National Guidelines for

IMPLEMENTATION OF HIV PREVENTION PROGRAMMES FOR MEN WHO HAVE SEX WITH MEN IN NIGERIA

2020

FOREWORD

Nigeria has a mixed HIV epidemic – a general epidemic in the general population and a concentrated epidemic with key populations. The HIV prevalence and transmission dynamics vary across regions and populations; some states have mostly concentrated epidemics. The 2018 Nigeria AIDS Indicator and Impact Survey(NAIIS) showed that the National HIV prevalence for 15-49-year-olds in the general population is 1.4%. The prevalence is higher among key populations (female sex workers, men who have sex with men and people who inject drugs) with the prevalence being as high as 46% for female sex workers and 37% for men who have sex with men in certain locations. There are no national data on HIV prevalence for transgender, though global statistics indicate that the HIV prevalence for transwomen is as high as that of men who have sex with men.

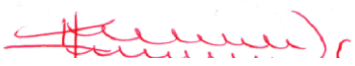
Men who have sex with men (MSM) in Nigeria are at high risk of contracting HIV infection. To reduce this risk, evidence-informed and human rights-based prevention interventions for key populations is a national priority for fast-tracking Nigeria's HIV response. It is therefore imperative to deliver effective high-quality and comprehensive HIV prevention programs to men who have sex with men while the country generates the data to support transgender people response.

Two special sub-population of importance are adolescent and young MSM, and MSM with disability. Although there are no data on the HIV profile of adolescent and young MSM, global estimates indicates that adolescents and young people is the only group that has shown a significant increase in estimated new infections. HIV testing opportunities for young MSM are therefore critical and so systems and structures need to be created to enable them access HIV testing services outside the barriers created in public health institutions that operate age-limits for sexual and reproductive health service delivery.

This document highlights principles, procedures and activities in the design and implementation of evidence-based HIV prevention programs for men who have sex with men. It considers new developments and contemporary and emerging issues in its design. It details the steps and tools needed to plan, implement, monitor, scale-up and expand programming for men who have sex with men. It also includes tools for monitoring and evaluation, and it provides details on the minimum HIV prevention programmes for men who have sex with men in Nigeria.

The document is intended for use by funders, development partners, non-governmental organisations and community-based organisations to guide the design and implementation of standard and high-quality HIV prevention programmes for men who have sex with men.

The National Agency for the Control of AIDS recognizes the efforts of stakeholders at various levels to control the HIV epidemic. This document is our effort to coordinate the MSM HIV prevention program in Nigeria to enable the country to achieve epidemic control by 2030.



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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
IBBSS	Integrated biological and behavioural surveillance survey
IP	Implementing Partners
HIV	Human Immunodeficiency Virus
KP	Key Populations
M&E	Monitoring and Evalution
MPPI	Minimum Prevention Package of Intervention
MSM	Men who have Sex with Men
NACA	National Agency for the Control of AIDS
NAIIS	Nigeria HIV/AIDS Indicator and Impact Survey
NPTWG	National Prevention Technical Working Group
OSS	One Stop Shop
SACA	State Agency for the Control of AIDS
SFH	Society for Family Health

STI	Sexually Transmitted Infection
TG	Transgender
UNAIDS	Joint United Nation Program on HIV/AIDS
WHO	World Health Organisation

Chapter 1.0

INTRODUCTION

Nigeria is a federation made up of 36 states and the Federal Capital Territory (Abuja). The states are grouped into six geo-political zones: North West, North East, North Central, South West, South East, and South South. The 2018 national HIV prevalence among the general population is estimated to be 1.4% [1] though there are differences across the geopolitical zones: from 0.6% in North West to 1.1% in North East; 1.2% in South West; 1.9% in South East; 2.1% in North Central; and 3.1% in South South 3.1% [1], and subpopulations with diverse factors driving the epidemic.

The Integrated Biological and Behavioural Surveillance Survey (IBBSS) was conducted among key populations in 13 states of Nigeria and the Federal Capital Territory in 2014. The national prevalence for men who have sex with men (MSM) was 22.9%: 22.2% for those who had insertive partners and 25% for those who had receptive partners. It was also 20.2 % for those who sold sex to male partners and 21.7% for those currently married. Among MSM, HIV prevalence ranged from 11.3 % in Cross River State to 41.3 % in Lagos State [2].

MSM are disproportionately affected by HIV compared with other reproductive-aged men in every region of the world. While the HIV prevalence is on the decline among other key populations, the HIV for MSM is increasing globally and in Nigeria [3]. The HIV prevalence among MSM has increased to about 10% per year over the last 7 years. Older MSM are more likely to be HIV positive because of their prolonged high-risk sexual activities [4].

Individual behavior associated with the rising HIV epidemic among MSM includes unprotected receptive anal intercourse [5], numerous lifetime male partners, injection and non-injection drug use, and high viral load in the index partner [6], but these behaviors are insufficient to explain the rising epidemic. Engagement of MSM in their care improved condom and lubricant use, but inconsistent use remained common [7].

Factors associated with high-risk behaviour for MSM include childhood adversity, intimate-partner violence, depressive symptoms, and suicidal ideation, which are collectively known as psychosocial syndemic and are associated with increased mental health challenges [8]. Mental health problems are common among MSM [9, 10], and many are willing to access mental health services if they are provided as part of the HIV prevention services provided by peer-led organisations [11]. Other risk factors, such as biological, couple-network level, community-level and structural drivers are implicated in the persistent high transmission rates among MSM, especially with the increased use of antiretroviral therapy.

A possible contributing structural factor to risky behaviour is sexual stigma, which is commonly defined as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination within a power imbalance system that affect gay men and other MSM related to same-sex practices [12]. Sexual stigma is enacted and felt stigma expressed as physical violence, rape, and fear of seeking health care because of concerns about discrimination. MSM in Nigeria experience sexual stigma [13-15]. Sexual stigma is a risk factor for HIV and sexually transmitted infection in Nigeria, with evidence of a probable cause-effect relationship between the two [16]. Also, the increase in HIV prevalence has been associated with internalized homophobia [17] and the criminalization of same-sex practices in Nigeria, which has resulted in increased fear and avoidance of healthcare [18, 19].

High levels of sexual stigma are a barrier to HIV testing and care for MSM. This is problematic for Nigeria with its concentrated HIV epidemic among key population. This had multiple implications: there is increasing online

sex-seeking behaviour of MSM in Nigeria. Online sex-seeking MSM are highly likely to acquire HIV infection between care visits, and they are also more likely to test positive for sexually transmitted infections. Yet, there are limited opportunities for this growing sub-population of MSM to benefit from internet-based risk reduction [20].

Less is known about the HIV epidemic among transgender, young MSM and MSM living with disability mainly because of challenges in sampling, lack of population-size estimates, and stigma and discrimination. Young MSM who engage in sex work are even more vulnerable to HIV [21]. People with disability in Nigeria have low comprehensive knowledge and self-perceived risk of HIV and low use of condom [22]. Transgender people are severely underserved in the response to HIV. Transgender women are 49 times more likely to acquire HIV than other adults and 19% of transgender women are infected with HIV [23].

Transgender women who sell sex are at higher risk of HIV infection than are those who do not sell [24]. The sellers also face high rates of violence and sexual stigma, substance use, sexual abuse and assault, and depression, with suicidal ideation and attempted suicide associated with widespread stigma and discrimination [24]. Transgender women's experiences of transphobia, discrimination, violence and criminalization impact negatively on their physical and mental health and limit their access to and use of vital services. Transgender women decline to disclose their gender identity, sexuality or sexual behaviour to their families, friends, neighbours and health-care providers. The HIV prevalence among transgender women sex workers is nine times higher than for non-transgender and three times higher than for male sex workers [25]. Transgender men have less burden of disease than do transgender women, though emerging data suggest that transgender men who have MSM have heightened vulnerability to HIV, and mental health concerns are common in the population [24].

Previous national HIV responses have focused on the needs of MSM to the exclusion of transgender men and women as a distinct population with a high risk for HIV infection. Interventions for transgender men and women is important. The TRUST study in Nigeria revealed that the HIV and sexually transmitted infection burden for MSM and transgender women is high, and strategic intervention is needed [26]. Inconsistent condom use was identified as a barrier to addressing the rising prevalence of HIV and sexually transmitted infection in the community. There are currently no epidemiological data on transgender men in Nigeria to aid the planning of a response. However, some implementing partners are working in this area and have produced some program data. The guidelines for transgenders will be developed as soon as there is epidemiological data to support distinct plans being made for the transgender community in Nigeria.

Chapter 2.0

PROFILE OF MEN WHO HAVE SEX WITH MEN

MSM is defined as male persons who engage in sexual activity with members of the same sex, regardless of how they identify themselves. MSM are males – of any age – who engage in sexual and/or romantic relations with other males. The use of the term MSM in this document encompasses the large variety of settings and contexts in which male-to-male sex takes place, across multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with particular community or social groups. [24].

In Nigeria, MSM are at high risk of contracting HIV. It is important to deliver high-quality, context-specific and effective HIV prevention programmes to these persons to reduce the number of new infections. This guideline provides policy makers, programme implementers, donor agencies, bilateral organizations and international organizations an overview of the steps and tools needed to plan, implement, monitor and improve the HIV prevention programmes for MSM.

2.1. Typology of MSM in Nigeria

In Nigeria, MSM have diverse typologies based on their sexual orientations and sexual behaviours. The National MSM HIV prevention programme targets sexually active members of the populations. It includes MSM who have engaged in oral and/or anal (receptive or insertive) sex with another man. MSM may be:

Homosexual: primary emotional, physical and sexual attraction is to the same sex/gender identity

Bi-sexual: primary emotional, physical and sexual attraction is to both male and female

Heterosexual: primary emotional, physical and sexual attraction is to the opposite sex/gender identity

Pansexual: sexual, romantic or emotional attraction towards people regardless of their sex or gender identity

Receptive MSM: the receptive partner in a penetrative sex (oral and/or anal).

Insertive MSM: insertive partner in a penetrative sex (oral and/or anal).

Versatile MSM: the receptive and/or insertive partner in a penetrative sex (oral and/or anal).

MSM sex workers: received money or other valuables/ incentives in exchange for sexual favours and who consciously define those activities as income generating even if they do not consider sex work as their occupation. This can be done in areas such as brothels, bars, restaurants, gardens, night clubs and on the streets or from a resident of public space.

Chapter 3.0
ELEMENTS OF HIV PREVENTION PROGRAMMES FOR MEN WHO HAVE SEX WITH MEN

3.1 Principles Guiding the Design and Implementation of HIV Prevention Programmes for Men Who Have Sex with Men

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

3.1.2. *Quality-focused and result-oriented*: The design and implementation of HIV prevention programmes for MSM must aim at meeting defined outcomes that meet 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 MSM have the inalienable right to quality HIV prevention services in synergy with other education and development opportunities that contribute to their general health and wellbeing. MSM also have the right to participate in the development/review, implementation, monitoring and evaluation of this policy and relevant programs that address their HIV risk.

3.1.4. *People-centered approach*: MSM have diverse needs. This guideline promotes access of MSM to integrated people-centered HIV prevention services wherein people and communities, not diseases, are at the center of planning and implementation. HIV prevention interventions should focus on empowering MSM, including those that are young and those living with disability, through education and support to take charge of their HIV prevention needs and risks rather than being passive recipients of services.

3.1.5. *Integrated services delivery*: HIV prevention programmes for MSM 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 public and private facility and community sites according to their needs.

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

3.1.7. *Data security consciousness:* The program shall adopt strategies that will enhance data security and safety during data collection, collation, analysis and usage. Research activities conducted with MSM 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 MSM communities. Local cultural needs and values of the communities where the programs will be implemented should inform the design of programs; this approach 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 Men who have Sex with Men

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

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

Table 1. Key Components and Elements of the HIV Prevention interventions for Men who have Sex with Men

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 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 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

3.2.1. *Behavioural interventions:* These should be offered directly to MSM by peer educators through outreach programmes and education sessions. These activities should promote access of MSM to condoms and lubricants, sexually transmitted infections and HIV prevention information and education, referral services, human rights education and community-based gender based violence prevention and response activities. Outreaches, which include both physical and virtual activities, should be used to make initial contact with MSM. At the initial contact, they are connected with specific programmes and services. For MSM that use drugs, harm reduction information and education should be offered.

3.2.2. *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 pre-exposure prophylaxis, viral hepatitis screening, tuberculosis screening and management, post-exposure prophylaxis and other clinical services that improve the sexual and reproductive health of MSM including post gender-based violence care. For MSM that use drugs, harm reduction and drug overdose management services should be offered.

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

3.3. Referrals and Linkages

The National MSM programme recognises the complementarity of clinical (biomedical) and non-clinical (behavioural and structural) interventions to enable MSM to develop competency for HIV prevention. Projects that provide HIV prevention services to MSM should have systems and structures that promote their access to clinical and non-clinical services. Safe spaces through community centre activities that promote MSM access to non-clinical services should have mechanisms that promote expedited access of MSM to clinical services in public and private health facilities. Similarly, health facilities that provide services to MSM should have linkages with community centres that promote their access to non-clinical services. Projects that adopt one-stop-shops strategic approaches should provide clinical and non-clinical services for MSM in safe spaces

All projects that implement HIV prevention programs should ensure that the location of the community-service site is accessible to the target population of MSM and that the package of services and the mode of provision of services are acceptable to them. Effective referral and linkage systems should be in place to facilitate the use of the services by MSM. This will require that:

- Appropriate local service providers are identified through community consultations and environmental assessments.
- Mutually supportive relationships exist between the implementing organisation, MSM, and the service providers.

- Effective system for making and tracking referrals and service delivery should be established.

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

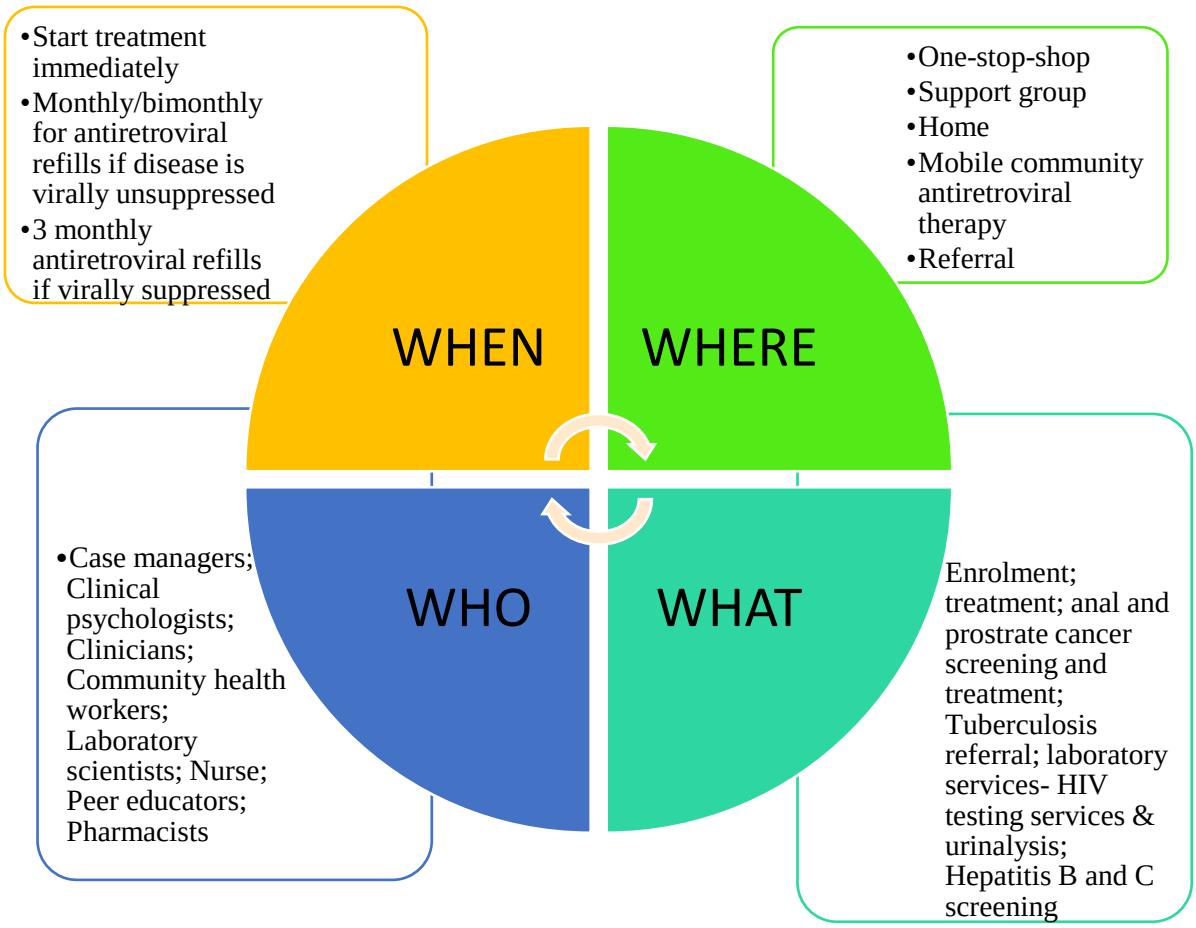
All projects that provide HIV prevention services to MSM should provide the minimum package of intervention for HIV prevention as prescribed by these guidelines – a combination of behavioural, biomedical and structural interventions. The content of intervention packages may differ by local need and availability of ancillary care services The content of the minimum package of intervention for MSM for any project should be defined in collaboration with the targeted population, who will be 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 them 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 prevention projects that target MSM should plan for legal aid to help seek redress and protection of 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 mechanisms of dispute resolution.

3.5. The One-Stop-Shop Model of Integrated Service Delivery

The goal of the one-stop-shop model for service delivery to key populations is an enabling environment that is stigma free, conducive, gender responsive, client friendly and safe for them to access comprehensive (biomedical, behavioural and structural) services. It is also expected to provide youth friendly services that enables young MSM to have access to HIV and sexual and reproductive health services. The community service delivery component of all one-stop-shop should identify the needs of their clients who have disability and adapt the delivery of their services to address these needs.

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 [27]. Figure 1 provides an overview of the structure for operationalizing a one-stop-shop. Non-clinical (behavioural and structural) interventions are provided in these spaces. Clinical (biomedical) interventions are provided only by professionals, and the space can serve as a drop-in centre for drug 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 MEN WHO HAVE SEX WITH MEN

4.1 Evidence-informed HIV Prevention Projects for Men who Have Sex with Men

4.1.1 Coverage: HIV prevention programmes should reach as many MSM in targeted clusters as possible. Information about MSM in the clusters can be obtained from the State Agency for the Control of AIDS. The most appropriate method for identify MSM for targeted intervention is through the use of the snowball techniques. Here peer navigators identify their peers from their population group to participate in intervention programmes.

When planning a project, information about the size and typology of MSM at the planned intervention sites should be obtained. Knowing the typology of MSM at the targeted intervention sites helps in the planning for service packages and delivery that meet their need. All projects should aim to reach 90% of MSM in targeted hotspots. Indicators of project success are the number of MSM services and the number demonstrating behaviour change. Organisations should work with the State Agency for the Control of AIDS to identify strategies for delivery of services to a high proportion of MSM in the State.

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

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

The details generated from the micro-planning process help in planning the project activities, one of which is the conduct of outreach and peer education. The aim is to reach a 100% saturation of service delivery for MSM within specific locations. There are community friendly tools with which peer educators can generate and analyse the information about MSM 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.

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 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 Accessibility, and Availability Mapping
- Improving the Program: 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 MSM at the hotspot and to design interventions that address these needs. Having MSM design, implement, and monitor the outreach activities increases the appropriateness and acceptability of the project by MSM. The micro-planning process builds the competency of MSM peer leaders to manage their community, nurture community participation and ownership, and help organize individuals into groups for positive community action. Specific plans for the outreach and peer education activities should be informed by the following factors:

4.1.2.1. Geographical location: Outreach should be implemented in hotspots where sex work takes place. Understanding the typology of the MSM in these hotspots will inform the design of outreach and peer education activities.

4.1.2.2. Typology of MSM: Each typology has unique characteristics and outreach needs. Typologies for MSM 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) MSM who sell sex are more vulnerable and should be given priority attention in comparison to medium-volume (5 to 9 clients per week) and low-volume (4 or fewer clients per week) MSM.

4.1.2.4. Types of sex: MSM who engage in unprotected anal sex should be prioritized, 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 MSM have different concerns and needs from that of older MSM. Younger MSM are more interested in economic empowerment opportunities.

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 the access of MSM living with disability to HIV education, information and 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 MSM vulnerability to HIV and sexually transmitted infections. MSM with these histories should be prioritized for interventions.

4.1.3. Outreaches and peer education: Outreaches and peer education activities are to be led by MSM. When planning outreaches, consideration should be given to the time when MSM will be available – the typology of the MSM at the hotspot will inform the time they are free and more likely to be receptive to sensitization, education

and mobile clinic activities. Consideration should be given to how to enable those who have significant control over MSM - MSM community leaders – have access to outreach information. The relationship of MSM with third parties, such as family members, also should be considered in the design and implementation of outreach programs. These third parties may be able to promote condom use, uptake of referral services, and protection against harassment and violence (sexual, physical, and verbal/emotional).

4.2 Programme Management and Coordination

4.2.1. Role of the National Agency for the Control of AIDS: The National Agency for the Control of AIDS shall provide the oversight function for the national HIV prevention program for MSM. It coordinates all projects and activities related to HIV prevention in the country. In collaboration with the National HIV Prevention Technical Working Group, the national and zonal offices of the National Agency for the Control of AIDS shall coordinate and monitor the State MSM HIV prevention programmes. It shall also provide guidance on programme modification and implementation strategies

4.2.2. Role of the State Agencies for the Control of AIDS: The State Agency for the Control of AIDS, in collaboration with the State Prevention Technical Working Group, is responsible for designing, coordinating, and monitoring the State MSM HIV prevention programme. Implementing partners are expected to develop projects that address components of the State MSM HIV prevention programme to ensure adequate coverage and equitable distribution of interventions and avoid duplication of effort. Monitoring effort should include ensuring that projects adhere to the national guidelines and that all MSM HIV prevention programs provide the minimum standards for quality interventions.

4.2.3. Role of Federal/State Ministry of Health: The National/State Agency for the Control of AIDS shall work in collaboration with the Federal/State Ministry of Health through the National/State AIDS Control Program, to implement the biomedical element of the national HIV prevention program for MSM. The logistic management for drug supplies and personnel training and capacity building for antiretroviral, sexually transmitted infection and pre-exposure prophylaxis management.

4.2.4. Role of Implementing Agencies: Agencies (non-governmental organisations/community-based organisations) that implement HIV prevention programs for MSM should submit to the State Agency for the Control of AIDS a project proposal with details on implementation of the project. The agencies should ensure that all targeted MSM 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 establishing monitoring and evaluation systems, as guided by the State Agency for the Control of AIDS.

*4.2.5. Implementation Team***:** Project implementation teams should include members with a variety of 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 MSM population. The project should have a programme coordinator 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 the project's biomedical interventions, while the counsellor(s) support behavioural change. The intervention team should also include program officers and peer educators who provide behavioural and structural interventions to a cohort of MSM.

4.2.5.1. Recruitment of staff: Candidates who are key-population friendly, whose attitudes, knowledge, and experiences will enable them to work successfully with MSM, should be prioritised for employment. The candidates should be sensitive to gender, sex, and sexuality, and should be 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 MSM are also essential. Staff members should include MSM.

*4.2.5.2 Establishing roles and responsibilities***:** The roles and responsibilities of each of the members of the implementation team should be clearly defined, but this does not imply that staff cannot play the role of each

other. Team leads should clearly communicate changing roles and responsibilities to team members. Team members should be aware of their roles and responsibilities and the lines of communication for the project.

4.3. Capacity Building

The capacity of the project staff should be built in a way that enables them to change-self, and facilitate and support risk reduction behaviour(s) of MSM. Peer educators need to have their values clarified and to understand the principles guiding the project. The implementation team are expected to ensure all MSM recruited for the organisation's project, have the knowledge and skills that will enable MSM to 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 MSM. 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 for reference at the end of the training. The training should be facilitated by trained trainers who can adapt the curriculum to local realities.

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 MSM 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 STRATEGIES

5.1 Behavioural Interventions

Behavioural interventions are offered to MSM by trained peer educators. The goal is to reduce the risk of contracting HIV and sexually transmitted infections by MSM. 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 MSM. Table 2 provides a summary of the behaviour intervention package for MSM.

Table 2. Behavioural Interventions Strategies

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 and harm reduction **Counselling, skills building and referral:** Interpersonal/gender-based violence prevention Mental health screening, psychosocial support	**Entry level:** Identify key stakeholders in the community such as key opinion leaders, local pimps, law enforcement agents and others Conduct community stakeholder dialogue Conduct key influencers/ gate keepers pre-intervention dialogue Validation of identified hotspots/intervention sites (physical and virtual) Selection of peer educators within respective MSM communities. **Intensive Level:** Train employed peer educators Peer educators to conduct monthly outreach to MSM 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 MSM reached with behavioral education Percentage of MSM reached with the Minimum Prevention Package of Intervention		
Condom and Lubricant programming using total market approach Demonstration, promotion of use, and distribution of male and female condoms and water-based lubricants	**Entry level:** Identify condom and water-based lubricant procurement mechanism Estimate condom requirement for MSM **Intensive level:** Distribute and track condoms and water-based lubricant to MSM 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 MSM who report consistent use of condoms with sex partner(s)		

5.2 Qualities of a MSM peer educator

Peer educators are critical to successful implementation of the behaviour intervention package. Peer educators should share many of the characteristics and life experiences as the population with whom they work. They

should be knowledgeable about the challenges and stigma experienced by MSM, as this knowledge fosters the peer educator's credibility and promotes trust. Peer educators are a link between communities and instituted services, thereby facilitating MSM community participation in interventions. It is therefore required that organisations/institutions that conduct HIV prevention interventions for MSM invest in building the capacity of peer educators to achieve the goal of the National HIV prevention program for MSM. It is also important that recruitment of the peer educators be standardized. The following are required qualities of MSM who will work as peer educators:

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

5.3 Peer Educators' Recruitment Process

The peer education recruitment should be conducted in a transparent manner and should provide equal opportunity for recruitment of interested MSM. The recruitment of MSM peer educators should happen after the entry level activities and before the 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. Sex workers who were met during mapping or initial outreach by the programme team and who meet the above-mentioned criteria should be encouraged to apply. The role of peer educators, the commitment involved, the reporting requirements, and the stipend to be paid should be discuss with all candidates.

5.4. 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 condoms distributed, and number of referrals and linkage to services made). The review should be conducted by use of the Opportunity Gap Analysis tool, which enables peer educators to self-reflect and self-review. The organisations/institutions are encouraged to hold quarterly reflection meetings with the peers to get direct feedback on the project and peer educators' performance.

5.5. Outreach and Peer Education Activities

The role of peer educators during outreaches is the building of rapport and trust with the MSM community; providing of information about how to prevent HIV transmission and about available services; distribution of condoms and lubricants; counselling of clients on HIV prevention; and referring for behavioural and biomedical interventions. The role of peer educators also includes supporting peers to access needed legal aid and other clinical and non-clinical interventions during crisis, helping peers learn about their rights and entitlements, and mobilising the MSM community for collective action. These interventions significantly increase the 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, which is 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 nature 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, and condom use should be demonstrated and condoms distributed; referrals should also be made to relevant service delivery points and safe spaces where education and training sessions are held. During peer education and outreach activities, MSM are:

- Provided facts on HIV, sexually transmitted infection and reproductive health
- Given male and female condoms and water-based lubricants and shown how to use them
- Assessed for risk and referred for prevention and care services
- Counselled for risk reduction
- Provided support in crisis
- Screened for gender-based violence and are referred for management
- Educated about their rights

5.6. Risk Reduction Counselling and Skills Building

Risk reduction counselling and skills building for risk reduction should focus on reducing the risk of acquiring HIV through oral, anal, and vaginal sex; through correct and regular use of condom and lubricants with clients and other sex partners; appropriate douching procedures; and management of dry sex and substance use. Risk-reduction counselling and skills-building sessions should also include efforts to identify MSM at risk or facing interpersonal/gender-based violence and counselled on how to prevention its occurrence. Counsellors should also screen for those who need legal aid, mental health care, psychosocial support, and cancer screening services. These individuals should be referred for services. Counselling services should be provided in safe and private space, possibly in the clinics and drop-in centres. Counsellors should provide options to MSM and encourage them to identify solutions to their problems. Risk-reduction counselling should follow these steps:

1. Conduct an initial and ongoing individual HIV, sexually transmitted infection, interpersonal/gender-based violence, mental health and cancer risk assessment.
2. Develop a personalized risk-reduction plan in collaboration with the MSM.
3. Refer for biomedical interventions (pre- and post-exposure prophylaxis, treatment of HIV and sexually transmitted infection, mental health and psychosocial support, cancer screening and management).
4. Monitor the progress of risk reduction routinely and modify/adjust the plan as needed.
5. Provide non-biomedical risk-reduction commodities (male/female condoms and lubricant).
6. Implement the personalized risk-reduction plan.
7. Routinely reinforce risk-reduction skills.
8. Identify other needs of MSM and refer them to projects that can address the needs.

5.7. 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 also 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 available and accessible for free. Demonstration of correct use of condoms and encouragement of their consistent use is important. Build the skills of MSM to negotiate condom use with sex partners and clients. Condoms, water-based lubricants, and other HIV prevention commodities are freely accessible by MSM through peer educators, outlets at hotspots, and clinics. Enough condom and water-based lubricants should be made available to each MSM based on the estimated number of clients. 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 STRATEGIES

6.1 Biomedical Interventions

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

Table 3. Biomedical Interventions Strategies

Programme Component	Checklist of Activities for Implementation	Tools
BIOMEDICAL INTERVENTIONS		
Sexually transmitted infection 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 MSM 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 MSM 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 MSM Refer and/or treat MSM for sexually transmitted infection using the syndromic management Support partner notification and treatment Institute follow-up systems for MSM managed for sexually transmitted infection in line with the national guidelines Strengthen linkages between community-level activities and health care facilities for sustainability **Exit level:**	**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 MSM groups that would look at progress review, feedback processes, and recommendations for sustainability	Format/tools for referral linkages Format for referrals
Expected Results and Indicators Percentage of MSM referred for sexually transmitted infection services Percentage of MSM 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 MSM for regular HIV testing services Refer MSM with high sexual risk behaviour for pre-exposure prophylaxis Refer MSM with accidental exposure to HIV for 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 MSM referred for HIV testing services Percentage of MSM counselled, tested for HIV and received result		

Sexual and reproductive health services HIV treatment, care, and support Reproductive health services and contraception **Allied services** Cancer screening Tuberculosis screening and management Viral hepatitis, diabetes, hypertension screening and management Mental health screening and psychosocial support Harm reduction services	**Entry level:** Follow/adapt the national standard operating procedure for treatment and care of MSM **Intensive level:** Refer HIV-positive MSM for care Refer HIV-positive MSM for tuberculosis screening and management Provide/refer for adherence counselling Follow-up of HIV-positive MSM by HIV-positive peers or acceptable outreach staff Refer MSM for prostate cancer, anal cancer, human papilloma virus, and HIV simplex virus screening Refer MSM for other health services screening such as viral hepatitis, diabetes, hypertension Refer MSM for mental health and psychosocial support when needed	Adapt tools from National Sexual Reproductive Health
Expected Results and Indicators Percentage of MSM newly initiated on antiretroviral therapy Number of MSM eligible for pre-exposure prophylaxis who receive it Percentage of MSM receiving pre-exposure prophylaxis who seroconvert Number of MSM eligible for post-exposure prophylaxis who receive it		

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

6.1.1. Sexually transmitted infections screening and treatment: The goal of sexually transmitted infections screening and treatment services for MSM is to identify, treat, and prevent sexually transmitted infections and their transmission. Plans for management of sexually transmitted infections should be done in collaboration with MSM at the clusters. They should be able to identify their preferred list of service delivery sites and barriers to service access and ways to overcome the barriers. They should also identify the best mode of service delivery for

MSM. Service delivery should be MSM friendly and accessible at appropriate times for them, and have infrastructure to provide confidential and comprehensive prevention, treatment and partner-notification services. Clinics providing sexually transmitted infection management services for MSM should include the following in line with the WHO/National sexually transmitted infection guidelines:

- Health promotion and sexually transmitted infection screening and prevention activities, such as promoting correct and consistent use of male and female condoms, 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 treatment of partners;
- Quarterly check-ups, syphilis screening, and treatment of asymptomatic infections;
- Partner management programmes;
- Follow-up services for MSM 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 MSM.

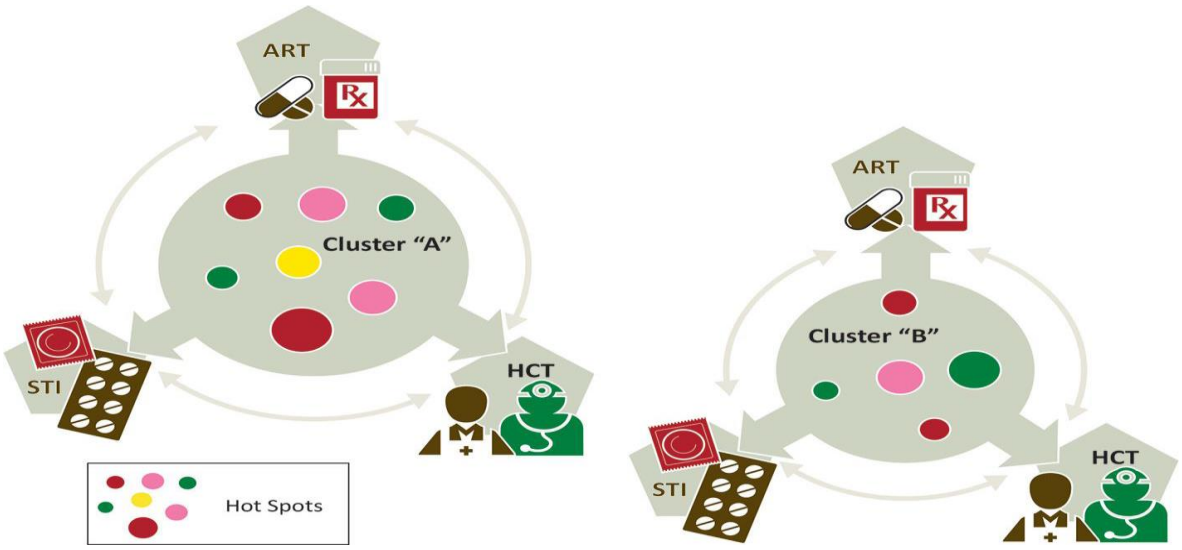
6.*1.2. Provision of HIV Testing Services***:** Clinical staff who provide HIV testing services should be trained on informed consent, privacy and confidentiality and on management of adverse outcomes of result disclosure. Provider-initiated HIV testing and counselling services should be provided to all MSM who attend clinics for other services. HIV testing should be provided in line with the national HIV testing and counselling guidelines. HIV-positive MSM should be referred for antiretroviral therapy. Clients who do not use condoms consistently and have repeated sexually transmitted infection should be referred also for pre-exposure prophylaxis. All MSM are eligible for long-term HIV prevention and treatment.

*6.1.3. Provision of Reproductive and Allied Health Services***:** Facilities should provide access to all forms of contraceptive methods and reproductive care, including screening for prostate and anal cancer and viral hepatitis infection, condoms access, counselling and referral for other sexual and reproductive health services when needed. Services to be provided directly or through referrals should include medical and psychosocial services to rape survivors, those who face intimate-partner and gender-based violence, and those dealing with mental health challenges. In addition, linkages should be developed with organisations that provide mental health and psychosocial support services. MSM should also be supported to access other allied services like tuberculosis screening and management, and viral hepatitis, diabetes, hypertension screening and management.

6.2. Cluster Approach to Service Delivery

Where there is a need to refer MSM 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 MSM 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 men who have sex with men



The "cluster approach" involves the following key steps:

- List and characterize all MSM hotspots identified at the implementation site
- Within each local government area, organise the MSM 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 MSM cluster. The list should be developed in consultation with MSM community groups; this creates a list of service delivery referral points for the project.
- Identify key gaps in service availability within each cluster and address those gaps by recruiting/establishing new service delivery points.
- Train the service providers at identified referral clinics to be MSM friendly and establish efficient referral system for MSM 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 MSM and to mitigate the violence and harassment of MSM.

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

Table 4. Structural Interventions Strategies

Programme Component	Checklist of Activities for Implementation	Tools
STRUCTURAL INTERVENTIONS		
Community mobilisation and dialogue Advocacy Access to justice Individual empowerment/incoming generating activities	**Entry level:** Analyse social, cultural, economic, and geographical context with MSM at target site Identify target sub-populations like adolescents and young MSM, and MSM living with disability Conduct stakeholder mapping and analysis Identify factors that promote stigma and discrimination, violence and exploitation of MSM in the locality and by whom Prioritize key issues to be addressed and develop mitigation plan **Intensive level:** Engagement with MSM community through awareness creation and dialogue Strengthen MSM self-worth through life skills training, mental health and psychosocial support Engagement with community stakeholders for formal and informal policy change, and institutional capacity development to support access of MSM to legal aid and justice.	**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

	Improve access of MSM to financial mitigation activities through partnerships with relevant public and private sector organisations and entities Adapt programmes to address the peculiar needs of adolescents and young FSWs, and FSWs living with disability **Exit level:** Development of sustainability plans Support possible formation of cooperatives of MSM	**Exit level:** National peer education guide
Expected Results and Indicators Percentage of MSM that report physical and/or sexual violence Percentage of MSM that report stigma-related barriers to access health and/or social services Percentage of MSM 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. Such organization/institution should form partnerships with organisations that can provide the services and work with them to develop a comprehensive plan for the targeted area of work with MSM. This approach includes the need to recognize and plan for sub-population of MSM community members, such as those who solicit for sex partners online and for adolescent MSM. Structural interventions should include screening for violence, a common but poorly reported incidence faced by MSM. Interventions should be provided to affected MSM 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 MSM peers as paralegals to support those who experience gender-based violence.
- Provide legal, psychosocial and medical support for victims of violence.
- Mobilise and sensitise MSM 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 MSM in discussing, planning, implementing, and monitoring projects that affect them. Community mobilisation will increase the sense of ownership and build solidarity and support in the community of MSM. The mobilisation and dialogue-leading process should be delegated to a MSM who is willing to take on the leadership role. The competency of the MSM in this leadership role should be built. The leadership role includes documenting, reporting, and acting as liaisons between the sex worker community and the legal system.

Liaisons should be trained on human-rights protection and on documentation, reporting/redress mechanisms. Crisis response teams should also be constituted with the liaisons and other volunteers, and their capacity to respond promptly to crises faced by MSM should be built. 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 regularly communicate with stakeholders. MSM should be encouraged to form cooperatives as a community economic empowerment strategy. MSM should be encouraged to form community committees to discuss ways to improve the project and other issues.

7.3. Advocacy

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

7.4. Individual Empowerment/Income-Generating Activities

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

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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	Referrals 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
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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