Programme Management and Organizational Capacity-building
Programme Management and Organizational Capacity-building

Starting, managing, monitoring and scaling up a programme—from both a centralized and community perspective

Community Empowerment

1. Community Empowerment

2. Addressing Violence against Sex Workers

Community mobilization and structural interventions

3. Community-led Services

4. Condom and Lubricant Programming

Fundamental prevention, care and treatment interventions

5. Clinical and Support Services

6. Programme Management and Organizational Capacity-building
What’s in this chapter?

This chapter has two distinct parts:

**Part I: Management systems for a programme serving multiple sex work locations within a country and multiple sex work sites within urban locations.** This part addresses:

- **how management systems support** effective HIV and STI prevention programmes with sex workers (Section 6.1)
- **how to design, organize and implement a programme at scale**, including:
  - establishing programme standards, data monitoring systems and an evaluation plan (Sections 6.2.1–6.2.3)
  - setting up management structures (Section 6.2.4)
  - implementing the programme in stages (Sections 6.2.5–6.2.7)
  - ensuring sex worker participation in programme implementation (Section 6.2.8)
  - developing staff capacity (Sections 6.3–6.4).

**Part II: Elements of organizational capacity-building for local sex worker organizations to expand services or areas served.** This part addresses:

- **how to build the capacity of sex worker organizations** (Sections 6.5–6.7)

The chapter also provides a list of **resources and further reading** (Section 6.8).
Part I: Programme Management

6.1 Introduction

This chapter explains how to establish a management system for an HIV and STI prevention and care programme serving multiple sex work locations within a country and multiple sex work sites within urban locations, with the goal of covering a high proportion of sex workers with at least minimal services. Such a programme requires centralized management and, depending on the size of the country, additional layers of management to support local implementing organizations.\(^1\)

Comprehensive HIV/STI prevention and care interventions with sex worker communities\(^2\) are complex and have many aspects that must be addressed simultaneously. For example, they require regular outreach to sex workers and their clients, usually in settings with significant social, cultural, religious and legal barriers. Sex workers’ needs may vary depending on their gender (female, male or transgender), as well as the settings in which they work (indoors,\(^3\) outdoors or arranged via the Internet or by mobile phone).

Many implementing organizations have little experience working with sex workers, while sex worker organizations may have limited organizational capacity to implement and scale up programmes themselves. Linking with existing clinical services often requires building the capacity of providers to deliver services to sex workers in a non-stigmatizing way. Establishing services outside the government or private sectors requires effort to build management infrastructure and processes. Finally, funding often comes from multiple sources, with different reporting requirements for government and other funders.

Management systems address all of these issues by:

- defining roles and responsibilities, providing oversight, managing relationships with external partners, doing advocacy and coordinating with other programmes
- planning and administering the activities of multiple interventions at various levels in the overall programme
- supporting the operational activities that support the work, including data reporting systems, commodity procurement, quality monitoring and improvement, support and supervision, training, etc.
- implementing financial procedures and controls.

This chapter is not a comprehensive strategic planning or management guide. Resources for essential aspects of strategic planning and programme management that are not unique to sex worker programmes are listed in Section 6.8. The chapter focuses on management approaches and systems that address the unique needs of sex worker programmes and have been used in successful programmes with a high degree of coverage. These unique aspects include:

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\(^1\) An implementing organization is an organization delivering a prevention intervention to sex workers. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes a nongovernmental organization provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

\(^2\) In most contexts in this tool, “community” or “communities” refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “outreach to the community” means outreach to sex workers, “community-led interventions” are interventions led by sex workers, and “community members” are sex workers.

\(^3\) “Indoor” sex workers work in a variety of locations including but not limited to their homes, brothels, guesthouses, bars, clubs and other sex work venues.
Coverage: High coverage of sex worker populations is essential to achieve impact at a population level, and coverage should be monitored at all levels—municipal, district, state/province and central. Planning for and calculating coverage requires an estimate of the total sex worker population (the denominator). For a country-wide view, the national AIDS control programme or a central management agency obtains or coordinates this coverage information, in partnership with all implementing organizations (see Section 6.2.6, Box 6.4). Programmes that achieve high coverage of sex workers and wide geographic scope (“scaled programmes”) require close partnerships between government, donors and implementing organizations.

Mobility and migration: Sex workers are often highly mobile, moving within a city, country or across state or national borders to follow fluctuating demand (e.g. due to festivals or temporary infrastructure or agricultural work). Interventions should be flexible to meet the varying demand for outreach and commodities, and to serve sex workers who may not speak the local language.

Sex worker leadership: Sex workers are best able to locate and communicate with their peers and to identify problems and issues in the community. An overarching goal of the programme should be to build the capacity of sex workers to take on this role. The programme design should also incorporate meaningful positions for sex workers in management and monitoring of the programme to make it more effective and sustainable (see Section 6.2.8 and Chapter 1, Section 1.2.6 and Chapter 3, Section 3.2).

Addressing structural constraints: To be as effective as possible, HIV interventions should not only focus on individual behaviour change but also address the broader factors that contribute to sex workers’ vulnerability, such as criminalization and other legal issues, stigma, discrimination, poverty, housing instability, violence, harassment and limited access to health, social and financial services. Interventions at various levels to address some of these structural constraints are highlighted in Chapters 1, 2 and 5.

Strict confidentiality and protection of data: Designing and managing a programme with sex workers requires information on the location of sex work sites, the size of the community and, ideally, a unique identifier that may be used across the programme to assess coverage and avoid double counting, particularly where there are multiple implementing organizations. Data that identify locations or individuals must be handled with strict confidentiality and protected from access by individuals, groups or organizations that might cause harm to the sex workers.

Flexibility and continuous programme learning: The sex work environment changes rapidly because of economic fluctuations, legal/social issues and new technologies, such as mobile phones and the Internet. Given this evolving context and the relative inexperience of most organizations in programming for sex workers, it is important to develop systems to quickly adjust the programme when necessary, and to disseminate lessons and innovations across it.
6.2 Planning and implementing an HIV/STI programme with sex workers

Creating a scaled programme requires collaboration among partners at different levels:

- the central level (for example, the national AIDS control programme or a central institution, if the programme is countrywide; a regional or state government/organization, if the programme is a sub-national one)
- an intermediate level (this could be an NGO or other partner at the level of a state, district or municipality)
- the local level (implementing organizations).

The elements of a scaled programme are outlined in Table 6.1 and described in detail below. In each case, the highest-level agency or institution takes the lead in planning each element, in collaboration with the agencies or organizations at the other levels. Although this chapter is written primarily from the viewpoint of central-level planning, there are multiple roles and responsibilities for each level of the programme in management, supervision and monitoring, as shown in Figure 6.3 (Section 6.2.4) and Figure 6.6 (Section 6.2.7). Many of the elements described for a scaled programme are relevant for a programme of any size.

Table 6.1 Elements of a scaled HIV/STI programme with sex workers

| Designing a scaled programme for sex workers | • Define programme and standards (Section 6.2.1)  
• Establish a data monitoring system for management (Section 6.2.2)  
• Plan the programme evaluation (Section 6.2.3) |
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<tr>
<td>Organizing a scaled programme for sex workers</td>
<td>• Define the management structure (Section 6.2.4)</td>
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</table>
| Implementing a scaled programme for sex workers | • Prioritize (Section 6.2.5)  
• Implement in a staged manner (Section 6.2.6)  
• Establish a supervision system (Section 6.2.7)  
• Progressively ensure full sex worker participation (Section 6.2.8) |

Designing a scaled programme for sex workers

6.2.1 Define programme and standards

It is very important to clearly articulate and understand the programme logic model, the specific interventions of the programme and the expected standards of implementation. Being able to articulate and understand them will:

- give clarity across the programme on the intervention elements and programme packages
- establish a basis for the design of the monitoring system (e.g. defining the process, input, output, outcome and impact indicators)
- make it possible to assess programme quality.

A logic model illustrates the programme’s interventions as well as how these are expected to lead to the desired impact. It identifies the technical skills and human resources required, as well as
Programme Management and Organizational Capacity-building

commodities and supplies, training and, depending on the size of the intervention, the budget. These elements are periodically adjusted based on new data and improved as lessons and local innovations are shown to be successful.

Many countries have strategic plans and implementation guides in which a logic model is implicit. However, defining a more explicit logic model helps clarify monitoring and evaluation. (Examples of country guidelines, strategic plans and standard operating procedures are listed in Section 6.8.)

Figure 6.1 is a programme logic model for a multi-component intervention with sex workers. The sequencing of expected changes is important to the programme evaluation design discussed in Section 6.2.3.

This logic model does not, however, articulate the standards expected during implementation. Technical and management standards for each aspect of the intervention are defined by the programme, ideally in collaboration with implementing organizations and consistent with the values and preferences of the community. For example:

- **Technical**
  - What is the target ratio of community outreach workers to community members?
  - How often is a community outreach worker expected to meet sex workers?
  - What is the content of the outreach session?
  - How often is voluntary HIV testing offered?
  - What drugs will be used to treat STIs?
  - How many condoms and lubricant packages should be distributed?

- **Management**
  - Supervision frequency by programme level and technical area, including frequency of meetings between community outreach workers and their supervisor/manager
  - Definitions of reporting indicators
  - Frequency of reporting monitoring data

The other chapters in this tool provide some recommendations for standards specific to sex work interventions (see for example Chapter 3, Section 3.4). Clinical service standards are defined by each country as part of its national guidelines or, if not available, by WHO regional or global guidelines. STI management guidelines often need to be developed or modified for sex worker populations, given the higher prevalence of STIs among sex workers in most countries, and to address diagnosis and management issues of rectal STIs, which are often not covered in national guidelines. Standards for outreach, organizational development and structural interventions are generally not readily available and should be developed or adapted to the specific setting.

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4 In this tool, “community outreach worker” is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff may be called “staff outreach workers” or also simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer educators”, “peer outreach workers” or simply “outreach workers”. The terms “community” or “peer” should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers.
Figure 6.1 Programme logic model for a multi-component programme with sex workers

Target services: Based on mapping and size estimation in each district, focusing on highest density, highest risk first. Implement multi-component intervention package for sex workers.

- **Free prevention commodities** (male latex condoms, female condoms, lubricant): Adequate supply to meet estimated need established through multiple channels.
  - **GOAL:** Adequate condoms such that no penetrative sex act goes unprotected.

- **Clinical services:** accessible, acceptable referrals or services established for:
  - Reproductive health, STIs, hormone replacement therapy
  - Voluntary HIV testing and counselling
  - HIV care and treatment
  - Tuberculosis, opioid substitution therapy, other

- **Community outreach workers** recruited, trained, helped to develop and use micro-planning tools (carry out mapping, size estimation, monitoring and planning).
  - Community committees established.

- **Organizational development activities** initiated (e.g. drop-in centres established, leadership and organizational development of community groups).

- **Structural interventions** supported:
  - Violence response teams, police sensitization, legal support, journalist and legal training, access to social entitlements.

- **Parallel promotion** of condoms to male clients through social marketing and increased outlets in hotspots.

- **Population estimates of sex workers done**
  - Maps of sex workers and hotspots completed
  - Increase in sex worker contacts and coverage

- **Ability to reach sex workers increases**
  - Ability to implement programme increases

- **Increased and sustained demand for services**
  - Increased ability to organize and self-advocate

- **Monitoring of service coverage and quality, routine programme data generation and analysis, corrective action taken ➜ increased coverage and service quality**

- **Social norms support safe sex behaviour**
  - Improved treatment-seeking behaviour
  - Increased STI clinic use, HIV testing, ART coverage

- **Decrease in HIV incidence in general population**
  - Decrease in HIV incidence in sex workers
  - Decrease in mortality of sex workers
  - Increase in agency5 of sex workers

- **Decrease in prevalence of curable STIs**
  - Increase in ART coverage

Source: Avahan India AIDS Initiative

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5 Agency in this context (and in other parts of this chapter where the word clearly does not mean “organization”) refers to the choice, control and power that a sex worker has to act for her/himself.
In Côte d’Ivoire, community-based and clinic-based HIV prevention activities for female sex workers began in 1991, with the establishment of a dedicated clinic in the capital city. Based on the success of this programme, multiple international and national partners supported national scale-up of the model from 1996. In order to standardize and ensure high-quality services for sex workers, the National Programme for HIV Prevention among Highly Vulnerable Populations and its partners developed a “Minimum Package of Prevention and Care Activities for Sex Workers” in 2007. Quality standards for each of these activities were developed during a two-year process involving all partners. A technical working group drafted a set of standards, which fell into three categories:

1. Input (health infrastructure, staff, etc.)
2. Process (clinical guidelines, procedures, algorithms)
3. Output (patient satisfaction, coverage of target population).

A consistent format was used for each standard: a statement of the standard; criteria describing the elements required to meet the standard; and indicators for measuring the criteria. A validation workshop with 50 participants was held, resulting in a finalized and endorsed national guide with quality standards in 2009. They were then implemented across the country with on-site training of implementing agencies, ongoing coaching, deployment of tools for measuring standards and quality audits.

6.2.2 Establish a data monitoring system for management

A routine data collection system is needed that aggregates and consolidates information so that dashboard\(^6\) indicators may be monitored, and to enable “drilling down”, i.e. the ability to look at detailed reports from lower levels. Central (national) management should be able to see data from the level of states/provinces and districts, while state/province managers and implementing organizations should be able to drill down to reports from frontline workers. This allows managers to identify areas or implementing sites whose performance is significantly different from others’ (for example, low condom and lubricant distribution, or low coverage of the estimated sex worker population) and that may need additional management attention for improvement.

A well-designed monitoring system:

- allows reported indicators to be developed from data that are routinely collected and that are useful for programme and management decisions at the level where they are collected. Data that are not useful and used at the level of collection will not be prioritized and will often not be of high quality. Note that at each level of implementation and management, additional data may be collected that are not reported upwards but are used instead to improve services.
- captures the sex worker’s interactions with community outreach workers or clinical services (e.g. formal contact with a community outreach worker, attended a clinic, was referred for a service, etc.) with minimal error (limited transfer and cross-posting of data)
- has clear indicator definitions and ongoing control of data quality
- aggregates data upwards but retains drill-down capability.

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\(^6\) Dashboard indicators are the most important programme monitoring indicators, aggregated to a national level. They provide an overview of how well the programme is functioning (rather like the gauges on the dashboard of a car inform the driver how well the engine is running).
Case example: Using routine monitoring data and qualitative interviews to improve services in India

Distribution of free condoms to sex workers through routine outreach was an essential component of the Avahan AIDS Initiative in India. An examination of routine monitoring data from condom distribution in early 2005, about one year after the programme had started, revealed that across about 120 NGOs, as many as 50% of the approximately 700,000 free condoms being distributed monthly were being given out by outreach workers who were not sex workers.

This raised questions about whether those most in need were receiving condoms and why community outreach workers, who were in more frequent contact with community members, were not charged with the primary responsibility for distributing the condoms. Discussions with the implementing NGOs, non-sex worker outreach workers, and community outreach workers revealed that some NGO staff lacked confidence that the community outreach workers knew how to adjust supplies to the individual needs of sex workers, when to reorder, and that they would actually distribute the condoms.

In response, the implementing NGOs at the state and local levels launched skills-building sessions to increase community outreach workers’ capacity to carry out these tasks. They also developed tools to record and monitor condom outreach, and trained non-sex worker outreach workers to coach and mentor community outreach workers rather than manage them closely. After these changes, sex worker participation in service delivery, including condom distribution, increased markedly: one year later, 2.5 million free condoms were being distributed each month.

For sex worker programmes, there are eight main data sources necessary to design, monitor and manage the programme (labelled A–H in Table 6.2). These are discussed on the following three pages. Table 6.3, which follows this section, is an example of a programme indicator table that may be used at higher levels in management to monitor progress towards the goal of scale-up.

Table 6.2 Main data sources for design, monitoring and management of HIV/STI programmes with sex workers

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<thead>
<tr>
<th></th>
<th>Main data sources for design, monitoring and management of HIV/STI programmes with sex workers</th>
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<tbody>
<tr>
<td>A</td>
<td>Special data-collection exercises</td>
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<tr>
<td>B</td>
<td>Programme data not routinely collected during direct contact between sex workers and programme services</td>
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<tr>
<td>C</td>
<td>Programme data from routine direct contact between sex workers and programme services</td>
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<tr>
<td>D</td>
<td>Administrative data related to services including drugs, consumables and referrals</td>
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<tr>
<td>E</td>
<td>Qualitative assessments</td>
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<tr>
<td>F</td>
<td>Quality monitoring</td>
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<td>G</td>
<td>Expenditure data</td>
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<td>H</td>
<td>Other outside data</td>
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Data sources for programme design, monitoring and management

A. Special data-collection exercises

Mapping of sex workers and population size estimates are examples of special data-collection exercises. They are necessary to start a programme, for budget and programme planning and for deciding how many services to place, and where (see Section 6.2.6, part A). Size estimates are also essential to estimating levels of coverage, using data on sex workers’ contact with fixed-site or outreach services. Site-based size estimates, rather than country- or province-based estimates, are crucial to developing a programme, as they help implementing organizations develop site-based intervention plans. Mathematical size estimate exercises may be used to validate these programme estimates. The size estimates are updated periodically, and remapping may be done if social, political or economic forces lead to significant changes in the sex worker population.

Note: Maps and other data containing information about sex workers (e.g. location, type of sex work practised) should be considered confidential and stored securely at a central location, such as a safe space (drop-in centre). Programme planners and implementing organizations should guard against the possibility of maps being obtained by law enforcement authorities or other groups who might use them to locate and close sites or otherwise cause harm to sex workers. If these confidential materials are disclosed, it is likely that the programme will lose the trust of the community.

Spot polling-booth surveys are another special data-collection exercise, used to assess reported condom use with clients and regular partners, needle sharing, or access to HIV services for monitoring progress.

B. Programme data not routinely collected during direct contact between sex workers and programme services

Monitoring of infrastructure (e.g. number of safe spaces, number of clinics) and personnel (e.g. number of people hired, trained and retrained by position, quality of training). These data are important to monitor service provision over the predetermined geographic area, and human resources. Monitoring the planned and unplanned turnover of community outreach workers is necessary to plan trainings for new recruits as well as progressive capacity-building activities.

Data from enrolment of sex workers as they become affiliated with the programme: Upon enrolment in the programme, the sex worker is assigned a unique identification code (which must maintain the sex worker’s anonymity). Useful data to collect at enrolment include:

- Variables that describe the demographics of the sex worker: age, gender, type of sex work practised (street-based, indoor, etc.), length of time in sex work.
- Variables that capture “baseline” behaviour: reported condom use at last penetrative commercial sex; estimate of partner numbers per week; whether voluntarily tested for HIV in the last year, etc.

These data are useful to estimate sex workers’ expected condom/lubricant needs (based on the type of sex work and average number of partners for penetrative sex) and give some gauge of risk in the population for prioritization of services. The data may be triangulated with other data for programme evaluation.

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7 A safe space or drop-in centre is a place where sex workers may gather to relax, meet other community members, and hold social events, meetings or training. See Chapter 3, Section 3.3, for details.
C. Programme data from routine direct contact between sex workers and programme services

Data on contacts by sex workers with outreach workers, outreach services and clinical services are key to monitoring programme coverage. Ideally, this information should be collected at the point of contact and aggregated upward to the NGO, district, state and central levels, with minimal transcription to minimize errors. Depending on the community outreach workers’ level of education, pictorial tools may be used. In this case, the role of the community outreach worker’s supervisor/manager is to capture this information anonymously in a format that can be made electronic (e.g. number of new and repeat contacts, number of condoms distributed, number of referrals, etc.).

In addition to data associated with routine outreach activities, some data the programme may want to monitor are generated more irregularly, such as data on incidents of violence or access to entitlements. Because these events are not routine and usually require an additional form to be submitted, they are more difficult to track. It is recommended that sites submit reports routinely even if there are no events to report, in order to understand whether low numbers reflect reality or represent a failure to report the information.

Tracking mechanisms. Sex workers may be highly mobile, moving from one area to another within a country or even migrating across borders. This makes it difficult to monitor the total number of sex workers receiving services, because as they move into areas serviced by a different team or implementing organization they may be counted as a “new” sex worker to the programme. One way to address this is to ask sex workers who appear new to the programme whether they have received services before and from where; another is to provide some sort of anonymous, non-stigmatizing ID card that indicates that the sex worker has received services from the programme. A local NGO or service unit might record new contacts, new-to-area contacts and previous contacts as a way to distinguish this while capturing the degree of mobility.

Biometric markers, such as electronically recorded fingerprints, have sometimes been proposed as a way to identify programme participants. The expense associated with installing electronic data collection devices at all service points and establishing and maintaining a centralized database makes this unfeasible for most programmes. However, even where the cost is not an issue, the use of biometric data is considered an infringement of sex workers’ rights, because of the potential for the abuse of the identifying data by law enforcement authorities or other groups. Therefore the use of biometric data is not recommended in programmes with sex workers.

D. Administrative data related to services, including drugs, consumables and referrals

Drugs and consumable supplies are managed with appropriate stock management policies and procedures. The importance of these administrative data is to: ensure consistent, uninterrupted supply of drugs, consumables and commodities; monitor consumption/distribution as a marker of coverage (e.g. condoms distributed compared to the estimated gap); and corroborate clinic reporting (e.g. STI drugs and syndromes reported).

Referral outcomes (i.e. whether a sex worker referred to a service attended the service, not the clinical outcome) should be assessed through an established communication channel with the referral service. (Clinical outcomes, such as the result of an HIV test or undetectable viral load, are important outcomes to monitor, but collecting this type of data is not the responsibility of sex worker interventions.)
E. Qualitative assessments

Regular qualitative assessments with community members can determine whether communication is being understood and whether there are unaddressed needs that could be met by the programme. They may also be used to further investigate and understand answers on quantitative surveys.

Box 6.3

Case example: Using qualitative information and other sources of data to inform programming in Ghana

In Ghana, two recent qualitative studies have described a trend of younger men who have sex with men also engaging in commercial sex with older men in order to receive material support, including clothing, rent and food. In 2012, FHI 360/SHARPER (the Strengthening HIV and AIDS Response Partnership with Evidence-based Results project, funded by USAID Ghana) identified a hidden sub-population of male sex workers working at brothels or via a network on the Internet. Discussions with these sex workers revealed that only a small proportion had been reached through traditional community-led interventions for men who have sex with men. SHARPER developed relationships with three of the seven identified sex work networks and in early 2013 began implementing outreach prevention education and HIV testing and counseling events. Just under 50% of those reached now know their HIV status, and HIV-infected male sex workers have been referred to HIV care and treatment services.

F. Quality monitoring

The standard-setting process outlined in Section 6.2.1 is the foundation of quality monitoring, as services are assessed against specified standards (quality assurance). Assessments may be done externally through quality audits or using participatory approaches. Taking action to solve any identified deficiencies (quality improvement) is an important step to maximizing service quality.

G. Expenditure data

These data are important to monitor the project’s financial status and ensure that payments to implementing organizations are punctual, to keep the programme running. In addition, if coded in a standardized manner across all of the implementing organizations, the data may enable the programme to estimate the cost per beneficiary for each of the implementing organizations and to reveal any that may need additional management scrutiny.

H. Other outside data

Data from other sources outside the programme, such as government surveillance, academic research, or surveys done by other institutions, may be useful to inform progress or highlight necessary adjustments in the programme.
Table 6.3 Illustrative monitoring indicators for multi-component sex worker intervention

These are illustrative indicators; additional ones may be appropriate for each intervention area. Programme planners should consult the WHO *Technical guide for countries to programme, monitor and set targets for HIV prevention, treatment and care for sex workers and men who have sex with men and transgender people* (under development by WHO) and other guidance in countries. Priority considerations are: useful indicators for implementation that may also be aggregated upwards; and consistency in definitions across all implementing partners in the country in order to get an overall picture of progress.

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<thead>
<tr>
<th>Component</th>
<th>Indicator</th>
<th>Data sources</th>
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<tr>
<td><strong>Establishing and maintaining programme infrastructure</strong></td>
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<tr>
<td>Presence in geographic area</td>
<td>% of districts/counties with contracts signed to establish services</td>
<td>Programme data/reports Planning documents based on mapping and size estimates</td>
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<td></td>
<td>% of towns/locations with comprehensive services established</td>
<td>Programme data/reports Planning documents based on mapping and size estimates</td>
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<td>Services in geographic area</td>
<td>% of project offices established</td>
<td>Programme data/reports Planning documents based on mapping and size estimates</td>
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<td>% of safe spaces (drop-in centres)/community centres established/open</td>
<td>Programme data/reports Planning documents based on mapping and size estimates</td>
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<td>% of interventions with established links to reproductive health services</td>
<td>Programme data/reports Site assessment reports</td>
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<td></td>
<td>% of interventions with established links to voluntary HTC services</td>
<td>Programme data/reports Site assessment reports</td>
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<td></td>
<td>% of interventions with established links to HIV care and treatment services</td>
<td>Programme data/reports Site assessment reports</td>
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<td>Project staff hired and trained</td>
<td>% of district/county director/coordinators</td>
<td>Programme reports Planning documents</td>
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<td></td>
<td>% of outreach supervisors/managers (target is 1 per 5–7 community outreach workers)</td>
<td>Programme reports Population size estimates</td>
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<td></td>
<td>% of technical staff at district/county level (target is to have enough to visit all sites at least monthly for supportive supervision/data review—usually 1 covers 3–5 sites). Illustrative technical areas: monitoring for management, clinical services (reproductive health, voluntary HTC, antiretroviral therapy [ART] care), structural interventions/advocacy, outreach, management/financial.</td>
<td>Programme reports Planning documents</td>
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### Component: Programme Management and Organizational Capacity-building

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<tr>
<td>% of finance and administration staff</td>
<td>Programme reports, Planning documents</td>
</tr>
<tr>
<td>% of community outreach workers (target is ~1 per 50 sex workers at a site)</td>
<td>Programme reports, Population size estimates</td>
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#### Staff turnover

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<td>Number of community outreach workers who discontinued working in the last month</td>
<td>Programme reports</td>
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#### Staff training

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<td>Number of community outreach workers trained during the last month</td>
<td>Programme reports</td>
</tr>
<tr>
<td>Number of outreach supervisors/managers trained during the last month</td>
<td>Programme reports</td>
</tr>
<tr>
<td>Number of technical staff trained during the last month</td>
<td>Programme reports</td>
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### Behavioural interventions

**Intensity of engagement with sex workers**

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</thead>
<tbody>
<tr>
<td>% of individual sex workers reached monthly with prevention package (as defined by the programme; see Section 6.2.1)</td>
<td>Micro-planning tools, Periodic denominator estimates</td>
</tr>
</tbody>
</table>

(Calculated by dividing total number of individual sex workers contacted by community outreach workers in a month by the total number of sex workers targeted)

### Condoms and lubricants

**Adequacy of condom distribution and supply**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio of condoms distributed to estimated condoms required per month</td>
<td>Micro-planning tools, Condom stock registers, Enrolment questions on kind of sex work practised and average number of partners, Other condom gap assessments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of NGOs/GOs/CBOs reporting any condom stock-outs for free distribution in the last month</td>
<td>NGO/GO/CBO condom stock registers</td>
</tr>
<tr>
<td>Number of NGOs/GOs/CBOs reporting any lubricant stock-outs for free distribution in the last month</td>
<td>NGO/GO/CBO stock registers</td>
</tr>
</tbody>
</table>

**Behaviour change**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of sex workers reporting condom use during last commercial sex</td>
<td>Enrolment questions (quasi-baseline), Routine question in clinic encounter, Small programme polling-booth survey</td>
</tr>
<tr>
<td>% of sex workers reporting condom use during last sex with regular partner</td>
<td>Enrolment questions (quasi-baseline), Routine question in clinic encounter, Small programme polling-booth survey</td>
</tr>
</tbody>
</table>
### Component Indicator Data sources

#### Clinical services

<table>
<thead>
<tr>
<th>Component</th>
<th>Indicator</th>
<th>Data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health/STI service use</td>
<td>% individual sex workers referred for STI services monthly</td>
<td>Referral forms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Periodic denominator estimates</td>
</tr>
<tr>
<td></td>
<td>% individual sex workers accessing STI services monthly</td>
<td>Clinic forms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Periodic denominator estimates</td>
</tr>
<tr>
<td>STI syndromes</td>
<td>% individual sex workers with STI syndrome who visit clinic quarterly</td>
<td>Clinic forms</td>
</tr>
<tr>
<td>HIV testing and counselling</td>
<td>% of sex workers referred to voluntary HTC services monthly</td>
<td>Referral forms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Periodic denominator estimates</td>
</tr>
<tr>
<td>HIV care and treatment</td>
<td>% of sex workers newly diagnosed with HIV referred to care services monthly</td>
<td>Programme forms</td>
</tr>
<tr>
<td></td>
<td>% of sex workers eligible for ART who are started on ART monthly</td>
<td>Programme forms</td>
</tr>
<tr>
<td></td>
<td>% of sex workers started on ART who remain in care and are adherent to regimens at one year</td>
<td>Clinic forms</td>
</tr>
</tbody>
</table>

#### Structural interventions/Community mobilization

| Rights violations                              | Number of reported incidents of violence against individual sex workers   | Violence report forms             |
|                                                | % of reports of violence responded to within [designated time period] by crisis response system | Crisis response forms             |
| Stigma                                        | Number of reported incidents of stigma in clinical services               | Stigma report forms               |
| Social entitlements                            | Number of sex workers accessing ration cards/voting cards/ID/bank accounts, etc. | Report forms                     |
| Community mobilization                         | % of community group members who are sex workers but not community outreach workers | Report forms                     |
6.2.3 Plan the programme evaluation

An evaluation plan should assess the programme’s fidelity to its original design (i.e. was it implemented to the scale and with the elements defined in the programme logic model?) as well as to its intended impact. An illustrative high-level evaluation framework is depicted in Figure 6.2. See Section 6.8 for a list of guidance documents for designing evaluation programmes for sex workers.

**Figure 6.2 Evaluation framework for a multi-component HIV/STI programme with sex workers**

- **Did the programme achieve scale/coverage of geographic area, and provide the population covered with high-quality services?**
  - Are coverage and frequency of service delivery according to plan?
  - Is coverage with community mobilization according to plan?
  - What was the cost of reaching the population?

- **What impact has the programme had on:**
  - HIV transmission?
  - Lives saved?
  - Sex workers' agency?
  - Has there been an increase in reported condom use by sex workers?
  - Has there been an increase in voluntary HIV testing by sex workers?
  - Has there been a reduction in STIs in sex workers?
  - Are sex workers accessing voluntary HTC and ART in the same proportion as in the general population?
  - Has the agency of sex workers increased?

- **Has there been a reduction in new HIV infections in sex workers?**

**Some key issues to consider when designing the evaluation are:**

- **Clarity on evaluation goal:** Since data analysis and dissemination are nearly always under-budgeted, it is best practice to define and budget for monitoring and evaluation activities at the start of the programme. It is recommended that 5–10% of the total project budget be allocated to monitoring and evaluation.

  Clarity is required on what is being measured, for whom and with how much “certainty” in the inference. These levels of certainty have been defined as adequacy, plausibility and probability:

  - **Adequacy evaluations** assess how well the interventions met the programme logic model and whether the expected change occurred.
  - **Plausibility evaluations** collect data to increase the level of confidence that changes observed were due to the programme, usually by choosing a control group. In the case of sex worker programmes, this is likely to be an historical control group obtained with baseline data collection.

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8 Agency in this context (and in other parts of this chapter where the word clearly does not mean “organization”) refers to the choice, control and power that a sex worker has to act for her/himself.
Most sex worker evaluations fall somewhere between adequacy and plausibility. It should be noted that good monitoring data are essential, first to demonstrate that the programme was implemented as planned, and second as a signal to managers and funders that the programme is on track.

- **Data triangulation:** True baseline surveys (i.e. before interventions are started) in sex work communities are difficult. Programmes need to build trust with the community before one asks intimate questions or takes biologic specimens. Building trust usually entails providing services, and baseline behaviour related to condom use may change quickly. It is therefore important to try and collect additional information on “baseline” condom use through enrolment questionnaires, or use condom distribution data to triangulate with survey data (see Section 6.2.2).

- **Validation of programme data:** Surveys used for evaluation should also be used to validate the other programme data, where possible. In particular, surveys may be used to:
  - estimate programme coverage and validate the monitoring estimates
  - do size estimates using more mathematically based approaches
  - assess the level of reported violence
  - assess the level of individual and community agency.

- **Dissemination plan:** Dissemination plans should involve activities at all levels—from central to local levels—including to the sex workers themselves. Dissemination creates ownership of the results to help improve programmes.

### Organizing a scaled programme for sex workers

#### 6.2.4 Define the management structure

A clear structure for implementation and well-defined roles and responsibilities are essential for smooth programme management. These include the roles and responsibilities at each level of implementation, both in the programme and outside (government, media, medical services, etc.). At the national/central level, the government or central management agency:

- sets programming standards
- monitors dashboard indicators from all implementing organizations in the country
- ensures that programmes are implemented in prioritized areas and sub-populations of sex workers
- has a centralized view of the monitoring data
- ensures a country-wide evaluation plan.

If government or a designated central management agency is not setting standards or requiring centralized indicator reporting, implementing organizations should work together to standardize a minimum package and centralize indicator collection in consultation with the government.

Figure 6.3 illustrates a management structure of a national programme, showing the oversight and reporting relationships with the programme as well as the external relationships managed at the various levels. Key management roles are:
• **setting milestones** coupled with field oversight for both quality and progress; regular review of progress against targets to adjust strategies and tactics; and use of programme experience and data to make mid-course corrections.

• **establishing an organizational culture** that aims to:
  › empower sex workers to manage the programme
  › empower staff at all levels to use local monitoring data to improve the programme.

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**Figure 6.3** Illustrative management structure for a national HIV prevention and care programme with sex workers (programme roles are not exhaustive)
Implementing a scaled programme for sex workers

6.2.5 Prioritize

Financial resources are usually insufficient to cover all sex workers in the entire country with the same package of services; as a result, programmes must prioritize both interventions and locations. This may be accomplished by varying the way in which technical components are delivered and by prioritizing those areas where the largest number of sex workers and those at highest risk may be reached. The following are considerations for prioritization:

Where to establish services

- **Locations with the largest number of sex workers in a geographic area:** This allows a few implementing organizations with the attendant management costs to reach a large proportion of sex workers. Large numbers of sex workers are usually found in urban areas or in places where there are large numbers of men without their families (extraction industries, construction projects, truck stops, migrant farm labour, etc.).

- **Locations with sex workers at higher risk of infection:** Higher risk is determined by factors such as the number of paying partners, type of sex (anal sex is higher risk) and the agency and experience of sex workers, e.g. brothel-based sex workers may be at higher risk than street-based sex workers because of their decreased agency and higher number of clients; newer sex workers may be at higher risk because they have less experience in negotiating condom use and avoiding or mitigating violent situations.

What services to provide: At a minimum, they should include:

- **Harm reduction commodities** including adequate availability of condoms and lubricant, and needles and syringes. These are essential for sex workers to protect themselves. In many settings, supplies are completely inadequate to the need. See Chapter 4 and Chapter 5, Section 5.5.3 for full details.

- **Community empowerment activities** to increase service reach and effectiveness and sex worker agency. As Chapter 3 explains in detail, community mobilization activities are increasingly shown to be cost-effective and should be considered part of an essential package and not just “nice to have”.

- **Referrals** to accessible and acceptable clinical services for reproductive health, STIs, hormone replacement therapy, HIV testing, antiretroviral therapy (ART), tuberculosis (TB), hepatitis B vaccine and management, and opioid substitution therapy (see Chapter 5 for more details). High-quality referral services are sometimes more difficult to establish than project-owned services. Referral services often require behaviour change on the part of the providers to ensure that they are non-discriminatory, non-stigmatizing and confidential; and on the part of sex workers, who may have experienced abuse or discrimination from service providers on earlier occasions. Sometimes it is necessary to work with administrative bodies to change clinic hours to make them more accessible to sex workers. Moreover, training of staff is often necessary to familiarize them with sex worker-specific clinical protocols. Some programmes use voucher schemes to increase access to clinical services from private providers. In the long run, however, effective referrals to respectful, accessible services may be more sustainable than programme-run clinical services if the level of use by the community is high.

- **Addressing key structural barriers** such as violence and police interference with service delivery. These are determined by the local context (see Chapter 2 for more details).
6.2.6 Implement in a staged manner

Implementing and executing the programme in clear stages helps achieve wide geographic coverage. First, the programme is rolled out nearly simultaneously across the target geographic areas (as opposed to a pilot-and-replicate approach) by creating a physical infrastructure in these areas. This is followed by a focus on implementing services and constant quality improvement. Finally, as the interventions mature, the focus of implementation shifts to making interventions and services more sustainable. Additional services may be layered on over time. Figure 6.4 summarizes the staged implementation of a programme.

Figure 6.4 Stages of implementing a multi-component programme with sex workers

<table>
<thead>
<tr>
<th>Start-up</th>
<th>Behavioural interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish coverage areas and infrastructure</td>
<td></td>
</tr>
<tr>
<td>Identify sites</td>
<td></td>
</tr>
<tr>
<td>Hire and train NGOs/staff</td>
<td></td>
</tr>
<tr>
<td>Map sex worker community</td>
<td></td>
</tr>
<tr>
<td>Recruit and train community outreach workers</td>
<td></td>
</tr>
<tr>
<td>Establish safe spaces (drop-in centres)</td>
<td></td>
</tr>
</tbody>
</table>

| Commodities (condoms and lubricants) |
| Identify source of condoms and lubricants |
| Establish forecasting and procurement |
| Estimate sex workers’ condom requirements |
| Estimate condom gap for venues |

| Clinical services |
| Establish services (STI/RH, HTC, ARV, PMTCT, TB, harm reduction) mapped |
| Establish referral linkages and reporting |
| Sensitize providers on sex worker issues—ensure acceptable services |

| Structural interventions |
| Conduct assessment of sex work environment, analyse key issues: stigma, discrimination, violence |
| Prioritize and develop mitigation plan |
| Work with local police to support outreach work |

<table>
<thead>
<tr>
<th>Roll-out of services</th>
<th>Improve coverage, quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro-planning</td>
<td></td>
</tr>
<tr>
<td>Monthly outreach/ referrals/ commodity distribution</td>
<td></td>
</tr>
<tr>
<td>Training and refresher training</td>
<td></td>
</tr>
<tr>
<td>Routine data review for oversight, programme modification</td>
<td></td>
</tr>
</tbody>
</table>

| Directly distribute and track condoms to sex workers through outreach |
| Identify additional outlets for commercial promotion |
| Advocate for/ establish condom social marketing |

| Clinical services |
| Regular referral of sex workers to services (STI/RH, HTC, HRT) |
| Facilitate sex workers’ access to HIV care, ART, PMTCT |
| Establish community counselling and support |
| Monitor clinic for stigma |

| Structural interventions |
| Ensure sex worker legal literacy |
| Establish crisis response system |
| Establish monitoring systems to track and report violence |
| Engage stakeholders |
| Capacity-building in advocacy |

<table>
<thead>
<tr>
<th>Increase sustainability</th>
<th>Improve systems, social norm change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social norm change in regard to condom use, service utilization</td>
<td></td>
</tr>
<tr>
<td>Quality forecasting, central procurement/ storage for government condoms</td>
<td></td>
</tr>
<tr>
<td>Condom social marketing established</td>
<td></td>
</tr>
<tr>
<td>Local implementers incorporated into national forecasting system</td>
<td></td>
</tr>
</tbody>
</table>

| Community agency improved to access services directly |
| Clinical service stigma reduced |
| Links with networks of HIV-positive people |

| Structural interventions |
| Sex worker groups strengthened |
| Sex worker groups with increased role in programme |
| Sex worker groups with increased capacity to advocate for themselves |

<table>
<thead>
<tr>
<th>Expand scope</th>
<th>Add services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Train community outreach workers in new services, e.g. TB verbal screening and DOTS provision, ART adherence monitoring</td>
<td></td>
</tr>
<tr>
<td>Addition of other prevention products</td>
<td></td>
</tr>
</tbody>
</table>

| Expansion/addition of clinical services |
| Sex worker groups engage other community priorities |
A. From start-up to establishing infrastructure across the target geographic area

**Mapping and size estimates:** Key steps in starting a programme include knowing where to establish services and contracting with implementing organizations.

- At the central planning level, reliable information about the size of a sex worker community in a given geographic area forms the basis for locating services, funding, setting performance targets, allocating programme resources and assessing coverage.
- At the implementation level, programmers have multiple purposes for mapping and size estimation information, including:
  - estimating the size of the community in a given area to determine personnel needs
  - defining locations of sex workers for locating interventions
  - obtaining information on risk behaviours, risk perceptions and barriers to inform the initial intervention design. See Box 6.4 and Figure 6.5 for more details on approaches to determining where to start services.

*Figure 6.5* Stages in determining where to establish services for sex workers

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Source: Adapted from *A Systematic Approach to the Design and Scale-up of Targeted Interventions for HIV Prevention among Urban Sex Workers* (Karnataka Health Promotion Trust, Karnataka, India, 2012).
Mapping, size estimation and micro-planning

Mapping and size estimation is a multi-stage process, focusing increasingly on local levels to refine the information and make it more accurate. (See also Figure 6.5.) Mapping should always be done discreetly so as not to draw undue attention to the activity.

First stage: “Where in the country does a significant amount of sex work occur?” To determine where services should be established, a central-level planner must first understand where sex workers are located. This information may be obtained by interviewing police in urban areas, health providers, and representatives of industries that attract a large number of male workers (extraction, construction, seasonal agriculture, etc.). An approximate number of sex workers should be obtained for each identified area in order to focus interventions initially on the locations with the largest number.

Second stage: “How many sex workers are operating in this municipality/area, and where?” Once the general geographic area is known, more detailed mapping and size estimation may be done. This exercise can be an adaptation of the PLACE method (Priorities for Local AIDS Control Efforts—see Section 6.8) or Participatory Site Assessments, depending on the level of sex worker involvement in the mapping and size estimation process.

- **First phase:** Local key informants (police, taxi drivers, NGO workers, truckers) are interviewed to identify where sex workers meet clients. Sex workers who are willing to assist may also be recruited to help list sites where sex work is solicited.

- **Second phase:** Locations identified by multiple informants or described as having large numbers of sex workers are investigated further. Detailed information is sought from sex workers on the number of sex workers by time of day, specific places where sex workers gather and additional areas near the location where other sex workers may be found. (The purpose of asking for additional locations is to find any unknown sites not identified by key informants in the first phase.)

  - Depending on the relationship with the broader sex work community in the areas, the findings may be validated by presenting and discussing them with the community.
  - Maps showing local landmarks and sex work locations may be prepared, either on paper or using electronic equipment, such as global positioning systems (GPS) or geographic information systems (GIS). (This information should be kept strictly confidential because of the potential for serious harm should law enforcement authorities gain access to and misuse it.)

The programme uses this information in close consultation with the community to decide where service points, such as safe spaces (drop-in centres) and clinics, should be located. Other clinics may be listed and mapped to establish referral relationships. The programme design is further refined and informed by sex workers who describe the locations, hours, habits and other information that will determine when, where and how services are set up.

Third stage: “Who are the sex workers and what is their risk and vulnerability?” In this stage, social network maps are used to identify precisely who may be reached by individual community outreach workers. and to further inform local planning, while including sex worker’s values and preferences. Full details can be found in Chapter 3, Section 3.2.2 part A.
Case example: Programmatic mapping and key population size estimation in Kenya

Since 2006, several small-scale size estimation studies have been done to understand the size and distribution of sex worker populations in Kenya. In 2012, a large-scale geographic mapping exercise was conducted by Kenya’s National AIDS & STI Control Programme (NASCOP), with support from the World Bank, to provide accurate information on the size, locations and characteristics of populations of sex workers, men who have sex with men and people who inject drugs in key urban and semi-urban areas. The goal was to improve the scale, quality and impact of HIV prevention programmes among these populations.

A total of 51 urban centres were mapped, representing 70% of towns with a general population of 5,000 or more in each province. These data, and data from other studies conducted since 2006, were then compiled to finalize the 2013 national estimates for populations of sex workers, men who have sex with men and people who inject drugs. NASCOP estimates that there are 133,700 female sex workers in Kenya. It is the first time that the government has developed national, provincial and city estimates. They serve as baseline data for NASCOP to analyse gaps in funding and programming and develop a scale-up plan to reach female sex workers (along with other groups at risk) as part of the upcoming national strategic plan.

Allocating responsibilities among implementing units/NGOs: In assigning implementing units or NGOs to begin services, it is important to carve out distinct catchment areas for coverage responsibility. As far as possible, overlaps in geographic areas should be avoided. This should be balanced against the size of the sex worker communities assigned to each implementing organization. If the target population is too small, it will make the intervention too costly per sex worker reached; if it is too large, it may exceed the organization’s management capabilities.

Hiring and training staff: A multi-component HIV intervention for sex workers requires team members with a variety of skills. The composition of a team depends on the services provided, how the services are delivered, the size of the sex worker community, and the geographic area being covered. Table 6.4 provides an example of an implementation team at a municipality/sub-municipality level.

The team includes both non-sex worker staff and community members. Non-sex worker staff should be sensitive to the context of sex work and the discrimination, violence and other problems sex workers face. They should also be able to discuss such topics as sex and service delivery needs in a non-judgemental manner. Although staff are hired for a specific role in the programme and will have a job description, they need to be flexible to adapt to new situations on the ground and incorporate new approaches. Given the overarching goal of sex worker progression and community empowerment, staff should be prepared to learn from the sex workers as well as serve as mentors to the process. Chapter 3, Box 3.3 describes the characteristics of successful community outreach workers.

Capacity-building of human resources is an important aspect of any programme but is particularly important in programmes with sex workers where the intent is to progressively increase their involvement in the programme. A full discussion of organizational capacity-building is in Part II of this chapter.
Table 6.4 Illustrative composition of an implementation team at the municipal/sub-municipal level for ~1,000 sex workers

<table>
<thead>
<tr>
<th>Position (number of staff)</th>
<th>General responsibility</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coordination and administrative personnel</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme coordinator (1)</td>
<td>Responsible for the overall implementation of the project.</td>
<td></td>
</tr>
<tr>
<td>Data officer (1)</td>
<td>Aggregate the data, generate the reports and monitor data quality.</td>
<td></td>
</tr>
<tr>
<td>Accountant (1)</td>
<td>Maintain accounts and pay local expenses of the programme.</td>
<td></td>
</tr>
<tr>
<td><strong>Medical personnel</strong></td>
<td><em>The number and type of medical personnel needed are based on the biomedical component(s) of the programme.</em></td>
<td></td>
</tr>
<tr>
<td>Physician (1)</td>
<td>Provide clinical services offered by the programme.</td>
<td>If clinical services to the community are entirely referral-based, this position is not necessary.</td>
</tr>
<tr>
<td>Nurse (1)</td>
<td>Provide/support clinical services offered by the programme.</td>
<td>If clinical services to the community are entirely referral-based, this position is not necessary.</td>
</tr>
<tr>
<td>Clinic support staff (1)</td>
<td>Greet patients, maintain reception area.</td>
<td></td>
</tr>
<tr>
<td><strong>Outreach personnel</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counsellor (1)</td>
<td>Identify and manage mental health issues, such as depression and anxiety. Provide additional support for behaviour-change processes</td>
<td>Even if clinical services are not offered by the programme, a counsellor may provide additional counselling to sex workers on issues related to referral clinical services.</td>
</tr>
<tr>
<td>Outreach supervisors/managers (~5)</td>
<td>Supervise community outreach workers on a weekly basis. Ensure that sex worker outreach information is recorded and incorporated into routine monitoring systems.</td>
<td></td>
</tr>
<tr>
<td>Community outreach workers (~20)</td>
<td>Routine outreach to sex workers, provision of commodities, referrals, follow-up and structural interventions. Support behaviour-change process. Support sex workers in responding to stigma, discrimination and violence.</td>
<td>Assumption is that one community outreach worker works 5 days a week, 4 hours per day and can meet 2 or 3 sex workers in a day. Will need time for routine meetings with outreach supervisors/managers and monthly implementing organization meeting. Number may be adjusted if sex workers are in close proximity (e.g. brothels) or are dispersed.</td>
</tr>
<tr>
<td>Office support staff (1)</td>
<td>Support routine office processes.</td>
<td></td>
</tr>
</tbody>
</table>
B. From rolling out services to improving coverage and quality
During this stage of implementation the focus is on ensuring coverage of the community with services and improving quality. This roll-out stage is a continuous process in which management at all levels reviews progress against targets and adjusts strategies and tactics, as necessary. Mid-course corrections are made based on new data, new approaches or environmental or structural changes that affect programming. The intensity and the quality of coverage increases as staff become more skilled in their positions. It is during this phase that flexibility and continuous programme learning are extremely valuable. A strong monitoring system with regular reviews is essential to the successful roll-out of services. It also signals to funders and the government whether programming is being implemented successfully.

C. Aiming toward systems improvement, social norm change and increased sustainability
The overall aim of programme implementation is to provide services to reduce HIV and STI transmission and to treat HIV and other related infections, while empowering sex workers to participate and progressively build their capacity to implement the programme, and addressing structural barriers through advocacy and policy change. This makes the programme more effective and potentially more sustainable. The ideal characteristics of such a programme include the following:

- Sex workers lead in implementing outreach, distributing condoms and lubricant and facilitating effective clinical referrals.
- Sex workers have enough individual and collective agency to address problems themselves with the police, the health system, the government and other sex workers.
- Sex workers have positions at local, district and national level on planning bodies for service delivery and violence response.
- Social norm change among sex workers and clients makes condom use routine.
- Sex workers are able to access health services without stigma and discrimination at the same frequency as the general population.
- Prevention commodity supplies are adequate, through both social marketing and strengthened country procurement and distribution mechanisms, and sex worker programmes are part of a commodity tracking system.

Programme implementation in this stage is a matter of strengthening systems, addressing structural barriers and empowering communities while simultaneously providing and measuring services. Some of the earlier intensive programme activities may be reduced as social norms regarding condom use and clinical service use change.

D. From expanding scope to adding services
Once the infrastructure, community engagement and coverage have been established and the programme is functioning well, it is relatively straightforward to add services.

6.2.7 Establish a supervision system
Regularly scheduled supervision meetings help create a “data use culture” that enables corrective action and continuous improvement at all levels, as well as independent problem-solving. Periodic meetings should be scheduled to review data at every level, from community outreach workers to NGO staff, to the state/provincial level, to central management. Visits by the supervision staff to the field also provide qualitative information on implementation to help interpret data and find solutions. As an example, a supervision and programme review system used by a large project in India is...
Case example: Expanding scope and layering on tuberculosis screening services in India

TB is prevalent in India and is a common opportunistic infection among HIV-infected individuals. In 2007, after comprehensive HIV prevention services had been scaled up over a period of three years, the Avahan India AIDS Initiative, in partnership with the country’s national TB programme, conducted intensified case-finding of sex workers through verbal screening for TB symptoms during routine outreach by community outreach workers and regular clinic visits. Sex workers with symptoms suggesting TB were accompanied to the TB diagnostic centre and, if necessary, to a DOTS (directly observed treatment – short course) treatment centre. In order to train community outreach workers to do this, low-literate tools were developed, including visual aids, such as flash cards, posters and a video. The TB verbal screening activity was easily incorporated into the community outreach workers’ tracking tools, helping to ensure routine implementation during outreach.

Over a period of three years, from April 2008 to March 2011, more than 18,000 individuals were identified as TB suspects from an estimated denominator of 300,000 and were referred to a TB diagnostic centre. Of these, 17% were diagnosed with TB.

Box 6.6

depicted in Figure 6.6, along with the level of data that was used as part of the review. It should be noted that community committee meetings and regular supervision meetings between community outreach workers and their supervisors/managers are two ways in which qualitative as well as quantitative data about the programme may be gathered. This is an important part of the community empowerment process described in Chapter 1.

Further functions of supportive supervision include:

- motivating and training staff
- sharing guidelines
- monitoring and evaluating staff performance
- managing day-to-day challenges
- facilitating organizational support.
Figure 6.6 Supervision and monitoring system for a national HIV prevention and care programme with sex workers

Programme level

- Central
  - State-level managers: 1 for every 1–2 states
  - Semi-annual/annual formal review meetings with state/province
  - Frequent informal engagement

Supervision system

- State/Province
  - Programme manager: 1 for every 3–5 NGOs
  - Technical manager (clinical services, behaviour change, structural interventions, monitoring) to meet standards for frequency of oversight
  - Monthly field visits/meetings with NGOs
  - Quarterly reviews with NGOs

- District/County
  - Field officers for monthly oversight of safe spaces (drop-in centres) and clinical services
  - Monthly all-staff meetings

- Municipality/Sub-municipality
  - Safe spaces (drop-in centres) managed
  - Clinical service delivery per standards
  - Outreach supervisor/manager (1 for every 5–7 community outreach workers) meets weekly

- Frontline worker/Community
  - Community outreach workers
    - 1 for every 30–65 sex workers
    - Daily field presence, minimum monthly contact with sex workers
    - Weekly planning meetings with outreach supervisor

Monitoring data

- Central
  - Dashboard indicators (with drill-down to identify unusual performance)
  - Financial information
  - Service quality reports

- State/Province
  - Information from below +
  - Additional administrative and financial information
  - Service quality reports

- District/County
  - Clinical service utilization, commodity distribution and contacts from below +
  - Condom supply
  - Training reports
  - Financial reports

- Municipality/Sub-municipality
  - Clinical services referral and use: RH/STI, HTC, HIV care, ART, TB, etc.

Coordination/co-planning

- Individual interactions (micro-planning tools)
  - Contacts/educational session
  - Condoms distributed
  - Referrals
6.2.8 Progressively ensure full sex worker participation

Sex worker programmes should be designed in such a way as to move from doing programmes for sex workers to doing them with sex workers, and ultimately to programmes done by sex workers. To accomplish this:

- Leadership by management at all levels should maintain a focus on the community empowerment component of the intervention just as much as the more technical components. This prioritization should be repeatedly articulated and given ongoing support.
- Capacity-building and mentoring of sex workers are necessary to provide them the tools, support and skills to increasingly deliver services, which results in better services and potentially increases the sustainability of the programmes (see Section 6.7 below, as well as Chapter 1, Section 1.2.2 and Chapter 3, Section 3.2).
- Human resource policies that define terms of reference for positions held by sex workers and clear advancement criteria are essential (see also Chapter 3, Section 3.2.2, part D).
- Management should explicitly address staff expectations and the processes of transferring responsibility from non-sex worker NGO staff to sex workers (see Chapter 1, Section 1.2.1).

6.3 Capacity-building/programme learning

In most settings, there is limited experience in sex worker interventions. Consequently, the capacity-building system also needs to recognize that not all implementing organizations have the same experience and background in sex worker programming. It is equally true for non-sex worker and sex worker staff that lack of experience does not mean lack of ability. Capacity of the non-sex worker and sex worker staff may be built through regular classroom training, field exposure, supervision/mentoring and interactive problem-solving sessions. Ideally, the training materials should be adapted or developed centrally to maintain quality of training and consistency with the minimum standards specified by the programme, and be based on an assessment of the capacity-building needs. Pre- and post-assessments are useful to monitor the quality of the trainings.

Case example: Organizational and technical assessment of state government agencies and civil society organizations for HIV prevention services in Nigeria

Between October 2012 and April 2013 Nigeria’s Strengthening HIV Prevention Services (SHiPS) project for most-at-risk populations undertook an organizational and technical assessment of State Agencies for the Control of HIV/AIDS (SACAs) and civil society organizations (CSOs) across selected states, to identify gaps to be addressed by capacity-building prior to scaling up HIV prevention services.

Two national tools were used to give a uniform and objective assessment: the National Harmonized Organizational and Capacity Assessment Tool (NHOCAT) for the SACAs, and the Partnership Assessment and Development Framework tool (PADEF) for the CSOs. A total of 11 SACAs and 62 CSOs were assessed. The empirical parameters in the PADEF were used to shortlist 37 CSOs as potential implementing partners for the scale-up; of these, 20 are currently engaged as implementing partners. Gaps in capacity identified in the NHOCAT and PADEF assessments were used to guide the development of a structured systems-strengthening programme for the SACAs in the SHiPS project states and the CSOs implementing the SHiPS project, with clear timelines and expected outcomes.

Sustained engagement through training, mentoring and coaching of SACAs, along with effective supportive supervision of the implementing CSOs, is gradually enhancing the ability of the CSOs to implement HIV programmes, and of the SACAs to coordinate them.
Non-sex worker staff: Training goals for non-sex worker programme staff include:
- acquainting the staff with the specifics of the project (e.g. intervention, reporting forms)
- building technical skills in new areas (e.g. examining for anal and oral STIs, counselling issues related to sex work)
- orienting staff to the issues of sex work and the overall goal of transferring skills and responsibilities to the sex worker community. This may require a change in staff members’ attitudes toward sex workers (sexuality, morality of sex work, etc.).

Some approaches to capture programme lessons include:
- routine visits for programme managers to learn about local innovations and transfer lessons to other sites
- regularly scheduled programme reviews with several implementing organizations together; they may also be used for cross-sharing
- cross-site meetings of technical officers to share approaches
- formal revision of programme approaches, minimum standards, standard operating procedures and reporting forms.

Sex worker staff: The programme goal is to increasingly involve sex workers in the management of the programme and to capacitate them to address some of the environmental and structural constraints that inhibit preventive behaviour. Training objectives are to strengthen the capacity of the sex workers to do outreach, increasingly manage all aspects of outreach and to move into other staff positions in the programme, including management. This can be phased as basic and advanced training. More details can be found in Chapter 3, Section 3.2.2 part B.

Although non-sex worker staff and sex worker staff may differ in their types and levels of experience, wherever possible training should take place jointly so that all participants can learn from one another and bridge the gaps in their knowledge and skills in a collaborative manner.

6.4 Staff development
Several good practices have been articulated to ensure that staffing is optimal and that staff are motivated and satisfied by their work. These practices include:
- clear job descriptions and roles and responsibilities for all positions in the programme, including sex worker positions
- clear reporting lines showing to whom each person is accountable
- team-building and a culture of mentoring
- clear criteria for performance reviews
- clear policies on leave, travel reimbursement, and remuneration for work, including equitable policies for sex workers. Ideally, these should be uniform across a country
- opportunities for training for different positions in the organization, such as outreach supervisor, clinic assistant, nursing, counselling, social work, office manager.
Part II: Building the Capacity of Sex Worker Organizations

6.5 Introduction

Organizational capacity-building is a comprehensive approach to strengthening an organization’s ability to plan, manage and finance itself so that it can implement its own vision and strategy, rather than only responding to the vision of donors. In the context of HIV prevention and more broadly, this approach is of particular importance to sex worker-led organizations, whether they are already established or come into being as a result of HIV prevention programming.

The development community has a long history of capacity-building. Early efforts generally aimed to help organizations manage the funds from a specific donor, or implement donor-supported technical programmes. Today, the approach to organizational capacity-building is to strengthen the organization as a whole, even where there is still a focus on improving the ability to implement a specific project. (In fact, capacity-building in the context of project implementation is generally more effective than organizational capacity-building in isolation, as it allows for practical application of the theoretical learning.)

Like other organizations, sex worker organizations face varying challenges to becoming stronger and more sustainable and benefit from different approaches. An established organization may have a better understanding of its community’s needs and be better be able to lead the process of capacity-building, whereas a recently formed organization may need more guidance. But certain principles apply to capacity-building in general. Support should be:

- **Comprehensive**: Acknowledging all the capacity-building needs of an organization allows for a more systematic approach and the opportunity to address all the essential needs.
- **Contextualized and customized**: The support should address the cultural, political and social settings and should also address the specific needs of the organization being strengthened.
- **Locally owned**: Those supporting capacity-building may understand the processes and can help identify needs. But if the organization is not making its own decisions, capacity-building efforts will not be as successful.
- **Readiness-based**: The type, level and amount of capacity-building should be based on the organization’s ability to absorb and use what is being given.
- **Inward/outward-oriented**: While it is essential for an organization to ensure the health of its staff and internal structures, it is also important to remember that any organization is part of a larger community and needs to understand opportunities for partnership and the potential benefits from external links.
- **Sustainability-based**: Capacity-building should strengthen an organization’s ability to maintain a resource base so that it may continue to function well.
- **Learning-focused**: An organization that does not continue to learn about its functions, beneficiaries, community, technical areas, etc. will become stagnant and cease to be relevant.

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9 Although the term capacity-building is used here, “capacity development”, “organizational development” or a number of other terms would serve equally well.
The role of community empowerment in capacity-building

The role of capacity-building is to institutionalize support for sex workers and to further empower these groups to lead their own responses. This is important in two respects:

- Because many sex worker populations are migratory and those responsible for the interventions may not remain with the organization in the long term, creating an organizational structure provides consistency over time and processes to ensure that key people are replaced if they leave.
- Although community empowerment supported by others may involve communities making their own decisions, such organizations are still led by outsiders. Organizations led by sex workers are not beholden to external forces and will, therefore, be empowering by definition.

Note that not all sex worker groups will (or should) become independent organizations. It is up to each community of sex workers to define its own way forward. This may entail the development of a CBO or NGO, but some organizations may find it easier and more appropriate to continue to work through other organizations.

6.6 Forming a registered organization

Chapter 1, Section 1.2.3 describes some of the ways sex worker organizations or collectives may be formed. Such organizations are likely at first to be informal groupings that then create structures and processes in order to carry out a community-led agenda more effectively.

Depending on the organization’s type, size and goals, as well as the country in which it is forming, it may decide to become a legally registered entity. The process to do this varies from country to country. It is important that the organization have a clear understanding of its expectations with respect to size, geographic reach, types of activities, etc. Mission and vision statements and a strategy statement or strategic plan help an organization to define these elements.

Most countries have NGO coordinating bodies that offer advice or guidance through the process of forming a formal organization. Networks of AIDS service organizations include the Asia Pacific Council of AIDS Service Organizations (APCASO) and the African Council of AIDS Service Organizations (AfriCASO). In individual countries, networks that cover all sectors, for example the Botswana Council of Non-Governmental Organizations (BOCONGO) and the Namibia NGO Forum (NANGOF), can also provide information. Sex worker-led organizations in neighbouring countries or regional networks of sex worker-led organizations can also often provide advice and support on dealing with registration and overcoming the barriers that face sex workers registering their own organizations.

The necessary registration materials must be obtained from the relevant government office. Precise requirements for documentation are set out by the government. Examples of the types of documentation required are:

- one of the following: memorandum of association, by-laws, constitution, charter, etc.
- report of annual activities

10 APCASO: www.apcaso.org
AfriCASO: www.africaso.net
BOCONGO: www.bocongo.org.bw
NANGOF: www.nangoftrust.org.na/
• financial reports/audit reports
• organizational resources
• organizational chart/staffing plan (and human resources manual, if available)
• board of directors and rules and regulations governing the board (board endorsement of registration is also needed)
• letters of support from key partners.

Some of these documents may not be available for organizations just starting up and may need to be developed. If the organization finds the requirements too complex or difficult to meet, it may be possible to register as a member of a network. This may be an appropriate intermediate step for a nascent organization on its way to registration, giving it the protection and support of the network as it grows and develops the materials needed for individual registration. The Global Network of Sex Work Projects (NSWP) does not require sex worker-led groups to be legally registered before applying for network membership and can provide links to other members who can provide support in building organizational capacity.11

6.7 Organizational capacity-building

Capacity-building for sex worker organizations presents specific challenges:
• The stigma and issues around the legality of sex work.
• Sex worker organizations, if staffed exclusively by sex workers, may initially lack the full range of technical skills needed to function optimally.
• Staff members who continue to engage in sex work for economic or other reasons may not have enough time to prioritize their work for the organization.
• The mobility of sex workers may make it difficult to retain staff and maintain consistency within the organization.

To deal with missing skills, some organizations outsource certain functions, such as financial management, to businesses that provide this service. One way to mitigate the loss of staff is to have more people involved in organizational activities, so that there is a larger number with institutional memory. This is especially important for mentoring leadership to facilitate smooth transitions.

Organizations can also build their capacities in certain areas. A best practice is for an organization to undergo a capacity assessment. There are many tools for this, including self-assessments, although a good facilitated assessment helps an organization bring out issues it might not identify itself. The assessment provides the organization with a capacity-building plan to address the identified areas for improvement. Chapter 1, Section 1.2.6 describes issues of leadership and financial management, while Sections 6.2.2 and 6.2.3 above describe data monitoring and programme evaluation. Other areas that are also generally explored in an assessment and that are the most important for organizations to build capacity are discussed here.

11 www.nswp.org
6.7.1 Governance

Good governance means the responsible management of an organization’s strategic vision and resources. Transparency, accountability, effective management and rule of law are essential components of good governance and of an organization’s ability to meet its mandate. Organizational assessments help organizations ensure the following, which are considered best practices in governance:

- clear vision and mission to drive the organization
- organizational structure that aligns with mission
- strong and active governing body (board) that helps guide and advocate
- participatory selection process for governing body and leadership
- defined processes for decision-making that engage and inform the membership
- community involvement in committees to oversee programmes.

It is important for an organization to have a clear vision. There are often many internal and external pressures on an organization to address issues that may not be within its real area of concern, and the vision allows it to stay focused on what it has identified as its core mission.

A board gives strategic direction, provides support in legal affairs, accounting, etc. and protects the organization. In the case of sex worker organizations, a board may include members with the connections and influence to advocate to reduce the stigmatization that sex workers face. A board may also help with fundraising. The size of a board is less important than the commitment of its members; they should be chosen based on their demonstrated commitment to the organization’s cause and to helping to establish and grow the organization.

6.7.2 Project management

An organization’s agenda is accomplished through concrete activities, often developed as programmes and projects. An organization is on the right track if it:

- develops and follows realistic workplans and budgets that are in line with its vision and mission
- defines technical interventions that are in line with local and international best practices
- ensures that its programmes and projects are responsive to the needs of its members.

Well-managed, technically sound projects and programmes not only ensure that organizational objectives are achieved, but also instil confidence in donors and key stakeholders about the competence of the organization.

6.7.3 Resource mobilization

Organizations should always be engaged in resource mobilization to fund efforts on a long-term basis. It is important that the organization be strategic and look beyond the short term, especially if it is currently benefitting from a grant that will end after several years. While there is no guarantee that an organization will be able to raise money, there are best practices that may help an organization do so. Important issues to consider with respect to resource mobilization include:

- Is the resource mobilization strategy in line with the organization’s vision and mission?
- Can resources be raised from members of the organization, i.e. through a small monthly or annual
membership fee? This increases a sense of ownership, but the sum should not be so high as to
exclude sex workers from joining.

- Are there government schemes that may be able to fund specific activities or programmes?

### 6.7.4 Networking

Developing a strong, successful sex worker organization is as much about relationships as it is about
systems. Networking involves donors, communities, government at both national and local levels,
service providers and NGO networks. Some of the functions of networking are ensuring human
rights, securing comprehensive services for beneficiaries and developing relationships with donors
(see Box 6.9 and also Chapter 1, Section 1.2.8).

Two areas of networking that are especially important for sex worker organizations are engagement
with the state, e.g. politicians, police, health and social entitlement programmes; and engagement
with non-state organizations and institutions.

#### Engagement with the state

- This is particularly important to enable sex worker programmes to advocate for access to health
  services, freedom from discrimination and harassment, protection from and redress for violence,
  and securing rights and entitlements as citizens.
- A partner organization working with the sex worker organization on capacity-building may have
  the connections to place members of community-led groups on committees that oversee health
  programmes, or provide access to politicians and other officials.
- Capacity-building may help sex workers unfamiliar with the structure of formal meetings, or the
  protocol for dealing with officials, learn how to participate and engage effectively.

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**Case example: Direct engagement by the community with the government in India**

In India in 2010, representatives of sex worker collectives and community groups representing the
transgender community, men who have sex with men and people who inject drugs were invited to give
presentations to a consultation meeting of the country’s Planning Commission, which formulates the
Government of India’s five-year plans. Their access to this high-level government body through its Civil
Society Window Initiative was facilitated by the Centre for Advocacy Research, a nongovernmental
organization that was working with the community groups on advocacy issues.

The representatives, who came from seven Indian states, talked about the challenges they faced in
accessing government schemes and social entitlements, and presented recommendations for improved
access to services including health, pensions, education and livelihood options. The following year these
recommendations were incorporated in the Planning Commission’s Approach Paper to the 12th Five Year
Plan. The paper called for targeted programmes for communities that suffer discrimination because of their
social and cultural identity, including sex workers and lesbian, gay, bisexual and transgender individuals.

The testimony of the community groups to the Planning Commission helped boost their credibility with
the government as advocates and opened doors for them to engage in policy dialogue with government
agencies responsible for women’s and children’s development, rural livelihoods and legal services.
Following state-level consultations, government departments were poised in September 2013 to issue
new regulations facilitating access to social benefits for sex workers, men who have sex with men and
transgendered persons.
Engagement with non-state organizations and institutions
This includes:
• other CBOs/NGOs or community-led organizations of sex workers
• religious and other community groups
• media
• other CBOs/NGOs working on related areas (social entitlements, rights, violence, health, etc.).

Capacity-building helps sex worker organizations analyse the significance of socially powerful groups or institutions, such as religious groups and the media, and learn how to engage and influence them. Examples include changing a church’s focus from condemning sex work to respect for people with HIV, or encouraging newspapers to report positively and accurately about sex workers’ efforts to reduce HIV infection.

Case example: Sex worker networks
Once sex worker collectives form, they can integrate with regional, national and global sex worker networks. For example, Karnataka Health Promotion Trust in India uses a “federal” model of governance in which local sex worker collectives form sub-district, district and state committees to increase the negotiating power of sex worker collectives at multiple levels. The Asia Pacific Network of Sex Workers connects sex worker projects from across the entire region. The Global Network of Sex Work Projects has representation from sex worker organizations across the world.

6.8 Resources and further reading

Strategic planning and programme management

Defining programme logic model, implementation components and standards


Routine programme monitoring system


Supervision system
1. STI Clinic Supervisory Handbook, Comprehensive STI services for Sex Workers in Avahan-Supported Clinics in India. New Delhi: Family Health International [no date].
   http://www.k4health.org/sites/default/files/maqpaperonsupervision.pdf

Evaluation
      http://www.cpc.unc.edu/measure/publications/ms-11-49a

Organizational capacity-building
   http://www.msh.org/resources/health-systems-in-action-an-ehandbook-for-leaders-and-managers
   www.aidstar-two.org/Focus-Areas/upload/AS2_TechnicalBrief_1.pdf
Further reading


