AWAC
Alliance of Women
Advocating for Change

DIFFERENTIATED
CARE

# CHLEGS & DIC MODEL

## Accelerating the 90-90-90 Targets

IAS

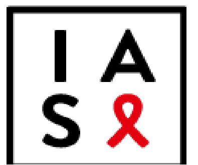
AUG 2018

# AWAC Community Health and Livelihoods Enhancement Groups (CHLEGS)" & Drop in Centre (DiC) Model for Female Sex Workers (FSWs) & Adolescents and Young Women at High Risk (AGYW), Uganda

**Kampala-Uganda**

**August - 2018**





## Acknowledgement

The CHlEGs & DiC documentation team would like to express appreciation to the stakeholders who assisted in the completion of this assignment.

We thank the AWAC staff, at the head office in Kampala and also in the field (Kampala, Wakiso and Mukono) for their time, guidance and input into the process that led to the production of this report.

We also thank the district officials in Kampala, Wakiso and Mukono for providing important information about the CHLEGs & DiC project. The district staff at the district provided advice, important background documents and statistical information.
Sincere appreciation goes to our enumerators (CHLEGs coordinators), thank you for the impeccable effort in data collection.

## Foreword

In spite of several initiatives to address the health and social economic plight of marginalized communities such as female sex workers, the health and social economic gains among FSWs and AGYW at high risk remain worrying.

Evidence based programming as one of the organizational core values prescribes that AWAC invests in innovative ways of doing business. The CHLEGs & DiC Model is informed by this culture. This paper provides an overview of some good practices for CHLEGs and DiC model on access to HIV, TB and SRH services to FSWs who are positive living and AGYW at high risk. This process conducted by AWAC to document the CHLEGs and DiC Model as a HIV, TB and STI differentiated service delivery model for Female Sex Workers was funded by International AIDS Society (IAS).

Data was collected mainly from CHLEGs under the leadership of female sex workers who are positive living, District Community Development Officers in Wakiso, Mukono and Kampala, Civil Society Organizations and from Referral health centres. Data collection was, through face to face interviews and focus group discussion using questionnaires that were designed and pre-tested.

This model has demonstrated success in linking FSWs who are living HIV positive and AGYW at high risk, to HIV care from testing locations that do not have co-located ART care that is needed for this risk group.

We hope it will be an invaluable resource in HIV programming for female sex workers and Adolescent girls and young women at high risk in Uganda

……………………………………..

Kyomya Macklean

Executive Director AWAC

## Introduction

In Uganda, the HIV prevalence among key population, specifically female sex workers (FSWs) is much higher than the national average of 6.2%[i]. The situation is worse among the Female Sex Workers ranging between 35-37%[ii.] In addition to that, the Uganda National HIV Strategic Plan 2015/16-2019/2020 indicates that FSWs bear a disproportionate burden of HIV and Sexual & Reproductive Health Rights (SRHR) challenges. FSWs have 4-5 times higher HIV prevalence than the general population-(35-37%) UNAIDS 2016).AWAC programs data reveals the prevalence of HIV and AIDS among FSWs is 38% which is a bigger percentage compared to the national prevalence of 6% (UPHIA, 2016).

Female Sex Workers generally live at the legal, social and economic margins of society and generally have poor health seeking behaviours. Criminalization of sex work has continued to fuel stigma, discrimination and exposure to violence. In spite of several initiatives to address the health and social economic plight of marginalized communities such as female sex workers, the health and social economic gains among FSWs and AGYW at high risk remain worrying.

In light of the above, AWAC innovated a model to contribute towards addressing health and social economic vulnerabilities experienced by FSWs. This paper provides an overview of some good practice for CHLEGs and DiC model on access to HIV, TB and SRH services to FSWs who are positive living and AGYW at high risk.

## ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AGYW | Adolescent Girls and Young Women |
| AIDS | Acquired Immunodeficiency Syndrome |
| ART | Antiretroviral Retro Therapy |
| AWAC | Alliance of Women Advocating for Change |
| CAO | Chief Administrative Officer (in districts) |
| CDD | Community Driven Development |
| CDDP | Community Drug Distribution Point |
| CHLEGs | Community Health and Livelihoods Enhancement Groups |
| CoSLA | Community Saving Loan Association |
| CSOs | Civil Society Organisations |
| DHO | District Health Officer |
| DiC | Drop in Centre |
| FGD | Focus Group Discussion |
| FSWs | Female Sex Workers |
| GoV | Gender Based Violence |
| HIV | Human Immunodeficiency Virus |
| IGAs | Income Generating Activities |
| LG | Local Government |
| M&E | Monitoring and Evaluation |
| NGO | Non-Government Organisation |
| SRH | Sexual Reproductive Health |
| STIs | Sexually Transmitted Infections |
| TB | Tuberculosis |

## TABLE OF CONTENTS

**Executive Summary ...... 8**

**1 BACKGROUND ...... 9**

1.2 Introduction ...... 9

1.2.1 The objectives of the CHLEGs & DiC model are as follows; ...... 9

1.2.2 Summary Logical framework for the CHLEGs & DiC model ...... 10

1.2.1 Process and Methodology used in documenting the CHLEGs model ...... 11

1.3 FINDINGS ...... 11

Success story ...... 19

Success story ...... 19

1.4 Effectiveness of CHLEGs & DiC Model ...... 19

1.5 Sustainability of the CHLEGs & DiC Model ...... 20

1.6 Impact(s) of the CHLEGs & DiC Model ...... 20

1.7 Gender ...... 21

1.8 HIV and AIDS ...... 21

1.9 Planning & Implementation of the model ...... 21

2.0 Monitoring & Evaluation ...... 21

2.1 Documentation & Reporting ...... 21

## EXECUTIVE SUMMARY

Before CHLEGs project began, Female Sex Workers (FSWs) who are positive living and Adolescent Girls and Young Women (AGYW)at high risk of acquiring HIV had limited options for access to essential HIV and AIDS, SRH, and TB services. The group faced systemic exclusion in access to financial support services. It also faced challenges of poor health seeking behaviours due to long waiting time at the health facility, stigma and discrimination which made it hard for eligible FSWs and AGYW at high risk to access HIV and AIDS, SRH, and TB services. In addition children and sexual partners of FSWs and AGYW at high risk had limited options for HIV testing care and treatment services. Poverty was another factor that compromised FSWs and AGYW`s ability to fulfil the linkage and clinical appointments and also compromised nutrition support. The heavily stigmatised environment in which FSWs operate heavily compromised disclosure, affected adherence to Anti retro Viral Therapy and contributed to social economic trauma among FSWs. There was high systemic discrimination from Village Savings and Loan Associations on grounds of illegal nature of sex work and its associated risks.

AWAC in consultation from its network organisations, stakeholders and its Partner Civil Society members designed and tested the effectiveness of CHLEGs and DiC Model in responding to the over whelming challenges with special emphasis on HIV and AIDS care and treatment services to FSWs and AGYW affected and infected with HIV/AIDS. In addition the initiative looks at savings and loan transfers under the Community Saving and loans Association (CoSLA) initiative based at hotspot level. CoSLA a CHLEGs component aimed at reducing systemic exclusion of FSWs and AGYW in Savings and access to Loans. The initiative has extended awareness and HIV literacy support.

The design of the intervention emphasised collaboration with and complimenting the work of other Differentiated Service Delivery Models, such as Community Drug Distribution Point (CDD), Peer to Peer (PP), to improve on the quality of services provided under this intervention.

During the documentation of this model, we were interested in learning more about CHLEGs Model and its effectiveness on decentralising HIV/AIDS, TB and SRH services to FSWs living with HIV and AIDS and AGYW at high risk in the three districts of Kampala, Wakiso and Mukono.

# 1 BACKGROUND

## 1.2 Introduction

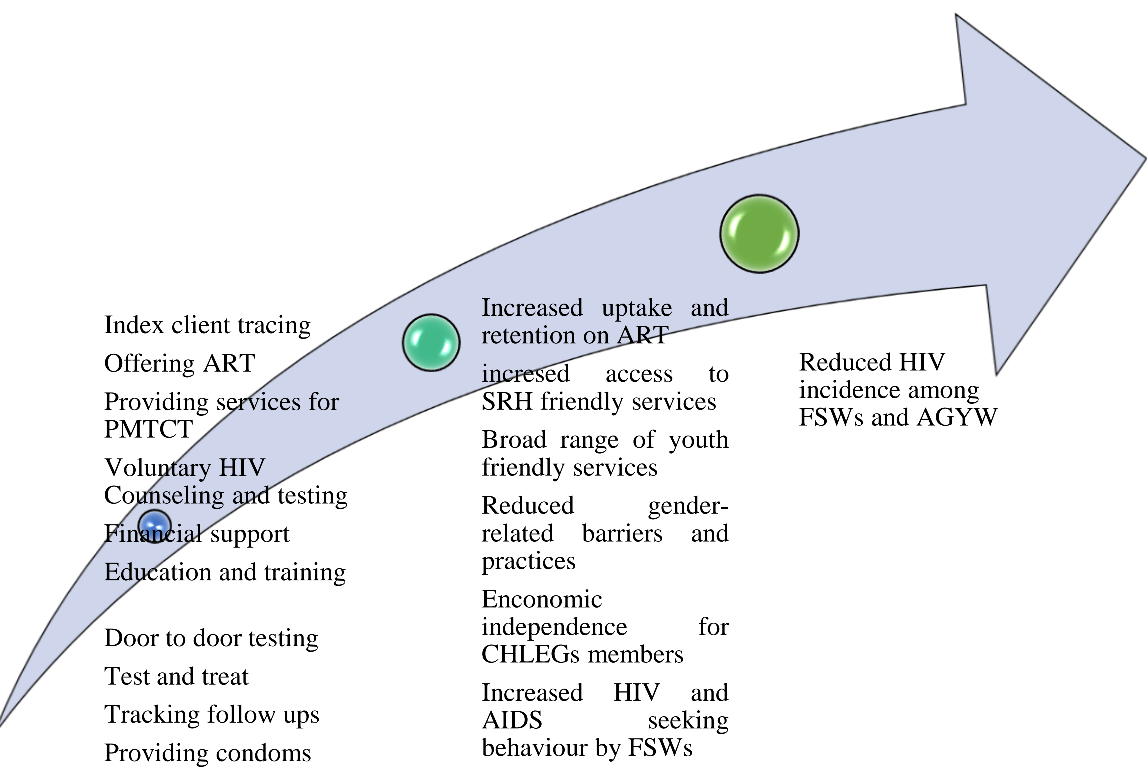
Evidence based programming as one of the organizational core values prescribes that AWAC invests innovative ways of doing business. The CHLEGs & DiC Model is informed by this culture. This model has demonstrated success in linking FSWs who are living HIV positive and AGYW at high risk, to HIV care from testing locations that do not have co-located ART care that is needed for this risk group. Using this model, the team successfully identified recently diagnosed HIV positive FSWs and AGYW and linked them to care and treatment. As a result, the percentage of FSWs and AGYW attending initial HIV care and treatment within six months of enrolling on ART program has increased.

This paper provides an overview of some good practices for CHLEGs model on access to HIV, TB and SRH services to FSWs who are positive living and AGYW at high risk.

### 1.2.1 The objectives of the CHLEGs & DiC model are as follows;

- Increase uptake, retention and adherence on anti-retroviral therapy by eligible FSWs and AGYW living with HIV/AIDS.
- To increase access, affordability and utilisation HIV/AIDS, TB and SRH friendly services for FSWs who and AGYW at high risk of HIV and STIs.
- To increase access to a broad range of youth friendly services for AGYW at high risk
- To reduce gender-related barriers and practices which affect the access to HIV – TB and SRH for FSWs who are living with HIV

### 1.2.2 Summary Logical framework for the CHLEGs & DiC model




The Community Health and Livelihoods Enhancement Groups (CHLEGs) and DiC Model is a client centred and community led approach focused on the interests and needs of FSWs living with HIV and AGYW at high risk of HIV and STIs across the HIV Prevention and Treatment Cascade (PTC) The intervention is aimed at offering comprehensive and friendly services in one spot to FSWs and AGYW on antiretroviral therapy (ART). CHLEGs & DiC Model is helps to minimize the time FSWs and AGYW at high risk spend at the facility seeking and accessing health services. The CHLEGs model is also effective in increasing health seeking behaviours among FSWs and AGYW, reducing stigma, discrimination and extending financial opportunities to reduce poverty that compromises their ability to fulfil the linkage and clinical appointments.

### 1.2.1 Process and Methodology used in documenting the CHLEGs model

The documentation of this Model was conducted using qualitative method that was used to explore CHLEGs intervention in response to HIV cascade flow. Information including success stories and experience were shared by CHLEGs Coordinators and members, AWAC key staffs, AWAC key partners, health workers, district official and local officials were CHLEGs and DiCs are currently implemented. Literature from other Differentiated Service Delivery Models complemented field work. Key informant interviews were selected based on their positions, deemed knowledge and experience with Differentiated Service Delivery Model. Primary data was generated from FSWs and AGYW at high risk of HIV and STIs, District Health Officials (DHO) and local community leadership. Key informant interviews, were held with key persons who were selected based on their roles and responsibilities, their presumed interface with female sex workers(FSWs) and AWAC`s previous working relationship. A sample of 120 participants was selected and involved in the interviews.

## 1.3 FINDINGS

While FSWs have been involved in HIV programming especially within the CSO sector, a lot needs to be done as not all strategic actions enacted embrace enabling environment to benefit FSWs living positively with HIV and AGYW at high risk. Based on the experiences shared from the community, the CHLEGs& DiC Model has bridged some of the gaps in access to HIV/AIDS, TB, SRH and financial services for FSWs living with HIV and AGYW at high risk.

CHLEGs & DiC Model has targeted the abandoned population that include; AGYW at high risk, specifically out of school, young mothers living with HIV/AIDS) and positive living FSWs. Besides, through CHLEGs activities like client contact tracing, the secondary beneficiaries include; sexual partners of FSWs and their children.

The CHLEGs coordinators, mobilise, create awareness and provide frequent psychosocial support and counselling to fellow positive living FSWs and AGYW at risk of HIV/AID and STIs during the community safe space meetings held on a weekly basis. The CHLEGs coordinators are instrumental in facilitating strong helping relationship among fellow FSWs in Community. FSWs` peer leaders and CHLEGs Coordinators mobilize sex workers for services and escort and link them into care.

FSWs living with HIV commune in Community Health and Livelihoods Enhancement Groups (CHLEGs) to save , accumulate savings and loan to eligible members in times of health crises or upon spotting of a strategic entrepreneurship opportunity. During the community safe spaces, CHLEGs members also support one another regarding; demand creation, tracing index client contacts, ART adherence, and disclosure, retention and stigma reduction.

The model has benefited FSWs within the targeted communities, especially those who have interfaced with the activities of CHLEGs in Kampala Wakiso and Mukono. The concept of CHLEGs & DiC also brought to light a hidden population who believed they were abandoned e.g positive living FSWs and AGYW at high risk said the local leader from Kinawataka.

CHLEGs & DiC Model has contributed to the decentralisation of HIV/AIDS, TB and SRH services to the community at hotspot level. The model includes a structure with a trained health worker in the HIV prevention response who responds to issues of female sex workers instantly. HIV testing and counselling is done and linkage to ART.

All over the Drop in Centre walls, there are IEC materials with targeted HIV, TB, STIs messages. These are aimed at educating those who come to the DiC on the HIV, TB and STIs prevention response. When a client enters the DiC, they are attracted to the pictures and messages displayed and enable

them to have more questions to ask the DiC focal persons on the issues related to HIV, TB and STIs. These messages are produced in both English and the local language that is best known by targeted people.

Recreational activities including pool table, board games (omweso, ludo and chess) have been so instrumental in relaxing the minds of CHLEGs members and other FSWs with challenges with HIV, TB and STIs. Recreational activities have brought together FSWs to share experience and also find solutions to the challenges they have in life. Some report that, the games in the DiC help them to forget the life threatening challenges since some come when they are depressed, have anxiety and general stress.

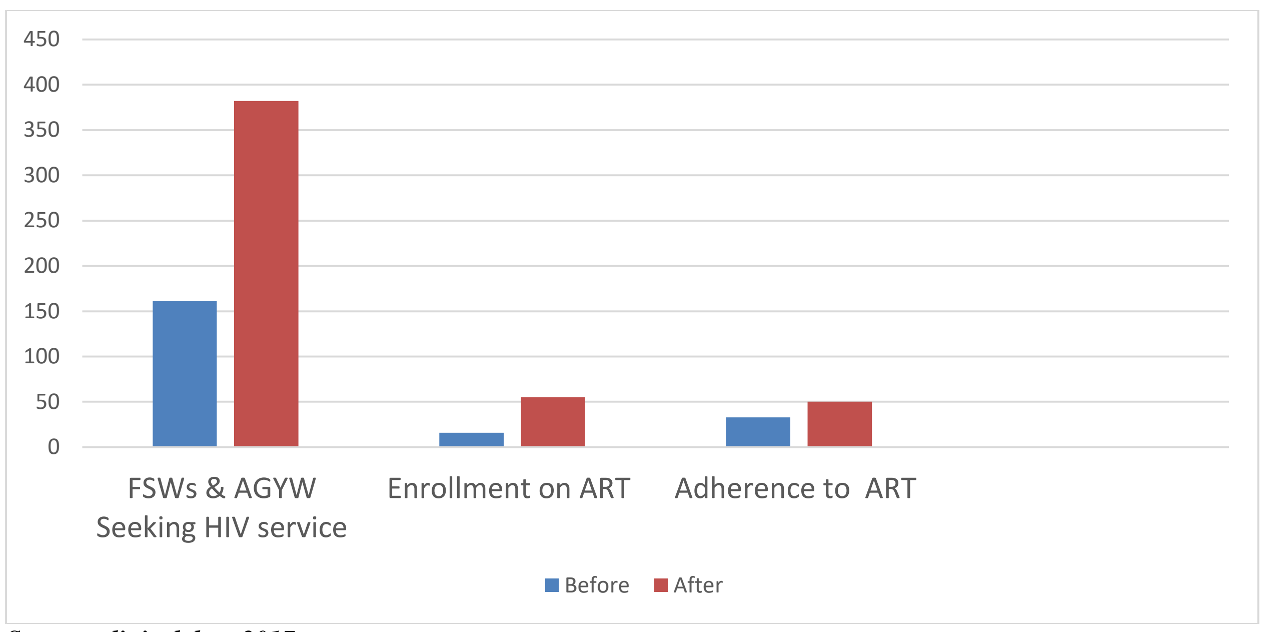
The CHLEGs & DiC Model has contributed to reduced risk behaviours among FSWs e.g; denying live sex for more money, adhering to ART and disclosure This can be supported by a positive living FSW who testified that she tested her viral load and found out her viral load was suppressed as narrated below:

> ***I used to live a life where I could drink alcohol all the time when at work as a sex worker, I was not mindful of my health or even taking ARVs despite the fact that I tested positive, in fact my life was all the time deteriorating, but when my colleague picked and persuaded me to join CHLEGs, I am realising a change in my life, I get time to visit the health centre to check my health and I have time to take my ARVs.***

## SUCCESS

The quantitative data from the AWAC clinical department has showed an increase in the access to HIV services by FSWs and AGYW as a result of the CHILEGs and DiC model. The results are illustrated in the table below;

**A graph illustrating the effects of CHILEGs and DiC model on HIV response among FSWs and AGYW at high risk**




***Source: clinical data 2017***

According to the AWAC clinical data for 2017, there has been an increase in the number of clients seeking HIV services, an increase in the enrolment rate for eligible clients and increase in the adherence rate as illustrated above and this is attributed to the CHILEGs and DiC models.

AWAC empowered FSWs by building their capacity in leadership, group formation, and this enabled them to form FSWs & AGYW at high risk community groups at the hotspot level. These groups were formed by positive living FSWs and AGYW at high risk of HIV/AIDS and STIs. Among these FSWs Community Groups include; Tusekimu Women Group with **50** FSWs living with HIV and AIDS as members and are between 18years+. In executing their mandates, these groups use the CHLEGs & DiC Model which they use to empower and equip fellow members with saving, providing psychosocial support targeting FSWs.

**During the FGDs;** Members of Tusekimu Women Group shared that they implement the CHLEGs & DiC Model through saving 3500 (USD$ 1)-10,000 (USD$ 3) - shillings every Wednesday during their group meeting and a contribution of 3500 (USD$ 1) as their welfare “munnomukabi”. During their group meeting on every Wednesday, they identify eligible clients who need further services, such as ART and refer these eligible clients to AWAC DiC or the near-by health centres that have friendly services. But when their member become sick during the other days not the meeting day, the members still give support to these eligible clients using the 3500 (USD$ 1) contribution that is contributed as

welfare during their usual meetings. A person who is given this contribution must return it after her situation is okay and without any interest attached. The group gives loans using the membership contribution fee of between 3500 (USD$ 1)-10,000 (USD$ 3) and any member who takes a loan returns it with an interest of 10%.

**A table below illustrates savings from January 2018 to June 2018**

| | **Total savings for CHILEGs by months** | | | | | |
|---|---|---|---|---|---|---|
| **CHILEGs group** | **January** | **February** | **March** | **April** | **May** | **June** |
| Tussekimu women Group | 250,000 | 300,000 | 450,000 | 1,000,000 | 2500,000 | 5,500,000 |
| Light Angels | 150,000 | 300,000 | 1,770,000 | 1,990,000 | 2,450,000 | 4,500,000 |
| Suubi Women Group | 50,000 | 250,000 | 990,000 | 1,350,000 | 2,000,000 | 2,990,000 |
| Mukono Girls Heal Initiative | 120,000 | 350,000 | 690,000 | 1050,000 | 1660,000 | 2100,000 |
| **Total amount** | **570,000** | **1,200,000** | **3,900,000** | **5,390,000** | **8,610,000** | **15,090,000** |

***Source: CHILEGs***

The above are weekly savings for the CHLEGs members from January to June 2018. Increase in the savings is based on the number of members in the group.

It is a must for every member of the group to attend group meetings, and any member who misses because of a genuine reason, has to inform the group and also send her husband to represent her.

Group members confirmed that, through their group, they have been able to support their families, send their children to school, and provide themselves with daily basics such as paraffin, match box, source and food. In addition, they use part of this money to meet their appointments with the health centres and DiCs.

The CHLEGs coordinators, mobilise, create awareness and provide frequent psychosocial support and counselling to fellow positive living FSWs and AGYW at risk of HIV/AID and STIs during the community safe space meetings held on a weekly basis. The CHLEGs coordinators are instrumental in facilitating strong helping relationship among fellow FSWs in Community. FSWs` peer leaders and CHLEGs Coordinators mobilize FSWs and AGYW

at high risk for services and escort and link into care, Community Health and Livelihoods Enhancement Groups (CHLEGs) where positive living sex workers to accumulate savings and loan to eligible members in times of health crises or upon spotting of a strategic entrepreneurship opportunity. During the community safe spaces, CHLEGs members also support one another regarding; demand creation, tracing index client contacts, ART adherence, and disclosure, retention and stigma reduction.

The model has benefited FSWs and AGYW at high risk within the targeted communities, especially those who have interfaced with the activities of CHLEGs in Kampala, Wakiso and Mukono district. The concept of CHLEGs also brought to light a hidden population who believed they were abandoned e.g positive living FSWs and AGYW at high risk said the local leader from Kinawataka.

The CHLEGs & DiC Model has decentralised social economic and health services to FSWs and AGYW in the community at the hot spot level. For instance it is said to be a safe space where positive living FSWs accumulate savings and loaning to eligible members in times of health crises or upon spotting of a strategic entrepreneurship opportunity. CHLEGs members also support one another regarding; demand creation, tracing index client contacts, ART adherence, and disclosure, retention and stigma reduction.

FSWs who are members of CHLEGs have gained various skills in developing business plans, saving, record and booking, mobilisation and communication, counselling and leadership skills, risk assessment and management e. For example some FSWs have started small business of their choice and interest in toiling in Kawempe-Light Angles Development group, craft, saloon and bakery. These ones secured financial additional loans from their CHLEGs under their CoSLA.

The initiative has enabled FSWs to graduate from not only looking at sex wok as the only survival activity but also looking at other financial alternatives. For instance through

***A display of some financial alternatives for CHLEGs members***

facilitating access to microfinance program and improved institutional maturity.

There are clear outcome indicators from CHLEGs beneficiaries on the impacts of CHLEGs & DiC model to the community. For instance, the intervention has contributed to increase in the retention of FSWs living with HIV and are on ART and this has contributed to viral load suppression among project targeted FSWs.

Targeted FSWs as CHLEGs members revealed to have accumulated savings which have helped them in times of health crises or upon spotting of a strategic entrepreneurship opportunity. For instance FSWs have participated in alternative businesses like bars and restaurant, charcoal selling, small boutiques, crafts and tailoring.

*A member of CHLEGs counting group weekly savings*

*I have been able to save through CHLEGs Community Savings and Loans Association and supported myself to picking ARVs on a scheduled date from the health facility, and i have nevermissed my appointment,* reported Namubiru (not real name) a positive living FSW.

Through the CHLEGs, members also support one another regarding; demand creation, tracing index client contacts, ART adherence, and disclosure, retention and stigma reduction. The CHLEGs spaces have given confidence to a number of FSWs-CHLEGs members to come out openly share experience and seek essential services. For instance;

> ***During one of the FGDs with CHLEGs in Wakiso District, a 32 year FSW and positive living testified that, she could not think that she could speak to anyone about her HIV status, that, she feared to be isolated and losing friends after exposure, but***

***the coming of CHLEGs has enabled her to create more friends who encourage her, counsel her and support her.***

***Above in one of the stake holders meeting the Kampala Capital City Authority Public Health specialist making presentation***

**Having interviews with the Mukono District HIV Focal person, When asked about the impact of CHLEGs in their community in his statement he said, "***I could not believe that groups like sex workers could have any development ideas, we thank AWAC for mobilising, engaging and connecting the group which we used to think are criminals in our community, to essential programs and services".*

Another point he made during the interviews was as follows, *"Our community has received many programs that target people living with HIV but CHLEGs is a unique programme that target a unique group which had been left behind, its services are decentralised to reach a sensitive group and we hope will reduce risky behaviours and also reduce the prevalence of HIV and AIDs among this group".*

CHLEGs have empowered FSWs who are living with HIV and AGYW at risk to self-manage their disease. Along with other factors, there is reported effective adherence that determines the changes in CD4 cell count, viral load and risk of resistance mutation accumulation while a patient is on ART, ie CHLEGs has been protective against loss to

adherence by FSWs who are positive living and on ART. In addition, the community also revealed that, counseling during the safe space meeting has helped the client to put their life experiences and feelings into spoken words.

*"Through the safe space meeting, we have realized that even just giving the client time to talk about his experiences can facilitate healing",* reported CHLEGs Coordinator.

### Success story

*Ever since AWAC HIV Testing outreach team came to our hotspot and diagnosed me with HIV, I have always been haunted by the monster of what might befall me in event of disclosing my HIV status to my spouse. One day my friends asked me what thoughts were eating at me and leaving me thinner with every passing day. I explained my situation to them and they then introduced me to CHLEG of fellow sex workers living with HIV. Two of the members supported me in disclosing to my husband through experience sharing and modeling disclosure. They were also present to support me as I disclosed to my spouse. As I speak, we are all taking our ARVs very well and we have never missed any clinical appointment. We always remind each other and we are supportive to our family. We thank God for my Caring Light Angels Women Group Sisters and AWAC.*

### Success story

*I will never forget this fellow sex worker who found me after I had been bedridden for a month in my room at our hot spot and literary came to my rescue. I was scared of getting to the health facility because I had missed ART clinical appointments and had not taken ARVs for a long time. In spite of being HIV positive, I went on selling live sexual services, drinking alcohol and also taking illicit substances. This fellow sex worker identified herself as AWAC supported CHLEGs member and counselled me on the benefits of sticking to medication and appointments and sharing with friends our worries and problems. She equally encouraged to join CHLEGs so as to tap into its health and social economic benefits.*

*Currently I am one of the CHLEGs members who adhere well to my drugs and clinical appointments. I no longer drink like i used to do. I feel happy and healthy.*

### 1.4 Effectiveness of CHLEGs & DiC Model

The effectiveness of the CHLEGs & DiC model was demonstrated by the findings from the CHLEGs beneficiaries which revealed that, the model has directly contributed to improved quality of lives of FSWs who are positive living and AGYW at high risk.

Four FSWs and AGYW led groups were supported by AWAC to formerly register and these groups directly implement CHLEGs and DiC model in their respective communities. These groups have bank accounts for security of their weekly savings, have work plans, take minutes whenever meetings held and registration using attendance lists. They report to the AWAC secretariat for further support.

### 1.5 Sustainability of the CHLEGs & DiC Model

Technical sustainability; this model uses a Client Based leadership ie CHLEGs leaders are fellow FSWs who are positive living and AGYW at risk. This group receives technical support from AWAC secretariat on the monthly basis and through its exchange learning meetings where all CHLEGs leaders are brought together to learn from each other. Technical support is in form of leadership, counselling and psycho-social support, advocacy, communication, documentation and reporting cases.

FSWs and AGYW groups that implement CHLEGs & DiC model are registered under districts and this gives an opportunity for these groups to tap into opportunities at the district including tapping, the Community Driven Development grants at the districts are expected to benefit these groups in the long run.

### 1.6 Impact(s) of the CHLEGs & DiC Model

Improvement in the health seeking behaviours among FSWs who are living with HIV and AIDS due to a reduction in the waiting time and reduced stigma, discrimination which made it hard to reach eligible FSWs and AGYW at high risk, their children and sexual partners with HIV testing services.

The model links members to financial support through their Community Savings and Loans Association leading to access to loans for those who have identified a strategic business for investment, thus a reduction in poverty that compromises FSWs` ability to fulfil the linkage and clinical appointments.

The approach also reduces disclosure challenges and poor adherence to Anti retro Viral Therapy

### 1.7 Gender

The approach has integrated gender issue into its activities where FSWs and AGYW at risk are the primary target, however, children of the FSWs and FSWs sexual partners have been also targeted as secondary beneficiaries of the approach. The intervention has so far benefited 2667 FSWs and AGYW, 324 sexual partners.

### 1.8 HIV and Aids

HIV/AIDS is a key critical factor in the design of the model, the design was based on a notion that, FSWs have high prevalence of HIV of up to 17% that is higher than the national HIV prevalence rate of 6.3%, adherence rate to ART by FSWs who are living positive and on ART is low and discrimination and stigma is high that deters access to HIV-TB and SRH.

### 1.9 Planning & Implementation of the model

The CHLEGs coordinators and AWAC technical team together with the local community and key stakeholders at the district are responsible for the implementation of this model.

### 2.0 Monitoring & Evaluation

Monitoring and Evaluation is one of the main tasks of AWAC. This is done on a basis of quarterly progress reports prepared by monitoring and evaluation officer AWAC at the secretariat. AWAC also undertakes a periodic monitoring and supervision of the progress and activities of CHLEGs & DiC.

### 2.1 Documentation & Reporting

Monthly progress reports are prepared by the CHLEGs coordinator and AWAC M&E officer who assess the impact of the model. The reports are forwarded to AWAC Head office for approval.

---

[i] MoH& ICAP, 2017

---

[ii] Vandepitte J., Bulenya J., Weiss H. A, Nakubwa S., Francia S. C., Hughes P., Hayes R., Grosskurth H. (2011). HIV and other Sexually Transmitted Infections in a Cohort of Women Involved in High Risk Behaviours in KampalabUganda. Sex Transm Dis 38, 316-323