARTNER 03

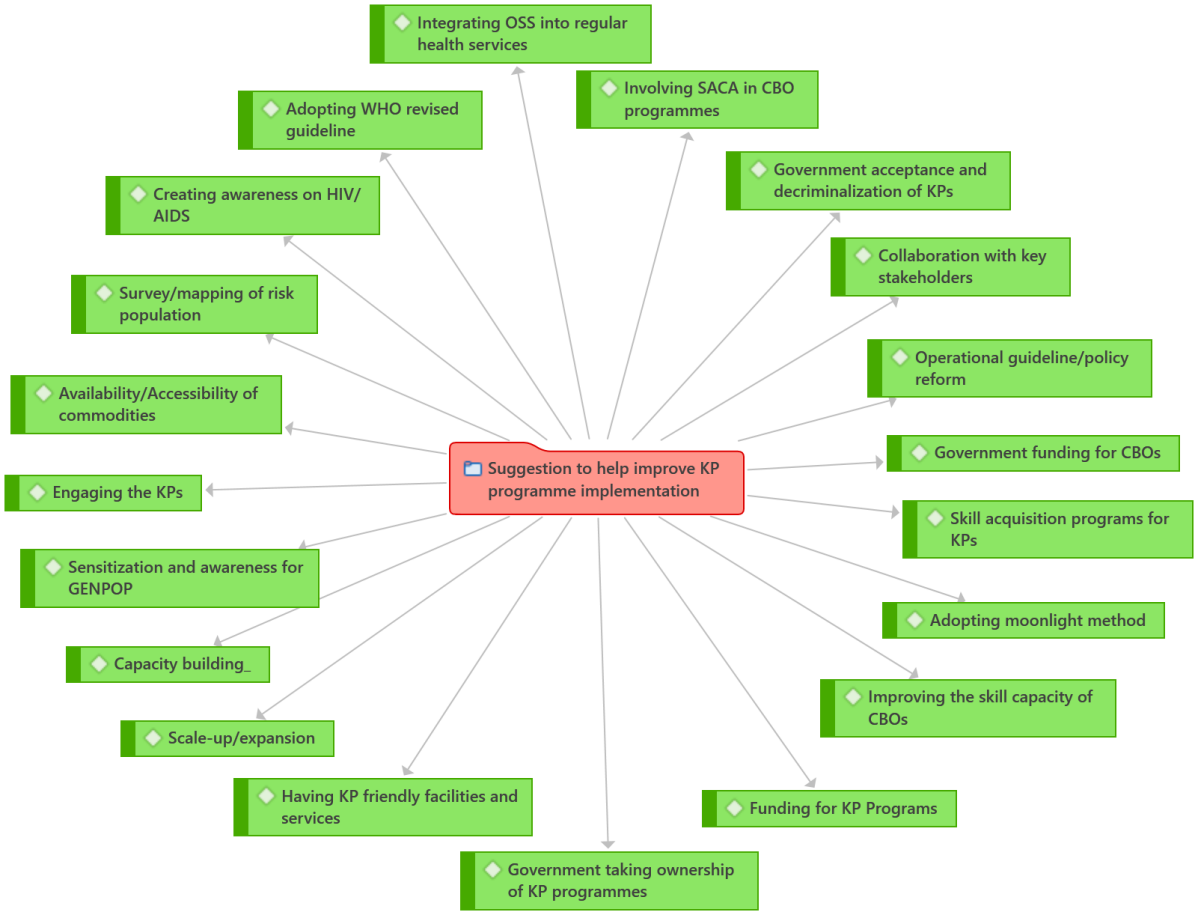

Figure 40: Suggestions to help Improve KP Programme Implementation

3.5 FINDINGS OF THE OSS ASSESSMENT

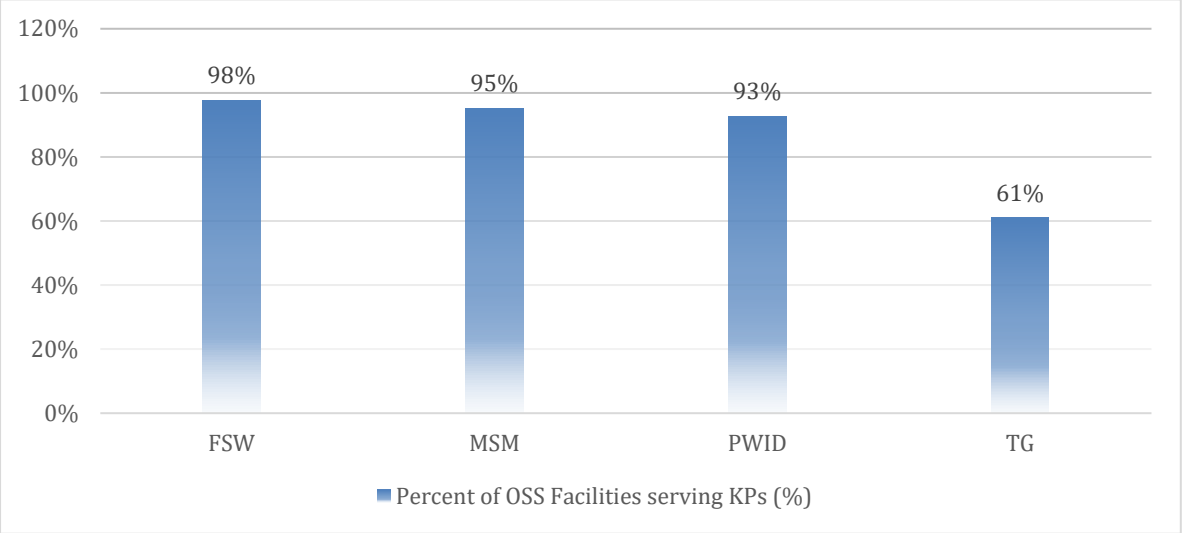

Figure 41: Percentage of OSS Facilities Serving Key Populations by Typology

In Figure 41, the percentage of OSS facilities serving KP typologies is highest for FSWs (98%), followed by MSM (95%), PWID (93%), and TG (61%).

Average Number of KPs Served per Assessed OSS Facility

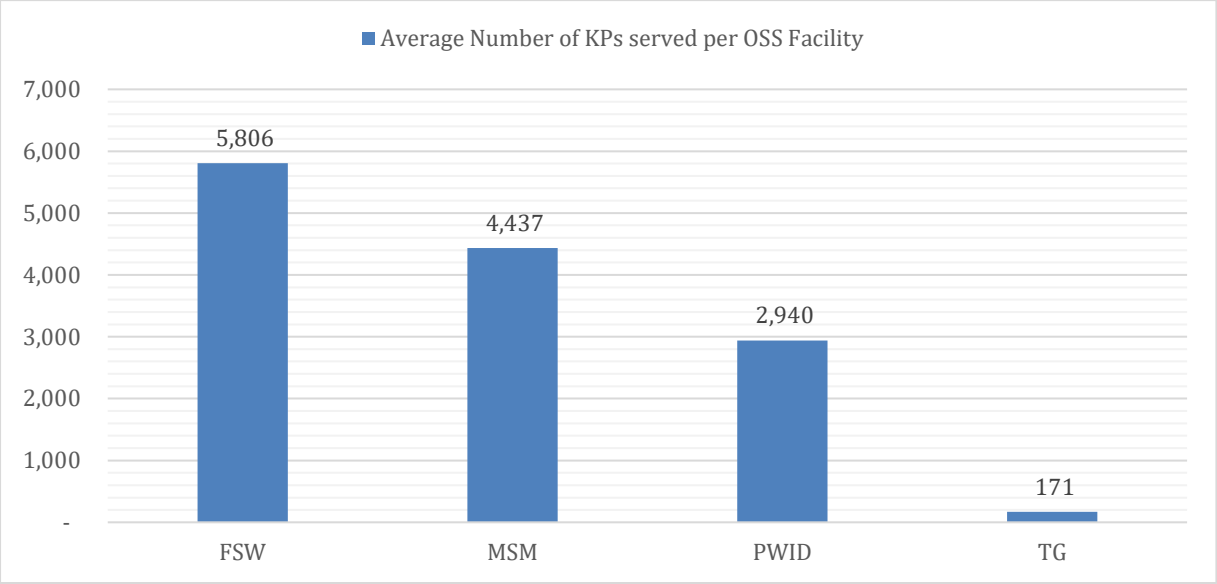

Figure 42: Average Number of KP Typologies Served per Assessed OSS Facility

In Figure 42, the average number of KP typologies served per assessed OSS facility is highest for FSWs (5,806), followed by MSM (4,437), PWID (2,940), and TG (171).

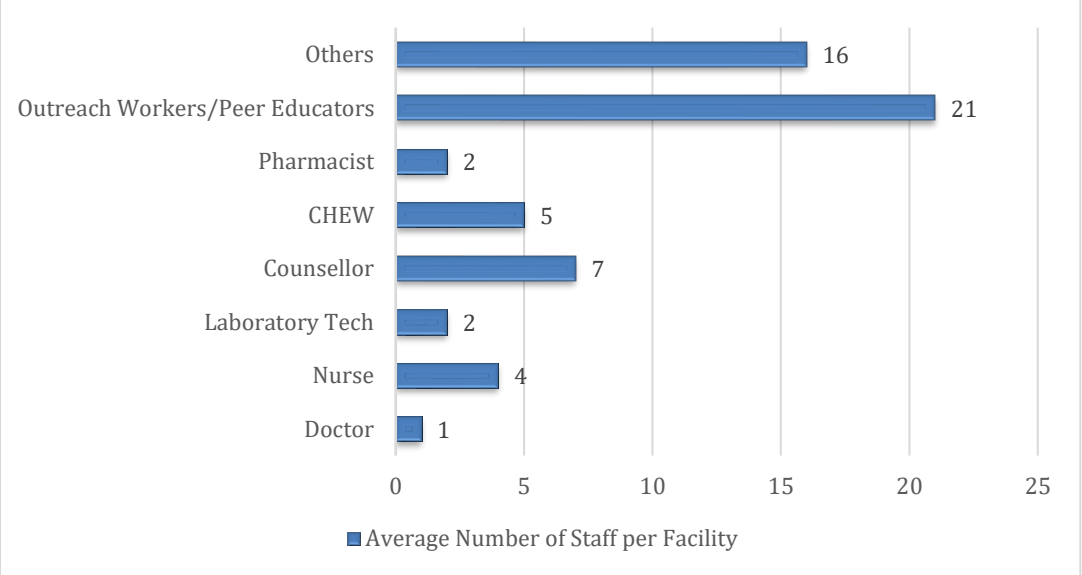

Figure 43: Average Number of Staff per Assessed OSS Facility

Figure 43 shows that the staff per facility varies from 1 for doctors to 21 for other roles, with outreach workers/peer educators having the highest averages.

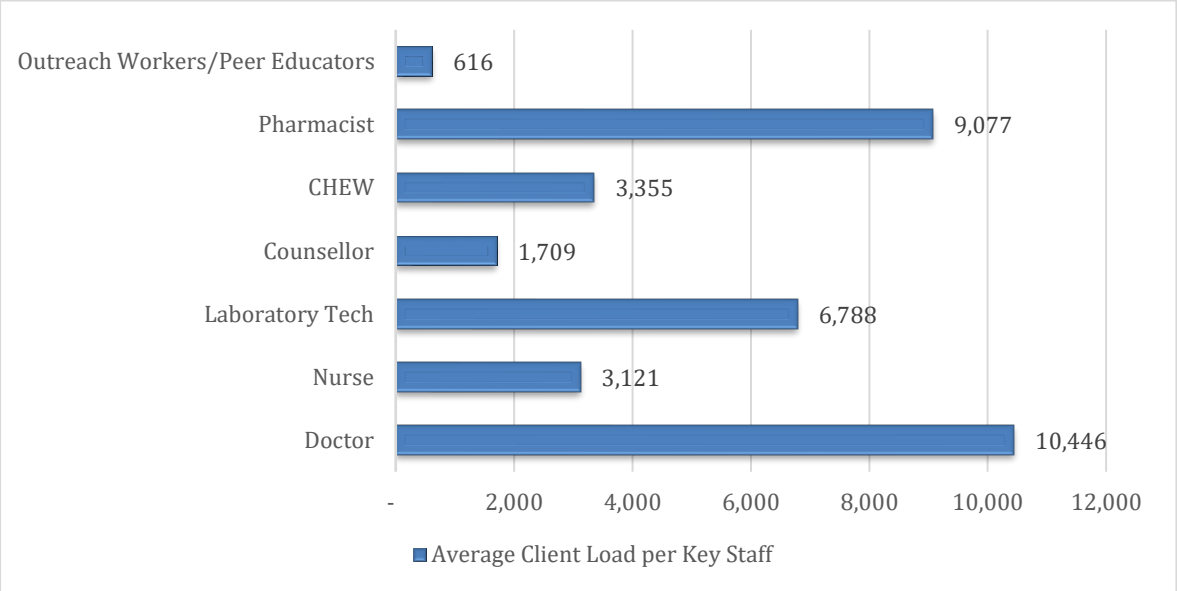

Figure 44: Average Client Load per Key Staff in Assessed OSS Facilities

Figure 44**.** indicates the number of clients per key staff member varies widely. For instance, Outreach Workers/Peer Educators have an average client load of 616, while doctors have an average of 10,446 clients.

Effective Coverage

Required Coverage Assessment

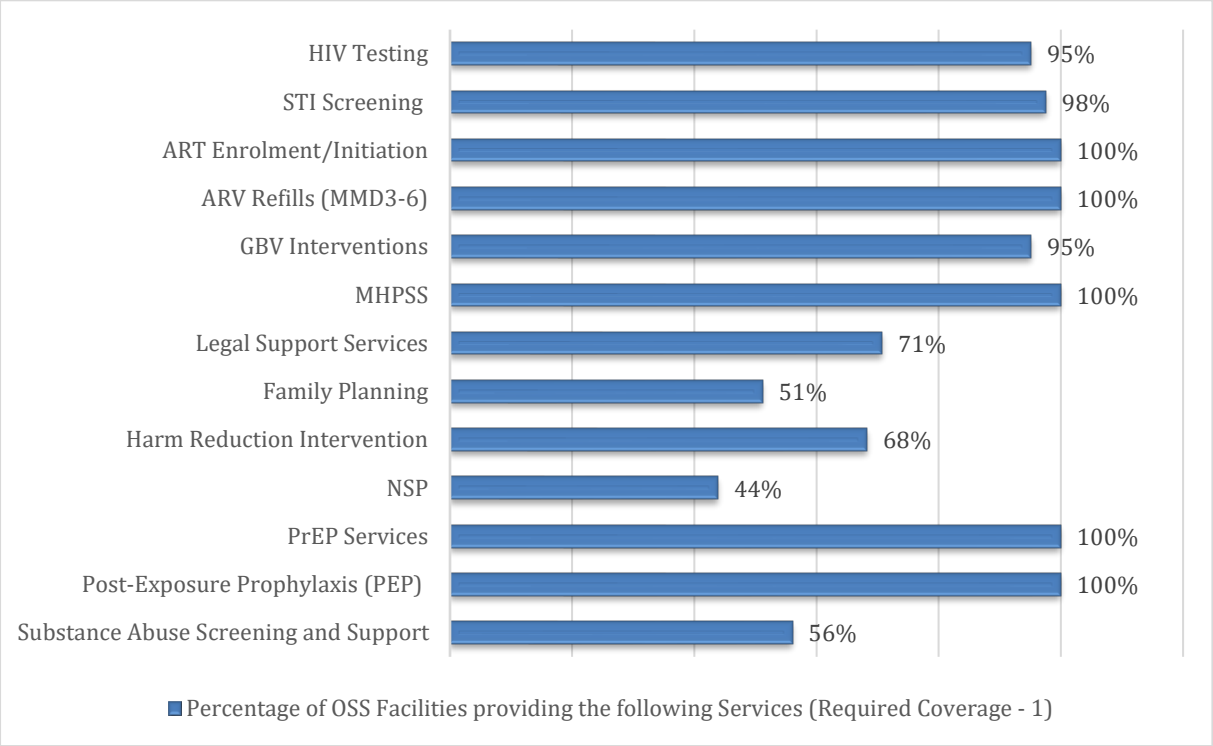

Figure 45: Percentage of Assessed OSS Facilities providing Required Services (Required Coverage 1)

HIV Testing (see Figure 45): 95% of OSS facilities provide HIV testing, indicating a high availability of this essential service.

STI Screening: 98% of OSS facilities offer STI screening, demonstrating a strong emphasis on sexual health beyond HIV.

ART Enrolment/Initiation, ARV Refills (MMD3-6), PrEP Services, and Post-Exposure Prophylaxis (PEP): These services are provided by 100% of OSS facilities, reflecting comprehensive HIV care and prevention.

GBV Interventions and MHPSS: 95% of OSS facilities offer interventions for gender-based violence (GBV) and mental health and psychosocial support (MHPSS), showing a holistic approach to care.

Legal Support Services, Family Planning, Harm Reduction Intervention, NSP, and Substance Abuse Screening and Support: These services are provided to a lesser extent, with percentages ranging from 44% to 71%. This indicates potential areas for improvement in service provision, particularly in legal support, family planning, and harm reduction.

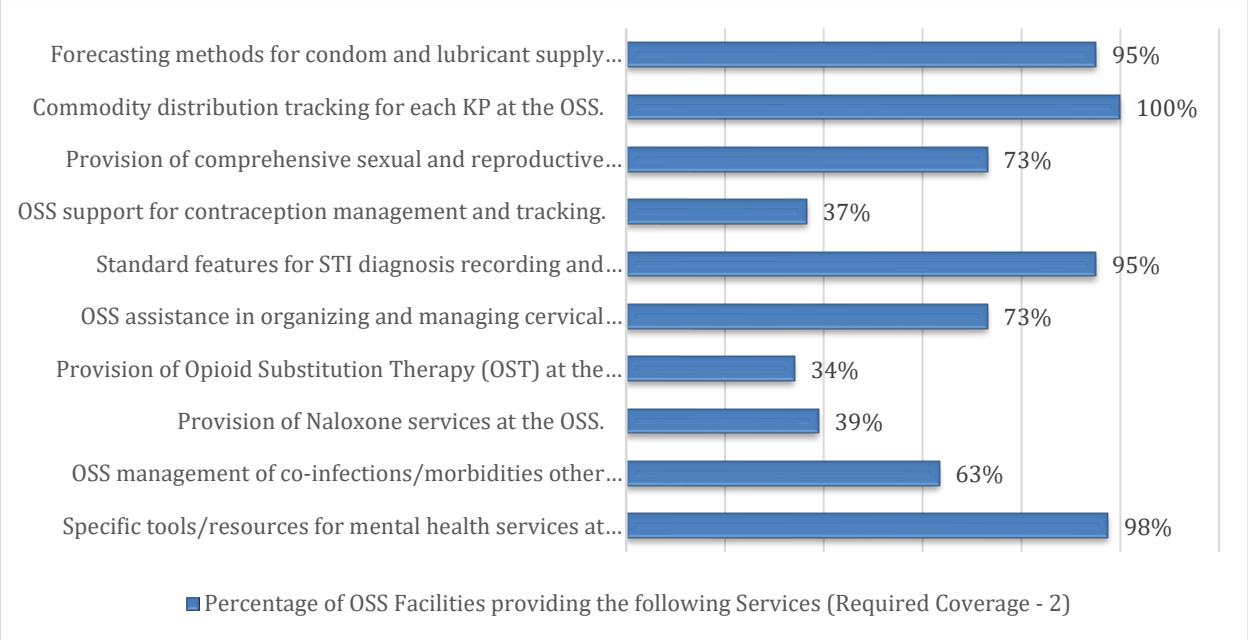

Figure 46: Percentage of Assessed OSS Facilities providing Required Services (Required Coverage 2)

Condom and Lubricant Supply (Figure 46**)**

- Forecasting methods for condom and lubricant supply at the OSS: This indicates that the majority (95%) of OSS facilities have established methods for forecasting the supply of condoms and lubricants. It suggests good preparedness in ensuring the availability of these essential items, which is crucial for promoting safe sexual health practices.
- Commodity distribution tracking for each KP at the OSS: The response rate of 100% suggests that all OSS facilities track commodity distribution for each Key Population (KP).

SRH Services (including anal health care)

- Provision of comprehensive sexual and reproductive health services at the OSS: This percentage of 73% indicates that approximately three-quarters of OSS facilities provide comprehensive sexual and reproductive health services. While it's a significant portion, there is still room for improvement to ensure that all facilities offer these essential services.
- OSS support for contraception management and tracking: With only 37% of facilities providing support for contraception management and tracking, there appears to be a gap in this aspect of sexual and reproductive health services. Strengthening support in contraception management could help improve family planning outcomes and overall reproductive health.
- Standard features for STI diagnosis recording and management at the OSS: The high percentage (95%) indicates that most OSS facilities have standard features for recording

and managing STI diagnoses. This is crucial for effective treatment, surveillance, and prevention of sexually transmitted infections (STIs).

- OSS assistance in organising and managing cervical screening programmes: With 73% of OSS facilities assisting in organising and managing cervical screening programmes, there is substantial support for cervical cancer prevention. However, efforts could be made to increase this percentage further to ensure broader access to cervical screening services.

Opioid Substitution Therapy (OST)

- Provision of Opioid Substitution Therapy (OST) at the OSS: This relatively low percentage (34%) indicates that there is limited provision of opioid substitution therapy at OSS facilities. Increasing access to OST is critical for addressing opioid addiction and reducing associated harms such as overdose and transmission of blood-borne diseases.
- Provision of Naloxone services at the OSS: Similarly, the percentage suggests that naloxone services are not widely available, with only 39% of OSS facilities providing them. Naloxone is a life-saving medication used to reverse opioid overdoses, and expanding access to it could help prevent overdose-related deaths.

Other Co-Morbidities

- OSS management of co-infections/morbidities other than TB and Viral Hepatitis: This percentage indicates that a majority (63%) of OSS facilities manage co-infections and other morbidities beyond tuberculosis (TB) and viral hepatitis. It reflects a moderate level of attention to addressing multiple health issues among the OSS population.
- Specific tools/resources for mental health services at the OSS: The high percentage (98%) suggests that almost all OSS facilities provide specific tools and resources for mental health services. This indicates a strong recognition of the importance of addressing mental health concerns among OSS users, which is critical for comprehensive healthcare delivery.

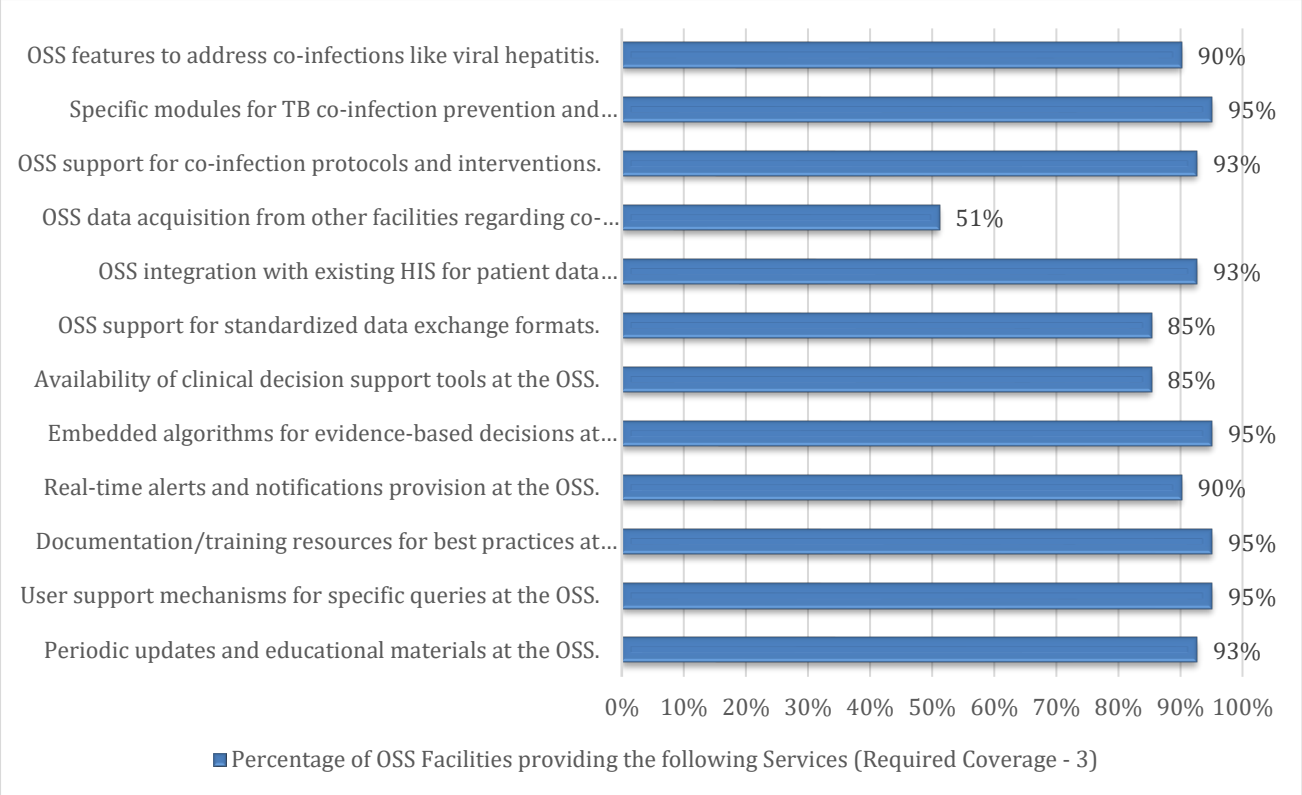

Figure 47: Percentage of Assessed OSS Facilities providing Required Services (Required Coverage 3)

Co-Infections (Figure 47**)**

- **OSS features to address co-infections like viral hepatitis**: A response rate of 90% indicates that the majority of OSS facilities have features in place to address co-infections such as viral hepatitis. This suggests a strong emphasis on addressing multiple health concerns simultaneously.
- **Specific modules for TB co-infection prevention and management at the OSS**: With a high response rate of 95%, it suggests that almost all OSS facilities have specific modules dedicated to TB co-infection prevention and management. This demonstrates a comprehensive approach to addressing TB co-infections within the target population.
- **OSS support for co-infection protocols and interventions**: A response rate of 93% indicates strong support for co-infection protocols and interventions across OSS facilities. This suggests a coordinated effort to implement effective strategies for managing co-infections.

Integration and Interoperability

- **OSS data acquisition from other facilities regarding co-infection**: With a response rate of 51%, it indicates that just over half of OSS facilities can acquire data from other facilities regarding co-infections.
- **OSS integration with existing HIS for-patient data management**: A high response rate of 93% suggests that the majority of OSS facilities are integrated with existing Health Information Systems (HIS) for patient data management. This facilitates efficient data sharing and enhances the continuity of care.
- **OSS support for standardized data exchange formats**: With a response rate of 85%, it indicates that the majority of OSS facilities support standardized data exchange formats. This promotes interoperability and facilitates seamless data sharing among healthcare systems.

Clinical Decision Support

- Availability of clinical decision support tools at the OSS: A response rate of 85% indicates that the majority of OSS facilities have clinical decision support tools available. These tools can help healthcare providers make informed and evidence-based decisions, enhancing the quality of care.
- Embedded algorithms for evidence-based decisions at the OSS: With a high response rate of 95%, it suggests that almost all OSS facilities have embedded algorithms for making evidence-based decisions. This ensures that healthcare providers have access to the latest research and guidelines to guide their practice.
- Real-time alerts and notifications provision at the OSS: A response rate of 90% suggests that the majority of OSS facilities provide real-time alerts and notifications. This can help healthcare providers stay informed about critical events or changes in patient conditions, enabling timely interventions.

User Training and Support

- **Documentation/training resources for best practices at the OSS**: With a high response rate of 95%, it indicates that the majority of OSS facilities provide documentation and training resources for best practices. This supports continuous learning and skill development among healthcare providers.
- **User support mechanisms for specific queries at the OSS**: Similarly, a response rate of 95% suggests that the majority of OSS facilities have user support mechanisms in place for

addressing specific queries. This ensures that healthcare providers have access to assistance when needed, promoting efficient service delivery.

- **Periodic updates and educational materials at the OSS**: A response rate of 93% indicates that the majority of OSS facilities provide periodic updates and educational materials. This facilitates ongoing professional development and ensures that healthcare providers are up-to-date with the latest practices and guidelines.

Summary Review of Qualitative Responses from Assessed OSS Facilities on Required Coverage

Condom and Lubricant Supply

The responses by the OSS facilities vary in terms of specificity and clarity regarding their forecasting methods/tools for condom and lubricant supply. Several facilities mention specific tools such as CRRRF (Combined Report and Requisition Form), inventory control cards, and requisition forms. Some responses indicate using consumption data, tracking reports, and inventory management systems. Others mention standard operating procedures (SOPs) and quantification of commodities as part of their forecasting methods. Some facilities did not provide a clear response to the inquiry. Lack of response may indicate either a lack of established forecasting methods or a failure to communicate them effectively.

GBV Interventions

The responses by the OSS facilities regarding the types of GBV interventions implemented, reflect a range of interventions implemented by OSS facilities to address GBV, including medical care, psychosocial support, referrals, and advocacy. These interventions demonstrate a commitment to providing comprehensive support to survivors and addressing the various forms of violence they may experience.

Family Planning

The responses by the OSS facilities regarding the specific family planning services provided vary in terms of the range of family planning services provided. Some facilities offer a comprehensive array of contraceptive options alongside counselling services, while others may focus primarily on condom distribution and education. The provision of injectables, oral contraceptives, long-term implants, and sterilisation services indicates a commitment to offering diverse options for family planning, enhancing accessibility and choice for clients. However, there are also instances where services are limited or not provided, potentially indicating challenges or gaps in service provision that may need to be addressed.

Integration and Interoperability

The responses by the OSS facilities regarding mechanisms for data exchange with external facilities reflect a variety of approaches to data exchange. They range from structured systems such as DHIS to manual processes using Excel. Some facilities demonstrate partnerships with external entities for data sharing, while others indicate limitations or absence of established mechanisms. Efforts to enhance interoperability, streamline reporting processes, and strengthen partnerships with external stakeholders could improve data exchange and facilitate more efficient and effective information sharing across facilities.

Clinical Decision Support

Regarding examples of clinical decision support tools used, some OSS facilities provided specific clinical decision support tools such as screening forms and assessment tools, while others listed medical equipment or relied on national guidelines and protocols. Non-responses or indications of the unavailability of basic medical equipment suggest a potential gap in providing specific clinical decision support tools or a need for further clarification on the types of tools utilised.

Availability Coverage Assessment

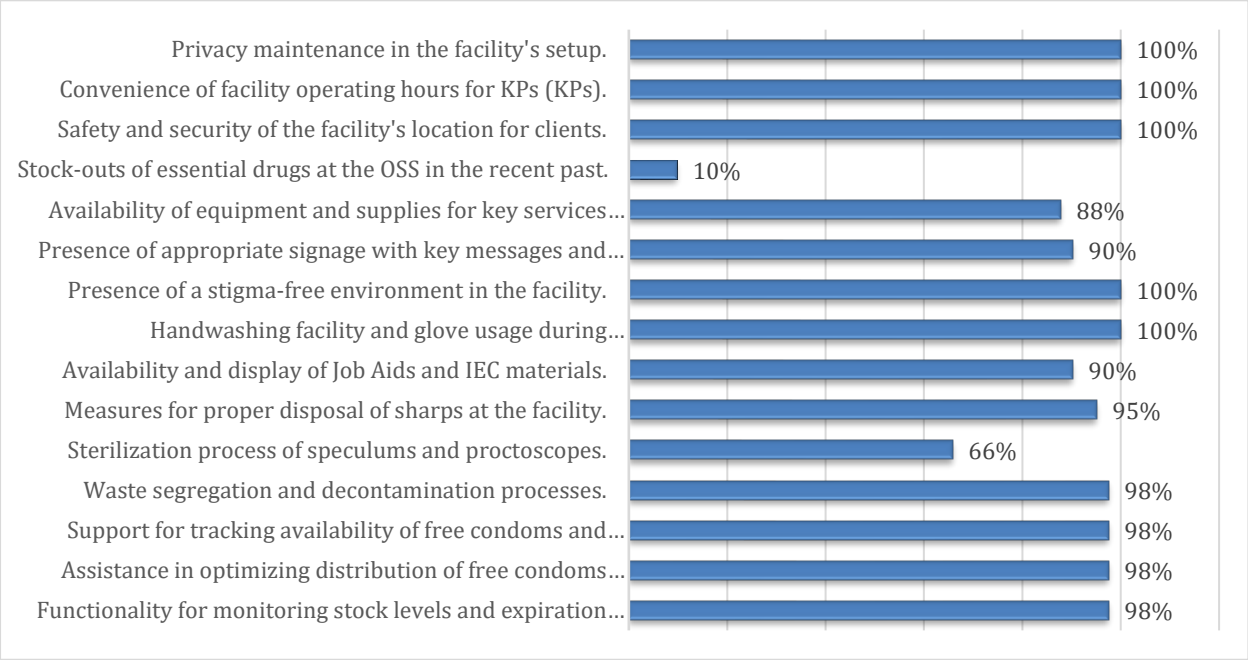

Figure 48: Percentage of Assessed OSS Facilities providing Availability Coverage Services (Availability Coverage)

Facility Set-Up (See Figure 48**)**

- All OSS facilities (100%) responded positively to maintaining privacy in their setup, which is a critical aspect of ensuring patient comfort and confidentiality.

Time of Operation

- Similarly, all OSS facilities (100%) have convenient operating hours for key populations (KPs), which enhances accessibility to services, showing a commitment to meeting the needs of the target population.

Location

- All OSS facilities (100%) ensure the safety and security of their locations for clients, which is crucial for building trust and encouraging regular attendance.

Stock-Out

- **Essential Drugs**: Only 10% of the OSS facilities reported experiencing stock-outs of essential drugs in the recent past. This suggests that most facilities maintain adequate supply chain management for essential medications but highlights an area for improvement for the minority of facilities experiencing shortages.

- **Equipment and Supplies**: 88% of the OSS facilities reported having sufficient equipment and supplies for key services, indicating good preparedness but also suggesting that some facilities may need additional resources.
- **Signage and Stigma-Free Environment**: 90% to 100% of the facilities reported having appropriate signage and maintaining a stigma-free environment, indicating a strong commitment to creating a supportive and inclusive atmosphere for clients.

Infection Control & Waste Management

- Across various aspects such as handwashing facilities, disposal of sharps, and waste segregation, facilities generally scored high, with percentages ranging from 66% to 100%, indicating good adherence to infection control protocols.

Condom and Lubricant Programming

- Facilities demonstrate robust support for condom and lubricant programming, with 98% reporting functionality for tracking availability, optimizing distribution, and monitoring stock levels and expiration dates. This reflects a proactive approach to sexual health promotion and disease prevention.

Summary Review of Qualitative Responses from OSS Facilities on Availability Coverage

Facility Set-Up

The responses by the OSS facilities regarding privacy maintenance methods reflect a variety of strategies implemented by OSS facilities to maintain privacy and confidentiality. These measures range from physical infrastructure adjustments (enclosed rooms, partitions) to procedural protocols (confidentiality agreements, designated service points) aimed at protecting sensitive information and providing a safe environment for clients.

Stock-Out

The responses by the OSS facilities regarding essential drugs affected by stock-outs and their durations indicate that various OSS facilities have strategies in place to mitigate the impact of stock-outs on clients, such as providing prescriptions or recommending alternative medications. However, the lack of specific details regarding the duration of stock-outs limits the comprehensiveness of the evaluation. More detailed information on the duration of stock-outs would be beneficial for understanding the extent of the issue and identifying potential areas for improvement in supply chain management.

Infection Control & Waste Management

- **Measures for Sharps Disposal**: The responses provided by various OSS facilities regarding measures for sharps disposal reflect a variety of measures implemented by OSS facilities to ensure the safe and proper disposal of sharps, including the use of designated containers, collaboration with waste management authorities, and adherence to waste management protocols. These measures contribute to maintaining a safe and hygienic environment for both staff and clients.
- **How Sterilization is Ensured**: Responses provided by various OSS facilities regarding how sterilization is ensured indicate a variety of methods employed by OSS facilities to ensure sterilization of equipment, including the use of disposable items, autoclaves, and collaboration with external facilities for sterilization. However, there may be variations in the adequacy and effectiveness of these methods, highlighting the importance of adhering to medical standards and guidelines for sterilization to ensure the safety of patients and healthcare workers.
- **Waste Segregation and Decontamination Processes**: Responses by the OSS facilities regarding waste segregation and decontamination processes demonstrate various approaches to waste segregation and decontamination, including the use of colour coding, sharp boxes, decontamination methods, collaboration with waste management authorities, and adherence to SOPs. These practices contribute to maintaining a safe and hygienic environment within OSS facilities, ensuring the protection of both staff and clients against potential health hazards.

Contact Coverage and Utilisation Coverage Assessment

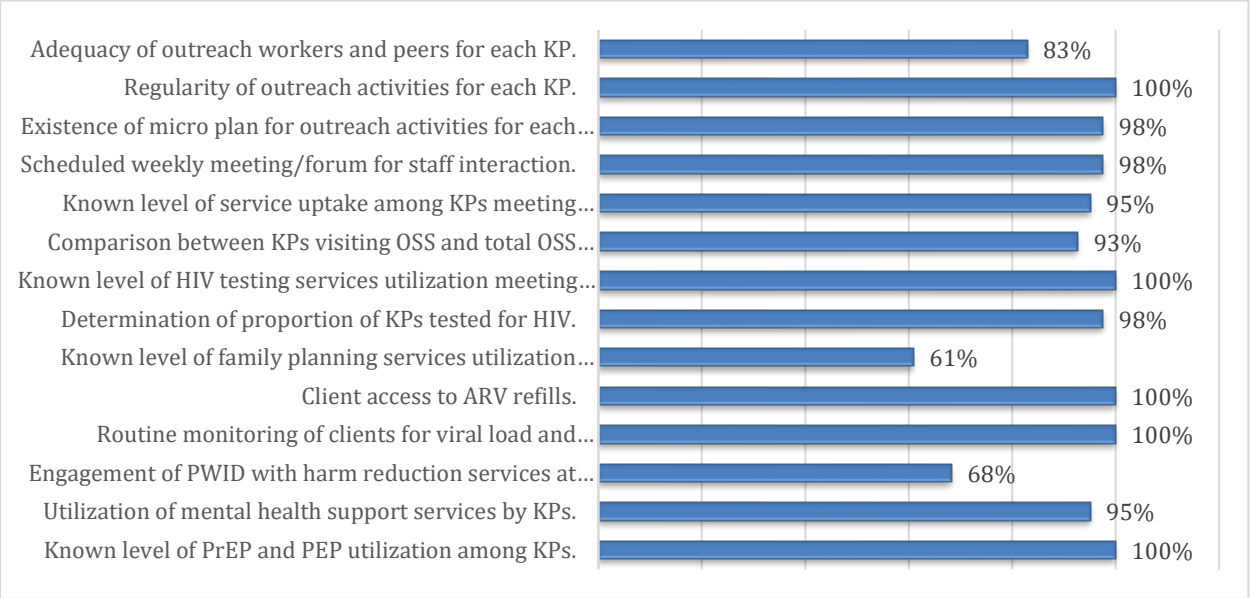

Figure 49: Percentage of Assessed OSS Facilities providing Contact and Utilisation Coverage Services (Contact and Utilisation Coverages)

Contact Coverage (Figure 49)

Key Population Demographics

- **Adequacy of outreach workers and peers**: 83% of OSS facilities responded positively to having adequate outreach workers and peers for each Key Population (KP). This indicates that the majority of facilities have sufficient personnel dedicated to outreach activities tailored to KPs.
- **Regularity of outreach activities**: All facilities (100%) reported regularity in their outreach activities for each KP. This demonstrates a commitment to consistent engagement with KPs, which is crucial for building trust and ensuring access to essential services.
- **Existence of micro plan for outreach activities**: 98% of facilities have a micro plan in place for outreach activities for each KP. Micro planning helps in detailing the specific strategies and objectives for reaching KPs effectively, ensuring targeted interventions.
- **Scheduled weekly meetings/forums for staff interaction**: A high percentage (98%) of facilities reported having scheduled weekly meetings or forums for staff interaction. Regular staff meetings facilitate communication, coordination, and sharing of best practices, contributing to efficient service delivery.

Utilisation Coverage (Figure 49)

Service Utilisation

- **Known level of service uptake among KPs meeting predefined standards**: 95% of facilities reported knowing the level of service uptake among KPs meeting predefined standards. This suggests that facilities have mechanisms in place to track and assess service utilisation, enabling them to monitor progress and identify areas for improvement.
- **Comparison between KPs visiting OSS and total OSS visits in the previous month**: A significant proportion (93%) of facilities reported conducting comparisons between KPs visiting the OSS and total OSS visits in the previous month. This indicates a proactive approach to understanding the utilisation patterns of KPs and tailoring services accordingly.

HIV Testing Services

- **Known level of HIV testing services utilisation meeting predefined target**: All facilities (100%) reported knowing the level of HIV testing services utilisation meeting predefined targets. This demonstrates a high level of awareness and monitoring of HIV testing services, essential for addressing the HIV epidemic among KPs.
- **Determination of the proportion of KPs tested for HIV**: 98% of facilities reported determining the proportion of KPs tested for HIV. This indicates a comprehensive approach to monitoring HIV testing coverage among KPs, which is crucial for early detection and linkage to care.
- **Known level of family planning services utilisation among KPs**: 61% of facilities reported knowing the level of family planning services utilisation among KPs. While this percentage is lower compared to other services, it still reflects efforts to monitor and address family planning needs among KPs.

ARV

- **Client access to ARV refills**: All facilities (100%) reported client access to ARV refills, indicating a high level of availability and accessibility of HIV treatment services for KPs.
- **Routine monitoring of clients for viral load and treatment effectiveness**: All facilities (100%) reported routine monitoring of clients for viral load and treatment effectiveness, demonstrating a commitment to ensuring the quality of HIV care and treatment services.

Harm Reduction Services Utilisation by PWID

- Engagement of PWID with harm reduction services at the OSS: 68% of facilities reported engagement of People Who Inject Drugs (PWID) with harm reduction services at the OSS. While not all facilities reported this service, the majority are providing essential harm-reduction interventions for PWID.

Mental Health Support Services Utilisation by KP

- Utilisation of mental health support services by KPs: 95% of facilities reported utilisation of mental health support services by KPs. This reflects recognition of the importance of addressing mental health issues among KPs and providing appropriate support services.

PrEP and PEP Utilisation by KP

- Known level of PrEP and PEP utilisation among KPs: All facilities (100%) reported a known level of PrEP and PEP utilisation among KPs. This indicates comprehensive monitoring of HIV prevention services, including Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), among KPs.

The majority of OSS facilities are performing well in terms of outreach activities, service utilisation monitoring, and provision of essential services tailored to the needs of Key Populations. However, there may be some areas, such as family planning services utilisation, where improvement or further attention is needed.

Summary Review of Qualitative Responses from OSS Facilities on Utilisation Coverage

It is important to compare the data on key populations (KPs) who visit the facility and those who are contacted through services. Some OSS facilities have provided direct data for this comparison, while others have focused more on waste management practices. However, to ensure effective outreach and engagement with KPs, it is essential for facilities to consistently track and evaluate service utilisation.

Another crucial aspect is to compare the number of KPs tested for HIV with the total estimated KP. While some OSS facilities have provided direct numerical data or detailed breakdowns of HIV testing numbers, others have given limited or incomplete information. Consistent tracking and reporting on HIV testing activities, along with comparisons with the total estimated KP, is necessary to assess testing coverage effectively and identify areas for improvement.

Similarly, it is important to compare the number of KPs who have started on ART with the total estimated KP. While some OSS facilities have provided direct numerical data or detailed

breakdowns of ART initiation numbers, others have given limited or incomplete information. Consistent tracking and reporting on ART initiation activities, along with comparisons with the total estimated KP, is necessary to assess coverage effectively and identify areas for improvement.

Quality-Adjusted Coverage Assessment

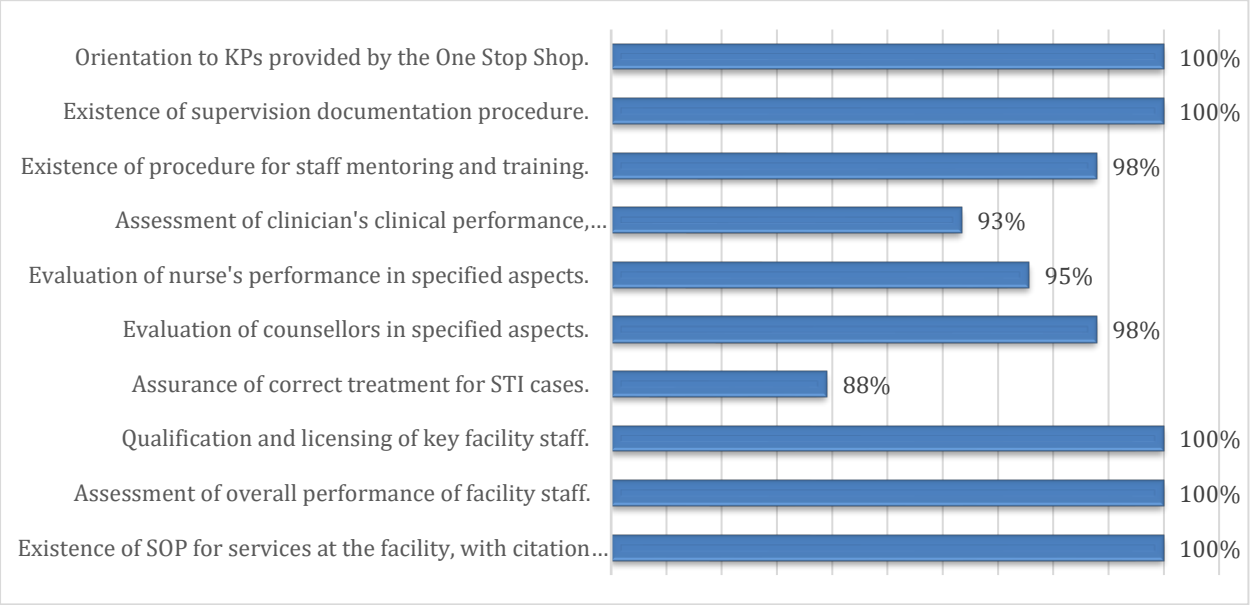

Figure 50: Percentage of Assessed OSS Facilities providing Quality-Adjusted Coverage Services (Quality-Adjusted Coverage)

Facility Performance (See Figure 50**)**

- **Orientation to KPs provided by the One Stop Shop**: This row indicates that 100% of OSS facilities reported providing orientation to Key Populations (KPs). This suggests that these facilities are committed to ensuring that KPs are adequately informed about the services available to them, which is crucial for promoting access and utilisation.
- **Existence of supervision documentation procedure**: Again, 100% of facilities reported having a supervision documentation procedure. This indicates that these facilities have structured processes in place for monitoring and evaluating staff performance, which is essential for maintaining quality standards and identifying areas for improvement.
- **Existence of procedures for staff mentoring and training**: The high percentage (98%) of facilities reporting the existence of procedures for staff mentoring and training suggests a commitment to staff development and continuous improvement. This is vital for ensuring that staff members are equipped with the necessary skills and knowledge to deliver high-quality services to KPs.

Clinician Clinical Performance

- **Assessment of clinician's clinical performance, especially in specified aspects**: With 93% of facilities reporting assessment of clinician's clinical performance, it indicates a strong focus on monitoring and maintaining the quality of clinical care provided to KPs. This ensures that clinicians are delivering services in line with established standards and guidelines.

Nurse Performance

- **Evaluation of nurse's performance in specified aspects**: Similar to clinician assessment, 95% of facilities reported evaluating nurse performance. This underscores the importance placed on ensuring that nursing staff are delivering care effectively and efficiently, contributing to overall service quality.

Counsellor Performance

- **Evaluation of counsellors in specified aspects**: 98% of facilities reported evaluating counsellor performance, indicating a recognition of the critical role that counselling plays in supporting KPs' health and well-being. Regular evaluation helps ensure that counselling services meet the needs of KPs and are delivered with sensitivity and effectiveness.

Correct STI Case Treatment

- **Assurance of correct treatment for STI cases**: While 88% of facilities reported providing correct treatment for STI cases, this indicates that there may be room for improvement in ensuring adherence to treatment protocols. It highlights the importance of ongoing quality monitoring to address any deficiencies in STI case management.

Facility Staffing and Training

- **Qualification and licensing of key facility staff**: All facilities reported having qualified and licensed key staff, reflecting a commitment to employing skilled professionals who meet regulatory requirements. This is essential for ensuring safe and effective service delivery.
- **Assessment of overall performance of facility staff**: Similarly, 100% of facilities reported assessing the overall performance of facility staff, indicating a proactive approach to maintaining high standards of service provision. Regular performance assessments help identify strengths and areas needing improvement among staff members.

SOP

- **Existence of SOP for services at the facility, with sighting if applicable**: Lastly, 100% of facilities reported having Standard Operating Procedures (SOPs) for services, ensuring that there are clear guidelines and protocols in place for delivering care. SOPs promote consistency, safety, and quality in service provision.

Summary Review of Qualitative Responses from OSS Facilities on Quality-Adjusted Coverage

Correct STI Case Treatment

While some OSS facilities provided specific data on STI visits by KPs, many lacked corresponding data on total facility visits by KPs, making it challenging to assess the proportion of STI visits accurately. Moving forward, improving data collection practices and ensuring comprehensive record-keeping will be essential for meaningful programme evaluation and quality improvement efforts.

Completeness of Patient Records, Laboratory Systems, Referral Networks, Facility Operation, and Technical Support Assessment

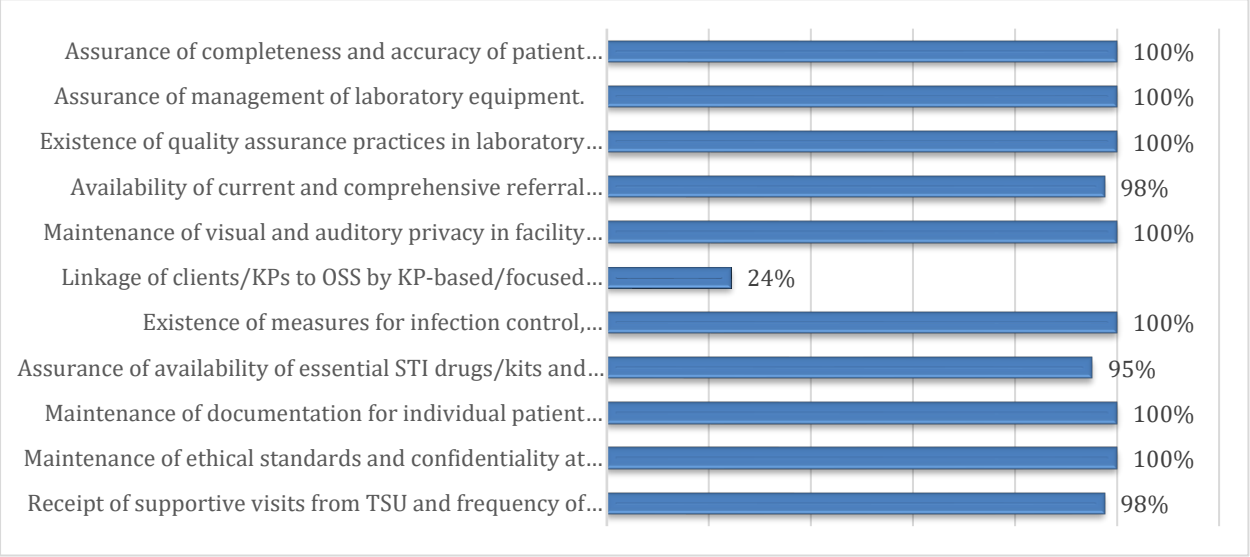

Figure 51: Percentage of Assessed OSS Facilities providing Operational and Support Services (Completeness of Patient Records, Laboratory Systems, Referral Networks, Facility Operation, and Technical Support)

COMPLETENESS OF PATIENT RECORD (Figure 51)

Recordkeeping

- **Assurance of completeness and accuracy of patient records**: All OSS facilities (100%) reported ensuring the completeness and accuracy of patient records. This indicates a strong commitment to maintaining high standards of recordkeeping, which is essential for effective patient management, continuity of care, and data-driven decision-making.

LABORATORY SYSTEMS (Figure 51)

Laboratory Management

- **Assurance of management of laboratory equipment**: Similarly, all facilities (100%) reported assuring the management of laboratory equipment. This suggests that facilities prioritize the maintenance, calibration, and proper functioning of laboratory equipment, ensuring reliable and accurate test results for patient care.
- **Existence of quality assurance practices in laboratory management**: All facilities (100%) also reported the existence of quality assurance practices in laboratory management. This indicates a systematic approach to monitoring and improving the quality of laboratory services, including proficiency testing, internal quality control, and participation in external quality assessment programmes.

REFERRAL NETWORKS (Figure 51)

Referral System & Networks

- **Availability of current and comprehensive referral directory**: A high percentage (98%) of facilities reported having a current and comprehensive referral directory. This is crucial for facilitating timely and appropriate referrals, ensuring that patients receive the necessary follow-up care and specialized services beyond the scope of the OSS.

FACILITY OPERATION (Figure 51)

Set-up and Operation

- **Maintenance of visual and auditory privacy in facility set-up**: Once again, all facilities (100%) reported maintaining visual and auditory privacy in facility set-up. This demonstrates a commitment to respecting patients' confidentiality and dignity, creating a safe and comfortable environment for accessing healthcare services.

CBOs

- **Linkage of clients/KPs to OSS by KP-based/focused CBOs, DiCs**: Only 24% of facilities reported linking clients/KPs to OSS through KP-based/focused Community-Based Organisations (CBOs) or Drop-in Centres (DiCs). This suggests a potential area for improvement in leveraging community partnerships to enhance service uptake among KPs.

Infection Control & Waste Management (Figure 51**)**

- **Existence of measures for infection control, handwashing, glove use, and waste management**: All facilities (100%) reported having measures in place for infection control, handwashing, glove use, and waste management. This indicates a strong emphasis on ensuring a safe and hygienic environment within the OSS, minimizing the risk of healthcare-associated infections and promoting staff and patient safety.

Drug and Condom Supply Management (Figure 51**)**

- Assurance of availability of essential STI drugs/kits and condoms: A high percentage (95%) of facilities reported assuring the availability of essential STI drugs/kits and condoms. This underscores the importance placed on ensuring access to essential medications and preventive measures for STI/HIV prevention and treatment.

Documentation and Reporting (Figure 51**)**

- **Maintenance of documentation for individual patient records and facility registers**: Once again, all facilities (100%) reported maintaining documentation for individual patient records and facility registers. This is critical for tracking patient care, monitoring service utilisation, and ensuring accountability in service delivery.

Ethical Standards and Confidentiality (Figure 51**)**

- **Maintenance of ethical standards and confidentiality at the One Stop Shop**: All facilities (100%) reported maintaining ethical standards and confidentiality at the OSS. This reflects adherence to professional codes of conduct and legal requirements, safeguarding patient rights and privacy.

TECHNICAL SUPPORT (Figure 51)

Support from Technical Units

- **Receipt of supportive visits from TSU and frequency of occurrence**: A high percentage (98%) of facilities reported receiving supportive visits from Technical Support Units (TSU), indicating ongoing technical assistance and capacity-building support. This

highlights the importance of collaboration and mentorship in enhancing service delivery and quality improvement efforts.

Summary Review of Qualitative Responses from OSS Facilities on Facility Operation

Infection Control & Waste Management

Infection control and waste management are top priorities at the OSS, as evidenced by the strong commitment to these practices outlined in the responses. The OSS facilities provide Personal Protective Equipment (PPE), hand hygiene facilities, proper waste disposal methods, and adhere to SOPs to maintain a safe and hygienic environment for both staff and clients. These measures are crucial for preventing the spread of infections and ensuring compliance with regulatory standards.

Documentation and Reporting

The responses also reveal a strong emphasis on maintaining accurate, confidential, and well-organised patient records at the OSS facilities. The OSS facilities have measures in place to ensure accessibility, security, and compliance with documentation standards. These efforts are essential for providing quality healthcare services, supporting continuity of care, and facilitating effective monitoring and evaluation of healthcare programmes.

Sustainability Assessment

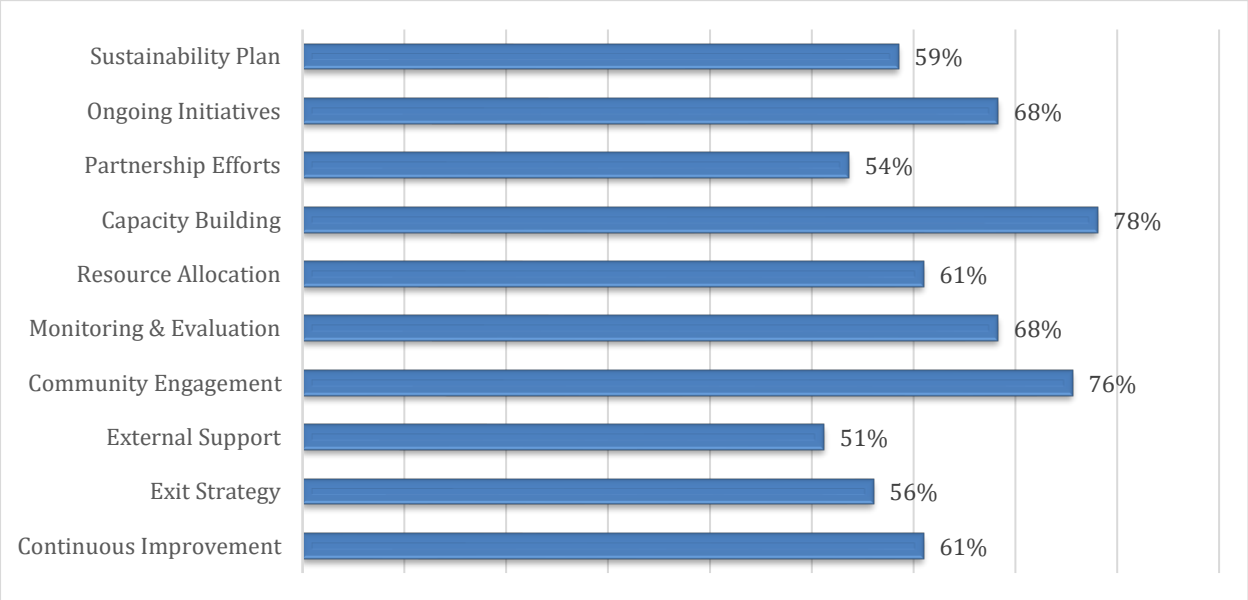

Figure 52: Percentage of OSS Facilities undertaking Sustainability strengthening activities (Sustainability)

Sustainability Plan (59%): While a majority of facilities have a documented sustainability plan, there is room for improvement to ensure that all facilities have a clear roadmap for sustaining the OSS KP HIV Programme. Having a well-defined plan is crucial for long-term viability and effectiveness.

Ongoing Initiatives (68%): It's positive that a significant portion of facilities are implementing ongoing sustainability initiatives. This demonstrates proactive efforts to address sustainability challenges and adapt to changing circumstances, contributing to the programme's resilience.

Partnership Efforts (54%): While over half of the facilities are engaged in partnerships with external agencies to support sustainability efforts, there is a need for greater collaboration with external stakeholders. Strengthening partnerships can leverage additional resources and expertise to enhance sustainability outcomes.

Capacity Building (78%): The high percentage of facilities with capacity-building efforts indicates a strong commitment to enhancing the skills and capabilities of the OSS team for sustainable programme management. Investing in training and development is essential for building internal capacity and resilience.

Resource Allocation (61%): While there is clarity in the allocation of resources for sustaining the OSS KP HIV Programme in the majority of facilities, there is still room for improvement. Ensuring efficient resource allocation is crucial for optimizing programme effectiveness and maximizing impact.

Monitoring & Evaluation (68%): The existence of a systematic monitoring and evaluation process in nearly 70% of facilities is commendable. Regular assessment of sustainability efforts is vital for identifying strengths, weaknesses, and areas for improvement, ultimately enhancing programme sustainability.

Community Engagement (76%): It's encouraging that a significant proportion of facilities involve KPs in sustainability planning and decision-making through community engagement strategies. Engaging with the community fosters ownership, trust, and accountability, which are essential for sustainable programme outcomes.

External Support (51%): While just over half of the facilities receive external support for sustaining OSS operations, greater support from external sources may be needed to bolster sustainability efforts. Diversifying funding sources and strengthening partnerships can help secure additional support.

Exit Strategy (56%): The existence of a well-defined exit strategy in slightly over half of the facilities indicates an awareness of the importance of planning for programme transition. A clear exit strategy ensures smooth transitions and minimizes disruptions to services if programme closure or transition is necessary.

Continuous Improvement (61%): Implementation of continuous improvement initiatives in 61% of facilities reflects a commitment to adapt and enhance sustainability plans over time. Embracing a culture of continuous learning and innovation is essential for long-term programme success and resilience.

CHAPTER 4

DISCUSSION

The Key Population Programme Review (KPPR) findings are presented in relation to specific study objectives, which were addressed through a series of interrelated research questions.

4.1 OBJECTIVE 1: UNDERSTANDING THE KEY POPULATION PROGRAMME STRATEGY

The Key Population Programme Review (KPPR) aimed to understand the strategy adopted and implemented by Nigeria for its key population programme. The focus was on the target populations, programme platforms, and programme intervention components. To achieve this objective, a combination of methods was used, including desk review, the Prevention Self-Assessment Tool - Lite (PSAT Lite), and qualitative approaches involving Focus Group Discussions (FGDs) and In-depth Interviews (IDIs). Each method provided unique insights into how Nigeria has addressed and continues to address the needs of key populations in its HIV prevention and care strategies over the years. Below is a detailed discussion of the findings based on the different focus areas and methods.

Key Population Programme Strategy in Nigeria

Target Populations

Desk Review: The desk review revealed that the programme targets several key populations at higher risk of HIV infection. Based on the coverage population identified for the KPPR, the specific target key population studied are the FSW, MSM, PWID and TG population.

The review highlighted that the FSW, MSM and PWIDs were amongst the earliest KP groups that the country targeted in the response. These groups have been part of previous surveys, including past waves of IBBSS, while TG groups became part of the response based on their inclusion in the 2020 IBBSS.

PSAT Lite: The PSAT Lite was administered to specific KP groups across 18 study states. It was conducted with programme managers, implementers, and community representatives, who participated in a session to address questions related to a specific KP typology. The PSAT-Lite highlighted the importance of developing customised strategies to tackle the distinct challenges

faced by each group. It considered various thematic domains or components as standardised by the country programme.

FGDs and IDIs: The FGD focused on key population (KP) community members categorised by their specific typology, while the IDI was administered to relevant stakeholders involved in the HIV response at national and state levels. The FGDs and IDIs are qualitative methods which were used to confirm contextual issues, gaps, and challenges in prevention service delivery for the key population. This reinforced the importance of specialised interventions based on their particular needs and vulnerability.

NSF 2021-2025 recognises FSW, MSM, TG, PWIDS, and People in Closed Settings as key populations for HIV programmes in Nigeria. Considering the restriction for assessing People in Closed Settings, the review focused on FSW, MSM, PWID and TG. In Nigeria, Key populations (FSW, MSM, and PWID) make up only 3.4% of the population, yet account for 11% of new HIV infections[26]. This KP categorisation is similar to what was found in a USAID study implemented by PHCDA in Kenya. This study recognized FSW, MSM, PWID and TG as KPs in Kenya.

Programme Platforms

Desk Review: The desk review revealed multiple platforms for KP services. These include The One Stop Shops(OSS), Community-Based Organisations(CBOs) and Outreach Programmes. The OSS offer comprehensive health services for key populations (KP) under one roof to reduce stigma, and cos CBOs provide tailored services delivered by organisations led by or working for/with key populations themselves. These CBOs are mostly situated in grassroots settings and Outreach Programmes that involve peer-to-peer sessions, cohort sessions, referrals, and continuous advocacy through outdoor and venue-based programmes (e.g., hotspots) targeting key populations in specific community locations.

The PSAT Lite assessment revealed HIV prevention performance in programme management and implementation domains. The programme management domain covered the following thematic components: leadership, coordination, policy, and financing while the programme implementation domain highlighted the quality-of-service delivery, biomedical/clinical, behavioural and structural interventions which are the critical pillars of the Combination Prevention approach in Nigeria.

[26] UNAIDS & NACA, (2020). Modes of HIV Transmission in Nigeria (MOT): Application of The Incidence Patterns Model, 2020

FGDs and IDIs: These interactions highlighted the critical role of CBOs in recruiting facilitators for HIV testing and linkage to care service delivery, as well as the strong collaboration between the various state AIDS control agencies and other stakeholders at national, state and community levels.

Given the barriers to accessing services posed by stigma and discrimination, this review reveals that service delivery via OSS facilities has increased service access for KP. According to this study, all facilities assessed (100%) reported that KPs are accessing HTS, ARV, PrEP and PEP at OSS facilities. The majority (95%) of the facilities reported utilisation of mental health support services by KPs. Also, 68% of OSS facilities reported that People Who Inject Drugs (PWID) access harm reduction services at the OSS, while 61% of facilities reported knowing the level of family planning services utilisation among KPs. This shows that KPs are accessing some services more than others at the OSS facilities.

All facilities (100%) reported regularity in their outreach activities for each KP typology, while only 24% of facilities reported linking clients/KPs to OSS through KP-based/focused Community-Based Organisations (CBOs) or Drop-in Centres (DiCs). This points to the need for the CBOs to focus more effort on linking peers to the OSS. Expanding the use of peer educators and counsellors will improve outreach efforts, ensuring that key populations are informed about and can access available services.

Programme Components

Service Delivery Strategies:

Desk Review: Using identified delivery platforms - such as OSS, cohort sessions, peer-to-peer sessions, and outreaches; the programme covers counselling, testing, treatment, referral, adherence, psychosocial services, mental health services, etc. These service components align with the minimum prevention service packages recommended globally for members of key populations. This is similar to the comprehensive package adopted and implemented in more than 40 countries including Tanzania, Botswana and Malawi[27].

PSAT Lite: The PSAT Lite emphasised the need for ongoing awareness campaigns, training, referral systems, and partnerships to improve clinical interventions.

[27] FHI360, (2021). The Power of Key-Population-Led HIV Programming, 2021. (https://www.fhi360.org/wp-content/uploads/drupal/documents/linkages-infograph.pdf)

FGDs and IDIs: Findings from Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) conducted across the 18 study states highlighted the importance of HIV testing and referral, peer education, integrated services (such as STI management, psychological support, and legal services), as well as capacity building.

Funding and Support:

Desk Review: Desk review found that significant donor contributions from PEPFAR and the Global Fund amount to over USD 4.1 million annually for prevention programmes targeting key populations.

PSAT Lite: Stakeholders from various states emphasised the need for increased funding and improved procurement processes to ensure consistent availability of supplies.

FGDs and IDIs: Findings from FGDs and IDIs indicated a heavy reliance on donor funding and the necessity for domestic financial support to mobilise resources for sustainable prevention services for key populations in the light of decreasing external support for HIV.

Community System Strengthening (CSS):

Desk Review: Optimising the gains achieved thus far in the national HIV response depends also on how well community structures are strengthened to adapt and response to the dynamic challenges in Nigeria's HIV space. Sustainable systems are mostly community-driven, as seen in countries or regions that have had a significant impact on Key Populations, such as Eswatini in its HIV prevention efforts. The Desk Review shows that the CSS framework focuses on community engagement, capacity building, and resource mobilisation. A lot of capacity building (mainly through training) has happened for KPs over the years in the response. These investments have contributed to the empowerment of the Key population to own and become more visible in the response.

PSAT Lite: In assessing the gains and functionality of the community strengthening channels, the PSAT Lite instrument highlighted the importance of providing operational support structures (including timely access and availability of logistics, provision of data flow protocols, and continuous capacity building through training and retraining of organisations, especially those who wor at the grass root levels.

FGDs and IDIs: Similarly, the FGDs and IDIs: discussed the active involvement of community members and the need for continuous capacity building.

Data and Research:

Desk Review: It is essential to have evidence in the form of data to make informed decisions about policies, programmes, and resource allocation. Research plays a crucial role in guiding the planning and implementation of effective prevention programmes. The Desk Review, highlighted the importance of conducting research such as IBBSS, size estimation studies, and ethnographic studies more regularly to better inform programming.

PSAT Lite: PSAT Lite sessions revealed the need for effective data management, standardised processes, and robust monitoring mechanisms.

FGDs and IDIs: The findings from FGDs and IDIs supported the use of the National Data Repository (NDR) for data tracking and validation.

Policy and Strategic Frameworks:

Desk Review: Policy and strategic framework provide guidelines for the planning, implementation and evaluation of key population programmes in Nigeria. Various policy and strategic frameworks exist to plan and manage KP programmes in Nigeria. The desk review confirmed that Nigeria's first National HIV Policies and Strategic Frameworks was developed in the year 2005 with thrust to define HIV/AIDS response, secondly, asses where the HIV programme was, determine HIV priority and objectives, define the responsibility of the policy direction, measure and evaluate results following implementation. Furthermore, the strategic plan/framework emphasises gender sensitivity, rights protection, and the inclusion of diverse populations in line with global and national standards. This demonstrates Nigeria's dedication and commitment to ending the HIV epidemic among key populations in Nigeria.

PSAT Lite: During the PSAT Lite sessions, participants recommended developing and advocating for specific laws and policies to protect key populations, especially from stigma and other acts of discrimination.

FGDs and IDIs: Discussed the modalities for adopting national and state strategic plans tailored to address unique state needs. This emphasises the need to contextualise by geography, socio-cultural norms, typology, etc., in KP prevention response.

In summary, the combined insights from the desk review, PSAT Lite, FGDs, and IDIs highlight a comprehensive and multifaceted approach to addressing the needs of key populations in Nigeria's HIV programme strategy. The strategy is well-coordinated, leveraging community-led initiatives, robust service delivery platforms, strategic funding, and continuous capacity

building to provide effective HIV prevention and care services. However, challenges remain, particularly in ensuring a consistent supply of resources, strengthening governance structures, and enhancing community participation in planning and monitoring processes. Addressing these gaps will be crucial for the sustainability and effectiveness of the programme in the long term.

4.2 OBJECTIVE 2: ASSESSING THE IMPLEMENTATION OF THE KP PROGRAMME STRATEGY

To assess the implementation of the Key Population (KP) programme strategy in Nigeria, focusing on achieving effective programme coverage and population-level impact, the Key Population Programme Review (KPPR) utilised several methods and tools namely: Desk Review, Polling Booth Survey (PBS), Focus Group Discussions (FGDs), In-depth Interviews (IDIs), and One-Stop Shop (OSS) assessment. These methods collectively provide a comprehensive evaluation of the programme's reach, effectiveness, and impact. Below is a triangulated discussion of the findings derived from these tools.

Desk Review:

The desk review highlighted several critical aspects of the KP programme implementation, which contribute to effective coverage and population-level impact:

Service Delivery Strategies:

Cohort Sessions and Peer-to-Peer Interactions: These methods ensure that key populations receive tailored information and support, fostering trust and encouraging consistent engagement with health services. The KPPR study found that peer educators, who are often members of the key populations themselves, conduct regular outreach and education sessions. These interactions help to establish trust, provide personalised support, and enhance the effectiveness of health interventions by addressing the unique needs and concerns of each subgroup.

Referral Systems and Outreach Activities: Facilitating access to services through referrals and outreach activities helps bridge the gap between key populations and facility/community healthcare providers, ensuring that individuals receive necessary care without significant barriers. Results from the desk review show that referral systems are a major component of Nigeria's KP response, enabling linkages between service facilities and key populations.

Findings indicate that there has been substantial coverage of referral services across the 18 study states, highlighting the effectiveness of this approach in ensuring comprehensive care.

Community System Strengthening (CSS): The CBOs played a pivotal role in service delivery, leveraging their local knowledge and connections to enhance health outcomes. The CSS framework emphasises the importance of capacity building and resource mobilisation, ensuring that these organisations can sustain and scale their efforts effectively.

Capacity Development: The programme's investment in training and capacity development for local partners and CBOs led to improved service delivery and better health outcomes. This includes participation in technical working group meetings and implementation reviews, which bolstered the capabilities of these organisations.

Evidence-Based Approaches and Integrated Service Delivery**:** Utilising research and continuous monitoring allowed for the adaptation and refinement of strategies. The integration of behavioural, biomedical, and structural interventions ensures a holistic approach to HIV prevention and care, addressing the complex needs of key populations.

Context-Specific Interventions: Tailoring interventions to the local HIV epidemic and specific needs of key population communities ensured cultural appropriateness and effectiveness, enhancing the programme's impact.

Polling Booth Survey (PBS):

The PBS provided quantitative insights into the programme's coverage and effectiveness in the under-listed areas:

HIV Testing and ART Coverage:

HIV Testing: High percentages of key populations, such as FSWs (58%), MSM (55%), PWID (58%), and TG (53%), reported having taken an HIV test in the last three months, indicating substantial reach and engagement.

ART Coverage: The percentage of key populations on ART varied, with MSM and TG showing higher coverage (25% each) compared to FSWs (14%) and PWID (16%), highlighting areas needing improvement.

STI Diagnosis and Treatment:

A significant proportion of key populations reported being diagnosed with STIs in the last 12 months, but there are gaps in treatment coverage, particularly among PWID (37% treated), indicating a need for enhanced STI management services.

Condom Use:

While condom use at the last sex was relatively high among FSWs (84%) and PWID (69%), it was lower among MSM (57%) and TG (52%). As revealed in Table 9 in the results section (Chapter 3), a comparison of these proportions with the IBBSS 2020 findings shows a decrease in condom use at last sex across the four typologies. Additionally, substantial reports of condom unavailability highlight supply chain issues that need addressing.

Focus Group Discussions (FGDs) and In-depth Interviews (IDIs):

Qualitative insights from FGDs and IDIs underscored the programme's strengths and areas for improvement in the under-listed areas:

Coordination and Oversight: Effective coordination by the Ministry of Health and integration of budgets among partners were crucial for covering service gaps and ensuring comprehensive reach.

Training and Capacity Building: Continuous training for CBOs and stakeholders enhanced the effectiveness of outreach and service delivery.

Mapping and Validation: Hotspot mapping and site validation ensure targeted and effective interventions, optimising resource allocation and service delivery.

Effective Implementation Strategies: Strategies such as peer education, hotspot programming, and community outreach are effective in engaging key populations, though resource limitations and stigma remain barriers.

One-Stop Shop (OSS) Assessment:

The OSS assessment highlighted the operational strengths and areas needing improvement within the programme in the under-listed areas:

Outreach and Service Utilisation: High percentages of OSS facilities reported having adequate outreach workers (83%) and conducting regular outreach activities (100%), ensuring consistent engagement with key populations.

Micro Planning and Coordination: Nearly all facilities (98%) reported having detailed micro plans for outreach, and regular staff meetings facilitate effective coordination and best practice sharing.

Comprehensive Service Provision: OSS facilities monitor PrEP and PEP utilisation and provide mental health support and harm reduction services, addressing broader health needs.

Community Engagement and Advocacy: Significant efforts are made to involve key populations in planning and decision-making, emphasising sustainability and advocacy for supportive environments.

In summary, the triangulated findings from these various methods indicate that Nigeria's KP programme has made some progress in achieving effective coverage and impact among key populations. The integration of community-led approaches, continuous capacity building, evidence-based practices, and comprehensive service delivery were central to this success. However, gaps in STI treatment, ART coverage, condom availability, and family planning services highlight areas needing targeted interventions and resource allocation. By addressing these gaps and enhancing coordination and community engagement, the KP programme can further improve its reach and effectiveness, ensuring better health outcomes for key populations in Nigeria.

Similar community-based, peer-led approaches have been implemented in other sub-Saharan African countries like South Africa, Kenya, and Uganda to increase access to HIV services for key populations[28]. These programmes have shown promising results in improving HIV testing, linkage to care, and viral suppression among KPs[29].

[28] FHI360, 2017
[29] Ibiloye et al, 2022, Ibiloye et all, 2023

4.3 OBJECTIVE 3: UNDERSTANDING BARRIERS CONTRIBUTING TO GAPS IN SERVICE AVAILABILITY, CONTACT, AND UTILISATION AMONG KEY POPULATIONS

The Key Population Programme Review (KPPR) employed Focus Group Discussions (FGDs), In-depth Interviews (IDIs), and One-Stop Shop (OSS) Assessments to identify and understand the barriers that contribute to gaps in the availability, contact, and utilisation of services among key populations (KPs) at both end-user and programme levels. The findings from these methods provide a comprehensive view of the challenges faced and the areas that require targeted interventions.

FGDs and IDIs:

FGDs and IDIs provided qualitative insights into the personal experiences and perceptions of key populations, revealing several critical barriers:

Hindrances to Accessing HIV Prevention Services:

Fear of Outcome: Many participants, reported that the fear of receiving a positive HIV test result discouraged them from seeking testing and other services. This fear significantly impacts morale and service uptake.

Lack of Funds: Financial constraints were a major barrier. Some participants highlighted difficulties in affording prevention materials such as condoms and preventive tablets, indicating that economic barriers restrict access to essential services.

Lack of Awareness: Some participants were often unaware of the available preventive services or how to access them, pointing to a significant gap in information dissemination and community outreach.

Unavailability of Injectable PrEP: Injectable PrEP, preferred by some KPs, was reported as scarce in some States. This limitation affects the choice and continuity of preventive measures.

Distance to Services: The distance to OSS and other service facilities was a common issue across various states, making it difficult for KPs to access services regularly.

Non-Availability of Needles and Syringes: PWID faced significant challenges due to the lack of needles and syringes, which are essential for safe injection practices and HIV prevention.

Attitudinal and Structural Barriers:

Negative Attitude of Health Workers: Some participants reported judgmental and discriminatory attitudes from healthcare providers, which discouraged them from accessing services. Such attitudes contribute to stigma and reduce service utilisation.

Laws and Policies: Legal barriers, such as the Same-Sex Marriage Prohibition Act of 2014, created a hostile environment for some KPs. These laws foster fear of arrest and harassment, deterring KPs from seeking services.

Lack of Sustainability and Ownership: Concerns were raised about the sustainability of KP programmes and the lack of government ownership. Participants noted that government facilities and staff often lacked the training and support needed to continue KP activities effectively.

Incentives and Motivation:

Dependence on Monetary Incentives: Initially, monetary incentives were used to motivate service uptake. However, as these incentives diminished, service utilisation declined. Some KPs began to view incentives as entitlements, leading to decreased motivation to access services without them.

These barriers indicate that a combination of personal, structural, and systemic issues hinder the effective availability and utilisation of services among key populations.

One-Stop Shop (OSS) Assessment:

The OSS assessment provided a detailed examination of the operational barriers faced by service facilities in the following areas:

Sustainability of OSS Operations:

Many OSS facilities lacked a documented plan to ensure continued functioning beyond external funding. This poses significant risks to the continuity and reliability of essential services for KPs.

Accessibility Challenges: Insecurity in certain areas and the lack of OSS facilities in remote communities hinder service reach. Logistical challenges further complicate the consistent and reliable provision of services across different locations.

Legal and Cultural Barriers: Stigmatisation and discrimination against KPs were prevalent, creating significant obstacles to accessing care. Societal prejudices and legal frameworks that do not support the rights of KPs exacerbate these challenges.

Resource Constraints: Shortages of essential supplies such as STI drugs, laboratory commodities, and inadequate staffing, strain the capacity of OSS facilities. Limited government engagement and support further restrict the ability of these facilities to address service gaps comprehensively.

Programme Implementation Shortcomings: Despite regular outreach activities by available staff, there are gaps in service utilisation monitoring and the provision of comprehensive services tailored to KPs' needs. Improved tracking of service uptake and more effective engagement strategies are needed.

Monitoring and Evaluation: The assessment highlighted the need for strengthened monitoring and evaluation mechanisms to better understand service utilisation patterns and identify areas for improvement. Consistent tracking and reporting on key metrics are essential for programme success.

To address these barriers, the report recommends developing sustainable operational plans, improving accessibility, combating stigma and discrimination, securing adequate resources, especially domestically, enhancing staffing, and strengthening monitoring and evaluation and accountability mechanisms.

In summary, the triangulated findings from FGDs, IDIs, and OSS assessments reveal a complex landscape of barriers affecting the availability, contact, and utilisation of services among key populations in Nigeria. Personal fears, financial constraints, lack of awareness, and distance to services hinder access at the end-user level. Structural issues such as negative attitudes from health workers, restrictive laws, and lack of sustainability further complicate service delivery at the programme level. Addressing these barriers requires a multifaceted approach that includes enhancing awareness, improving accessibility, securing sustainable funding, combating stigma, and strengthening monitoring and evaluation to ensure comprehensive and effective service delivery to key populations.

Similar barriers have been documented in studies from other sub-Saharan African countries like Tanzania, Malawi, and Angola.

In Tanzania, key barriers included lack of social support, high-risk networks, community stigma, and legal/policy factors that criminalize KP behaviours which are similar to the barriers identified in our study in Nigeria.

In Malawi and Angola, the availability of HIV testing, and prevention services was limited at venues frequented by KPs, highlighting the need for more targeted, venue-based outreach. This is more advanced than the practice in Nigeria where services are more at CBO locations than KP activity venues. Nigeria needs to learn and adapt this approach.

Across the region, advocates have called for addressing structural barriers like punitive laws, building the capacity of KP-led organisations, and improving data collection to support KP programming[30]. Nigeria is in a similar situation with other countries in the region in this regard.

4.4 OBJECTIVE 4: IDENTIFYING GOOD PRACTICES FOR SCALING UP TO ADDRESS COVERAGE GAPS

The Key Population Programme Review (KPPR) aimed to identify good practices that could be scaled up to address coverage gaps within the Key Population (KP) Programme in Nigeria. The review employed several methods/tools, including a desk review, the Prevention Self-Assessment Tool - Lite (PSAT Lite), Focus Group Discussions (FGDs), In-depth Interviews (IDIs), and One-Stop Shop (OSS) Assessments. These tools collectively provide a comprehensive understanding of effective strategies and practices that could enhance the programme's reach and impact.

Desk Review:

The desk review identified multiple good practices across various aspects of the KP programme:

Community System Strengthening Framework (CSS):

Framework Development: The CSS framework highlighted the critical roles of key populations, community organisations, and public/private sector actors. It enhanced understanding, funding, and technical support for community-based organisations (CBOs), thereby improving health outcomes.

[30] UNDP, 2021; Musuka et al, 2022

Core Components: The framework addresses six core components, such as capacity building and resource mobilisation, providing a structured approach to designing, implementing, monitoring, and evaluating interventions to strengthen community health outcomes.

Capacity Development and Sustainability:

Capacity Building: Significant efforts in capacity building have enabled local partners and CBOs to deliver better health outcomes through technical training and engagement in programme coordination.

Workshops and Training: These have improved programme design, implementation, and accountability, expanding access to HIV services and ensuring effective use of resources.

Greater Involvement of Key Populations:

Active Participation: Key population groups have actively participated in the programme, demonstrating their capacities and enhancing the legitimacy and independence of CBOs in obtaining and using donor grants.

Service Uptake and Outcomes: Increased engagement has led to higher service uptake, with notable success in viral suppression (82%) and treatment retention (77%), contributing significantly to the achievement of the 95-95-95 targets. This progress indicates that a substantial proportion of people living with HIV are aware of their status, are receiving sustained antiretroviral therapy, and are achieving viral suppression, thereby reducing the likelihood of HIV transmission.

Resource Mobilisation:

Funding: The National AIDS Spending Assessment (NASA) report indicated substantial annual spending on prevention programmes for key populations, ensuring consistent financial support for these initiatives. This is identified as a good practice, with several assessments having been conducted over the years to monitor and manage resource allocation effectively. Sustaining these assessments is crucial for evidence-based management of resources allocated for HIV prevention services for key populations. Details from the desk review indicate that these assessments have been conducted periodically, with the latest assessments providing critical data for ongoing and future programme planning.

Prevention Self-Assessment Tool - Lite (PSAT Lite):

The PSAT Lite provided insights into effective practices that could be expanded to improve programme coverage and effectiveness:

Leadership and Coordination:

Functional State Structures: Establishing state structures and coordination agencies, along with regular stakeholder engagements and meetings, has facilitated consistent programme management and strategy review.

Financing:

Community-Led Coordination: Community-led coordination of activities, supported by state stakeholders and implementing partners (IPs), ensures budget allocations for CBOs and monitoring activities.

Laws, Policies, and Regulations:

Non-Discriminatory Practices: Adoption and implementation of national guidelines to ensure non-discriminatory practices and specific measures to protect key populations.

Programme Implementation:

Service Delivery and Monitoring: High scores in service delivery and programme monitoring indicate effective implementation, with areas needing improvement in structural interventions and targeting.

Clinical Interventions:

Addressing Stockouts: Ensuring the consistent availability of essential supplies and increasing funding for comprehensive services, including HIV testing and PrEP.

Behavioural Interventions:

Engaging Key Populations: Involving key populations in developing Social and Behavioural Change Communication (SBCC) interventions ensures tailored and effective messaging.

Service Delivery:

Feedback Systems: Establishing feedback systems to align service design with the needs of outreach workers and expanding OSS sites to increase coverage and accessibility.

Structural Interventions:

Advocacy for Laws and Policies: Advocating for laws and policies to protect marginalised groups and enhancing capacity for training and awareness programmes.

Targeting and Planning:

Key Population Size Estimations: Conduct regular estimations to inform targeted interventions and resource allocation.

Programme Monitoring:

Community-Led Monitoring: Establishing community-led monitoring platforms and regular Technical Working Group (TWG) meetings to ensure timely interventions and decision-making.

Focus Group Discussions (FGDs) and In-depth Interviews (IDIs):

FGDs and IDIs identified several good practices for policy and implementation:

Policy Level Good Practices:

State Annual Budget Inclusion: Reviewing and including key populations in budget preparation ensures necessary funding for assessment and implementation.

Job Creation for KPs: Creating job opportunities for KPs, such as through data collection initiatives, helps improve their socio-economic conditions.

Memoranda of Understanding (MoU): Establishing MoUs among stakeholders enhances coordination and funding for KP programmes.

Strategies for KP Programme Implementation:

Coordination and Oversight: Effective coordination by health ministries ensures the alignment of partners' plans with state budgets and national guidelines.

Training and Capacity Building: Comprehensive training for CSOs and other implementers ensures effective service delivery.

Hotspot Mapping: Thorough mapping identifies areas with high concentrations of KPs, ensuring targeted interventions.

Review and Validation of Data: Regular data review helps in identifying and addressing gaps in KP programmes.

State Strategic Plan and Policy:

National Data Repository: Utilising a national data repository helps to identify gaps and this can be used to improve programme implementation.

Adoption of National Strategic Plan: Customising the national strategic plan to fit local contexts ensures effective design and aids coordinated implementation.

Minimum Preventive Package of Intervention (MPPI): This comprehensive strategy includes interventions for various high-risk groups, despite being resource-intensive.

One-Stop Shop (OSS) Assessment

The OSS assessment highlighted good practices that enhance the effectiveness, sustainability, and reach of the programme:

Strengthening Linkages and Support:

Seamless Referral Pathways: Establishing strong linkages with other healthcare providers ensures comprehensive care for KPs.

Developing Sustainable Funding Models:

Revenue-Generating Activities: Exploring sustainable funding models, including revenue-generating activities, secures financial support.

Continuous Capacity Building:

Ongoing Training: Regular capacity-building efforts ensure OSS staff are well-equipped to manage programmes and provide quality services.

Providing Comprehensive Services:

Holistic Health Needs: Incorporating additional services like legal aid and support for co-infections addresses the holistic health needs of KPs.

Enhancing Community Engagement:

Inclusive Decision-Making: Involving KPs in programme planning ensures services meet their specific needs and preferences.

Adequate Resource Allocation:

Proper Allocation: Ensuring sufficient resources, including staff and medical supplies, maintains service quality and meets demand.

Robust Monitoring and Evaluation:

Continuous Improvement: Strong monitoring and evaluation processes enable progress tracking and strategy adaptation for better outcomes.

Advocacy and Sensitisation Efforts:

Reducing Stigma: Advocacy for policy changes and sensitisation efforts increase awareness and support for KPs, therby improving service uptake.

In summary, the triangulated findings from the desk review, PSAT- Lite, FGDs, IDIs, and OSS assessments collectively highlight a range of good practices that can be scaled up to address coverage gaps within the KP programme in Nigeria. These practices encompass community systems strengthening, capacity building, active involvement of key populations, resource mobilisation, effective programme implementation, and robust monitoring and evaluation. Scaling up these practices will enhance the programme's reach and impact, ultimately improving health outcomes for key populations and contributing to the overall goal of ending the HIV epidemic in Nigeria.

In South Africa, the PEPFAR-supported DREAMS partnership has empowered adolescent girls and young women through a comprehensive package of services, including education subsidies, HIV testing, and gender-based violence prevention. In Kenya, the LINKAGES project has used a combination of peer outreach, mobile testing, and community-based ART distribution to improve HIV services for key populations. Also, in Malawi, the SHAPE project has built the capacity of local CBOs to provide HIV services and advocate for the rights of key populations. These are country-specific adaptations of combination prevention interventions that have gained significant visibility and impact among the targeted populations. While Nigeria has developed a combination prevention approach tagged Minimum Prevention Package Interventions (MPPI), the programme is yet to attain similar visibility, impact and focused funding.

4.5 OBJECTIVE 5: PROVIDING RECOMMENDATIONS FOR EFFECTIVE COVERAGE

The findings from the Polling Booth Survey (PBS), Prevention Self-Assessment Tool - Lite (PSAT Lite), Focus Group Discussions (FGDs) and In-depth Interviews (IDIs), and One-Stop Shop (OSS) Assessment collectively offer a comprehensive set of recommendations. These methods/tools underscore the need for a multi-faceted approach, integrating community engagement, tailored service delivery, structural changes, data-driven programming, capacity building, and sustainable funding.

Polling Booth Survey (PBS):

The PBS highlighted several key recommendations to enhance the coverage of key populations:

Enhanced Community Engagement:

Increasing the involvement of key populations in planning, implementation, and monitoring ensures that interventions are tailored to their specific needs. Strengthening community-led monitoring provides real-time feedback on programme performance and facilitates rapid response to emerging issues.

Targeted Outreach and Services:

Expanding the use of peer educators and navigators improves outreach efforts, ensuring that key populations are informed about and can access available services. Developing and implementing tailored services addresses the unique needs of subgroups within key populations, such as youth, women, and transgender individuals.

Addressing Structural Barriers:

Implementing anti-stigma and anti-discrimination campaigns reduces societal barriers that prevent key populations from accessing services. Strengthening legal and policy frameworks protects the rights of key populations, ensuring safe and equitable access to healthcare services.

Improving Service Delivery Models:

Scaling up One-Stop Shops (OSS) and key population-friendly facilities provides integrated services in a single location, improving access and adherence to HIV prevention and treatment. Enhancing mobile outreach services reaches key populations in remote or underserved areas.

Data-Driven Programming:

Utilising data from surveys, monitoring, and evaluations continuously improves programme strategies, ensuring they are responsive to evolving needs. Implementing innovative data collection methods captures more accurate and timely information about key populations and the impact of interventions.

Capacity Building:

Investing in training and capacity-building for healthcare providers improves the quality of services offered to key populations. Strengthening the organisational capacity of community-based organisations (CBOs) enhances their ability to deliver effective services and advocacy.

Sustainability and Funding:

Diversifying funding sources ensures the sustainability of programmes, including exploring public-private partnerships and social enterprise models. Advocating for increased domestic funding and integration of key population services into national health insurance schemes ensures long-term financial stability.

Prevention Self-Assessment Tool - Lite (PSAT Lite):

The PSAT Lite provided several recommendations focusing on clinical, implementation, behavioural, service delivery, structural, targeting and planning, and programme monitoring aspects:

Clinical Interventions:

Improving the availability and accessibility of condoms, lubricants, and essential medications to address stockouts and limited availability.

Enhancing coverage of HIV testing services, including oral PrEP, reaches remote areas.

Facilitating legal assistance at OSS provides comprehensive support.

Implementation Arrangement:

Routine capacity-building exercises for KPs and establishing clear career progression plans ensure ongoing skill development.

Strengthening adherence to data flow protocols and comprehensive geographical coverage improves programme reach and effectiveness.

Behavioural Interventions:

Strengthening the capacity of CBOs to deliver effective behavioural interventions ensures comprehensive programme coverage.

Promoting the active involvement of CBOs in planning and monitoring processes enhances representation and tailored interventions.

Service Delivery:

Expanding service coverage to all Local Government Areas (LGAs) overcomes barriers to accessing OSS services in remote areas.

Addressing delays in product procurement ensures uninterrupted supply.

Structural Interventions:

Expanding comprehensive programmes targeting violence and stigma against KPs especially MSM improves access and acceptance.

Ensuring adequate funding and regular training sessions for health workers and law enforcement agencies address legal and structural barriers.

Targeting and Planning:

Conducting regular needs assessments informs intervention planning and resource allocation.

Involving key populations in microplanning ensures tailored interventions.

Programme Monitoring:

Strengthening coordination among stakeholders for routine monitoring and evaluation ensures timely interventions and continuous improvement.

FGDs and IDIs:

The qualitative findings from FGDs and IDIs highlighted the following recommendations:

Community-Based Testing Strategies:

Implementing community-based testing strategies tailored to key populations and providing inclusive HIV services through community facilitators improves coverage.

Peer Education:

Implementing peer education through CBOs ensures effective outreach and education within the community.

Collaboration of State SACA with Stakeholders:

Ensuring collaborations between the State AIDS Control Agencies (SACA) and stakeholders provide accurate services and support.

MPPI Model:

Implementing the Minimum Package of Prevention Intervention (MPPI) Model enhances the effectiveness of prevention efforts.

Facilitators of Accessibility:

Establishing Drop-in Centres (DICs) and Outreach Service Sites (OSS) provides accessible spaces for services.

Addressing Barriers:

Addressing various barriers to service utilisation, including stigma, privacy concerns, and product quality, improves access and effectiveness.

One-Stop Shop (OSS) Assessment:

The OSS Assessment emphasised several recommendations for effective coverage, including the under-listed:

Linkages and Support:

Strengthening linkages with other healthcare providers ensures seamless referral pathways and comprehensive care.

Sustainable Funding:

Developing sustainable funding models, including exploring revenue-generating activities, ensures long-term viability.

Capacity Building:

Continuous capacity-building efforts for OSS staff ensures effective programme management and quality service provision.

Comprehensive Services:

Incorporating additional services such as legal aid and support for transgender individuals addresses holistic health needs.

Community Engagement:

Involving key populations in decision-making ensures services are tailored to their specific needs and preferences.

Resource Allocation:

Ensuring adequate allocation of resources, including human resources and medical supplies, maintains service quality.

Monitoring and Evaluation:

Implementing robust monitoring and evaluation processes tracks progress and identifies areas for improvement.

Advocacy and Sensitisation:

Advocacy for policy changes and sensitisation efforts reduce stigma and discrimination, creating a supportive environment for service access.

High-Level Advocacy:

Engaging in high-level advocacy with governments and donors secures continued support and resources for OSS operations.

Functional and Operational Oversight:

Ensuring OSS facilities are functional and aligned with standards, through routine oversight activities, improves service delivery.

Autonomy and Financial Planning:

Providing OSS facilities with autonomy and implementing financial and managerial plans to ensure sustainability.

Collaboration with Local Health Authorities:

Local health authorities working closely with local health teams ensure effective service delivery.

Supervision and Support:

Providing supportive supervision ensures adherence to standards and effective programme implementation.

Creating an Enabling Environment:

Establishing an enabling environment within communities reduces stigma and ensures accessibility of services.

Legal Support and Collaboration:

Involving legal teams in KP programming addresses legal barriers and promotes a supportive legal environment.

In summary, the triangulated findings from PBS, PSAT Lite, FGDs and IDIs, and OSS assessment converge on several key recommendations to ensure effective coverage of key populations for population-level impact. These include enhancing community engagement, addressing structural barriers, improving service delivery models, data-driven programming, capacity building, and sustainable funding. By integrating these recommendations, the KP programme can achieve a more inclusive, responsive, and sustainable approach, ultimately improving health outcomes for key populations in Nigeria.

In South Africa, the Sisonke Movement, a sex worker-led organisation, has been advocating for the decriminalization of sex work and improved access to healthcare services for sex workers. In Kenya, the National Empowerment Network of People Living with HIV/AIDS (NEPHAK) has been working to reduce stigma and discrimination against key populations, particularly men who have sex with men (MSM) and transgender individuals. Also, in Botswana, the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) has been advocating for the rights of key populations and providing legal support to address structural barriers to accessing services.

In contrast to these countries, while there are local KP networks with some level of organisational clout, KP networks in Nigeria are somewhat muted and with much less visibility.

INCORPORATION OF IBBSS 2020 RESULTS

The IBBSS 2020 results have been pivotal in shaping the current KP programmes in Nigeria, addressing the identified gaps and reinforcing successful strategies. Below are the key areas where the IBBSS 2020 findings have influenced the programme design:

1. HIV Testing and ART Coverage:

The IBBSS 2020 provided critical insights into the rates of HIV testing and ART coverage among KPs. The data indicated that while testing rates were relatively high, ART coverage needed improvement. The KP programme has since intensified its efforts to:

Increase ART Coverage: Enhanced ART provision has been a focal point, with targeted interventions to improve ART uptake among FSWs, MSM, PWID, and TGs. This includes a more robust linkage to care protocols and follow-up mechanisms to ensure those who test positive receive and adhere to treatment.

Support Community-Based Testing: Leveraging mobile clinics and community health workers to bring testing services closer to KPs has improved accessibility, especially for those reluctant to visit formal health facilities.

2. STI Diagnosis and Treatment:

The IBBSS 2020 highlighted significant gaps in STI treatment coverage, particularly among PWID. In response, the KP programmes have integrated:

Enhanced STI Management Services: There has been a concerted effort to provide comprehensive STI diagnostic and treatment services within the OSS and through outreach activities. Training healthcare providers on syndromic management of STIs and ensuring a steady supply of necessary medications have been prioritized.

Regular Screening Campaigns: Periodic STI screening campaigns have been implemented, focusing on high-prevalence areas identified in the IBBSS 2020. This proactive approach aims to identify and treat STIs promptly, reducing transmission and improving overall health outcomes for KPs.

3. Condom Use and Availability:

The IBBSS 2020 findings revealed a decline in condom use at last sex across all key population typologies and highlighted supply chain issues. To address this:

Condom Distribution and Supply Chain Management: The programme has strengthened its supply chain mechanisms to ensure a consistent and reliable supply of condoms. Distribution networks have been expanded to include non-traditional outlets frequented by KPs.

Condom Promotion Campaigns: Intensive behaviour change communication (BCC) campaigns have been launched to promote condom use, emphasizing their role in preventing HIV and other STIs. These campaigns use peer educators and leverage social media to reach younger KPs.

4. Peer Education and Outreach:

Recognizing the importance of peer-led interventions, the IBBSS 2020 findings have led to:

Scaling Up Peer Education: The number of peer educators has increased, and their training enhanced to cover new insights and trends identified in the IBBSS 2020. This ensures they are well-equipped to address the evolving needs and concerns of KPs.

Digital Outreach: Given the barriers to physical outreach posed by stigma and discrimination, digital platforms have been increasingly utilised for education, counselling, and linkage to services. This has expanded the reach of the programme, particularly among younger MSM and TG populations.

5. Community System Strengthening (CSS):

The IBBSS 2020 underscored the role of community-based organisations (CBOs) in effective service delivery. In response, the KP programmes have focused on:

Capacity Building for CBOs: Investments have been made in training and capacity development for CBOs, enabling them to deliver services more effectively and sustainably. This includes training on new prevention technologies and data management.

Engagement and Advocacy: There has been increased support for CBO-led advocacy initiatives aimed at reducing stigma and discrimination and fostering an enabling environment for KPs.

6. Integrated Service Delivery:

The holistic approach to service delivery has been reinforced by the IBBSS 2020 findings, leading to:

Comprehensive OSS Services: OSS facilities have been equipped to provide a range of services, including HIV testing, ART, PrEP, PEP, STI treatment, mental health support, and harm reduction. This integrated model ensures that KPs receive all necessary services in one location, improving uptake and continuity of care.

Mental Health and Substance Abuse Services: Recognizing the intersection of mental health, substance abuse, and HIV risk, the programme has integrated mental health support and substance abuse treatment into its service offerings.

Incorporating the IBBSS 2020 results into the current KP programme design has been instrumental in addressing critical gaps and enhancing the effectiveness of interventions. By leveraging data-driven insights, the KP programmes in Nigeria have been able to tailor their strategies to meet the needs of KPs better, improve service delivery, and ultimately achieve better health outcomes. Continued monitoring and adaptation of these programmes based on emerging data will be essential in sustaining and scaling the progress made.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 CONCLUSION

The Key Population Programme Review has shown several interesting findings that will potentially inform policy and programmes in Nigeria as it undertook a holistic search into what has happened in the HIV prevention response for the Key Population in the period under review. The review, which is the first of its kind in the country, has established a baseline for subsequent efforts to build on. In conclusion, aligning with the outlined review objectives, it is envisaged that all the findings will contribute to the strengthening of HIV prevention among Key populations in Nigeria.

5.2 SUMMARY OF KEY FINDINGS

5.2.1 HIV Prevalence and Key Populations

The Key Population Programme Review highlights significant fluctuations and persistently high rates of HIV prevalence among key populations (KPs) in Nigeria compared to the general population. Female Sex Workers (FSW), Men who have Sex with Men (MSM), People Who Inject Drugs (PWID), and Transgender People (TG) exhibit much higher HIV prevalence rates: FSW: HIV prevalence decreased from 24.5% in 2007 to 19.4% in 2014, then slightly decreased to 15.5% in 2020. MSM: A worrying trend was observed with HIV prevalence rising from 13.5% in 2007 to 25% in 2020. PWID: Similar trends were noted, with HIV prevalence fluctuating but remaining significantly higher than in the general population. TG: Although newer data for this group is more limited, preliminary findings indicate a high vulnerability to HIV. The 2020 IBBSS shows that HIV prevalence amongst TG is 28.8, the highest amongst all KP groups.

These trends underscore the critical need for targeted interventions to address the unique challenges faced by these populations.

Programmatic Achievements

The report outlines several notable successes in the implementation of HIV prevention and treatment programmes:

One-Stop Shops (OSS): OSS have been instrumental in providing comprehensive, stigma-free health services, integrating testing, treatment, psychosocial support and other services in one location.

Community-Based Organisations (CBOs): The engagement of CBOs has enhanced programme coverage and effectiveness by leveraging local knowledge and trust within key populations.

Service Delivery Platforms: Various platforms, including mobile clinics, peer education, and outreach programmes, have effectively expanded access to HIV services. These achievements demonstrate significant progress in building an inclusive and responsive healthcare framework for KPs.

Service Delivery and Coverage

Strengths in service delivery and coverage have been identified, showcasing the programme's ability to adapt and meet the needs of key populations using the underlisted strategies:

Peer-to-Peer Interactions: These have proven effective in promoting HIV testing, treatment adherence, and prevention practices among KPs.

Community Engagement: Active involvement of KPs in programme planning and implementation has been pivotal in improving service uptake and trust.

Diverse Service Platforms: The use of OSS, mobile clinics, and outreach programmes has enhanced accessibility and convenience for KPs, ensuring that services are brought closer to those in need.

These strategies have collectively improved service coverage, although gaps remain in some areas.

Barriers and Challenges

Several barriers to accessing HIV services were identified, hindering the effectiveness of the programme:

a) Stigma and Discrimination: Negative attitudes and discriminatory practices by healthcare providers and society at large remain significant barriers.

b) Legal Issues: Criminalisation of certain behaviours associated with KPs, such as sex work and drug use, exacerbates their vulnerability and limits access to services.

c) Resource Constraints: Inconsistent funding shortages of essential supplies and trained personnel affect service delivery.

d) Fear and Lack of Awareness: Personal fears of a positive HIV diagnosis and a lack of awareness about available services hinder uptake.

Addressing these barriers is crucial for improving health outcomes among key populations.

Good Practices

The review identified several good practices that can be scaled up to enhance programme effectiveness:

a) Community System Strengthening (CSS): Empowering local organisations and communities through funding, technical support, and capacity building has proven effective.

b) Integrated Service Delivery: Combining behavioural, biomedical, and structural interventions provides a holistic approach to HIV prevention and treatment.

c) Evidence-Based Programming: Utilising data and research to inform programme strategies ensures that interventions are responsive to the evolving needs of KPs.

d) Community Engagement and Advocacy: Involving key populations in programme planning and advocacy efforts ensures that services are tailored to their needs and enhances ownership and sustainability.

These practices have shown promise in addressing coverage gaps and improving service delivery, making them critical components for future programme enhancements.

5.3 IMPLICATIONS FOR PUBLIC HEALTH HIV EPIDEMIC CONTROL

Impact on Key Populations

The findings of the Key Population Programme Review have profound implications for the health and well-being of Key Populations (KPs) in Nigeria:

a) Health Outcomes: The persistently high HIV prevalence rates among KPs, especially MSM, FSW, TG and PWID, indicate ongoing vulnerability and a significant public health

burden. The high rates of HIV in these groups compared to the general population highlight the urgent need for targeted and sustained interventions.

Access to Services: The successes in service delivery through OSS and CBOs demonstrate that when services are tailored to the needs of KPs and delivered in a stigma-free environment, uptake improves. However, barriers such as stigma, discrimination, and legal issues continue to hinder access to critical health services, impacting the overall health outcomes of KPs.

c) Psychosocial Well-being: Beyond the physical health implications, the review underscores the significant psychosocial challenges faced by KPs, including high levels of violence, discrimination, and mental health issues. Addressing these aspects is crucial for holistic health interventions.

Policy and Strategic Frameworks

The findings of the review provide important insights into the alignment and potential gaps between the current HIV response for KPs and national policies and strategic frameworks:

a) National Strategic Plan Alignment: The achievements in service delivery and community engagement align well with the goals of the National Strategic Plan 2023-2027[5], which emphasises equitable access to HIV services and the protection of human rights. The focus on integrating community-based approaches and evidence-based programming supports these strategic priorities.

b) Policy Gaps: Despite alignment in many areas, the review highlights significant policy gaps, particularly in addressing stigma and discrimination within healthcare settings and the legal environment. Current policies may not adequately protect KPs from criminalisation and human rights abuses, which are critical barriers to effective HIV prevention and treatment.

c) Strategic Prioritisation: The findings suggest a need for more strategic prioritisation of resources for KP Programmes within the national HIV response. Resources should be allocated more strategically prioritising higher-impact activities.

Sustainability of Interventions

The sustainability of current HIV interventions for KPs is a significant concern, particularly in the context of funding and resource challenges:

Funding Constraints: The review notes heavy reliance on external funding sources, such as PEPFAR and the Global Fund. With decreasing external financial support, there is an urgent need to secure domestic funding to ensure the continuity and scaling up of successful interventions.

Resource Allocation: Inconsistent resource allocation, including shortages of essential supplies and trained personnel, threatens the sustainability of HIV services for KPs. Strengthening health systems and ensuring stable supply chain management are critical for maintaining service delivery.

Community Involvement: Sustained community engagement and capacity building are essential for the longevity of HIV interventions. Empowering CBOs and community-led organisations as well as fostering local ownership of health programmes can enhance resilience and adaptability to funding fluctuations.

Monitoring and Evaluation: The sustainability of interventions also hinges on robust monitoring and evaluation frameworks. Continuous data collection, analysis and use, research, and programme reviews are necessary to adapt strategies and ensure that interventions remain effective and responsive to the needs of KPs.

The implications of the Key Population Programme Review findings are far-reaching for public health in Nigeria. The high HIV prevalence among KPs, combined with significant barriers to accessing services, underscores the need for sustained and targeted interventions. Aligning national policies with the realities faced by KPs, securing stable funding, and fostering community-led initiatives are critical steps towards improving health outcomes and achieving long-term sustainability in the HIV response for key populations.

5.4 RECOMMENDATIONS

5.4.1 Strategic Recommendations

A) Enhancing Service Delivery

To improve the reach and quality of HIV prevention and treatment services for key populations (KPs), several other strategies should be adopted and implemented:

a) Expand One-Stop Shops (OSSs): Increase the number of OSSs across the country, particularly in underserved areas. OSS has proven effective in providing a holistic HIV continuum of care, and stigma-free services, and expanding their reach can ensure more KPs access the care they need.

b) Strengthen Mobile Outreach Programmes: Enhance mobile clinics and outreach services to reach KPs in remote or hard-to-reach areas. Mobile units can provide testing, counselling, treatment, and distribution of prevention tools like condoms and PrEP.

c) Peer-Led Initiatives: Continue to support and expand peer-to-peer education and support programmes. Peers can effectively reach KPs, promote safe practices, and encourage service utilisation.

d) Integrated Service Delivery: Optimise integrated health services that address not only HIV but also other co-morbidities such as STIs, TB, and mental health issues. This holistic approach can improve overall health outcomes and ensure comprehensive care.

e) Leverage Technology: Utilise digital health platforms to provide information, virtual counselling, and appointment scheduling. Mobile apps and online platforms can increase accessibility and convenience for KPs.

f) Continuous Training and Capacity Building: Provide ongoing training for healthcare providers to ensure they are equipped with the up-to-date knowledge and skills in HIV care and KP-specific issues.

B) Reducing Barriers to Access

Addressing the barriers that KPs face in accessing services is crucial for improving health outcomes:

a) Policy Advocacy: Advocate for policies that protect the rights of KPs and reduce stigma discrimination and legal barriers. This includes decriminalising behaviours associated with KPs, such as sex work and drug use, and ensuring legal protections against discrimination.

b) Training for Healthcare Providers: Evidence has shown that implementing comprehensive training programmes for healthcare providers focused on stigma reduction, cultural competence, and sensitivity towards KPs, can improve the quality of care which makes health facilities user-friendly. Therefore, sustaining training and re-training efforts is recommended.

c) Community Sensitisation: Conduct community sensitisation campaigns to reduce stigma and discrimination against KPs. Education and awareness programmes can lead to behavioural change and foster a more inclusive environment.

d) Legal Support Services: Enhance legal support services to help KPs navigate legal challenges and protect their rights. This can include providing legal aid, advocacy, and support in cases of discrimination or violence.

e) Engage Law Enforcement: Work with law enforcement agencies to educate them on the rights of KPs and the importance of non-discriminatory practices. This can help reduce harassment and violence against KPs.

f) Improve Accessibility: Ensure that health services are physically accessible to KPs. This involves increasing the number of service delivery points making facilities more accessible.

This also includes improving physical accessibility for KPs living with disability by making the architecture of the SDPs more physically accessible through the provision of ramps etc.

C) Resource Mobilisation

Securing sustainable funding is essential for the continuity and expansion of HIV services for KPs:

a) Increase Domestic Funding: Advocate for increased allocation of domestic resources to HIV programmes targeting KPs. This can include budgetary allocations from national and state governments.

b) Diversify Funding Sources: Explore and secure funding from diverse sources, including private sector partnerships, philanthropic organisations, and international donors. A diversified funding base can reduce dependency on any single source.

c) Innovative Financing Mechanisms: Implement innovative financing mechanisms such as social impact bonds, health insurance schemes for KPs, and public-private partnerships. These can provide sustainable funding streams.

d) Community-Based Resource Mobilization: Encourage community-based fundraising initiatives and engage local businesses and philanthropists in supporting HIV programmes for KPs.

e) Strengthen Financial Management: Enhance financial management practices to ensure efficient use of available resources. This includes robust financial planning, transparent accounting, and regular audits.

f) Advocacy and Awareness: Increase advocacy efforts to highlight the importance of investing in HIV services for KPs. Raising awareness among policymakers and the public can generate support for sustained funding.

By implementing these strategic recommendations, the Key Population Programme can significantly enhance service delivery, reduce barriers to access, and secure sustainable funding. These steps are critical for improving health outcomes for KPs in Nigeria and ensuring the long-term success of the HIV response.

5.4.2 Programmatic Recommendations

A) Community Engagement and Empowerment

Strengthening community engagement and empowering key populations (KPs) is critical for the success and sustainability of HIV prevention programmes for KPs. The following initiatives are recommended to enhance community involvement and leadership:

a) Participatory Programme Planning: Involve KPs in the design, planning, implementation and evaluation of HIV programmes. This ensures that interventions are tailored to the specific needs and preferences of KPs, increasing their relevance and effectiveness.

b) Community Advisory Boards: Establish and support community advisory boards comprising representatives from KPs. These boards can provide ongoing feedback, guide programme development, and ensure that community voices are heard.

c) Leadership Training: Provide leadership and advocacy training for KP members to enable them to take active roles in programme governance and advocacy efforts. Empowered community leaders can drive change and foster community mobilisation.

d) Peer Support Networks: Strengthen peer support networks to enhance community solidarity and mutual support. Peer networks can facilitate information sharing, emotional support, and linkage to services.

e) Micro-Grants for Community Initiatives: Offer micro-grants to support community-led initiatives that address HIV prevention, care, and support. These small grants can fund innovative projects designed by and for KPs.

f) Awareness Campaigns: Conduct community awareness campaigns to reduce stigma and discrimination within KP communities and the broader public. These campaigns can promote positive health behaviours and encourage service utilisation.

B) Capacity Building

Routine training and capacity development for healthcare providers and community workers are essential to ensure high-quality service provision for KPs.

a) Comprehensive Training Programmes: Design comprehensive training programmes for healthcare service providers and community workers focusing on HIV care, KP-specific issues, and cultural competence. This includes initial training as well as regular refresher courses.

b) Sensitivity and Stigma Reduction Training: Provide targeted training to reduce stigma and discrimination within healthcare settings. This training should address personal biases, promote empathy, and underscore the importance of non-discriminatory practices.

c) Technical Skill Development: Enhance the technical skills of healthcare providers in areas such as HIV testing, antiretroviral therapy (ART) management, and co-morbidity treatment (e.g., STIs, TB, mental health).

d) Supportive Supervision: Improve the functionality of the existing supportive supervision systems to provide ongoing mentoring, support, and performance feedback to healthcare

providers and community workers. This helps maintain high standards of care and addresses challenges promptly.

e) Training for Peer Educators: Develop specialised training programmes for peer educators to equip them with the knowledge and skills needed to effectively support and educate their peers. This includes training in communication, counselling, and health promotion.

f) Resource Development: Create and disseminate training manuals, IEC materials, SOPs, guidelines, and toolkits that are easily accessible and tailored to the needs of healthcare providers and community workers.

C) Integrated Service Delivery

Strengthening the integration of behavioural, biomedical, and structural interventions (MPPI) is crucial for providing a comprehensive KP HIV prevention programme:

a) Holistic Health Services: Offer holistic health services that address the full spectrum of needs for KPs, including HIV prevention and treatment, STI management, mental health services, and harm reduction for PWID. Integrated service delivery ensures that all aspects of health are addressed in a coordinated and cost-efficient manner.

b) Co-Location of Services: Co-locate services within OSS or other accessible venues to provide a one-stop solution for KPs. This reduces the need for multiple visits to different facilities and enhances service uptake.

c) Case Management Approach: Improve on the case management approach where each KP client is assigned a case manager who coordinates their care across different service cascades. This ensures continuity of care and personalised support.

d) Behavioural Interventions: Strengthen the Integration of behavioural interventions such as counselling, peer support, Strategic Behavioural Change Communication (SBCC) and educational programmes into biomedical and structural services. Addressing behavioural determinants of health is essential for promoting long-term behaviour change.

e) Structural Interventions: Implement structural interventions that address the broader social determinants of health, such as poverty, housing instability, and legal barriers. Collaborate with other sectors to provide comprehensive support services, including legal aid, housing assistance, and economic empowerment programmes.

f) Data-Driven Decision Making: Utilise data and evidence to inform the integration of services. Continuous monitoring and evaluation help identify gaps, measure impact, and refine service delivery models based on emerging needs and best practices.

Implementing these programmatic recommendations will significantly enhance the effectiveness and sustainability of HIV interventions for key populations in Nigeria. By fostering community engagement and empowerment, building the capacity of healthcare providers and community workers, and integrating comprehensive services, the programme can address the multifaceted needs of KPs and improve health outcomes.

5.4.3 Monitoring and Evaluation

A) Enhanced Data Collection

Accurate and timely data collection is crucial for effective monitoring and evaluation (M&E) of HIV programmes for key populations (KPs). The following recommendations can enhance data collection and management systems:

a) Comprehensive Data Management Systems: Strengthen existing data management systems to ensure robust quality data across all administrative levels and from multiple sources, including OSS, mobile clinics, and community-based organisations. These systems should be user-friendly and accessible to all relevant stakeholders.

b) Standardised Data Collection Tools: Utilise standardised data collection tools and protocols to ensure consistency and reliability of data across different sites and service providers. This includes harmonised indicators and reporting formats.

c) Training for Data Management Team: Provide regular training for all data administrative levels, including data collectors, healthcare providers and community workers, on accurate and ethical data collection practices. Emphasise the importance of data quality, confidentiality, and informed consent.

d) Real-Time Data Reporting: Implement real-time data reporting mechanisms to facilitate timely decision-making. Mobile and digital reporting tools can enable immediate data entry and access, reducing delays in data availability.

e) Data Quality Audits: Conduct regular data quality audits to identify and address issues such as missing data, inaccuracies, and inconsistencies. Establishing data verification processes ensures the integrity and reliability of collected data.

f) Disaggregated Data Analysis: Ensure data is disaggregated by key demographic variables, such as age, gender, and specific KP group (e.g., FSW, MSM, PWID, TG). This allows for more precise analysis and tailored interventions.

g) Feedback Mechanisms: Develop feedback mechanisms that allow KPs and service providers to report data-related challenges and suggest improvements. This can enhance the relevance and usability of collected data.

B) Regular Programme Review

Conducting regular reviews of the programme is essential for identifying gaps and areas for improvement. The following strategies are recommended:

a) Periodic Evaluations: Schedule periodic evaluations of the programme, including mid-term and end-term reviews. These evaluations should assess the effectiveness, efficiency, and impact of interventions.

b) Stakeholder Involvement: Engage a broad range of stakeholders, including KPs, community leaders, healthcare providers, policymakers, and funders, in the review process. Their insights and feedback are invaluable for comprehensive programme assessments.

c) Key Performance Indicators (KPIs): Establish clear and measurable KPIs to monitor progress towards programme goals. Regularly track these indicators to evaluate programme performance and identify areas needing attention.

d) Gap Analysis: Conduct systematic gap analyses to identify areas where the programme is falling short or where additional resources and efforts are needed. This includes assessing service coverage, quality, and accessibility.

e) Adaptive Management: Utilise an adaptive management approach that allows for flexibility and responsiveness to emerging challenges and opportunities. Implementing changes based on review findings ensures the programme remains relevant and effective.

f) Documentation and Reporting: Maintain detailed documentation of review processes, findings, and recommendations. Transparent reporting fosters accountability and facilitates knowledge sharing among stakeholders.

C) Utilising Research and Evidence

Incorporating research and evidence into programme strategies and interventions to ensure that the HIV response is informed by the latest knowledge and best practices:

a) Research Partnerships: Establish partnerships with academic institutions, research organisations, and think tanks to conduct studies on HIV among KPs. These collaborations can generate valuable insights and innovative solutions.

b) Operational Research: Prioritise operational research that evaluates the implementation of interventions in real-world settings. This research can identify practical challenges and effective strategies for scaling up successful approaches.

c) Evidence-Based Interventions: Use research findings to inform the design and implementation of interventions. Evidence-based programming increases the likelihood of achieving desired outcomes and improves resource allocation.

d) Data Utilisation: Promote the use of collected data for programme planning, monitoring, and evaluation. Regularly analyse and interpret data to guide decision-making and optimise programme performance.

e) Knowledge Dissemination: Disseminate research findings and evidence through various channels, including publications, conferences, workshops, and online platforms. Sharing knowledge helps to build capacity and foster a culture of continuous learning.

f) Feedback Loops: Create feedback loops that allow for the incorporation of new evidence into programme strategies. Regularly update interventions based on the latest research to ensure they remain relevant and effective.

Implementing these monitoring and evaluation recommendations will significantly enhance the effectiveness, efficiency, and impact of HIV programmes for key populations. By improving data collection and management, conducting regular programme reviews, and utilising research and evidence, the programme can continually adapt and respond to the evolving needs of KPs, ultimately improving health outcomes and achieving long-term success.

5.4.4 Policy and Legal Reforms

Advocating for Legal Changes

Legal reforms are essential to create an enabling environment that supports the health and well-being of key populations (KPs). The following recommendations focus on reducing criminalisation and discrimination through targeted legal advocacy:

Decriminalisation of Key Behaviours: Advocate for the decriminalisation of behaviours associated with KPs, such as sex work, same-sex relations, and drug use. The criminalisation of these behaviours drives KPs underground, away from essential health services, and exacerbates stigma and discrimination.

Legal Protection Against Discrimination: Work towards enacting and enforcing laws that protect KPs from discrimination in healthcare, employment, housing, and other areas of public life. Legal protections are vital to ensure that KPs can access services and live without fear of harassment or violence.

Amending Existing Legislation: Identify and advocate for the amendment of existing laws that negatively impact KPs. This includes laws that indirectly discriminate against KPs or are used to justify discriminatory practices.

Policy Harmonisation: Ensure that national and local policies are harmonised to support the rights and health of KPs. This includes aligning policies with international human rights standards and best practices in public health.

Engaging Policymakers: Engage with policymakers, legislators, and legal experts to build support for necessary legal reforms. This includes organising advocacy campaigns, policy dialogues, and sensitisation workshops to highlight the public health and human rights impacts of current laws**.**

Protecting Human Rights

Protecting the human rights of KPs is crucial to ensuring their access to justice and healthcare. The following recommendations aim to promote human rights and equitable treatment:

Human Rights Training for Law Enforcement: Provide comprehensive training for law enforcement officials on the rights of KPs and the importance of non-discriminatory practices.

This can help reduce incidents of harassment, abuse, and violence against KPs by law enforcement.

Access to Legal Aid: Establish and support legal aid services that offer assistance to KPs in navigating legal challenges and defending their rights. Legal aid can provide representation in court, advice on legal matters, and support in cases of discrimination or violence.

Rights-Based Healthcare Policies: Promote the development and implementation of healthcare policies that are grounded in human rights principles. This includes ensuring that healthcare providers are trained to respect the dignity and rights of all patients, regardless of their background.

Monitoring and Reporting Mechanisms: Create mechanisms to monitor and report human rights abuses against KPs. This includes setting up hotlines, reporting platforms, and independent oversight bodies that can investigate and address complaints.

Community-Based Human Rights Education: Implement community-based education programmes to raise awareness among KPs about their rights and available legal protections. Empowering KPs with knowledge about their rights can help them advocate for themselves and seek justice when needed.

International Collaboration: Collaborate with international human rights organisations and networks to strengthen advocacy efforts and draw attention to human rights issues faced by KPs. Leveraging international support can add pressure on domestic legal and policy reforms.

Implementing these policy and legal reforms is essential for creating a supportive and equitable environment for key populations in Nigeria. By advocating for legal changes and protecting human rights, the programme can help reduce stigma, discrimination, and barriers to accessing healthcare and justice. These reforms are crucial for improving the overall health and well-being of KPs and ensuring the long-term success of HIV interventions.

5.4.5 Final Note

Call to Action

The findings and recommendations outlined in this Key Population Programme Review Report underscore the urgent need for comprehensive, coordinated efforts to address the HIV epidemic among key populations (KPs) in Nigeria. The data clearly show that KPs—such as Female Sex

Workers (FSWs), Men who have Sex with Men (MSM), People Who Inject Drugs (PWID), and Transgender individuals (TG)—continue to bear a disproportionate burden of the HIV epidemic. The programmatic achievements, while commendable, highlight the critical areas that require sustained focus and enhancement. As the country programme moves forward, it is imperative to translate these findings into concrete actions that can drive meaningful change. Underneath are a few suggestions on what may be required to optimize the gains in the response. The report recommends a multi-pronged approach to address HIV among key populations in Nigeria. These includes:

- Government policy changes to decriminalize behaviours associated with KPs and improve access to healthcare.
- Strategic resource allocation for KP-focused HIV programmes
- Strengthen healthcare systems to deliver better services for KPs.
- Empower KPs to participate in programme development and advocate for their rights.
- Collaborate across sectors like health, justice, and education to address the wider issues KPs face.
- Use evidence from data to inform KP programmes.

ANNEX

Table 4.2.4: FSW Summary of PSAT Lite Result by States

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Abia	3.3	3	2.4	2.9	3.3	4.2	4	3	2	2.7	4	3.3
Adamawa	3.7	2	3.2	3.2	3.8	5	5	4.2	2	4.1	4.6	4.3
Akwa-Ibom	3	2	2	2.5	3.5	4.8	4.3	4.3	4	4	5	4.3
Anambra	3	3	3.4	3.2	5	5	5	4.4	5	4.6	5	4.7
Bayelsa	2.2	1	1	1.5	1.5	3	5	4.1	5	3.2	3.3	3.4
Delta	3	1	2.2	2.4	2.5	3.6	2.7	2.7	3	2.1	3.6	2.8
Edo	3.2	4.5	2.2	3	4.5	4	4.7	4.1	4	4.1	3.9	4.1
Enugu	2.8	1.5	1.8	2.2	1.8	4.2	3.3	2.5	1	2	3.9	2.8
Gombe	4.2	1	1.4	2.6	3.8	3.6	4.3	3.5	4	3	5	3.7
Imo	3.2	3	1.4	2.5	2.8	4.6	5	2.7	3	3.4	3.3	3.4
Kaduna	4	4.5	3.2	3.8	3.8	3.4	5	4.2	5	2.7	3.6	3.7
Kano	4	3.5	3.2	3.6	4	4.6	4.3	4.1	5	4.2	5	4.4
Kogi	3.3	3	3.2	3.2	5	4.4	5	4.2	5	4.7	4.9	4.6

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Lagos	5	5	4.4	4.8	3	5	5	5	5	5	5	4.8
Niger	3.8	3	2.6	3.2	4.3	5	4.3	3.7	5	4.1	5	4.3
Oyo	4.3	5	4.4	4.5	5	5	5	4.3	5	5	5	4.8
Rivers	2.7	3	1.4	2.2	5	4.8	3.7	3	5	3.9	4.6	4
Taraba	4.3	4	1.8	3.3	3.3	4.2	4.3	2.7	4	2	4	3.2
NATIONAL	**3.5**	**2.9**	**2.5**	**3**	**3.7**	**4.4**	**4.4**	**3.7**	**4**	**3.6**	**4.4**	**3.9**

Table 4.3.4: MSM Summary of PSAT Lite Result by States

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Abia	3.2	3	2.4	2.8	4	3.8	4	2.7	2	2.6	4	3.2
Adamawa	3.5	2	3.2	3.2	3.8	5	5	4.3	2	4	4.7	4.3
Akwa-Ibom	3	2	2	2.5	3.5	4.8	4.3	4.2	4	3.9	5	4.3
Anambra	4	3	3.6	3.7	5	5	5	4.3	5	4.3	5	4.7
Bayelsa	2.2	1	1	1.5	1.5	3	5	4.7	5	3	3.3	3.5
Delta	3	1	2	2.3	2.5	3.8	2.7	2.3	3	2	3.6	2.7
Edo	3.2	4.5	2.2	3	4	4	4.7	4	4	3.4	3.9	3.9
Enugu	2.2	4	1.8	2.3	2.5	4.4	2.3	2.8	2	2.2	4	3
Gombe	4	1	1.4	2.5	3.8	3.8	4.3	3.4	5	3.2	5	3.8
Imo	3.2	3	1.4	2.5	2.8	4.6	5	2.8	3	2.8	3.3	3.3
Kaduna	4	3.5	3.2	3.6	3.8	3.4	5	4.1	5	2.8	4.3	3.8
Kano	4	3.5	3	3.5	3.3	4.6	3.7	4.1	5	3.7	5	4.1
Kogi	3.3	3	3.2	3.2	5	4.4	5	4.1	5	4.7	4.9	4.6

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Lagos	5	5	4.4	4.8	3	5	5	5	5	5	5	4.8
Niger	4	3	2	3.1	5	5	5	3.5	5	3.9	5	4.3
Oyo	4.3	5	4.4	4.5	5	5	5	4.8	5	5	5	4.9
Rivers	2.8	3	1.2	2.2	5	4.8	3.7	3.6	5	3.1	4.4	4
Taraba	4.3	2.5	2	3.2	3.3	4.6	4.7	3	4	2.1	4	3.4
NATIONAL	**3.5**	**2.9**	**2.5**	**3**	**3.7**	**4.4**	**4.4**	**3.8**	**4.1**	**3.4**	**4.4**	**3.9**

Table 4.4.4: PWID Summary of PSAT Lite Result by States

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Abia	2.4	3	2.4	2.5	4	4.2	4	2.9	2	2.2	4	3.2
Adamawa	3.7	2	3.2	3.2	3.8	5	5	3.8	2	4.1	4.6	4.2
Akwa-Ibom	3	2	2	2.5	3.5	4.6	4.3	4	4	3.9	5	4.2
Anambra	3	3	3.4	3.2	5	5	5	4.4	5	4.6	5	4.7
Bayelsa	2.2	1	1	1.5	1.5	2.6	4	3.8	5	3.2	3.3	3.2
Delta	2.8	1	2	2.2	2.5	3.8	2.3	2.1	3	1.8	3.6	2.5
Edo	3.2	4.5	2.2	3	4	4	4.7	3.5	4	4	3.7	3.9
Enugu	2.2	4	1.8	2.3	2.5	4.4	2.3	2.3	2	1.9	4	2.7
Gombe	4	1	1.6	2.6	3.8	4.6	4.3	3.7	5	3	5	3.9
Imo	3.2	3	1.2	2.4	2.8	4.6	4.3	2.5	3	2.9	3.3	3.1
Kaduna	4	3.5	3.2	3.6	3.8	3.4	5	3.7	5	2.7	3.6	3.5
Kano	3.5	3.5	3.2	3.4	4	4.6	5	3.3	5	4.2	5	4.2
Kogi	3.3	3	3.2	3.2	5	4.4	5	4.3	5	4.7	4.9	4.6

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Lagos	5	4.5	4.4	4.7	3	5	5	4.7	5	5	5	4.7
Niger	3.7	3	2.2	3	3.3	4.6	5	3.3	5	4.3	4.4	4
Oyo	4.3	5	4.4	4.5	5	5	5	4.4	5	5	5	4.8
Rivers	2.5	3	1.4	2.2	5	5	3.3	3.3	5	2.9	4.6	3.8
Taraba	4.3	2.5	2	3.2	3.3	4.8	4.7	2.6	4	2.1	4	3.2
NATIONAL	**3.4**	**2.9**	**2.5**	**3.0**	**3.7**	**4.4**	**4.3**	**3.5**	**4.1**	**3.5**	**4.3**	**3.8**

Table 4.5.4: TG Summary of PSAT Lite Result by States

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Abia	1	1.5	1	1.1	1	1	1	1	1	1	1	1
Adamawa	3.5	2	3.2	3.2	3.8	4.6	2	4.3	2	3.8	4.6	4
Akwa-Ibom	2.8	2	2	2.4	3.5	4.2	4.3	4	4	3.9	5	4.2
Anambra	4	3	3.6	3.7	5	5	5	4.3	5	4.6	5	4.7
Bayelsa	1	1	1	1	1.3	1	1	1	1	1	1	1

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Delta	3	1	2	2.3	2.5	3.8	2.7	2.3	3	1.9	3.6	2.7
Edo	3.3	4.5	1.6	2.8	4	4	4.7	4	4	3.8	3.9	4
Enugu	1.7	3	1.8	1.9	1.8	2	1	1.9	1	1.2	3.4	1.9
Gombe	4.2	1	1.2	2.5	3.8	4.4	4.3	3.4	5	2.8	5	3.8
Imo	2.8	3	1.4	2.3	2.8	3.8	5	2.7	3	2.4	3.3	3.1

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Kaduna	1.5	2	1	1.4	1.3	1	1.3	1.9	1	1.2	1	1.3
Kano	3	2.5	3	2.9	3.3	4.6	3.7	4.1	5	3.8	5	4.2
Kogi	3.3	3	3.2	3.2	5	4.4	5	4.1	5	4.7	4.9	4.6
Lagos	5	5	4.4	4.8	2	5	2	4.6	5	5	5	4.4
Niger	4	3	2	3.1	4	4.2	5	3.6	5	3.4	4	3.9

STATE	PROGRAMME MANAGEMENT				PROGRAMME IMPLEMENTATION							
	Leadership and Coordination	Laws, Policies and Regulations	Financing	PROGRAMME MANAGEMENT	Targeting and Planning	Implementation Arrangement	Service Delivery	Clinical Interventions	Behavioural Interventions	Structural Interventions	Programme Monitoring	PROGRAMME IMPLEMENTATION
Oyo	3.7	5	2.2	3.3	2	1	2	4.6	5	5	5	4.1
Rivers	1	1	1	1	1	1	1	1	1	1	1	1
Taraba	4.3	2.5	2	3.2	3.3	4.6	4.7	3	4	2.1	4	3.3
NATIONAL	**3**	**2.6**	**2.1**	**2.6**	**2.9**	**3.3**	**3.1**	**3.1**	**3.3**	**2.9**	**3.7**	**3.2**

Eligibility Screening Questionnaire: FSW

Instructions: Complete the entire screening questionnaire for every potential respondent that comes to the survey location for the 1st visit.

"Hello. My name is _____. I would like to first thank you for taking the time to participate in the survey. The person who asked you to participate in the survey may have told you that this survey is about assessing knowledge and practices around HIV and behaviours. But before we start the survey, I need to first find out if you are eligible to participate. If you are eligible to participate, then I will introduce you to one of our interviewers who will do a polling booth survey, (and add other elements of the study). Let me also tell you that everything you tell us will be confidential. We will not take your name and no one will be able to link your responses to you personally. Do you mind if I start?"

This eligibility screening will take about 15 minutes

No.	Question	Coding of answers
For Participants		
1	Were you born biologically female?	Female Male ineligible
2	How old were you on your last birthday?	---------- years [Under 18 years) ineligible
3	Have you received money or gifts in exchange for sexual intercourse with a male client at least once in the past three months?	Yes No ineligible
4	Do you agree to participate in this study? (explain the study if need be)	Yes No ineligible
5	Have you participated in this specific survey in the past 1 month?	Yes ineligible No

For Interviewer		
6	Participant is under the influence of alcohol/drugs	Yes ineligible No
7	Participant is willing to provide verbal/written informed consent	Yes No ineligible
8	Participant has been recruited from the selected cluster	Yes No ineligible

Participant eligible to participate? Yes ☐ N ☐

Signature of the researcher: …….

Date:……

……

Individual Questionnaire

Female Sex Workers

Study Title:

Unique Code☐☐☐ ☐☐ ☐☐

DATE ☐☐ ☐☐ ☐☐

Sub county:_____ PBS#_____ TEAM _____

Sl	QUESTION	CATEOGRY	SKIP
1	How old are you?	AGE IN COMPLETED YEAR ☐☐	
2	How old were you when you had first sex with a	AGE ☐☐	

	man (vaginal, anal, oral) for exchange of money or gifts?	NEVER HAD SEX DON'T KNOW NO ANSWER	95 ◄ 98 99	END
3	How many sex acts you have in a week?	NUMBER OF SEX ACTS NONE DON'T KNOW NO ANSWER	☐☐ 00 98 99	
4	How many different male clients/ partners have you had in the last one month?	NUMBER OF MALE CLIENTS NONE DON'T KNOW NO ANSWER	☐☐ 00 98 99	
5	Where do you predominantly solicit/ meet/ hookup with your male clients?	PHYSICAL SITES VIRTUAL	1 2	
6	How old were you when you first received a HIV service either from a peer educator or a government facility or NGO.	AGE IN COMPLETED YEARS NOT AWARE OF ANY SERVICES NEVER RECEIVED ANY HIV SERVICES NO ANSWER	☐☐ 1 2 99	 14
7	What HIV services have you received in the last one year	PEER EDUCATION CONDOMS LUBRICANTS HIV TESTING PREP PEP ART RISK REDUCTION COUNSELLING VIOLENCE RESPONSE SUPPORT STIGMA RELATED SUPPORT INCOME GENERATION	1 2 3 4 5 6 7 8 9 10 11	

		EDUCATION SUBSIDIES	12	
		MENTAL HEALTH SUPPORT	13	
		HEALTH EDUCATION	14	
		STI TREATMENT	15	
		SRH SERVICES	16	
		STERILE NEEDLES	17	
		MAT SERVICES	18	
		ANY OTHERS (SPECIFY)	97	

PBS QUESTIONNAIRE for FSW

POLLING BOOTH SURVEY 2023

Before Starting the Survey, Please Administer a Screening Question to all Participants

Introduction

Hello. My name is _____. I am from NACA/West African Centre for Public Health and Development, and would be conducting the polling booth survey with you. Polling Booth Survey is a group interview method. Similar to the confidential voting that we adopt in elections, here, you will give your answers to the questions by secretly putting the cards into one of the three boxes. Just like the way it is done in the election, all the votes will be pooled together, to measure the prevalence of a certain knowledge and behaviour in the group. However, no one will know who gave what answer to which question. There is no way of linking a particular response to a particular person.

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

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

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

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

Please do not put two cards at a time.

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

As I mentioned earlier, there are many personal and sensitive questions asked. These questions are formulated based on the scientific understanding of the knowledge and behaviours related to HIV/AIDS. You may feel embarrassed; you may feel shy or you may sometimes feel angry to hear these questions. Please do not consider the appropriateness of the questions given our social and cultural norms. Instead, consider these items as useful for designing the content of the HIV prevention programme. You may like to discuss these with our team separately after this session.

We also request you to be honest in answering these questions.

Let us start with an example. Please hold up the first card, bearing the number **1**. [*Moderator and Assistant to make sure that everyone has held Card number 1*.] **Did you eat a banana in the past 48 hours (2 days)?** If you ate a Banana in the past 48 hours (2 days), please put Card No. 1 into the GREEN box. If you have not eaten a Banana in the past 48 hours (2 days), please put the card into the RED box. If you do not eat bananas at all, please put your card into the WHITE box. Has everyone put their card into the GREEN, the RED or WHITE box?

[*Moderator and Assistant to collect the cards separately and count the cards in GREEN, RED and WHITE boxes. Discuss with the participants about the confidentiality process, about how we only come to know the percentage of persons who ate bananas in the past 48 hours (2 days) and we will not know who among the participants ate the bananas. Give back Card 1 to the participants. Return all the ballot boxes to the participants*].

Now pick up the card bearing number 1 and listen carefully to the question:

1. The last time you had sex with any paying client, did he use a condom?

If your answer is YES to this question, please drop the card numbered 1 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 2 and listen carefully to the question:

2. During the past 3 months, was there any occasion when you had sex with any paying client without using a condom?

If your answer is YES to this question, please drop the card numbered 2 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 3 and listen carefully to the question:

3. During the past 3 months, was there a time when you intended to use a condom with any of your sexual partners but did not use it because a condom was not available at that time and place?

If your answer is YES to this question, please drop the card numbered 3 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 4 and listen carefully to the question:

4. Have you taken an HIV test in the last 12 months?

If your answer is YES to this question, please drop the card numbered 4 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> tested for HIV or tested HIV positive before 12 months, please drop this card into the WHITE box.

Now pick up the card bearing number 5 and listen carefully to the question:

5. Did you take an HIV test during the past 3 months?

If your answer is YES to this question, please drop the card numbered 5 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you

have never or tested HIV positive before 3 months, drop the card numbered 9 in the WHITE box

Now pick up the card bearing number 6 and listen carefully to the question:

6. *Was there a time in the last 12 months when you wanted to take an HIV test but could not take it because it was not available or accessible?*

If your answer is YES to this question, please drop the card numbered 6 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never or tested HIV positive before 12 months, drop the card numbered 6 in the WHITE box

Now pick up the card bearing number 7 and listen carefully to the question:

7. Are you living with HIV? *[Please note that you DO NOT have to disclose your HIV test result]*

If your answer is YES to this question, please drop the card numbered 7 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never taken a HIV test or do not know your status, drop the card numbered 10 in the WHITE box.

Now pick up the card bearing number 8 and listen carefully to the question:

8. If you are living with HIV, are you enrolled in an ART clinic?

If your answer is YES to this question, please drop the card numbered 8 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you are not living with HIV or do not know the HIV status, please drop this card into the WHITE box.

Now pick up the card bearing number 9 and listen carefully to the question:

9. If you are living with HIV, are you currently taking ARV (Antiretroviral drugs for HIV management)?

If your answer is YES to this question, please drop the card numbered 9 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you are not living with HIV or do not know the HIV status, please drop this card into the WHITE box.

Now pick up the card bearing number 10 and listen carefully to the question:

10. *If you are taking ARV, was there an occasion in the last 12 month when you were unable to take ARV as they were not available or accessible?*

If your answer is YES to this question, please drop the card numbered 10 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you are not living with HIV or do not know the HIV status or you are living with HIV but not taking ART, please drop this card into the WHITE box.

Now pick up the card bearing number 11 and listen carefully to the question:

11. In the last 12 months, were you diagnosed with sexually transmitted infections (STIs)?

If your answer is YES to this question, please drop the card numbered 11 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 12 and listen carefully to the question

12. In the last 12 months, were you treated for any sexually transmitted infections (STIs)?

If your answer is YES to this question, please drop the card numbered 12 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you never had an STI in the last 3 months, put the card in the WHITE box.

Now pick up the card bearing number 13 and listen carefully to the question

13. In the last 12 months, w*as there an occasion, when you needed STI treatment but the treatment was not available?*

If your answer is YES to this question, please drop the card numbered 12 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you never had an STI in the last 12 months, put the card in the WHITE box.

Now pick up the card bearing number 14 and listen carefully to the question

14. Have you taken PrEP in the last 12 months? *(Moderator to explain clearly what PrEP is)*

If your answer is YES to this question, please drop the card numbered 14 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you are living with HIV, please drop your card in the WHITE box.

Now pick up the card bearing number 15 and listen carefully to the question

15. Are you currently taking PrEP? *(Moderator to explain clearly what PreP is)*

If your answer is YES to this question, please drop the card numbered 15 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> taken PrEP or are living with HIV, put your card in the white box.

Now pick up the card bearing number 16 and listen carefully to the question

16. Was there an occasion in the last 12 months when you wanted to take PrEP but PreP was not available?

If your answer is YES to this question, please drop the card numbered 16 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> taken PrEP or are living with HIV, put your card in the white box.

Now pick up the card bearing number 17 and listen carefully to the question

17. Have you taken PEP in the last 12 months? *(Moderator to explain clearly what PEP is)*

If your answer is YES to this question, please drop the card numbered 17 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> taken PEP or living with HIV, put your card in the white box.

Now pick up the card bearing numbe18 and listen carefully to the question

18. During the past 12 months, was there a time when you needed to use PEP but could not use it because PEP was not available at that time and place?

If your answer is YES to this question, please drop the card numbered 19 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never or not taken PEP in the last 12 months or living with HIV, put your card in the WHITE box.

Now pick up the card numbered 19 and listen carefully to the question:

19. In the last 3 months, did you ever visit or receive services from the project clinic or DIC or public health facility?

If your answer is YES to this question, please drop the card numbered 19 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you do not know or had never been to the clinic, please drop this card into the WHITE box.

Now pick up the card numbered 20 and listen carefully to the question:

20. In the last 3 months, were you met by a peer educator from the programme?

If your answer is YES to this question, please drop the card numbered 20 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box

Now pick up the card numbered 21 and listen carefully to the question:

21. In the past 12 months, were you ever beaten up by police, when you were doing sex work?

If your answer is YES to this question, please drop the card numbered 21 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never been beaten up by police when you were doing sex work put your card in the WHITE box.

Now pick up the card numbered 22 and listen carefully to the question:

22. *In the last 12 months, did you receive information on violation of rights and support provided when you experience violence from peer educators, advocacy officers or clinic team?*

If your answer is YES to this question, please drop the card numbered 22 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 23 and listen carefully to the question

23. In the past 12 months, when you experienced any violence, were you supported by the intervention/ clinic/ OSS? (support means medical, psychological, legal, safety/ shelter etc.)

If your answer is YES to this question, please drop the card numbered 23 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you did not/have never experienced violence please drop the card in the WHITE box.

Now pick up the card numbered 24 and listen carefully to the question:

24. In the last 12 months, did you experience discrimination by health care providers due to your sex work identity?

If your answer is YES to this question, please drop the card numbered 24 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never experienced discrimination by health care providers then put your card in WHITE box.

Now pick up the card numbered 25 and listen carefully to the question:

25. In the last 12 months, when you experienced stigma and discrimination, were you supported by the intervention/ clinic/ OSS? (support means medical, psychological, legal, safety/ shelter etc)

If your answer is YES to this question, please drop the card numbered 25 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never experienced discrimination at the family or community or health care providers, then put your card in WHITE box.

Now pick up the card numbered 26 and listen carefully to the question:

26. Do you know that having penetrative sex with a man without a condom will increase the risk of contracting HIV?

If your answer is YES to this question, please drop the card numbered 26 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card numbered 27 and listen carefully to the question:

27. Do you know that using ARVs consistently by HIV positive individuals and being virally suppressed reduce the risk of transmitting HIV?

If your answer is YES to this question, please drop the card numbered 27 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Eligibility screening questionnaire for Men who have Sex with Men/Transgender

PBS no:

Instructions: Complete the full eligibility screening questionnaire for every potential participant that comes to the survey location / location.

"Hello. My name is ____*[name of community researcher]*____. First, I would like to thank you for taking the time to participate in this Polling Booth Survey, which will ask you about knowledge, practices, and behaviours related to HIV and other sexually transmitted infections. Before we start the survey, I need to find out if you are eligible to participate. You may also be asked to take part in a focus group discussion, if you are agreeable. Let me assure you that everything you tell us will remain confidential and anonymous. We will not take your name, and no one will be able to link your responses to you personally. Do you mind if I start?"

This eligibility screening will take about 5 minutes.

No.	Screening question	Coding of answers
For Participants		
1	Were you born biologically?	Female Male
	What do you identify as?	Female Male Others
2	How old were you on your last birthday?	years [Less than 18 years] □ *ineligible*
3	Have you had at least one anal sex act (insertive or receptive) with another man in the last 3 months?	Yes No □ *ineligible*
4	Do you agree to participate in this study? (explain the study if need be)	Yes No □ *ineligible*

5	Have you participated in this specific survey in the past 1 month?	Yes *ineligible* No
For Interviewer		
6	Participant is under the influence of alcohol/drugs	Yes *ineligible* No
7	Participant is willing to provide verbal/written informed consent	Yes No *ineligible*
8	Participant has been recruited from the selected cluster	Yes No *ineligible*

Participant eligible to participate? **Yes** ☐

No ☐

Signature of community researcher: _____

_____

Date:

6: Individual questionnaire

Unique Code: ☐☐☐☐☐☐

DATE: ☐☐ ☐☐ ☐☐☐☐

DD MM YYYY

INTERVIEWER NAME:

SIGNATURE:

Sl	QUESTION	CATEOGRY		SKIP
1	How old are you?	AGE IN COMPLETED YEAR ☐☐		
2	What is your gender identity?	MAN	1	
		WOMAN	2	
		GENDER NON-CONFORMING	3	
		TRANSGENDER WOMEN	4	
		TRANSGENDER MAN	5	
		OTHERS	6	
3	How do you predominantly describe your sexual orientation/identity?	GAY	1	
		BI SEXUAL	2	
		HETEROSEXUAL	3	
		MALE SEX WORKERS	4	
		OTHERS	5	
		NO ANSWER	99	
4	How old were you when you had first sex with a man (anal or oral)?	AGE ☐☐		
		NEVER HAD SEX	95 ◄	END
		DON'T KNOW	98	
		NO ANSWER	99	
5	How old were you when you had first sex with a man (anal, oral) for money or gifts?	AGE ☐☐		
		NEVER HAD SEX FOR EXCHANGE FOR		
		MONEY OF GIFTS	95	
		DON'T KNOW	98	
		NO ANSWER	99	
6	How many sex acts do you have in a week?	NUMBER OF SEX ACTS ☐☐		
		NONE	00	
		DON'T KNOW	98	
		NO ANSWER	99	
7	How many different male clients/partners	NUMBER OF MALE CLIENT ☐☐		

	have you had in the last one month?	NONE DON'T KNOW NO ANSWER	00 98 99	
8	Where do you predominantly solicit/ meet/ hook up with your male clients?	PHYSICAL SITES VIRTUAL OTHERS (SPECIFY)	1 2 3	
9	How old were you when you first received an HIV prevention, testing or treatment service either from a peer educator or a government facility or NGO?	AGE IN COMPLETED YEARS NOT AWARE OF ANY SERVICES NEVER RECEIVED ANY HIV SERVICES NO ANSWER	1 2 99	END
10	What HIV services have you received in the last one year?	PEER EDUCATION CONDOMS LUBRICANTS HIV TESTING PREP PEP ART RISK REDUCTION COUNSELLING VIOLENCE RESPONSE SUPPORT STIGMA RELATED SUPPORT INCOME GENERATION EDUCATION SUBSIDIES MENTAL HEALTH SUPPORT HEALTH EDUCATION STI TREATMENT SRH SERVICES STERILE NEEDLES MAT SERVICES ANY OTHERS (SPECIFY)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 97	

PBS QUESTIONNAIRE for MSM and TG

POLLING BOOTH SURVEY 2023

Before Starting the Survey, Please Administer a Screening Question to all Participants

Introduction

Hello. My name is _____. I am from NACA/West African Centre for Public Health and Development, and would be conducting the polling booth survey with you. Polling Booth Survey is a group interview method. Similar to the confidential voting that we adopt in elections, here, you will give your answers to the questions by secretly putting the cards into one of the three boxes. Just like the way it is done in the election, all the votes will be pooled together, to measure the prevalence of a certain knowledge and behaviour in the group. However, no one will know who gave what answer to which question. There is no way of linking a particular response to a particular person.

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

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

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

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

Please do not put two cards at a time.

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

As I mentioned earlier, there are many personal and sensitive questions asked. These questions are formulated based on the scientific understanding of the knowledge and behaviours related to HIV/AIDS. You may feel embarrassed; you may feel shy or you may sometimes feel angry to hear these questions. Please do not consider the appropriateness of the questions given our social and cultural norms. Instead, consider these items as useful for designing the content of the HIV prevention programme. You may like to discuss these with our team separately after this session.

We also request you to be honest in answering these questions.

Let us start with an example. Please hold up the first card, bearing the number **1**. [*Moderator and Assistant to make sure that everyone has held Card number 1*.] **Did you eat a banana in the past 48 hours (2 days)?** If you ate a Banana in the past 48 hours (2 days), please put Card No. 1 into the GREEN box. If you have not eaten a Banana in the past 48 hours (2 days), please put the card into the RED box. If you do not eat bananas at all, please put your card into the WHITE box. Has everyone put their card into the GREEN, the RED or WHITE box?

[*Moderator and Assistant to collect the cards separately and count the cards in GREEN, RED and WHITE boxes. Discuss with the participants about the confidentiality process, about how we only come to know the percentage of persons who ate bananas in the past 48 hours (2 days) and we will not know who among the participants ate the bananas. Give back Card 1 to the participants. Return all the ballot boxes to the participants*].

Now pick up the card bearing number 1 and listen carefully to the question:

1. The last time you had anal sex with a non-regular partner, was a condom used?

If your answer is YES to this question, please drop the card numbered 1 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 2 and listen carefully to the question:

2. The last time you had anal sex with a non-regular partner, was a lubricant used?

If your answer is YES to this question, please drop the card numbered 2 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 3 and listen carefully to the question:

3. Have you ever exchanged anal sex for money or goods with other men in the last 12 months?

If your answer is YES to this question, please drop the card numbered 3 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 4 and listen carefully to the question:

4. The last time you had sex with any paying client, did he use a condom?

If your answer is YES to this question, please drop the card numbered 4 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> had a paying client/exchanged sex for money or goods with other men, please drop this card into the WHITE box.

Now pick up the card bearing number 5 and listen carefully to the question:

5. The last time you had sex with any paying client, did he use a lubricant?

If your answer is YES to this question, please drop the card numbered 5 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> had a paying client/exchanged sex for money or goods with other men, please drop this card into the WHITE box.

Now pick up the card bearing number 6 and listen carefully to the question:

6. Do you have a regular male partner who does not pay you or gives you gifts for sex? (A regular non-paying male partner may include live-in partners, sponsors, friends with benefits).

If your answer is YES to this question, please drop the card numbered 6 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 7 and listen carefully to the question:

7. The last time you had sex with a regular non-paying male partner, did he use a condom?

If your answer is YES to this question, please drop the card numbered 7 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> had a regular male partner who does not pay you or gives you gifts for sex, please drop this card into the WHITE box.

Now pick up the card bearing number 8 and listen carefully to the question:

8. The last time you had sex with a regular non-paying male partner, did he use a lubricant?

If your answer is YES to this question, please drop the card numbered 8 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> had a regular male/female partner who does not pay you or gives you gifts for sex, please drop this card into the WHITE box.

Now pick up the card numbered 9 and listen carefully to the question:

9. Do you have a main/live-in/regular female sexual partner?

If your answer is YES to this question, please drop the card numbered 9 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card numbered 11 and listen carefully to the question:

10. The last time you had sex with your main/live-in/regular female sexual partner, did you use a condom?

If your answer is YES to this question, please drop the card numbered 10 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you <u>never</u> had a main/live-in/regular female sexual partner, please drop this card into the WHITE box.

Now pick up the card bearing number 11 and listen carefully to the question:

11. During the past 3 months, was there any occasion when you had sex with non-regular sexual partners or clients without using a condom?

If your answer is YES to this question, please drop the card numbered 11 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 12 and listen carefully to the question:

12. During the past 3 months, was there a time when you intended to use a condom with any of your sexual partners but did not use it because a condom was not available at that time and place?

If your answer is YES to this question, please drop the card numbered 12 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 13 and listen carefully to the question:

13. During the past 3 months, was there a time when you intended to use a lubricant with any of your sexual partners but did not use it because lubricant was not available at that time and place?

If your answer is YES to this question, please drop the card numbered 13 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 14 and listen carefully to the question:

14. Have you taken an HIV test in the last 12 months?

If your answer is YES to this question, please drop the card numbered 14 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> tested for HIV or tested HIV positive before 12 months, please drop this card into the WHITE box.

Now pick up the card bearing number 15 and listen carefully to the question:

15. Did you take an HIV test during the past 3 months?

If your answer is YES to this question, please drop the card numbered 15 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you

have never or tested HIV positive before 3 months, drop the card numbered 9 in the WHITE box

Now pick up the card bearing number 16 and listen carefully to the question:

16. Was there a time in the last 12 months when you wanted to take an HIV test but could not take it because it was not available or accessible?

If your answer is YES to this question, please drop the card numbered 16 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never or tested HIV positive before 12 months, drop the card numbered 6 in the WHITE box

Now pick up the card bearing number 17 and listen carefully to the question:

17. Are you living with HIV? *[Please note that you DO NOT have to disclose your HIV test result]*

If your answer is YES to this question, please drop the card numbered 17 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never taken a HIV test or do not know your status, drop the card numbered 10 in the WHITE box.

Now pick up the card bearing number 18 and listen carefully to the question:

18. If you are living with HIV, are you enrolled in an ART clinic?

If your answer is YES to this question, please drop the card numbered 18 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you are not living with HIV or do not know the HIV status, please drop this card into the WHITE box.

Now pick up the card bearing number 19 and listen carefully to the question:

19. If you are living with HIV, are you currently taking ARV (Antiretroviral drugs for HIV management)?

If your answer is YES to this question, please drop the card numbered 19 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you are not living with HIV or do not know the HIV status, please drop this card into the WHITE box.

Now pick up the card bearing number 20 and listen carefully to the question:

20. *If you are taking ARV, was there an occasion in the last 12 month when you were unable to take ARV as they were not available or accessible?*

If your answer is YES to this question, please drop the card numbered 20 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you are not living with HIV or do not know the HIV status or you are living with HIV but not taking ART, please drop this card into the WHITE box.

Now pick up the card bearing number 21 and listen carefully to the question:

21. In the last 12 months, were you diagnosed with sexually transmitted infections (STIs)?

If your answer is YES to this question, please drop the card numbered 21 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 22 and listen carefully to the question

22. In the last 12 months, were you treated for any sexually transmitted infections (STIs)?

If your answer is YES to this question, please drop the card numbered 22 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you never had an STI in the last 3 months, put the card in the WHITE box.

Now pick up the card bearing number 23 and listen carefully to the question

23. In the last 12 months, w*as there an occasion, when you needed STI treatment but the treatment was not available?*

If your answer is YES to this question, please drop the card numbered 23 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you never had an STI in the last 12 months, put the card in the WHITE box.

Now pick up the card bearing number 24 and listen carefully to the question

24. Have you taken PrEP in the last 12 months? *(Moderator to explain clearly what PrEP is)*

If your answer is YES to this question, please drop the card numbered 24 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you are living with HIV, please drop your card in the WHITE box.

Now pick up the card bearing number 25 and listen carefully to the question

25. Are you currently taking PrEP? *(Moderator to explain clearly what PreP is)*

If your answer is YES to this question, please drop the card numbered 25 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> taken PrEP or are living with HIV, put your card in the white box.

Now pick up the card bearing number 26 and listen carefully to the question

26. Was there an occasion in the last 12 months when you wanted to take PrEP but PreP was not available?

If your answer is YES to this question, please drop the card numbered 26 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> taken PrEP or are living with HIV, put your card in the white box.

Now pick up the card bearing number 27 and listen carefully to the question

27. Have you taken PEP in the last 12 months? *(Moderator to explain clearly what PEP is)*

If your answer is YES to this question, please drop the card numbered 27 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have <u>never</u> taken PEP or living with HIV, put your card in the white box.

Now pick up the card bearing number 28 and listen carefully to the question

28. During the past 12 months, was there a time when you needed to use PEP but could not use it because PEP was not available at that time and place?

If your answer is YES to this question, please drop the card numbered 28 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never or not taken PEP in the last 12 months or living with HIV, put your card in the WHITE box.

Now pick up the card numbered 29 and listen carefully to the question:

29. In the last 3 months, did you ever visit or receive services from the project clinic or DIC or public health facility?

If your answer is YES to this question, please drop the card numbered 29 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you do not know or had never been to the clinic, please drop this card into the WHITE box.

Now pick up the card numbered 30 and listen carefully to the question:

30. In the last 3 months, were you met by a peer educator from the programme?

If your answer is YES to this question, please drop the card numbered 30 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box

Now pick up the card numbered 31 and listen carefully to the question:

31. In the past 12 months, were you ever beaten up by police, because of your sexual orientation?

If your answer is YES to this question, please drop the card numbered 31 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never been beaten up by police when you were doing sex work put your card in the WHITE box.

Now pick up the card numbered 32 and listen carefully to the question:

32. *In the last 12 months, did you receive information on violation of rights and support provided when you experience violence from peer educators, advocacy officers or clinic team?*

If your answer is YES to this question, please drop the card numbered 32 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 33 and listen carefully to the question

33. In the past 12 months, when you experienced any violence, were you supported by the intervention/ clinic/ OSS? (support means medical, psychological, legal, safety/ shelter etc.)

If your answer is YES to this question, please drop the card numbered 33 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you did not/have never experienced violence please drop the card in the WHITE box.

Now pick up the card numbered 34 and listen carefully to the question:

34. In the last 12 months, did you experience discrimination by health care providers due to your sex work identity?

If your answer is YES to this question, please drop the card numbered 34 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never experienced discrimination by health care providers then put your card in WHITE box.

Now pick up the card numbered 35 and listen carefully to the question:

35. In the last 12 months, when you experienced stigma and discrimination, were you supported by the intervention/ clinic/ OSS? (support means medical, psychological, legal, safety/ shelter etc)

If your answer is YES to this question, please drop the card numbered 35 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box. If you have never experienced discrimination at the family or community or health care providers, then put your card in WHITE box.

Now pick up the card numbered 36 and listen carefully to the question:

36. Do you know that having penetrative sex with a man without a condom will increase the risk of contracting HIV?

If your answer is YES to this question, please drop the card numbered 36 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card numbered 37 and listen carefully to the question:

37. Do you know that using ARVs consistently by HIV positive individuals and being virally suppressed reduce the risk of transmitting HIV?

If your answer is YES to this question, please drop the card numbered 37 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Eligibility Screening Questionnaire: PWID

Instructions: Complete the entire screening questionnaire for every potential respondent that comes to the survey location for the 1st visit.

"Hello. My name is _____. I would like to first thank you for taking the time to participate in the survey. The person who asked you to participate in the survey may have told you that this survey is about assessing knowledge and practices around HIV and behaviours. But before we start the survey, I need to first find out if you are eligible to participate. If you are eligible to participate, then I will introduce you to one of our interviewers who will do a polling booth survey, (and add other elements of the study). Let me also tell you that everything you tell us will be confidential. We will not take your name and no one will be able to link your responses to you personally. Do you mind if I start?"

This eligibility screening will take about 15 minutes

No.	Question	Coding of answers
For Participants		
1	Were you born biologically female or male?	Female Male
2	How old were you on your last birthday?	---------- years [Under 18 years) ineligible
3	Have you ever in your life shot up or injected any drug other than those prescribed for you?	Yes No ineligible

	Shooting up means anytime you might have used drugs with needle either by mainlining, skip popping of muscling.	
4	Do you agree to participate in this study? (explain the study if need be)	Yes No☐ ineligible
5	Have you participated in this specific survey in the past 1 month?	Yes☐ ineligible No
For Interviewer		
6	Participant is under the influence of alcohol/drugs	Yes☐ ineligible No
7	Participant is willing to provide verbal/written informed consent	Yes No☐ ineligible
8	Participant has been recruited from the selected cluster	Yes No☐ ineligible

Participant eligible to participate? Yes ☐ N☐

Signature of the researcher: ……

Date:……

……

Individual Questionnaire

People who inject Drugs

Study Title:

Unique Code☐☐☐ ☐☐ ☐☐

DATE ☐☐ ☐☐ ☐☐

Sub county:_____ PBS#_____ TEAM _____

Sl	QUESTION	CATEOGRY		SKIP
1	How old are you?	AGE IN COMPLETED YEAR ☐☐		
2	How old were you when you first injected addictive/non-medical drugs? (Including self-injection or injection by another.	AGE ☐☐ NEVER INJECT 95 ◄ DON'T KNOW 98 NO ANSWER 99		END
3	How many times do you inject drugs in a week?	NUMBER ☐☐ NONE 00 DON'T KNOW 98 NO ANSWER 99		
4	How old were you when you first received a HIV service either from a peer educator or a government facility or NGO.	AGE IN COMPLETED YEA☐☐ NOT AWARE OF ANY SERVICES 1 NEVER RECEIVED ANY HIV SERVICES 2 NO ANSWER 99		14
5	What HIV services have you received in the last one year	PEER EDUCATION 1 CONDOMS 2 LUBRICANTS 3 HIV TESTING 4 PREP 5 PEP 6 ART 7 RISK REDUCTION COUNSELLING 8 VIOLENCE RESPONSE SUPPORT 9 STIGMA RELATED SUPPORT 10 INCOME GENERATION 11		

		EDUCATION SUBSIDIES	12	
		MENTAL HEALTH SUPPORT	13	
		HEALTH EDUCATION	14	
		STI TREATMENT	15	
		SRH SERVICES	16	
		STERILE NEEDLES	17	
		MAT SERVICES	18	
		ANY OTHERS (SPECIFY)	97	

PBS QUESTIONNAIRE for PWID

POLLING BOOTH SURVEY 2023

Before Starting the Survey, Please Administer a Screening Question to all Participants

Introduction

Hello. My name is _____. I am from NACA/West African Centre for Public Health and Development, and would be conducting the polling booth survey with you. Polling Booth Survey is a group interview method. Similar to the confidential voting that we adopt in elections, here, you will give your answers to the questions by secretly putting the cards into one of the three boxes. Just like the way it is done in the election, all the votes will be pooled together, to measure the prevalence of a certain knowledge and behaviour in the group. However, no one will know who gave what answer to which question. There is no way of linking a particular response to a particular person.

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

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

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

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

Please do not put two cards at a time.

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

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We also request you to be honest in answering these questions.

Let us start with an example. Please hold up the first card, bearing the number **1**. [*Moderator and Assistant to make sure that everyone has held Card number 1*.] **Did you eat a banana in the past 48 hours (2 days)?** If you ate a Banana in the past 48 hours (2 days), please put Card No. 1 into the GREEN box. If you have not eaten a Banana in the past 48 hours (2 days), please put the card into the RED box. If you do not eat bananas at all, please put your card into the WHITE box. Has everyone put their card into the GREEN, the RED or WHITE box?

[*Moderator and Assistant to collect the cards separately and count the cards in GREEN, RED and WHITE boxes. Discuss with the participants about the confidentiality process, about how we only come to know the percentage of persons who ate bananas in the past 48*

hours (2 days) and we will not know who among the participants ate the bananas. Give back Card 1 to the participants. Return all the ballot boxes to the participants].

We will now start with the first question.

Now pick up the card bearing number 1 and listen carefully to the question:

1. **Have you ever injected heroin or any narcotic drug?**

If your answer to this question is YES, please drop the card numbered 1 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box

Now pick up the card bearing number 2 and listen carefully to the question:

2. **Have you injected heroin or any narcotic drugs in the last one month?**

If your answer to this question is YES, please drop the card numbered 2 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 3 and listen carefully to the question:

3. **The last time you injected drugs, did you use a new needle and syringe?**

If your answer to this question is YES, please drop the card numbered 3 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 4 and listen carefully to the question:

4. In the last 3 month, did you share an injecting needle with another person?

If your answer to this question is YES, please drop the card numbered 4 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 5 and listen carefully to the question:

5. During the past month, was there a time when you wanted a new needle but a new needle was not available at that time and place?

If your answer to this question is YES, please drop the card numbered 5 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 6 and listen carefully to the question:

6. Have you have had any abscesses/ wounds at an injection site in the last three months?

If your answer to this question is YES, please drop the card numbered 6 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 7 and listen carefully to the question:

7. Have you ever undergone any drug rehabilitation/ treatment programme?

If your answer to this question is YES, please drop the card numbered 7 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 8 and listen carefully to the question:

8. Have you experienced drug overdose in the last six months?

If your answer to this question is YES, please drop the card numbered 8 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 9 and listen carefully to the question:

9. Have you ever undergone Medically Assisted Treatment (MAT) as a result of drug overdose?

If your answer to this question is YES, please drop the card numbered 9 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 10 and listen carefully to the question:

10. During the past 3 month, was there any occasion when you had sex with a paying client?

If your answer to this question is YES, please drop the card numbered 10 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 11 and listen carefully to the question:

11. During the past 3 month, was there any occasion when you paid for sex?

If your answer to this question is YES, please drop the card numbered 11 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 12 and listen carefully to the question:

12. The last time you had sex with a paying client/or bought sex, did you use a condom?

If your answer to this question is YES, please drop the card numbered 12 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 13 and listen carefully to the question:

13. During the past month, was there a time when you intended to use a condom with any of your sexual partners but did not use it because a condom was not available at that time and place?

If your answer to this question is YES, please drop the card numbered 13 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 14 and listen carefully to the question:

14. **The last time that any of your sexual partners used a condom; did it burst or slip off?**

If your answer to this question is YES, please drop the card numbered 14 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 15 and listen carefully to the question:

15. Have you ever taken an HIV test?

If your answer to this question is YES, please drop the card numbered 15 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 16 and listen carefully to the question:

16. Have you taken an HIV test during the past three months?

If your answer to this question is YES, please drop the card numbered 16 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 17 and listen carefully to the question:

17. Have you ever been enrolled into HIV care and treatment programme?

Any service, government or private providing HIV care and treatment.

If your answer to this question is YES, please drop the card numbered 17 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 18 and listen carefully to the question:

18. Are you currently taking ARV (Anti-Retroviral drugs for HIV management)?

If your answer to this question is YES, please drop the card numbered 18 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 19 and listen carefully to the question:

19. In the past six months, have you been arrested or beaten up by law enforcement agency when you were injecting drugs or at the spot?

If your answer to this question is YES, please drop the card numbered 19 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 20 and listen carefully to the question:

20. Do you think sharing needles can spread HIV?

If your answer to this question is YES, please drop the card numbered 20 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 21 and listen carefully to the question:

21. In the last three months did you experience any of the following symptoms of a sexually transmitted infection?

Female group: Foul smelling discharge from the vagina, ulcer/wound around vagina, or severe lower abdominal pain during intercourse

Male group: Sores on the penis, testicles, anus and surrounding areas; white discharge (pus) from penis or anus; painful testicles (balls); pain or bleeding while defecating (bowel movements); itchy genital area, penis or anus; swollen glands on the inside of the legs?

If your answer to this question is YES, please drop the card numbered 21 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 22 and listen carefully to the question:

22. In the last three months, have you been treated for any sexually transmitted infections (STIs)?

If your answer to this question is YES, please drop the card numbered 22 into the GREEN

box. If your answer to this question is NO, please drop this card into the RED box.

Now pick up the card bearing number 23 and listen carefully to the question:

23. In the last three months, have you ever visited or received services from the KP friendly facilities or OSS?

If your answer to this question is YES, please drop the card numbered 23 into the GREEN box. If your answer to this question is NO, please drop this card into the RED box.

Table 14: KPPR Training Schedule by States

State	Date	Venue
Abia	5th -9th December, 2023	Oncordia Hotel, Umuahia
Adamawa	13th - 15th December 2023	Tannel Hotel and Resorts Limited Jimeta, Yola
Akwa Ibom	11th – 15th December 2023	Edinan Hotel and Suites Ltd. Plot 91 Block V, Akwa Ima Estate, Off Aka Etinan Road, Ibesikpo Asutan, Uyo
Anambra	12th – 16th December, 2023	Chariots Hotels, 7 Emeka Nwosu Street, Opposite Government House Awka
Bayelsa	5th - 9th December, 2023	Ididie Hotel Ekeki, Yenagoa
Delta	11th - 15th December 2023	Prof Chike Edozien Secretariat, Mariam Babangida Way, Asaba
Edo	5th – 9th December, 2023	Elora Royal Hall & Suites 162 Sapele Road, Benin City, Edo State
Enugu	11th – 15th December, 2023	Bridge Waters Hotel, Enugu
Gombe	5th – 9th December, 2023	Hajiya Amina Hall, Opposite Jalo Waziri House, Bauchi Road, Gombe.
Imo	12th - 16th December, 2023	Double Day Hotel, Owerri, Imo State
Kaduna	5th – 9th December, 2023	A.T. Catering Services, Command Guest House, Muhammadu Buhari Way Kaduna.
Kano	11th – 15th December, 2023	Conference Hall, State Agency for the Control of AIDs (SACA), Kano

State	Date	Venue
Kogi	11th-15th December, 2023	Halim's Hotel and Suits, Lokoja, Kogi State.
Lagos	5th - 9th December, 2023	Adebola House, Opebi Ikeja
Niger	5th-9th December, 2023	Brighter Hotel and Suits, Minna, Niger State.
Oyo	11th-15th December, 2023	77 Palms Hotel, beside Officer's Mess, Agodi GRA, Ibadan.
Taraba	5th – 9th December, 2023	Star Exclusive Hotel Jalingo
Rivers	11th -15th December, 2023	SOZ Cravings, Port Harcourt.

Table 15: KPPR Entry Meeting

State	Date	Venue
Abia	4th December, 2023	Oncordia Hotels, Umuahia, Abia.
Adamawa	9th December 2023	Tannel Hotel and Resort Limited
Akwa Ibom	8th December 2023	Lord Lugard Hall, IBB Way, Uyo
Anambra	12th December 2023	Chariot Hotel, Awka
Bayelsa	4th December, 2023	Ididie Hotel, Yenagoa

State	Date	Venue
Delta	11th December, 2023	Conference Hall, State Agency for the Control of AIDs (SACA), Felix Olorogun Annex, State Secretariat, Maryam Babangida Way, Asaba.
Edo	4th December, 2023	Conference Hall, State Agency Control of AIDs (SACA)), Sapele Road, Benin City, Edo State
Enugu	8th December 2023	Bridge Waters Hotel, Enugu
Gombe	4th December 2023	Amina Hall, Gombe
Imo	12th December 2023	Double Day Hotel, Owerri, Imo State
Kaduna	4th December 2023	Conference Hall, State Ministry of Health
Kano	6th December 2023	Conference Hall, State Agency for Control of AIDs (SACA)
Kogi	8th December, 2023	Conference Hall, State Agency for Control of AIDs (SACA), Lokoja
Lagos	5th December, 2023	Adebola House, Opebi Ikeja
Niger	4th December, 2023	Brighter Hotel and Suits Minna, Niger State.
Oyo	8th December, 2023	Conference Hall, State Agency for the Control of AIDs (SACA), Ibadan
Taraba	4th December, 2023	Star Exclusive Hotel, Jalingo
Rivers	8th December, 2023	SOZ Cravings, Port Harcourt

15b KPPR Exit Meetings

State	Date	Venue
Abia	14th February, 2024	Oncordia Hotel, Umuahia.
Adamawa	14th February, 2024	Leslie Events and Meals, Yola
Akwa Ibom	13th February, 2024	MLE Event Centre, Uyo
Anambra	13th February, 2024	Cynthaz Multibiz, Awka
Bayelsa	14th February, 2024	Ididie Hotel, Yenagoa
Delta	9th February, 2024	Nice View Hotel, Asaba
Edo	15th February, 2024	Conference Hall, State Agency Control of AIDs (SACA)), Sapele Road, Benin City, Edo State
Enugu	16th February, 2024	Danic Hotel, Enugu
Gombe	7th March, 2024	Amina Hall, Gombe
Imo	14th February, 2023	Double Day Hotel, Owerri, Imo State
Kaduna	14th February, 2024	Conference Hall, State Ministry of Health, Kaduna
Kano	16th February, 2024	Conference Hall, State Agency for Control of AIDs (SACA), Kano

State	Date	Venue
Kogi	15th February, 2024	Conference Hall, State Agency for Control of AIDs (SACA), Lokoja
Lagos	14th February, 2024	Conference Hall, State Agency for Control of AIDs (SACA), Ikeja
Niger	19th February, 2024	Brighter Hotel and Suits Minna, Niger State.
Oyo	15th February, 2024	Conference Hall, State Agency for the Control of AIDs (SACA), Ibadan
Taraba	19th February, 2024	Conference Hall, State Agency for the Control of AIDs (SACA), Jalingo
Rivers	16th February, 2024	SOZ Cravings, Port Harcourt

Table 16: National KPPR Technical Team

S/N	Name	Designation/ Organisation
1	Dr. Temitope Ilori	DG NACA
2	Dr. James Anenih	NACA
3	Francis Agbo	NACA
4	Dr Fatimah M. Jajere	Focal person / NACA
5	Dr. Rose Aguolu	NACA
6	Idoteyin Ezirim	NACA
5	Olutosin Adebanjo	NACA
6	Seun Oshagbami	NACA
7	Ezinne Okey-Uchendu	NACA
8	Kingsley Essomeonu	NACA
9	Nibretie Workneh	Global Fund
10	Dr. Koubagnine Takpa	UNAIDS
11	Doris Ogbang	UNAIDS

12	Dr. Ibrahim Dalhatu	CDC/PEPFAR
13	Dr. Mustapha Bello	CDC/PEPFAR
14	Dr. Olugbenga Asaolu	USAID/PEPFAR
15	Dr. Prosper Okonkwo	APIN
16	Ikpu Chris Terfa	Concerned Youths for Development Initiative
17	Peter Kass	NKPHRN
18	Dr. Bodunde Onifade	AIDS Healthcare Foundation
19	Aniedi Akpan	Drug Harm Reduction Advocacy Network Nigeria (DHRAN)
20	Niyi Orisawayi	Institute of Human Virology Nigeria (IHVN)
21	Bummi Amoo	Apin Public Health Initiatives (APIN)
22	Guladima Joseph	Drug Harm Reduction Advocacy Network Nigeria (DHRAN)
23	David Olufu	Drug Harm Reduction Advocacy Network Nigeria (DHRAN)
24	Naziga Francis	PM, RIVSACA
25	Godpower Omoregie	Society for Family Health (SFH)
26	Yahaya Bright Waziri	Society for Family Health (SFH)
28	Dr. Usman Bashir	PM, KNSACA
29	Charles Durueke	PM, IMOSACA
31	Efosa Godwin Edegbe	NEPWHAN
32	Oche Ekele David	ECEWS
33	Akanji Micheal	Heartland Alliance
34	Sanni Olufunsho	CIHP
35	Elizabeth Shoyemi	CPHI
36	Uchenna Clifford Ononaku	KP Coordinator, FCT
37	Parinita Bhattacharjee	PHDA
38	Bernadetta Kina	PHDA
39	Dr. Kalada Green	WACPHD
40	Chukwuebuka Ejeckam	Focal Person /WACPHD

Table 17 KPPR Study Management Team

S/N	Names	Organisation
1	Francis Agbo	NACA
2	Dr Fatimah Jajere	NACA
3	Idoteyin Ezirim	NACA
4	Olutosin Adebanjo	NACA
5	Dr Kalada Green	WACPHD
6	Chukwuebuka Ejeckam	WACPHD
7	Judith Ariri-Edafe	WACPHD

Table 17: ABIA STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Emma-Ukaegbu Uloaku	DG Abia SACA
2	Iro Chinedu	M&E SACA
3	Ukali Agbai Ukeh	KP Coordinator
4	Edeh Nneka	SFH
5	Nwankwo Gideon	KP Rep
6	Ezekwem Numan	KP Rep
7	Chigbo Peace	KP Rep
8	Agbahime Chukwudi	KP Rep

Table 18: ABIA STATE FIELD TEAM

S/N	Names	Designation
1	Ugwuagbo Paul Henry	Supervisor
2	Arinze Ifeyinwa	Supervisor
3	Augustine Samuel E.	Finance and Admin Officer

S/N	Names	Designation
4	Ogah Juliet	Interviewer
5	Onyike Grace Ikpo	Interviewer
6	Gideon Nwankwo	Interviewer
7	Kanu Ndubuisi Collins	Interviewer
8	Samuel Uwa	Interviewer
9	Ebogu Justina	Interviewer
10	Chukwu Emeka	Interviewer
11	Precious Ezinne Agbai	Interviewer
12	Ezekwem Victor Chibuike	Interviewer

Table 19: ADAMAWA STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Adamu Abdullahi	ADSACA
2	Adamu Haske Dauda	ADSACA
3	Bello Mohammed Hamman	SASCP/SMOH
4	Umar Ilyasu	SASCP
5	Elijah Danjuma	PACA
6	Akor Livinus O.	M&E SFH
7	Nelson Ndarosom	TAHRA
8	Anza Samuel	TAHRA
9	Gwandi Geoffrey	GHASAF
10	Danladi Maureen	HELPROW
11	Bellow Zuwaira	IPS

Table 20: ADAMAWA STATE FIELD TEAM

S/N	Names	Designation
1	Thomas Vakkai Godswill	Supervisor
2	Al Mustapha Ahmed Rasheeda	Supervisor
3	Abubakar Abdulrazaq Ahmad	Finance and Admin Officer
4	Tyson Thomas	Interviewer
5	Samson Yunana Wabu	Interviewer
6	Obiesili Samuel Julian	Interviewer
7	Mahmud Mohammed Mukhtar	Interviewer
8	Iqra Al Mustapha	Interviewer
9	Samuel Stephen	Interviewer
10	Blessing Eyum Ochani	Interviewer
11	Bashir Mohammed Jibrin Sule	Interviewer
12	Liz Tanyishi	Interviewer
13	Alice Sallama Kevin	Interviewer
14	Agbo Ogaga Kennedy	Interviewer
15	Leah Joshua	Interviewer
16	Miracle Gabriel	Interviewer
17	Magaji Musa Marcus	Transcriber
18	Patience Alfred	Transcriber

Table 21: AKWA IBOM STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Okupe Ubong	AKSACA
2	Akpan Enobong	AKSACA
3	Umo-Udofia Uduak	SASCP
4	Usanga Ime	SASCP
5	Ekanem Aniekan	HALG
6	Ugboaja Zadok	HALG
7	Edem Udofia	LHN
8	Asuquo	IHRI
9	Umoh Godspower	IHRI
10	Jaja Sophia	LAFI
11	Umoenang Favour	OAPHO

Table 22: AKWA IBOM STATE FIELD TEAM

S/N	Names	Designation
1	Umoh Ekemini	Supervisor
2	Udo Ime	Supervisor
3	Ejike-Nwachi Anthonia	Finance and Admin Officer
4	Essien Victor Eyo	Interviewer
5	Emmanuella Bassey	Interviewer
6	Abigail Nsima Joseph	Interviewer
7	Ekemini Amadi Billion	Interviewer
8	King Moses Tom	Interviewer

S/N	Names	Designation
9	Okure Ubong Linus	Interviewer
10	Michael Asuquo Ubokulo	Interviewer
11	Harrison Emmanuel	Interviewer
12	Ewezu Kanu Ekpezu	Interviewer
13	Asian Emmanuel	Interviewer
14	Agu Grace Jane	Transcriber

Table 23: ANAMBRA STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Ementa John Bosco	ANSACA
2	Welumkalu Ngozi	ANSACA
3	Osita Kosiso	ANSACA
4	Abadom Ikechukwu	M&E SASCP
5	Tonia Mbagwu	SASCP
6	Emelike Chinenyenwa	PACA
7	Asogwa Kingsley	NDLEA
8	Chima Ezinwanyi D.	Hero's Health Community Support Initiative
9	Owhor Suzzy Chiburuoma	ED EBG
10	Orji Israel	BGCSF (MSM)
11	Anaeto Chinenye	No Hate (TG)

Table 24: ANAMBRA STATE FIELD TEAM

S/N	Names	Designation
1	Ani Kingsley	Supervisor
2	Agbo Ejiofor	Supervisor
3	Okehie Ogechi	Finance and Admin Officer
4	Okwudili Anene Onwughalu	Interviewer
5	Ezeh Chinaza Eucharia	Interviewer
6	Chinwe Martina Ogochukwu	Interviewer
7	Anaedum Vivian Chidi	Interviewer
8	Ugwuanyi Martha Nkemdilim	Interviewer
9	Ezenwamba Kenechukwu Patrick-Mary	Interviewer
10	Salvation Nimrod	Interviewer
11	Mercy Chinazam Ezeanokwulu	Interviewer
12	Nwangene Chukwuebuka Samuel	Interviewer
13	Hilary Nwogo Chidubem	Interviewer
14	Goodness Chigozirim Iheonunekwu	Transcriber
15	Adebayo Adeyemi Opeyemi	Transcriber

Table 25: BAYELSA STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Lambert Precious	BYSACA
2	Doris Diepreye	BYSACA
3	Awudu Toboulayefa Stella	SASCP SMOH
4	Adolphinus Izibenua	SASCP SMOH

S/N	Names	Organisation
5	Pepple Charles	KP Rep
6	Briggs Jeremiah	KP Rep
7	Etuk Comfort	KP Rep
8	Abule Anna	KHAN Initiative
9	Happy Ebitimi Okoko	Healthy Choice Foundation
10	Sarah Evim	Synergy Care

Table 26: BAYELSA STATE FIELD TEAM

S/N	Names	Designation
1	Omodu Happy Pere-Ela	Supervisor
2	Kekong Geoffrey	Supervisor
3	Columbus Godwin Oyewole	Finance and Admin Office
4	Zikala Frank Kentebe	Interviewer
5	Ntiense Okon Ekpo	Interviewer
6	Godspower Eluannatel Lennard	Interviewer
7	Ezekiel Ayebatari Ayebatonbara	Interviewer
8	Patricia Robert	Interviewer
9	Tamaratokoni Anna Kalama	Interviewer
10	Tonbrapade Dennis Alabrah	Interviewer
11	Maduekwe Vivian Chidimma	Transcriber
12	Ovey Alexander	Transcriber

Table 27: DELTA STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Osifo Grace	Dir. PPC SACA (CMO)
2	Edwin Ukuegbogho	Dir. M&E SACA
3	Osanebi Franklin	SASCP
4	Obi Ogechukwu Nkiruka	SASCP
5	Uwadia Ngozi Paul	SACA
6	Odum Micheal	ECEWS
7	Obiasulu Obinna	KP Rep
8	Ibot Helen Theresa	KP REP
9	Okalonu Steven	KP REP
10	Casimir Philips	KP REP
11	Andy Asuquo Ekanem	PACA

Table 28: DELTA STATE FIELD TEAM

S/N	Names	Designation
1	Ejiofor Juanita	Supervisor
2	Nnebife Ikechukwu	Supervisor
3	Adigwe Ifeoma	Finance and Admin Officer
4	Fombo Davis Soprinye	Interviewer
5	Stanley Okereke	Interviewer
6	Ishaya Joshua Gideon	Interviewer
7	Ashinze Richard	Interviewer
8	Ikeagwulonu Chidimma Jennifer	Interviewer

S/N	Names	Designation
9	Iwhuwhavbe Ejiro Betty	Interviewer
10	Goodness Nwabeke	Interviewer
11	Chime Chinecherem Mirabel	Transcriber
12	Ibi Yvonne Ogheneovo	Transcriber

Table 29: EDO STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Oguta Imeagene Amidu	EDOSACA
2	Suleman Evelyn	EDOSACA
3	Waziri-Ateboh Armstrong	SASCP
4	Elegbofor Blessing	KP Rep
5	Daniel Kent	KP Rep
6	Ajayi Wesley Osas	KP Rep
7	Uwuigbe Destiny	KP Rep
8	Ekong Joseph	ECEWS
9	Osayande C. Friday	NEPWHAN
10	Osagie Osato	ECEWS

Table 30: EDO STATE FIELD TEAM

S/N	Names	Designation
1	Oluwatoyin Irigo	Supervisor
2	Idowu Martins	Finance and Admin Officer
3	Ikeduba Lynda Chioma	Interviewer

S/N	Names	Designation
4	Ojo Oladele Fagbamila	Interviewer
5	Onwutah Akosa Jerry	Interviewer
6	Ashefor Innocent	Interviewer
7	Adelakun Vincent Ayomide	Transcriber
8	Odine Joshua	Transcriber

Table 31: ENUGU STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Mgbor Martin	ENSACA
2	Odihirin Precious	CCRM/Caritas
3	Nwatu Favour	SASCP
4	Ugwu Nkemjika U.	SASCP
5	Ugwu Faith Obioma	SIRP
6	Ome Ajai Eyeuche	NDLEA
7	Ihebuzor Daberechi	ECEWS

Table 32: ENUGU STATE FIELD TEAM

S/N	Names	Designation
1	Nwamadi Christiana	Supervisor
2	Yunana Victoria	Finance and Admin Officer
3	Onyeama Chukwuekezie B	Interviewer
4	Ikeagwulonu Chiamaka Linda	Interviewer
5	Ewoh Kenechukwu Malachy	Interviewer

6	Ifunaya Augustine	Interviewer
7	Rachel Upev	Transcriber
8	Chiemezie Precious Chigozirim	Transcriber

Table 33: GOMBE STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Mohammed Hassan Dawaki	PM SACA
2	Ladu Asabe Dunkura	SASCP
3	Maisamari Fatima	CMO KP Focal
4	Salisu Ahmed Aliyu	NEPHWAN
5	Abdullahi Umar Maikano	KP Rep
6	Yahaya Nasir	KP REP
7	Salisu Muhammed	KP REP
8	Gift Haslan	KP REP
9	Bala James Buba	SFH
10	Madina Emily	CIHP
11	Mohammed Aishatu Gadam	GSPHCDA

Table 34: GOMBE STATE FIELD TEAM

S/N	Names	Designation
1	Abdulkadir Victoria J.	Supervisor
2	Ejiogu Franklin	Supervisor
3	Mamman Sheba	Finance and Admin Officer
4	Maryam Salihu Sabiya	Interviewer

S/N	Names	Designation
5	Gayus Rejoice Dauda	Interviewer
6	Idris Yahaya Bikincha	Interviewer
7	Yusuf Umar	Interviewer
8	Namze Ismaila	Interviewer
9	Elias Malachi	Interviewer
10	Saidu Hussaini Baba.	Interviewer
11	Aliyu Abdullahi	Transcriber
12	Son-Allah Ishaku	Transcriber

Table 35: IMO STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Durueke Charles C.	DG IMOSACA
2	Ugwuezumba Chinedu	IMOSACA
3	Akhigbe Kennedy	PACA
4	Iwuchukwu Chinonyerem E.	SASCP SMOH
5	Odoemelam Prince	SASCP SMOH
6	Ukmbia Valentine	KP Rep
7	Samuel Ozonna	KP Rep
8	Obidinma Chigozie	Impact Hub
9	Mark Victor	MHSI
10	Njere Christiana N.	EXCO HSEH
11	Ikwuegbu Obiageri	Caritas
12	Ebenezer Okechukwu Chukwu	YABS

S/N	Names	Organisation
13	Amoati Charles	ECEWS

Table 36: IMO STATE FIELD TEAM

S/N	Names	Designation
1	Ahunanya Wisdom	Supervisor
2	Maasu Oluchi Roselyn	Supervisor
3	Valentine Chidera Mbalusi	Interviewer
4	Ariri Franklin	Interviewer
5	Davies Soalabo	Interviewer
6	Chris Ebenezer Chidoro	Interviewer
7	Anita-Queen Chinwe Ibe	Interviewer
8	Udom Chibugo Favour	Interviewer

Table 37: KADUNA STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Bashir Mohammed	KADSACA
2	Ramatu Garba	KADSACA
3	Aishatu Usman Tanko	SASCP/SMOH
4	Zipporah Katung	SASCP
5	Abbah Peace	KP Rep
6	David Adams	KP Rep
7	Kalen Umar Najolly	KP Rep
8	James Stephen Yangal	KP REP

9	Odawn Stephen	IP FSW

Table 38: KADUNA STATE FIELD TEAM

S/N	Names	Designation
1	Joshua David	Supervisor
2	Saulawa Fahad	Supervisor
3	Umar Abdullahi	Finance and Admin Officer
4	Musa Monday Yagwan	Interviewer
5	Amoo Hajara Yetunde	Interviewer
6	Lawan Salihu Sabiya	Interviewer
7	Bala Bahijjah Sanusi	Interviewer
8	Hauwa Muhammad	Interviewer
9	Jennifer Agbaji	Interviewer
10	Ayanshola-Femi Ethnan Ebunoluwa	Interviewer
11	Habibu Salmanu Rabi'A	Interviewer
12	Ahmed Tijjani Sani	Interviewer
13	Enoch Akut	Interviewer
14	Halymah Sadiyat Ndanusa	Transcriber
15	Bello Azeez Sunday	Transcriber

Table 39: KANO STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Bashir Usman	KSACA
2	Saleh Salwatu	KSACA

S/N	Names	Organisation
3	Abdullahi Muhammed Sidi	KSACA
4	Galadanchi Fatima Hussaini	KSACA
5	Muhammed Abubakar Umma	KSACA
6	Hassan Abdullahi	KP Mobilizer
7	Innocent Mary Ladi	THSIW
8	Mohammed Ismael Yahaya	LITSAMM Youth
9	Hassan Ibrahim	AIHI (MSM)
10	Mustapha Abdullahi	AIHI (TG)
11	Sadiya Abdullahi Yaro	ED (FSW)

Table 40: KANO STATE FIELD TEAM

S/N	Names	Designation
1	Buhari Muhammad	Supervisor
2	Danladi Zainab Ibrahim	Supervisor
3	Usman Iliya	Finance and Admin Officer
4	Abdulhamid Mukhtar	Interviewer
5	Aliyu Sunusi	Interviewer
6	Sunusi Salisu Adam	Interviewer
7	Sagir Hassan Abdullahi	Interviewer
8	Fatima Buhari Abubakar	Interviewer
9	Shehu Muftahu	Interviewer
10	Hauwa Ibrahim Hassan	Interviewer
11	Juliet Chidera Nwobodo	Transcriber

S/N	Names	Designation
12	Abdulrazaq Muhammed Hussaini	Transcriber

Table 41: KOGI STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Yunusa Sheidu	KOSACA
2	Ibrahim Anate	KOSACA
3	Ejigbo Abigail	SMOH
4	Ejembi Grace	SMOH
5	Suberu A. Yawa	SMOH
6	Samuel Musa	KP Rep
7	Husseini Theresa	KP Rep
8	Salifu Eneojo	KP Rep
9	Okoye Joshua	KP Rep
10	Ayeh Godwin	GHP

Table 42: KOGI STATE FIELD TEAM

S/N	Names	Designation
1	Adah Aromeh	Supervisor
2	Omirigbe Stanley	Supervisor
3	Musa Abubakar	Finance and Admin Officer
4	Ahmed Yakubu	Interviewer
5	Okai Muhammed Siaka	Interviewer
6	Onoja Simon Akogwu	Interviewer

S/N	Names	Designation
7	Mbam Terkuma Solomon	Interviewer
8	Ogunnubi Caleb Johnson	Interviewer
9	Akor Daniel	Interviewer
10	Irikiti Esther	Interviewer
11	Shehi Zakari	Interviewer
12	Ahmed Munir Mohammed	Interviewer
13	Alafin Deji Gabriel	Interviewer
14	Sunday Emmanuel	Transcriber
15	Isiaka Kabir Ogirima	Transcriber

Table 43: LAGOS STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Fisher Oladipupo	LSACA
2	Olayinka-Agbola Yeside	LSACA
3	Dare Ifeoluwa	LSACA
4	Animashaun Folakemi	LSACA
5	Adedigba Oluwakemi	SMOH
6	Agbedia Onome	SMOH
7	Onyia Christian	CIHP
8	Animashaun Azeez	KAP
9	Mbah Johnpaul	HALG
10	Lawal Lateef	KAP
11	Jidanke-Ofia Jessica	CPHI

S/N	Names	Organisation
12	Victor Gilbert	KAP
13	Sosan Babatunde Oluwaremilekun	HCF

Table 44: LAGOS STATE FIELD TEAM

S/N	Names	Designation
1	Zamije A. Sylvester	Supervisor
2	Akinrogunde Akintomide	Supervisor
3	Atiren Oritsegbubemi Frances	Finance and Admin Officer
4	Augustina Ebiyomi	Interviewer
5	Bola-Olarinde Mofiyinfoluwa	Interviewer
6	Sunday Elijah Sule	Interviewer
7	Aruna Aweni	Interviewer
8	Rotimi John Oyebamiji	Interviewer
9	Ogoh Martins	Interviewer
10	Ogungbire Janet Boluwatife	Interviewer
11	Joy Ashefor – Abubakar	Interviewer
12	Enwemasor Nwakaego Abisola	Transcriber
13	Israel Ifenyin	Interviewer
14	Augustina Adanna Nwaneri	Interviewer
15	Akinade Oluwatomisin Victoria	Interviewer
16	Oladunjoye Oluwatomisin Ruth	Interviewer
17	Safiya Yakubu	Interviewer
18	Afolabi Abiola Ayokomi	Transcriber

Table 45: NIGER STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Garbe Ishak Umar	NGSACA
2	Usman Aishat Hasiya	SACA
3	Abdulhakeem Yakubu	SACA
4	Binta Abdulmalik	SASCP
5	Hauwa Shuaib Abdulkadir	SASCP
6	Sanni Moses Peter	KP Rep
7	Daniel Samuel	KP Rep
8	Paul Nelson Chijioke	KP Rep
9	Atueri Martins	KP Rep
10	Saka Olawumi Mudinat	KP Rep
11	Abraham Cynthia	GBV/OVC FP
12	Ozonoh Valentine	AgZM
13	Ajang Precious	HALG
14	Philip Verlum	HALG
15	Faith Timothy	CHI Rep

Table 46: NIGER STATE FIELD TEAM

S/N	Names	Designation
1	Christopher Ogbu	Supervisors
2	Nwagbo Chimere Raphael	Supervisors
3	Akpegi Patrick Onahi	Finance and Admin Officer

S/N	Names	Designation
4	Adiele Joy Chidiebere	Interviewer
5	Ajakaiye Titilayo Lydia	Interviewer
6	Alhassan Muhammad	Interviewer
7	Aliyu Usman	Interviewer
8	Bokungi Isah Mohammed	Interviewer
9	Faruna Rabietu Iko-Ojo	Interviewer
10	Gloria Ojo Yahaya	Interviewer
11	Kalu Onyedikachi Bethel	Interviewer
12	Moses Omonya Onwe	Interviewer
13	Nasiru Mamman	Interviewer
14	Shehu Baba	Interviewer
15	Stephanie Ajuma Okoriko	Interviewer
16	Yahaya Ndagi	Interviewer
17	Felicia Yakubu	Transcriber
18	Idowu Solomon Ajibola	Transcriber

Table 47: OYO STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Ogunkunle Olukayode	OYSACA PM
2	Abass Waheed Akinola Lanre	OYSACA
3	Abdulwahab Taiwo Taofeek	OYSACA
4	Ajao Afusat Bolatito	OYSACA
5	Akinyode Akinfemi	SMOH

S/N	Names	Organisation
6	Ayanyemi Micheal	SMOH
7	Bello Ayomide	I-AIHD
8	Muritala Raimot	YABS
9	Oha Blessing	COSWOTTI
10	Mlewedum Charles	KAP Secretariat
11	Adeleye Adetayo	APIN-PHI

Table 48: OYO STATE FIELD TEAM

S/N	Names	Designation
1	Matthew Mercy Hannah	Supervisor
2	Olatunde Samson	Finance & Admin Officer
3	Afolabi Deborah Omowunmi	Interviewer
4	Emiade Kudirat Adedolapo	Interviewer
5	Lanre-Abass Akeem	Interviewer
6	Ovie Christian Oghumu	Interviewer
7	Akanji Ayomide Ife	Transcriber
8	Ayoola Ayobami Ojewusi	Transcriber

Table 49: RIVERS STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Naaziga Francis	RIVSACA
2	Isaiah Moses	RIVSACA
3	Briggs Tamunosaki	SASCP RSMOH

S/N	Names	Organisation
4	Edewor Ufuoma	SASCP RSMOH
5	Oru Nelson	IAH
6	Mbamalu Chimezie	GIHR
7	Wiro Silverline	SLWIHRD
8	Temiye Folasaye	Diadem Consults
9	Oladapo Austen	IAH
10	Jeremiah Ogbonnaya	KP Rep
11	Awaso Talent	GIHR

Table 50: RIVERS STATE FIELD TEAM

S/N	Names	Designation
1	Banigo Godswill	Supervisor
2	Somiari Sobere	Supervisor
3	Ruth Uwasomba	Finance & Admin Officer
4	Chihurumnanya Okezie	Interviewer
5	Chukwudi Agi	Interviewer
6	Gogo Okechi Vitalis	Interviewer
7	Ibibia Koko	Interviewer
8	Margaret Richard Mazadu	Interviewer
9	Sogbeba Dokubo	Interviewer
10	Tumini Green	Interviewer
11	Amadi Monalisa Blessing	Transcriber
12	Udeagha Maureen Ihudiya	Transcriber

Table 51: TARABA STATE KPPR STATE TECHNICAL COMMITTEE

S/N	Names	Organisation
1	Danjuma Garba	TACA
2	Sadiq Hajara Ibrahim	TACA
3	Ambrose Nathaniel	SASCP
4	Audu Guh Nana	SASCP
5	Kini Ssale Emmanuel	KP Rep
6	Bitrus B. Denis	KP Rep
7	Enoch Istifanus	KP Rep
8	Shehu Vicky	KP Rep
9	Abdurrasaq Muhmmed Murtala	WACHEF
10	Ganne Lale	AHNI
11	Nwosu Onyeka E.	RISE

Table 52: TARABA STATE FIELD TEAM

S/N	Names	Designation
1	Anuye Steve Paul	Supervisor
2	Suleiman Hajara	Finance & Admin Officer
3	Bemgba Gwaza Martins	Interviewer
4	Idris Bashir	Interviewer
5	Muhammad Sadisu Haruna	Interviewer
6	Tor Evelyn Nyiekumbur	Interviewer
7	Blessing Yakubu Ikwulono	Transcriber

S/N	Names	Designation
8	Celestina Simeon Onovo	Transcriber

Table 53: KPPR REPORT WRITING TEAM

S/N	Names	Organisation
1	Francis Agbo	NACA
2	Dr. Fatimah Jajere	NACA
3	Dr. Rose Aguolu	NACA
4	Idoteyin Ezirim	NACA
5	Olutosin Adebanjo	NACA
6	Dr. Habiba Mansur	NACA
7	Joy Egwuonwu	NACA
8	Cyprian Nom	NACA
9	Dr. Amina Abubakar	NACA
10	Khadija S. Murtala	NACA
11	Abraham Andrew	NACA
12	Ibrahim Aliyu	NACA
13	Doris Ogbang	UNAIDS
14	Dr. Olugbenga Asaolu	USAID
15	Michael Akanji	HALG
16	Galadima Joseph	CIPH
17	Fadeke Abuworonye	CIPH
18	Balogun Kehinde	PHIS3
19	Mariam Olawale	PHIS3

S/N	Names	Organisation
20	Olajumoke Kalejaiye	CPHI
21	Kanayochukwu Okeke	CPHI
22	Susan Haruna	KPSEC
23	Kalada Green	WACPHD
24	Chukwuebuka Ejeckam	WACPHD
25	Akan Udoete	WACPHD
26	Adediran Adesina	WACPHD
27	Jerry Ejembi	WACPHD
28	Oladayo Soladoye	WACPHD
29	Osayende Ayewah	WACPHD
30	Kufre Ndueso	WACPHD
31	Judith Edafe-Ariri	WACPHD
32	Susan Olujimi	WACPHD
33	Sophia Somiari	WACPHD
34	Oletta Ogio	WACPHD
35	Blessing Aturu	WACPHD
36	Moses Mallongah	WACPHD
37	Kelechukwu Amadi	WACPHD
38	Janma Atuma	WACPHD
39	Peace Uwadoka	WACPHD
40	Kefas Komos	WACPHD


KEY POPULATION HEALTH
AND RIGHT NETWORK


Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria


APIN
Public Health Initiatives


fhi360
THE SCIENCE OF IMPROVING LIVES


World Health
Organization


UNAIDS


HEARTLAND
ALLIANCE
LTD/GTE (HALG)
...Towards Excellence and impact


UNFPA


NATIONAL AGENCY FOR THE CONTROL OF AIDS
NACA


CENTRE FOR
POPULATION HEALTH
INITIATIVES


WEST AFRICAN CENTRE
WACPHD
FOR PUBLIC HEALTH & DEVELOPMENT


Institute for
Global Public Health
University of Manitoba


UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF
NIGERIANS AND AMERICANS
IN PARTNERSHIP TO FIGHT HIV/AIDS


SACA


PHDA
Partners for Health and
Development in Africa


Excellence Community Education
Welfare Scheme
ECEWS
...Improving Education and Health in Nigeria


SFH
Society for Family Health
...Creating Change, Enhancing Lives


INSTITUTE OF
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AHF
AIDS HEALTHCARE
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Centre for Intergrated
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