National Guidelines for

IMPLEMENTATION OF HIV PREVENTION PROGRAMMES FOR PEOPLE WHO INJECT DRUGS IN NIGERIA

2020

Foreward

The prevalence of HIV in Nigeria is estimated at 1.4% for persons 15-49 years of age, with a total estimated 1.8 million persons living with HIV. The distribution is higher among females than among males (0.9%). The rate of new infections is 8.0 per 10,000 persons across both genders and age groups. People who inject drugs (PWID) account for up to 9% of new HIV infections in Nigeria. The government is committed to dealing with the negative societal impact of drug use, and its impact in driving the HIV epidemic.

Interventions that address risk reduction at several levels among PWID are critical. This guideline on HIV prevention programing for PWID recognizes that persons with disabilities and adolescents are found among PWID, and they are at higher risk of exposure to HIV. The guideline addresses the needs of these sub-populations and aims to improve the effectiveness and efficiency of HIV prevention programmes and services for PWID. This guideline provides strategic and operational information and guidance for the prevention of HIV infection among PWID in Nigeria. The purpose of the guideline is to outline the principles, key programme elements, and procedures for delivery and management of evidence-based HIV prevention programmes.

This is the first guideline for HIV prevention programming among PWID in Nigeria. It was developed with inputs from members of the National Prevention Technical Working Group, other stakeholders programming for the PWID, and PWID community members. The guideline will strengthen the ability of organizations and field workers to provide HIV prevention services for PWID. It is designed in line with national HIV prevention plan and will be used by all stakeholders involved in HIV response for PWID. It will assist in the planning and implementation of HIV prevention programmes to improve the health of PWID and their networks, reduce the rate of new infection, and also in supporting Nigeria's efforts towards achieving the 90:90:90 target.

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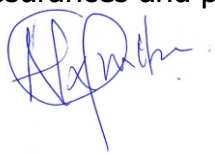

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Oraganisation
CSO	Civil Society Organisation
FMOH	Federal Ministry of Health
HIV	Human Immunodeficiency Virus
IBBSS	Integrated biological and behavioural surveillance survey
IP	Implementing Partners
KP	Key Populations
NACA	National Agency for the Control of AIDS
NAIIS	Nigeria HIV/AIDS Indicator and Impact Survey
NPTWG	National Prevention Technical Working Group
M&E	Monitoring and Evalution
MPPI	Minimum Prevention Package of Intervention
OSS	One Stop Shop
PWID	People Who Inject Drug
SACA	State Agency for the Control of AIDS
SFH	Society for Family Health
UNAIDS	Joint United Nation Program on HIV/AIDS
WHO	World Health Organisation

Chapter 1.0
INTRODUCTION

Nigeria is a federation made up of the Federal Capital Territory (Abuja) and 36 states. The states are grouped into six geo-political zones: North West, North East, North Central, South West, South East, and South-South. The estimated national prevalence of HIV among the general population was 1.4% for persons 15-49 years of age. The prevalence among females in this age range was an estimated 1.9%, twice that of males, 0.9% [1].

The HIV epidemic in Nigeria is complex, with substantial differences in prevalence across regions and subpopulations and with diverse factors driving the epidemic. Integrated biological and behavioural surveillance surveys among key populations, including people who inject drugs (PWIDs) and other key populations, were reported in Nigeria in 2014. The national HIV prevalence among PWID (age 15-49 years) was 3.4%. The HIV prevalence ranged from 1.2% in Lagos to 7% percent in Kano. The HIV prevalence among female PWID was about 5 times higher than among male PWID (13.9% vs 2.6%) [2].

The prevalence of any drug use in Nigeria during the past year is estimated at 14.4% or 14.3 million people aged 15-64 years. Drug use in our country in 2016 was higher than the global annual prevalence of 5.6% for any drug use among adults. However, the prevalence of drug use across the geo-political zones varies: It is highest in the South West (22.4%), followed by the South South (16.6%), South East (13.8%), North East (13.6%), North West (12.0%) and the North Central (10.0%) [3]. Of the 14.3 million people who use drugs in Nigeria, 376,000 are high-risk users [3].

Reported drug use was most common among those between the ages of 25 and 39 years, whereas the rates of past-year use were lowest among those below 24 years of age. Cannabis was the most-often used drug, followed by opioids, mainly non-medical prescription opioids and cough syrup. It is estimated that one of five high-risk drug users, injects drugs -- 80,000 users inject drugs in Nigeria. The most common drugs injected in the past year were pharmaceutical opioids, followed by cocaine and heroin [3]. Since 2013, the estimate for PWID in some states of Nigeria had increased dramatically; in Lagos, the PWID estimate in 2013 was 1186, whereas in 2018 it was 20,700.

The association between injection drug use and HIV is well established. Unsafe injection practices, such as sharing contaminated needles [4], are a major risk factor for transmission of blood-borne infections such as hepatitis B, C, and HIV. Unsafe injection is also associated with fatal and non-fatal drug overdose and bacterial infections at injection sites. Drug abuse can lead to social problems, such as disruption of family lives, loss in productivity, and legal problems. Also, nearly 1 in 8 persons in the general population has experienced consequences due to others' drug usein their families, workplace and communities.

Access to HIV services for PWID is limited. Barriers to access include criminalization of drug use, stigma associated with drug use, limited information about available services, low risk perception, and poor health-seeking behavior. Also, drug treatment and support services are limited, and, where they exist, they are limited in scope and may not cater to the needs of HIV-positive persons. Fewer than half of high-risk drug users had received HIV testing and counselling while in treatment [3]. This proportion was higher among females than in males, and it was lower among those injecting drugs than in all high-risk drug users; only 12% of high-risk drug users reported referral for anti-retroviral therapy [3].

There is less known about adolescents and young PWID and PWID living with disability. Persons living with disability in Nigeria have low comprehensive knowledge and self-perceived risk of HIV, low condom use and females face a high level of gender-based violence [5]. Global studies indicate that young PWID have higher prevalence of HIV. Also, when youth from other key populations such as sex workers, MSM and transgender youth also inject drugs, the HIV prevalence climbs even higher [6].

To set priorities for the national HIV prevention programme for PWID, it is important to understand the epidemic and what drives HIV transmission locally. This effort involves understanding the transmission dynamics and identifying populations with high HIV prevalence and transmission. HIV prevention programmes for PWID will need to give priority to reducing the risk associated with risky injecting practicessince nearly half of PWID report sharing needles or syringes [3]. Attention also should be paid to femaleswho are more likely to share these items. Interventions to prevent HIV among PWID will reduce harm and improve the health of the PWID and reduce the adverse effects of drug use in the larger society. To achieve this, the HIV prevention programmes must be evidence-informed, tailored to specific contexts, and appropriate for the target population.

Chapter 2.0

PROFILE OF PEOPLE WHO INJECT DRUGS

PWID can be defined as any person who has injected drugs recreationally at least once in the past 12 months. PWID refers to people who inject non-medically sanctioned psychotropic (or psychoactive) substances, which include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other routes. This definition of injecting drug use does not include people who self-inject medicines for medical purposes, referred to as "therapeutic injection", or individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance [7]. Globally, injection-drug use accounts for about 10% of HIV infections [8]. People who inject drugs can be in these categories:

High-risk drug use: those who use and/or inject opioids, crack/cocaine, amphetamines, or pharmaceuticals and have used them more than 5 times in the past 30 days for non-medical purposes.

Drug dependence: it is an adaptive state that develops from repeated drug administration that results in withdrawal symptoms upon cessation of drug use.

Pharmaceutical opioids/opiates: medicines made from poppy extracts (natural or synthetic) that are used to relive pain and other medical conditions.

2.1. Characteristics of PWID in Nigeria

In Nigeria, PWID have diverse typologies based on their pattern of drug use. The National PWID HIV prevention Programme targets all typologies of PWID who are at risk of HIV because of sharing of injection drug tools, reduced ability to make informed decision due to drug use, and risk for HIV infection resulting from sexual intercourse. The typology of PWID can be based on the following:

Social status: knowing the social status of a PWID will determine the way in which interventions should be targeted, based on whether the PWID are high, middle or low socio economic status. This knowledge can also help identify locations for interventions.

Gender status: The risk of HIV infection for female PWID is significantly higher than that for male PWID. The HIV prevention needs of the two populations also differ as female PWID are more in need of sexual and reproductive health services than male PWID including prevention of mother-to-child HIV transmission services. Gender stratification of PWID for their HIV response need is important

Sexual orientation: PWID may be heterosexual, lesbian, gay, bisexual, transgender, queer or intersex.

Sexual behaviour: This considers the risks associated with unprotected anal sex and transactional sex.

Chapter 3.0
HIV PREVENTION PROGRAMME ELEMENTS FOR PEOPLE WHO INJECT DRUGS

3.1 Principles Guiding the Design and Implementation of HIV Prevention Programmes for People who Inject Drugs

3.1.1. *Evidence-based*: Research, evidence and innovation are critical for effective programme development, including addressing barriers and for strategic expansion of services towards universal coverage. Programmes are expected to be designed after conducting a needs assessment for community members. All programmes implemented for PWID are expected to have clearly defined monitoring and evaluation strategies that will enable yearly improvement in the conduct of the programmes.

3.1.2. *Quality-focused and result-oriented*: The design and implementation of HIV prevention programmes for PWID must meet defined outcomes that correspond with the objectives of the national HIV Prevention Plans. Programmes and services must be implemented with commitment to high-quality and cost-efficiency.

3.1.3. *Rights-based approach*: All PWID have the inalienable right to quality HIV prevention services in synergy with other education and development opportunities that contribute to their general health and well-being. PWID also have the right to participate in the development/review, implementation, monitoring and evaluation of this policy and relevant programmes that address their HIV risk.

3.1.4. *People-centered approach*: PWID have diverse needs. This guideline promotes access of PWID to integrated, people-centered HIV prevention services, wherein people and communities, not diseases, are the center of planning and implementation. HIV prevention interventions should focus on empowering PWID including those that 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.

3.1.5. *Integrated services delivery*: HIV prevention programmes for PWID shall provide biomedical (clinical) and behavioural and structural interventions that address vulnerability to violence, stigma, and discrimination. HIV prevention services will be delivered in ways that ensure that people receive a continuum of care delivered at the facility (public or private) and community sites according to their needs.

3.1.6. *Cost-effective approaches*: The programme shall be cost-effective to ensure there is value for all allocated resources invested in achieving the set objectives.

3.1.7. *Data security consciousness*: The programme shall adopt strategies that will enhance data security and safety during data collection, collation, analysis and usage. Research activities conducted with PWID will require that the researcher obtain a certificate of confidentiality from the national health research ethics committee through the oversight ethics committee.

3.1.8. *Context specific:* Interventions developed should respond effectively to the local HIV epidemic and the needs of local PWID. Local cultural needs and values of the communities where the programmes are implemented should inform the design of the programmes. This policy will foster practices that make the service-delivery environment safe, supportive, and protective for care recipients.

3.2 Key Components of HIV Prevention Programmes for People who Inject Drugs

NACA advocates for a combination prevention approach that consists of behavioral, biomedical, and structural intervention for PWID.

3.2.1. *Behavioural interventions* should be offered directly to PWID by peer educators through outreach programmes and education sessions. These interventions should promote access of PWID to male and female condoms. Outreaches are used to make initial contact with PWID within the community. At the initial contact, PWID connect with specific programmes and services. The goal is reduced risk of PWID contracting HIV and sexually transmitted infections.

3.2.2. *Biomedical interventions inv*olve testing and diagnosis of infections; HIV treatment; access to pre-exposure prophylaxis; retention in care; management of sexually transmitted infections; and promotion of access to pre-exposure prophylaxis and other clinical services that improve the health of PWID.

3.2.3. *Structural interventions* address critical social, political, and environmental systems and beliefs that increase the vulnerability of PWID. These interventions include access to legal aid, economic empowerment, and mental health care when needed. Efforts to address sexual stigma in the community and mitigate its impact on PWID is critical for effective community response.

The key elements of an HIV prevention Programme for PWID are summarized in Table 1 below and are described in the sections that follow.

Table 1. Key components and elements of the HIV Prevention intervention for people who inject drugs

Key component	Elements
Behavioural interventions	Outreach (physical and virtual) to create awareness about HIV and sexually transmitted infection prevention. Peer education through interpersonal communication to improve understanding on HIV and sexually transmitted infection prevention strategies, human rights, sexuality and risk and harm reduction education, contraceptive information and education, community level mental health screening, gender based violence prevention. Demonstration, promotion, and distribution of male and female condoms and water-based lubricants.
Biomedical interventions	HIV testing services. Testing and treatment of sexually transmitted infections. Access to male and female condoms and water-based lubricants. Linkage and follow up of HIV positive clients to antiretroviral therapy. Access to cervical, anal cancer, hepatitis and tuberculosis screening and management. Access to pre and post-exposure prophylaxis. Access to contraceptive counselling and services. Access of female PWID to prevention of mother to child transmission of HIV services other sexually reproductive health services Access to post gender based violence care Access to mental health services

	Access to psychosocial counselling, support and treatment adherence counselling and services Access to harm reduction interventions, drug overdose management, rehabilitation services.
Structural interventions	Vocational and life building skills development Economic empowerment activities and linkages Provision of safe spaces and community centers including safe shelters for victims of gender based violence Community led organizational development and individual capacity strengthening. Access to legal aid Capacity building for law enforcement agencies, judiciary and legislature Capacity building for healthcare workers Community mobilization and dialogue Advocacy for creating an enabling environment for interventions Law and policy advocacy including intra and intercommunity advocacy. Access to justice through legal aid including but not limited to alternative dispute resolution mechanisms, litigation, human rights education Referral and linkages service strengthening and expansion

3.3. Concept and principle of harm reduction

Harm reduction refers to policies, programmes and practices that aim to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs, without necessarily reducing drug consumption. The harm-reduction approach to drugs, which is based on a commitment to public health and human rights, benefits people who use drugs, their families and the community.

Harm reduction is a targeted approach that focuses on specific risks and harms. The identification of harms, their causes, and appropriate interventions require proper assessment of the problem and the actions needed. Harm-reduction interventions should be tailored to address factors that makes PWID vulnerable -- age, sex, sexual orientation and history of incarceration. The full complement of harm-reduction efforts according to the World Health Organisation should include:

- Opioid substitution therapy
- Needle and syringe programmes
- HIV testing services
- Antiretroviral therapy
- Prevention and treatment of sexually transmitted infections
- Pre-exposure prophylaxis
- Condom programmes for PWID and their sexual partners
- Information, education and communication for PWID and their sexual partners
- Prevention, vaccination, diagnosis and treatment for viral hepatitis
- Prevention, diagnosis, and treatment of tuberculosis
- Overdose management, including provision of naloxone

3.4. Referrals and Linkages

The National PWID programme recognizes the complementarity of clinical (biomedical) and non-clinical (behavioural and structural) intervention services to enable PWID develop competency for HIV prevention. Projects providing HIV prevention services to PWID should have systems and structures that promote access of the population to clinical and non-clinical services. Community centres that promote access of PWID to non-clinical services should have mechanisms that promote expedited access of PWID to clinical services in public and/or private health facilities. Similarly, health facilities that provide services to PWID should have linkages with community centres that promote access of community members to non-clinical services. Projects that establish one-stop-shops should provide clinical and non-clinical services for PWID in safe spaces.

All projects that implement HIV prevention programmes should ensure that the location of the community-service site, the package of services, and the mode of provision of services are acceptable to the target PWID population. The projects should also ensure that effective referral and linkage systems are in place to facilitate use of the services by PWID. This effort will require that:

Appropriate local service providers are identified through community consultations and environmental assessments,
Mutually supportive relationships exist between the implementing organisation, PWID, and the service providers.
Effective system for making and tracking referrals and service delivery be established.

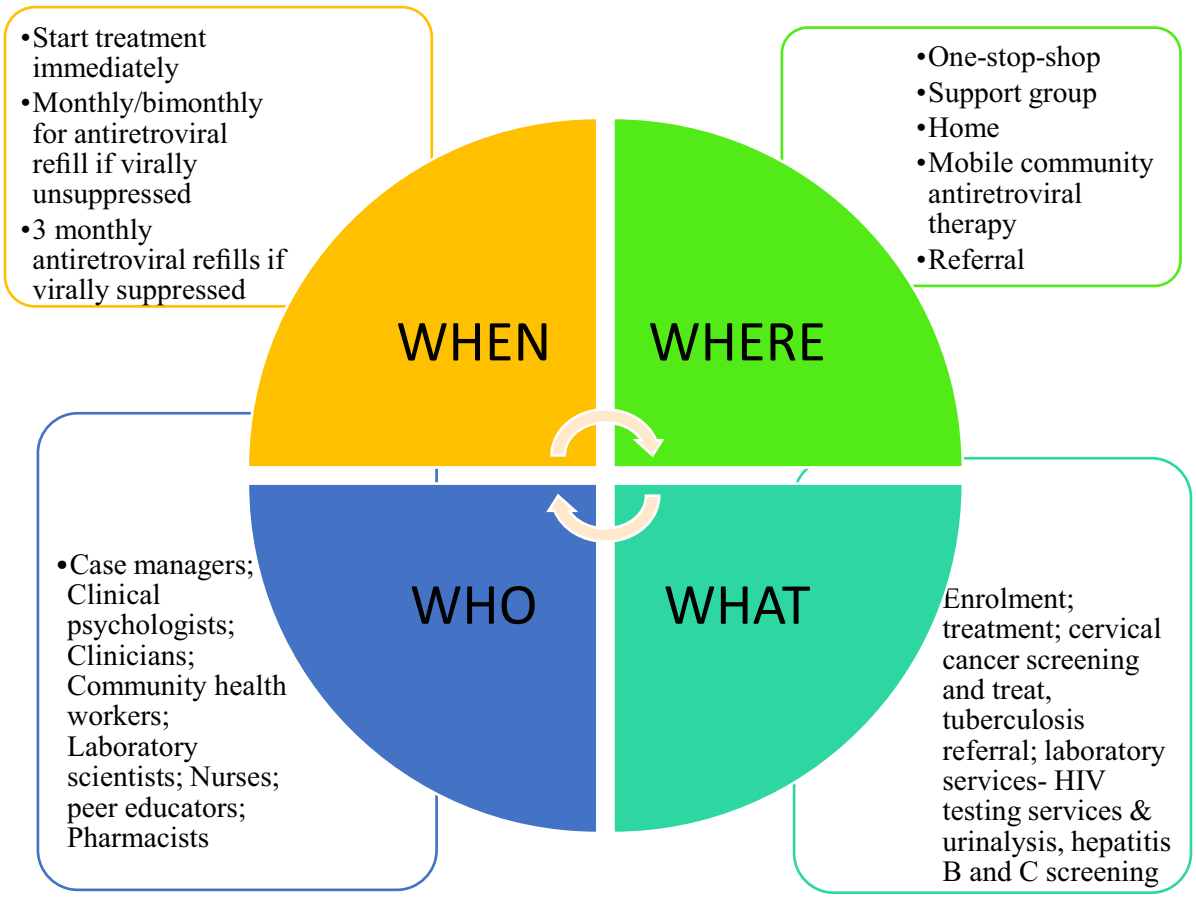
3.5. Adaptation of Minimum Package of Intervention for HIV Prevention Programmes

All projects that provide HIV prevention services to PWID should provide the minimum prevention package of intervention for HIV prevention as prescribed by these guidelines – a combination of behavioural, biomedical and structural interventions. The content of packages may vary by local need and availability of ancillary-care services. The content of the minimum package of intervention for PWID for any project should be defined in collaboration with the targeted population of service recipients, using a participatory approach. All projects should include activities that prevent and address violence, harassment and human-rights abuse due to legal, social and cultural barriers that predispose PWID to stigma and discrimination. These issues include stigma and discrimination, including exclusion from health and social services, economic vulnerability, low self-esteem, difficulty in contributing to community decision making, and access to social entitlements. HIV prevention projects that target PWID should plan for legal aid to help redress and protect their rights. Human-rights education and information should be included in the peer-education curriculum to enable learning about prevention and management of intra-community violations and alternative dispute resolution mechanisms.

3.6. The One-Stop-Shop model of integrated service delivery

The goal of the One-Stop-Shop Model for service delivery for key populations is an enabling environment that is stigma free, conducive, gender responsive, client friendly and safe for key populations to access comprehensive (biomedical, behavioural and structural) services. One-stop-shops are primary health-care delivery structures that are operated by community-based organisations and community members. The shops provide access and coverage of a suite of mutually reinforcing prevention, treatment, care, support and protection services for key populations [9]. Figure 1 provides an overview of the structure of operating a one-stop-shop that ensures access of PWID to behavioural, biomedial and structural interventions. The space can serve as a drop-in centre for drugs pick-ups.

Figure 1: A diagrammatic representation of the one-stop-shop service delivery model for key populations



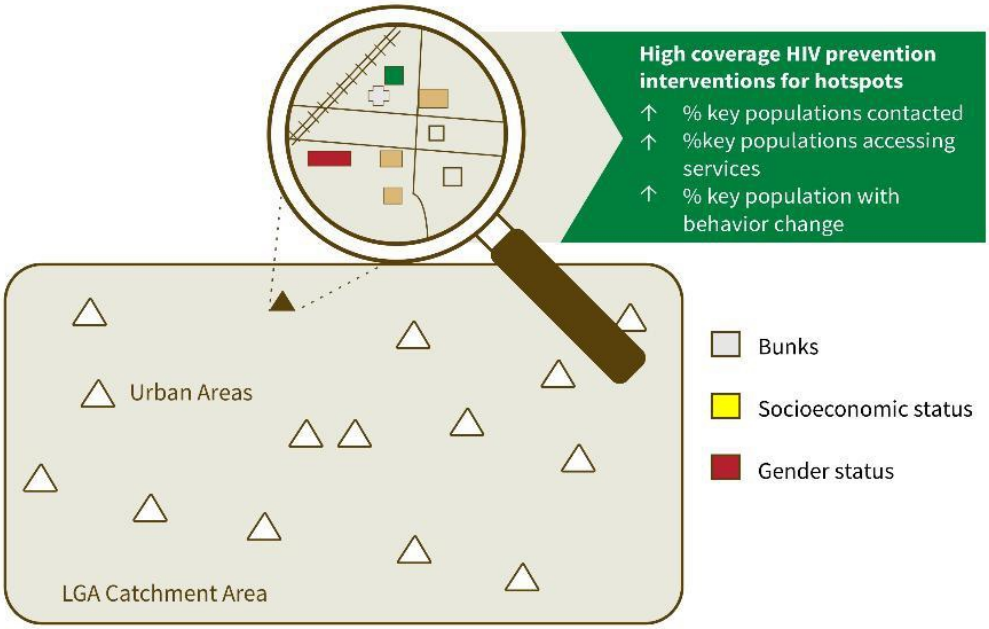
Chapter 4.0
MANAGING AND SCALING UP HIV PREVENTION FOR PEOPLE WHO INJECT DRUGS

4.1 Evidence informed HIV Prevention Projects for People who Inject Drugs

3.1.1 Coverage: HIV prevention programmes should reach as many PWID in targeted clusters as possible. Information about the PWID population in the targeted clusters can be obtained from the State Agency for the Control of AIDS. For the HIV prevention programmes, clusters refer to areas where large number of PWID can be reached. The cluster approach to PWID service delivery aims to improve the predictability, timeliness, and effectiveness of HIV prevention response. It strengthens leadership and accountability and enhance partnerships and complementarity of HIV prevention, treatment and allied service delivery.

When planning a project, the estimated size and typology of PWID at the planned intervention sites should be obtained. Figure 2 shows the areas where various typology of PWID spend time (these locations are called "hotspots"). Knowing the typology of PWID at the targeted intervention sites enhances the planning for service packages and their delivery that meet the need of the targeted population. All projects should aim to reach 90% of PWID in targeted hotspots. Indicators of project success are the number of PWID that access services and the number that demonstrate behaviour change. Organisations should work with the State Agency for the Control of AIDS to identify effective strategies to deliver services to a higher proportion of PWID in the State.

Figure 2. Cluster Area Approach to HIV Prevention Intervention Design



4.1.2. Micro-Planning: Micro-planning decentralizes outreach management and planning to grassroots-level workers (peer educators and outreach workers). It should be used to ensure that peer-led outreach is effective and efficient. Appropriate planning and activity implementation to reach large numbers of PWID within hotspots is essential. Micro-planning involves four main stages:

1. **Site load mapping**: Peer-led mapping is used to systematically validate and define hotspots and their logical geographical boundaries.
2. **Spot analysis**: Spot profiling informs the delivery and components of HIV prevention programmes, per peer and per location. A simple tool collates relevant information on a particular location where PWID are known to congregate
3. **Contact mapping/Peer social network analysis**: In each location, peer educators make a list of all PWID whom they know personally, and they compare lists. Decisions are made about which peer educator will take responsibility for outreach, education, and monitoring for which spot and which individual PWID (contact mapping).
4. **Registration**: This involves enrolling PWID into the project. All enrolled PWID should be profiled according to their demographics and client volume to determine their risk and vulnerability levels.

Details generated from the micro-planning process help in planning the project activities, one of which is the conduct of the outreaches and peer education. The aim is to reach 100% saturation of PWID within specific locations. Community-friendly tools are available with which peer educators can generate and analyse the information about PWID at hotspots that they are in-charge of as "hotspot managers". Seven micro-planning tools have been field-tested for use in Nigeria:

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

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

Tool 3: Condom accessibility and availability mapping benefits participants by disclosing the condom availability points and determining if they are easily accessible to MSM and transgender.

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

Tool 5: Contact mapping helps participants map their contacts within the community of sex workers. Based on this understanding, participants select peers and plan outreach activities in all hotspots.

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

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

The tools can be classified as tools for:

Improving the quality of outreach: Spot Analysis, Contact Mapping, and Site Load Mapping
Improving service delivery: Preference Ranking, Condom and Harm-Reduction Service Accessibility, and Availability Mapping
Improving the Programme: Opportunity Gap Analysis
Facilitating the creation of an enabling environment: Stakeholder Analysis

The outcome of the analysis helps the "hotspot managers" identify the needs of the PWID at the hotspots and design interventions to address the needs. Having PWID design, implement, and monitor the outreach activities increase the appropriateness and acceptability of the project by PWID. The micro-planning process builds the competency of PWID peer leaders to manage their community, nurture community participation and ownership, and organize individuals into groups for community actions. Plans for the outreach and peer-education activities should be informed according to these factors:

4.1.2.1. Geographical location: Outreaches should be implemented in hotspots where sex work takes place. Understanding the typology of the PWID in these hotspots will inform the design of outreaches and peer-education activities.

4.1.2.2. Typology of PWID: Each typology has unique characteristics and outreach needs. Typologies for PWID should include those who solicit sex through online contacts, as the risk for sero-conversion is very high for this population.

4.1.2.3. Volume of sex: High-volume (ten or more clients per week) PWID who sell sex are more vulnerable and should be given priority in comparison to medium-volume (5 to 9 clients per week) and low-volume (4 or fewer clients per week) PWID.

4.1.2.4. Types of sex: PWID who engage in unprotected anal sex should be given priority, as the risk of contracting HIV through unprotected anal sex is 8-9 times higher than through unprotected vaginal sex.

4.1.2.5. Age: Younger PWID have different concerns and needs from those of older PWID.

4.1.2.6. Disability: The relationship between HIV and disability will receive due attention in this guideline due to the higher risk of exposure of persons with disabilities among all key populations to HIV. People living with HIV may also develop impairments, which hinders their full and effective participation in society on an equal basis with others. The guidelines will prioritise process that facilitates their access to HIV education, information and prevention and gender based violence prevention services; and promote the building of the capacity of service providers to provide disability-friendly services.

4.1.2.7. Vulnerability: History of exposure to violence and consumption of alcohol or drugs increase PWIDs' vulnerability to HIV and sexually transmitted infections. PWID with these histories should be given priority for intervention.

4.1.3. Outreaches and peer education: Outreaches and peer-education activities are to be led by PWID. When outreaches are being planned, consideration should be given to the time when PWID will be available – the typology of the PWID at the hotspot will inform the time they are free and most likely to be receptive to sensitization, education and mobile-clinic activities. Consideration should be given to enabling those who have control over PWID -- PWID community leaders – to have access to outreach information. The relationship of PWID with third parties, such family members, should be considered in the design and implementation of outreach programmes. The third parties may be able to promote condom use and uptake of referral services and offer protection against harassment and violence (sexual, physical, and verbal/emotional).

4.2 Programme Management and Coordination

4.2.1. Roles of Institutions: It is the responsibility of the State Agency for the Control of AIDS, in collaboration with the State Prevention Technical Working Group, to design, coordinate and monitor the State PWID HIV prevention programme. Implementing partners are expected to develop projects that address components of the State PWID HIV prevention programme in ways that ensure adequate coverage and equitable distribution of interventions and avoid duplication of effort. The monitoring efforts should include ensurance that projects adhere to the national guidelines and that all PWID HIV prevention programmes provide the minimum standards for quality interventions.

4.2.2. Role of implementing agencies: Agencies (non-governmental/community-based organisations) that have HIV prevention programmes for PWID should submit to the State Agency for the Control of AIDS a project proposal with details on the project implementation. The agencies should ensure that all targeted PWID receive biomedical, behavioural, and structural interventions as agreed in the contract/proposal. The agencies should submit quarterly reports on their progress to the State Agency for the Control of AIDS. Additional responsibilities include local problem solving, recruitment of the local team, and setting up monitoring and evaluation systems, as guided by the State Agency for the Control of AIDS.

*4.2.3. Implementation Team***:** Project-implementation teams should include members who have various skills. Composition of the team will be determined by the types of services to be provided, their delivery method, and the size of the targeted PWID population. The project should have a programme coordinator who is responsible for programme implementation, an accountant managing the projects' expenses, and a monitoring officer responsible for collating and analyzing the project data and generating reports. The team may also include doctors and nurses to provide biomedical interventions and counsellor(s) to support the behaviour change efforts. The intervention team should also include programme officers and a peer educator who provides behavioural and structural interventions to a cohort of PWID.

4.2.4. Recruitment of staff: Candidates who are key-population friendly and whose attitudes, knowledge, and experiences will enable them to work successfully with PWID should be given priority for employment. They should be sensitive to issues of gender, sex, and sexuality and able to deliver services in a non-judgmental manner. Sensitivity to and understanding of the challenges posed by poverty, discrimination, and gender-based violence to female PWID are also essential. Staff members should include PWID.

*4.2.5. Establishing roles and responsibilities***:** The roles and responsibilities of each member of the implementation team should be clearly defined. This policy does not imply that staff cannot switch each other's roles, but team leaders should clearly communicate changed roles and responsibilities to team members. Team members should be aware of their roles and responsibilities and the line of communication for the project.

4.3. Capacity Building

The capacity of the project staff should enable them to change-self and facilitate and support risk reduction behaviour(s) of PWID. Peer educators should have their values clarified and understand the principles guiding the project. The implementation team is expected to ensure that all PWID recruited for the organisation's project have the knowledge and skills that will make PWID feel empowered and able to "own" the interventions. Capacity of staff can be built through classroom training, field exposure, practical sessions, and experiential and interactive sessions with other PWID. Trainings should be conducted in languages best understood by the staff, using methods suited to the cultural ethos and practices of the host communities.

The training should be guided by a nationally standardized training curriculum and a training/facilitator's manual. Participants should have reference materials that they can keep at the end of the training for reference purposes. Trained trainers who can adapt the curriculum to the local realities should facilitate the training.

4.4. Data Collection Tools

Appendix A provides the details of the data collection tools for the HIV prevention programme. It also provides details of those expected to collect the data. Further details about the tools can be obtained from the office of the National, Zonal or State offices of the Agency for the control of AIDS.

It is essential that all projects on PWID in the country keep adequate documentation of their activities. All projects – donor or non-donor funded - are required to submit quarterly reports through the State Agency for the Control of AIDS, to the zonal offices of the National Agency for the Control of AIDS. These data shall be uploaded to the non-health sector data collection platform. Quarter reports should be collated using the non-health sector data reporting tools developed and disseminated by the National Agency for the Control of AIDS.

Chapter 5.0
IMPLEMENTATION OF BEHAVIOURAL HIV PREVENTION PROGRAMMES

5.1 Behavioural Interventions

Behavioural interventions are offered to PWID by trained peer educators. The goal is reduced risk of PWID contracting HIV and sexually transmitted infections. Addressing homophobia, transphobia, stigma and discrimination is central to implementing successful evidence-informed and rights-based services for HIV prevention, diagnosis, treatment and care for PWID. Table 2 provides a summary of the behaviour intervention package for PWID.

Table 2. Programme Behavioural Interventions

Programme Component	Checklist of Activities for Implementation	Tools for data collection
BEHAVIOURAL INTERVENTIONS		
Outreach Interpersonal communication Small group discussions Community stakeholders' meetings **Peer Education:** HIV and sexually transmitted infections' prevention Human rights, sexuality and risk reduction **Counselling, skills building and referral:** Interpersonal/gender-based violence prevention Legal aid, mental health, psychosocial support	**Entry level:** Identify key stakeholders in the community, such as bunk managers, law enforcement agents and others Conduct community stakeholder dialogue Conduct key influencers/ gate keepers pre-intervention dialogue Validation of identified hotspots/intervention sites Selection of peer educators within respective PWID community. **Intensive Level:** Train employed peer educators Peer educators to conduct monthly outreach to PWID communities using drama/role plays, film shows, games Conduct monthly review and refresher meetings with peer educators Conduct quarterly community stakeholders' update meetings Process documentation and dissemination findings using	**Entry level:** Validation format tool Stakeholder analysis tool Spot analysis tool Mapping by civil society and community-based organisation partners Site-load mapping Baseline participatory monitoring and evaluation **Intensive Level:** Peer educators' recruitment criteria tool Peer education plus manual Contact listing by peer educators Community conversation tool kit Peer educator monitoring tool Opportunity Gap Analysis

	drama/role play, community conversation toolkit **Exit level:** Formation of community-led social structures/groups Plan for sustainability of formed social structures/groups Promote voluntary peer educators from the community End of project evaluation/dissemination Sustainable sexual behaviour programmes	**Exit level:** Evaluation tool Final reporting template Best practice document Success story documentation Opportunity Gap Analysis
Expected Results and Indicators Percentage of PWID reached with behavioral education Percentage of PWID reached with Minimum Prevention Package of Intervention		
Condom and Lubricant programming Demonstration, promotion of use, and distribution of male and female condoms and water-based lubricants	**Entry level:** Identify condom procurement mechanism Estimate condom and water based lubricant requirement for PWID **Intensive level:** Distribute and track condoms and water based lubricant to PWID through outreach team Identify traditional/non-traditional outlets and establish distribution systems in all sites **Exit level:** Outlet sustainability of condom and water based lubricant distribution	**Entry level:** Condom and water based lubricant availability mapping Peer educator card Peer education plus manual **Intensive Level:** Condom and water based lubricant accessibility and availability map Condom and water based lubricant distribution tool **Exit level:** Condom and water based lubricant distribution format
Expected Results and Indicators Number of condoms distributed Number of lubricants distributed Percentage of PWID who report consistent use of condoms with sex partner(s)		

5.1.1 Qualities of a PWID peer educator: Peer educators are critical to the successful implementation of the behavioural intervention package. They should share many of the characteristics and life experiences as the population with which they work. They should be knowledgeable about the challenges and stigma experienced by PWID, as this knowledge fosters peer educators' credibility and promotes trust. Peer educators are a link

between communities and instituted services, thereby facilitating participation of the PWID community in interventions. It is therefore required that organisations/institutions conducting HIV prevention interventions for PWID invest in building the capacity of peer educators to enable them to achieve the goal of the National HIV prevention programme for PWID. Thus, peer educators' recruitment should be standardized. The following are required qualities of PWID who will work as peer educators:

A PWID operating in the hotspot/site of intervention
A recognized member and leader in the PWID community
Acceptable to other members of the PWID community
Knowledgeable about the local PWID context and network
Has a good social network in the site where (s)he works
Able to organise and conduct educational sessions/provide information
Highly motivated to mobilise the PWID community to protect itself
Prepared to commit a certain amount of time to peer education activities
Good listening, communication, and interpersonal skills
Committed to being accessible to her/his peers in times of crisis

5.1.2. Peer educators' recruitment process: The peer-education recruitment should be conducted in a transparent manner and provide equal opportunity for recruitment of all interested PWID. The recruitment should occur after the entry-level activities and before commencement of the intensive-level activities. Validation of the hotspots and clustering of the outreach sites will enable the organization/institution to identify how many peers are needed and where they are needed. PWID who were met during mapping or initial outreach by the programme team and who meet the above-mentioned criteria should be encouraged to apply. All candidates should be informed about the role of peer educators, the commitment involved, reporting requirements, and stipend to be paid.

5.1.3. Peer Educators' performance appraisal: A performance appraisal should be conducted every three months to determine how well the peer educators are performing -- number of contacts made, number of condom distributed, and number of referrals and linkage to services. The review should be conducted using the Opportunity Gap Analysis tool, which enables peer educators to self-reflect and self-review. The organisations/institutions are encouraged to organise quarterly reflection meetings with the peers to get direct feedback on the project and peer educators' performance.

*5.1.4. Outreach and Peer Education activities***:** The role of peer educators during outreaches is to build rapport and trust with the PWID community; provide information about how to prevent HIV transmission and about available services; distribute condoms and lubricants; counsel clients on HIV prevention; and refer for behavioural and biomedical interventions. The role of peer educators also includes supporting peers to access legal aid and other clinical and non-clinical interventions during crisis, helping peers learn about their rights and entitlements, and mobilising the PWID community for collective action. These interventions significantly increase clients' levels of knowledge about HIV, reduce the prevalence of sexually transmitted infections, and increase condom use in intervention communities. For more information, please refer to the Peer Education Plus Manual for details about peer education in Nigeria, available online at http://www.sfhnigeria.org/The A to Z of the Peer.pdf.

The frequency of contact that peer educators make with peers will depend on the design of the project. The number of contacts between peer educators and peer(s) per week should be defined. During these contacts, educational information should be provided, condom use should be demonstrated and condoms distributed; and referrals should be made to relevant service delivery points and safe spaces where education and training sessions are held. During peer education and outreach activities, PWID are:

Provided information on HIV/STI and reproductive health
Shown how to use and given male and female condoms and water-based lubricants
Assessed for risk and referred for prevention and care services
Counselled for risk reduction

Provided support in crisis
Screened for gender-based violence and referred for management
Education on community-based human rights

*5.1.5. Risk reduction counselling and skills building***:** Risk-reduction counselling and skills building for risk reduction should focus on reducing the risk of acquiring HIV from oral, anal, and vaginal sex through correct and regular use of condom and lubricants with clients and other sex partners, appropriate douching procedures, management of dry sex, and substance use. Risk-reduction counselling and skills-building sessions should be provided in safe and private spaces, possibly in the clinics and drop-in centres. Counsellors should provide options to PWID and encourage them to identify solutions to their problems. Risk-reduction counseling should follow these steps:

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

5.1.6. Demonstration, promotion, and distribution of condoms, lubricants, and other commodities: Condom use is important for the prevention of sexually transmitted infections, including HIV. Lubricants are important to reduce the risk of tears of the lining of the anus and/or the vagina during sex. Demonstration, promotion, and distribution of female and male condoms, lubricants and other commodities, such as pre-exposure prophylaxis tablets, is important. Condoms, lubricants and other commodities should be made available and accessible at no charge. The correct and consistent use of condoms and lubricants should be encouraged. Skills on how to negotiate the use of condoms with clients should be taught. Condoms, water- based lubricants, and other HIV prevention commodities are freely accessible by PWID through peer educators, outlets set up at hotspots, and clinics. Enough condom and water-based lubricants should be made available to each PWID, based on the estimated number of clients. Access and use of water-based lubricants during vaginal and anal sex should be promoted. Promotion of condom use should be free of coercion.

Chapter 6.0
IMPLEMENTATION OF BIOMEDICAL HIV PREVENTION PROGRAMMES

6.1. Biomedical Interventions

Biomedical interventions are interventions that directly influence the biological systems through which the virus infects a new host. Table 3 highlights the biomedical interventions to be provided to PWID as part of a combination of HIV prevention package.

Table 3. Programme Biomedical Interventions

Programme Component	**Checklist of Activities for Implementation**	Tools
BIOMEDICAL INTERVENTIONS		
STI control and Management Screening and treatment of sexually transmitted infections Sexually transmitted infection syndromic case management	**Entry level:** Identify sites where clinical services will be provided to PWID Adopt the national standard operational guidelines for sexually transmitted infection management Advocate to relevant stakeholders and policymakers for inclusion of a budget line on biomedical intervention for PWID Identify and build capacity of existing community structures to continue to implement community based activities after project exit **Intensive level:** Train and retrain clinic staff on the use of the standard operational guidelines and procedures Provide risk reduction counselling to all PWID Refer and/or treat PWID for sexually transmitted infection using the syndromic management Support partner notification and treatment Institute follow-up systems for PWID managed for sexually transmitted infection in line with the national guidelines Strengthen linkages between community-level activities and health care facilities for sustainability	**Entry level:** Preference ranking Community mapping tool Facility mapping tool Facility assessment tool **Intensive level:** National sexually transmitted infection syndromic management guidelines/tools

	Exit level: Strengthen linkages between community-level activities and health care facilities Institute forums for the continued engagement of community stakeholders with health facilities and PWID groups that would look at progress review, feedback processes, and recommendations for sustainability	**Exit level:** Format/tools for referral linkages Format for referrals
Expected Results and Indicators Percentage of PWID referred for sexually transmitted infection services Percentage of PWID accessing sexually transmitted infection services		
HIV Testing Services Mobile HIV testing services Facility-based HIV testing services Community-based HIV testing services HIV self-testing Referrals	**Entry level:** Adopt the national standard operating procedure guidelines for HIV testing services Identify organisations that can be linked to the programme to provide HIV testing services, or train counsellors to provide the services. Establish linkages between HIV testing services providers and clinics that can provide HIV positive client with antiretroviral services, and HIV negative clients with high sexual risk behaviours with pre-exposure prophylaxis services in the hotspots **Intensive level:** Follow-up of PWID for regular HIV testing services Refer PWID with high sexual risk behaviour for pre-exposure prophylaxis Refer PWID with accidental exposure to HIV or post-exposure prophylaxis Promote community counselling systems and PLHIV networks **Exit level:** Linkages with HIV positive networks	Adapt national standard operating procedure tools
Expected Results and Indicators Percentage of PWID referred for HIV testing services Percentage of PWID counselled, tested for HIV and received result Percentage of PWID who tested HIV-positive		

PMTCT and sexual and reproductive health services HIV treatment, care, and support Reproductive health services, contraception and perinatal care **Harm reduction services** Needle and syringe exchange programme Overdose management (Access to naloxone) **Allied services** Viral hepatitis Cancer screening Tuberculosis screening and management Diabetes, hypertension screening and management Mental health screening and psychosocial support	**Entry level:** Follow/adapt the national standard operating procedure for treatment and care of PWID **Intensive level:** Refer HIV-positive female PWID for PMTCT services and adhere to national PMTCT guidelines Promote PMTCT among female PWID as part of peer education package Provide/refer for adherence counselling Follow-up of HIV-positive PWID by HIV-positive peers or acceptable outreach staff Refer PWID for contraception Refer HIV-positive PWID for tuberculosis screening and management Refer PWID for cervical cancer, prostate cancer, anal cancer, viral hepatitis, human papilloma virus, and HIV simplex virus 2 screening Refer PWID for other health services screening such as diabetes, hypertension. Refer PWID for mental health and psychosocial support when needed	Follow/adapt the national standard operating procedures for treatment and care of PWID Adapt tools from National Sexual Reproductive Health Adopt maternal and child health training tool
Expected Results and Indicators Percentage of PWID who accessed needle exchange services Percentage of PWID who accessed overdose management services Percentage of pregnant PWID referred for antenatal care Percentage of pregnant PWID living with HIV receiving antiretroviral therapy Percentage of female PWID initiated on long acting contraception Percentage of PWID newly initiated on antiretroviral therapy Number of PWID eligible for pre-exposure prophylaxis who receive it Percentage of PWID receiving pre-exposure prophylaxis who seroconvert		

Number of PWID eligible for post-exposure prophylaxis who receive it

Biomedical intervention for PWID can be provided directly by the implementing organization/institution or through referrals and linkages to clinical-care services. PWID's initiation and continued management of biomedical interventions should be delivered by professionals, as defined in the national standard operation procedure guidelines. All linkage clinical care centres should be trained to be PWID friendly. Biomedical intervention can be provided through intervention site-based or mobile clinics. Referrals can also be made to public and private health sectors. All referred clients who are HIV-positive should be followed-up by a HIV-positive peer educator if the PWID consents to this.

6.1.1. Sexually transmitted infections screening and treatment: The goal of sexually transmitted infections screening and treatment services for PWID is the identification, treatment, and prevention of sexually transmitted infections. Plans for management of sexually transmitted infections should be made in collaboration with PWID at the clusters. The PWID should be able to identify their preferred list of service delivery sites, barriers to access to service and ways to overcome these barriers. They should also identify the best mode of service delivery for them. Service delivery should be PWID friendly and accessible at appropriate times for the PWID and have infrastructure to provide confidential and comprehensive prevention, treatment and partner-notification services. Clinics providing sexually transmitted infection management services for PWID should include the following in line with the WHO/National sexually transmitted infection guidelines:

Health promotion and sexually transmitted infection prevention activities, such as instruction on correct and consistent use of male and female condoms, use of water-based lubricants, and other safe sexual practices;
Provision of free male and female condoms and lubricants, if available
Immediate diagnosis and clinical management of sexually transmitted infection;
Provision of sexually transmitted infection medicines and directly observed therapy for single-dose regimens;
Pre- and post-exposure prophylaxis for HIV;
Health education and counselling for treatment compliance, correct and consistent use of condoms, and regular partner treatment;
Quarterly check-ups, syphilis screening, and treatment of asymptomatic infections;
Partner management programmes;
Follow-up services for PWID with sexually transmitted infection;
Referral links to HIV counselling and testing centres, HIV care and support, and other relevant services;
Linkages with outreach activities targeted at PWID.

*6.1.2. Provision of HIV Testing Services***:** Clinical staff who provide HIV testing services should be trained on informed consent, privacy and confidentiality and on the management of adverse outcomes of result disclosure. Provider-initiated HIV testing and counselling services should be provided to all PWID who attend clinics for other services. HIV testing should be provided in accordance with the national HIV testing and counselling guidelines. HIV-positive PWID should be referred for antiretroviral therapy. Clients who do not use condom consistently or have repeated history of sexually transmitted infection should be referred for pre-exposure prophylaxis. All PWID are eligible for long-term HIV prevention and treatment support.

6.1.3. Harm Reduction Services: PWID should have access to the full range of harm reduction services. Organisations/institutions supporting PWID access to HIV prevention services should ensure that clients are able to access the full range of services directly or through referral and linkages. These services include community systems and structures to promote needle and syringe exchange, and overdose management. The implementation of the harm reduction services should be planned in collaboration with the community of PWID where intervention will take place.

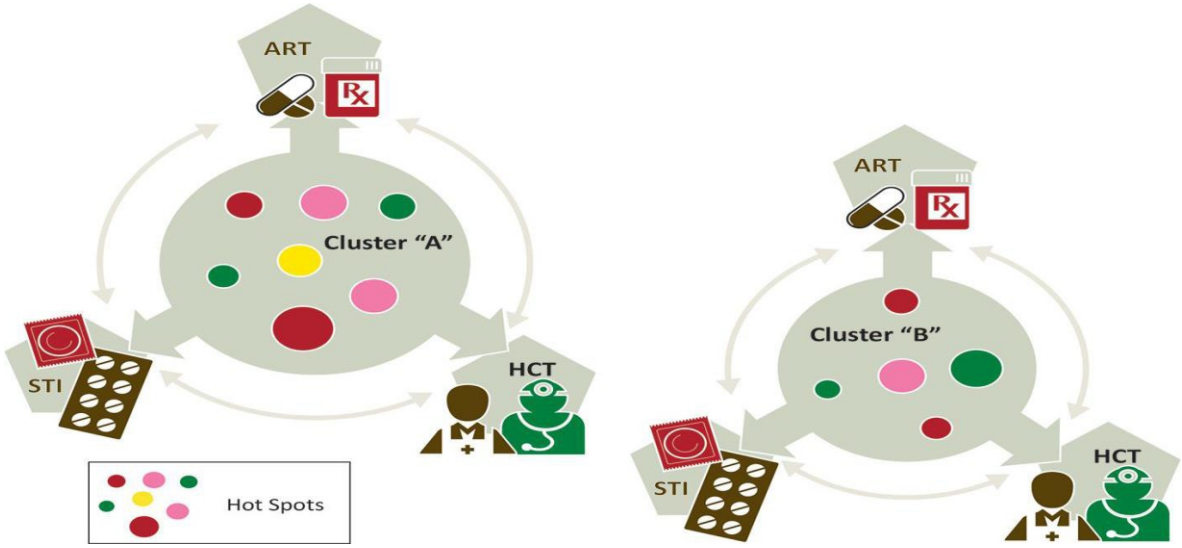
6.1.4. Prevention of Mother-to-Child Transmission and provision of HIV treatment, care, and support services: The goal of HIV care and treatment is to restore the immune system, reduce HIV and AIDS-related morbidity and mortality, improve quality of life, decrease viral load, and reduce HIV transmission to partners of sex workers. HIV-positive PWID must have access to a core package of HIV care and treatment services, which includes clinical assessment of disease stage, viral-load assessment, CD4 count determination, co-trimoxazole prophylaxis, antiretroviral therapy, PMTCT for pregnant PWID, management of opportunistic infections, and psychosocial support. A follow-up plan must be instituted for all HIV-positive female PWID to reduce the risk of poor adherence to treatment and loss to follow-up.

6.1.5. Provision of Reproductive and Allied Health Services: Facilities should provide access to all forms of contraceptive methods and reproductive care including condoms, pregnancy screening, counselling and referral for other sexual and reproductive health services. Services to be provided directly or through referrals should include medical and psychosocial services to rape survivors, those who face intimate-partner violence, and those with mental health challenges. In addition, linkages should be developed with organisations that provide economic empowerment services. PWID should also be supported to access other allied services like tuberculosis screening and management, viral hepatitis, diabetes, hypertension screening and management

6.2. Cluster Approach to Service Delivery

Where there is a need to refer PWID for biomedical interventions, appropriate local service delivery organisations and institutions operating within the programme catchment area should be identified and partnered with. Effective referral mechanisms for PWID should be established. Figure 3 is a diagram depicting the "cluster" concept, with clusters of hotspots linked to a network of services within proximity to the hot spots.

Figure 3. "Cluster approach" for biological service delivery for People Who Inject Drugs



The "cluster approach" involves the following key steps:

List and characterize all PWID hotspots identified at the implementation site

Within each local government area, organise the PWID hotspots into geographic “clusters” based on their proximity.
List, describe, and map the health services delivery points available in the local government area hosting the project implementation site
List and describe the available health services delivery points for each PWID cluster. The list should be developed in consultation with PWID community groups. This collaboration creates a list of service delivery referral points for the project.
Identify key gaps in service availability within each cluster and address these gaps by recruiting/establishing new service delivery points.
Train the service providers at identified referral clinics to be PWID friendly and establish efficient referral system for PWID to the service delivery points.
Institute an active follow-up mechanism for all referred clients.
In addition to the development of service delivery networks within each cluster, map other key service delivery points, including local police stations and social support organisations. Work proactively with law enforcement officials to support local HIV prevention programmes for PWID and to mitigate the violence and harassment of PWID.

Chapter 7.0
IMPLEMENTATION OF STRUCTURAL INTERVENTIONS TO REDUCE HIV VULNERABILTY

7.1. Structural interventions

Structural interventions address the critical social, legal, political, and environmental enablers that increase the vulnerability of PWID to HIV infection and to sexual, physical, and emotional violence, and reduces their ability to access HIV prevention services. The HIV risk of PWID is heightened by societal and community factors, such as cultural norms, social marginalization, and criminalization, which limit their opportunities and access to services that could reduce their vulnerability. Structural interventions aimed at reducing the vulnerability of PWID should focus on creating an enabling environment for improving their access to health services and commodities and the protection of their rights. Table 4 highlights the structural interventions to be provided to PWID as part of a combination of HIV prevention package.

Table 4. Programme Structural Interventions

Programme Component	Checklist of Activities for Implementation	Tools
STRUCTURAL INTERVENTIONS		
Community mobilisation and dialogue Advocacy Advocacy Access to justice Individual empowerment/incoming generating activities	**Entry level:** Analyse social, cultural, economic, and geographical context with PWID at target site Identify target sub-populations like adolescents and young PWID, and PWID living with disability Conduct stakeholder analysis Identify factors that promote stigma and discrimination, violence and exploitation of PWID in the locality and by whom Prioritize key issues to be addressed and develop mitigation plan **Intensive level:** Engagement with PWID community through awareness creation and dialogue Engagement with community stakeholders for formal and informal policy change, institutional capacity development Improve access of PWID to financial mitigation activities through partnerships with relevant public and private sector organisations and entities	**Entry level:** Venue/community profiling tool Stakeholder analysis tool Risk and vulnerability assessment tool **Intensive level:** Crisis analysis tool Community Committees Tools for linkages for IGA programming

	Strengthen PWID self-worth through life skills training, mental health and psychosocial support Adapt programmes to address the peculiar needs of adolescents and young PWID, and PWID living with disability **Exit level:** Development of sustainability plans Support possible formation of cooperatives of PWID	 **Exit level:** National peer education guide
Expected Results and Indicators Percentage of PWID that report physical and/or sexual violence Percentage of PWID that report stigma-related barriers to access health and/or social services Percentage of PWID that report harassment and discrimination when accessing services		

Some of these activities may be beyond the scope of services provided by the implementing organization/institution. In that circumstance, the organization/institutions form partnerships with organisations that can provide the services and work with them to develop a comprehensive plan for the targeted work with PWID. This partnering includes the need to recognize and plan for sub-populations of PWID such as adolescent PWID. Structural interventions should include screening for violence, a common but poorly reported incidence faced by PWID. Interventions should be provided to affected PWID to prevent future occurrence and address mental health impact of exposures. Possible interventions include:

Sensitization of law enforcement agencies to improve public health, including the health of sex workers.
Training of PWID peers as paralegals to support those who experience gender-based violence.
Legal, psychosocial and medical support for victims of violence.
Mobilisation and sensitisation of PWID on their rights and entitlements.
Documentation of experiences of violence.
Medical management of sexual violence, such as access to post-exposure prophylaxis, emergency contraception, and/or post-trauma services.

7.2. Community Mobilisation and Dialogue

Community mobilisation is the process of engaging groups of PWID in discussing, planning, implementing, and monitoring projects that affect them. This mobilization will increase the sense of ownership and build solidarity and support in the community of PWID. The mobilization and dialogue-leading process should be delegated to a PWID who is willing to take on the leadership role. The competency of the PWID to play this role effectively should be built. The leadership role includes documenting, reporting, and acting as liaisons between the PWID community and the legal system.

Liaisons should be trained on human-rights protection and reporting/redress mechanisms. Crisis response teams should also be constituted with the liaisons and other volunteers, and their capacity to respond promptly to crisis faced by PWID should be developed. Liaisons should also facilitate dialogue with other stakeholders, including the host community, to promote a supportive and protective environment. Dialogues should be held with law enforcement agencies to explore ways to mitigate the risk of violence for community members.

In addition, the project implementation team should hold regular dialogues with stakeholders. PWID should be encouraged to form cooperatives as a community economic empowerment strategy and community committees for discussions on ways to improve the project and other issues.

7.3. Advocacy

The project, in collaboration with PWID, should develop an advocacy plan with the aim of creating a supporting environment that reduces the risk of PWID to violence and police harassment.

7.4. Individual Empowerment/Income-Generating Activities

PWID should be provided the opportunity to learn life skills and access to education so they can become economically independent through small-scale income-generating activities. They should also be provided access to financial mitigation activities through partnerships and linkages with relevant public and private sector organisations and entities. Drop-in centres can also be established to facilitate access to legal,psychological, and medical support for victims of violence.

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Appendix A

Routine Monitoring Forms and Registers

The following forms are recommended for use for key population HIV prevention intervention

S/N	Forms and Registers	Completed by whom
1	Recruitment form	Implementing partner Programme team / PE Supervisor
2	Peer session attendance form	Peer Educator
3	Peer Educators Monthly tracking form	Peer Educator
4	Peer Educator Supervisor's Monthly summary form	Community based organisation / Civil Society Organisation Staff
5	Quarterly PITT	Community based organisation / Civil Society Organisation Staff
6	Referral forms	Peer Educator / Service provider / Person referred
7	Client summary form	Community based organisation / Civil Society Organisation Staff
8	Structural intervention tracking form	Community based organisation / Civil Society Organisation Staff
9	Structural monthly summary form (Income generation activity, Advocacy form, Community dialogue, Crisis management)	Community based organisation / Civil Society Organisation Staff
10	Condom distribution outlet register	Community based organisation / Civil Society Organisation Staff
11	Summary forms	Community based organisation / Civil Society Organisation Staff

S/N	NAME	ORGANISATION
1.	Mr. Alex Ogundipe	NACA
2.	Dr. Funke Oki	NACA
3.	Dr. Uduak Daniel	NACA
4.	Dr. Tolulope Oladele	NACA
5.	Mrs.Ezinne Okey-Uchendu	NACA
6.	Dr. Idoteyin Ezirim	NACA
7.	Mr. Kingsley Essomeonu	NACA
8.	Mrs. Hafsatu Aboki	NACA
9.	Mrs. Mercy Egemba	NACA
10.	Mr. Ajaja Olaleye	NACA
11.	Ms. Ajiboye Oluwatosin	NACA
12.	Mrs. Hasiya Bello	NACA
13.	Mrs. Roseline Akinola	NACA
14.	Dr. Salaudeen J.O	FMoH
15.	Samson Omoighe	NASCP
16.	Mrs. Ima John-Dada	NASCP
17.	Mr. Nduka Augustine	NDLEA
18.	Dr Uche Okoro	FACA
19.	Gabriel Undelikwo	UNAIDS
20.	Dr. Murphy Akpu	PEPFAR
21.	Dr. Abiye Kalaiwo	USAID
22.	Mr. Victor Adamu	CDC
23.	Adeolu Ogunrombi	WHO
24.	Dr Green Kalade	UoM
25.	Ejekam Ebuka	UoM
26.	Dr. Samuel Nwafor	UMB
27.	Dr. George Eluwa	Pop Council
28.	Mr. Toafeek Adeleye	AHF
29.	Aisha Omoh	SFH
30.	Segun Oyedeji	SFH
31.	Pat Igbene	SFH
32.	Berkisu Momoh	SFH
33.	Ngozi Ajaero	IHVN
34.	Francia Akolawole	IHVN
35.	Comfort Ige	IHVN
36.	Scott Adamu	APIN Public Health Initiative
37.	Olubunmi Amoo	APIN Public Health Initiative
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39.	Dr. Ngozi Madubuike	NDLEA
40.	Enemo Amaka	KAP Secretariat
41.	Emmanuel Anene	ICTHARAE
42.	Helen Beyioku Alade	DldAN
43.	Anthony Nkwocha	PITCH
44.	Abah David Ali	LAPI

45.	Okiwu Henry .C	YouthRise
46.	Edward A Ogiji	APYIN
47.	Odizuru Onyebuchi	APYIN
48.	Patience Etim	Interperter
49.	Emmanuel Anene	KAP
50.	Patrick Enwerem	EVA
51.	Susan Kerma	KAP
52.	Winifred Mike-Ibe	SBCC TWG
53.	Patience Boniface	SBCC TWG
54.	Ibobo Daniel.B	SBCC
55.	Ibe Ifeanyi Amanze	SBCC
56.	Akpet Loretta Amba	SBCC
57.	Ajuk Francis Felix	SBCC
58.	Kelechi Igbojionu	Zinnok Initiative
59.	Prof. Morenike	Consultant

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