National AIDS Council

HIV Biological And Behavioral Surveillance Survey Among Female Sex Workers Seychelles 2015

Final Report

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Abbreviation and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
BCC	Behavioral Change Communication
CSOs	Civil Society Organizations
FSW	Female Sex Workers
HCT	HIV Counseling and Testing
IBBSS	Integrated Behavioral and Biological Surveillance Survey
IEC	Information, Education and Communication
INLS	Instituto Naional de Luta Contra o SIDA
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSM	Men having Sex with Men
NAC	National AIDS Council
NAS	National AIDS Secretariat
NGOs	Non- Governmental Organizations
PE	Peer Educators
PWID	People who Inject Drugs
PLHIV	People Living with HIV
SADC	South African Development Community
STIs	Sexually Transmitted Infections
SWs	Sex Workers
TB	Tuberculosis

Preface

It is with great satisfaction that the National AIDS Council (NAC) presents the ***Female Sex Workers Integrated Biological and Behavioural Survey 2015: Final Report***. It has been a hectic year and a half of hard work, under the guidance of the Steering Committee, the Technical Working Group, the Study Team and the various support personnel such as research officers, nurses and laboratory technicians who have worked tirelessly to ensure that the study was completed on time.

It has also been a challenging time to ensure that the survey obtains the necessary ethical clearance to be conducted in Seychelles, to coordinate activities between Seychelles, Mauritius and Angola and to manage the day-to-day small and great difficulties to ensure a smooth operation of the project as a whole.

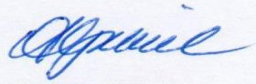
It has been a learning experience for the Seychellois team who has obtained a lot of new knowledge and skills in conducting respondent-driven sampling survey with key marginalized populations. There was a need for a long time to study FSW such as was done in 2011 with MSMs and PWIDs. FSWs are considered as a key population according to the ***National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs in Seychelles 2012-2016***.

The data from the FSW IBBS 2015 confirms that FSW are a key population at risk for HIV and that the HIV epidemic is a concentrated one in Seychelles. Through the survey, there was an opportunity to improve access to HIV care and treatment and to support positive preventioninterventions among FSWs. There are clear areas that need urgent attention, such as the school drop outs of girls before completion of secondary education, early pregnancy, and employment opportunities for women and girls with social problems and low educational knowledge and skills.

The National AIDS Council now has a lot of work to do to ensure that the results of the FSW IBBS 2015, which provided a safe environment for FSW-friendly HIV counseling and testing at the time of data collection from 13th July to 13th August 2015, will be used judiciously to enhance programme development and service delivery to FSWs in Seychelles. The estimated population of 586 FSWs, most likely on Mahé alone, is another sign that there is a need for urgent action.

Thus, it is my hope that, as a nation and as individuals, we will come together to ensure that no-one is left behind in any of the National Response to HIV and AIDS and that FSWs are provided with a comprehensive set of services to suit their particular needs as a group, as sub-groups and as individuals.

It is my sincere hope that we can work together to make this happen. For us, for our children and for the future of our nation.

Signature 

Dr Anne Gabriel
National AIDS Council

Executive Summary

The Female Sex Work Integrated Biological and Behavioural Survey 2015 (FSW IBBS 2015) was been commissioned by SADC. The study has being conducted to better understand the prevalence of HIV in Seychelles and to identify drivers of the epidemic for policy formulation and programmatic actions developments and adjustments, in line with the ***National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs in Seychelles 2012-2016***.

The survey participants were sampled with a methodology known as respondent driven sampling (RDS). This method is widely usedfor reaching hard to reach populations that are stigmatizedor considered at high risk for HIV and sexually transmittedinfections (STI's). Seychellois women and girlsaged 15 years and above who had exchanged sex for money in the past six months preceding the survey and who lived, worked or socialized in Seychelles were eligible toparticipate. In total 156 eligible FSWs were recruited toparticipate in the survey.

The survey was conducted between July 2014 and December 2015. This report presents the findings on HIV, STIs (syphilis, Hepatitis B and C) and population size estimations.

The HIV prevalence among FSWs was 4.6%. Hepatitis C prevalence was 34.6%. The behavioural data showed that FSWs were engaged in sexual behaviours that placed them at risk of contracting HIV and other STIs, with multiple partners including one-time partners (60.9%) and non-paying casual partners (20.5%). Male condom use was low (27.5%) with regular partner due to mutual trust. Female condom use was also very low.

Most of the FSWs were relatively young (around 24 years), with one or two children and having left school during the secondary education years (47.4%). Most (81.4%) were also single or were in co-habitation with a partner. Earnings pre and post sex work were very different, with only 0.6% earning about US$720 monthly doing other previous work and 21.2% with earnings of more than US$800 monthly with sex work.

The FSWs were knowledgeable on HIV (50.6%). However, when they personally had a health issue, only 50% went to a medical facility, usually a government one, for services. Even more alarming, there were 25% who did not seek medical assistance at all when they were experiencing symptoms. This may indicate a lack of trust in the health system. When it came to HIV and AIDS, the FSWs showed a lot of tolerance and understanding. However, when they were personally affected, they showed fear of letting others know their status or shame of being HIV positive (28.8%) or even self-blame (24.4%).

Use of illegal drugs was quite high (94.2%) and current use was also high (86.5%). Injecting drug use was reported by 39.7% and 30.8% were currently injecting, especially heroin.

Population size estimate showed that there were 586 FSWs on Mahé, the main island of the Seychelles. The survey did not extend to the other islands (Praslin and La Digue).

Recommendations included better informed service delivery, including a drop-in centre for FSWs and engagement of NGOs in helping to deliver targeted services such as goods, products, counselling and health services. Alternative skills training programmes were also suggested for those FSWs who may wish to stop working as such and seek other employment.

Chapter One: Introduction

The Seychelles mid-year population in 2015 is 93,419 , 50.4% women and 49.6% males with an annual growth rate of 1.0%. The age group 15 - 49 year olds accounts 84% of cases detected. The four key populations namely (MSM, PWIDs, SW and prison inmates) have not all been studied adequately. The study conducted in 2011 (MOH/COI/UNAIDS) with MSMs and PWIDs showed a HIV prevalence of 13.2% and that of Hepatitis C at 41.9% for MSMs; a HIV prevalence of 5.8% and 46.5% for Hepatitis C for PWIDs. So far, no study has been done amonsgt Female Sex Workers (FSW) and prison inmates.

In Seychelles, a number of studies conducted in recent years have yielded data about the HIV and AIDS pandemic in the country. The Knowledge, Attitudes, Behaviours and Practices and Biological Surveillance Study 2012 indicates that the prevalence of HIV in the general population is 0.87%. The four key populations (MSM, PWID, FSW and prison inmates) have not all been studied adequately. So far, there have been studies conducted on migrant workers, MSM and PWID. None has been done for prison inmatesand sex workers.

Seychelles is faced with a concentrated epidemic; HIV prevalence remains relatively low, with 0.87% in the general population. The HIV prevalence among 15 to 24 years is also low (0.76%). This result was obtained from the IBBS 2012 conducted in the general population and tests at outreach activities. The pandemic is a concentrated one, as indicated from the IBBS 2011 conducted with two key populations (MSM and PWID) which showed prevalence rates of 14% and 4% respectively.

However, for FSW, the Drug and Alcohol Council (DAC) and the Social Development Division conducted surveys in 2010. The DAC survey interviewed 33 SWs of whom 27 or 82% were female and 6 or 18% were males. There was 94% of the sample who admitted to abusing drugs, with the preferred drug being heroin, with 29 respondents out of 31 using only heroin or heroin in combination with other drugs. The findings also showed that 32 out of 33 respondents or 97% were injecting drugs. This study is further justified as there is a need to better understand the epidemic in Seychelles.

Respondent-driven sampling (RDS) was employed to sample approximately 150 FSWs over a period of 6 to 8 weeks. For the purposes of this study the populations being studied include those 15 years and older and live or work in Angola, Mauritius and Seychelles. Specific eligibility criteria of FSWs include being born female and having had penetrative vaginal sex in the past six months. This study will involve the collection of behavioral data through a face-to-face interview, and a HIV rapid test through finger prick. HIV testing will follow national guidelines for Voluntary Counseling and Testing (VCT) and participants who receive positive test results were provided referral for treatment and services. Findings were disseminated among stakeholders to inform prevention, care and treatment services for FSWs in Seychelles.

The Southern African Development Community (SADC) already has the highest prevalence of HIV infections globally, and levels of *new* infections (incidence) also remain high and are rising. If the

current trend continues, the region will not reach the MDG target of reversing and halting the epidemic by 2015.

The SADC Epidemic Report for 2007 examined *HIV prevalence rates among young adults aged 15-24*, a key indicator of the number of new infections in countries. Prevalence reported in Member States population surveys ranged from 2.7% to 16.2%, and it is clear in many parts of the region where more than one person in every ten aged 15-24 is infected with HIV.Infections among women outweigh male infections in this age cohort, making prevention among girls and young women of particular and urgent concern. Data is still limited for identifying trends in the number of new infections in Member States. However, in several countries, it appears that prevalence in this age group did not decline and in some cases actually increased, in the years leading to 2008.Overall there is recognition that HIV incidence remains too high in the majority of MS for them to avoid serious impact on their countries.

SADC leadership has demonstrated long-standing commitment to reversing the HIV and AIDS epidemic, and mitigating its impact on human development. The *Maseru Declaration on HIV and AIDS (2003)* by SADC Heads of State reaffirmed this and reinforced earlier commitments under other continental and global initiatives. Of particular significance are the *Millennium Development Goals (MDGs)* adopted in 2000, the *Abuja Declaration on HIV and AIDS, Malaria and other Communicable Diseases* (2001), the *Declaration of Commitment of the United Nations General Assembly Special Session on HIV and AIDS (UNGASS)* of 2001 and the United Nations General Assembly Declaration on Children.

At regional level, the epidemic is considered a priority and the regional response has been guided by the SADC Strategic Frameworks (2000–2004 and 2003-2007). At national level, all Member States have developed *National policies* on HIV and AIDS and *National Strategic Plans (NSPs)*. In addition, since 2000 there has been *a major improvement in the levels of funding* of national HIV and AIDS programmes. This has transformed the opportunities for scaling-up of programmes.

In addition to mobilizing resources for the secretariat, an autonomous Regional Fund was established under the Framework, to raise resources for national and regional responses from Member States, the private sector and ICP. By March 2009, MS had contributed $533 000 to the Fund.

In Seychelles, the cumulative number of People Living with HIV (PLHIV) since 1987 until December 2013 was 578, with 334 males and 244 females. There were 218 people on treatment, of whom 118 were men and 100 were women.

With the National AIDS Council, the National AIDS Control Programme and the Disease Surveillance and Response Unit, there is continual monitoring of the progress made in the national response to HIV and AIDS. The national strategic framework is also a tool to help monitor programmatic actions and indicators of success. Since the first case of HIV was discovered in 1987, the country has made great strides in developing strategies in all priority areas to address the pandemic. In policy development, there are now two generations of national strategic plans and national policies. The national workplace policy has been reviewed and a new one has been drafted. The national strategic framework also consists of a costed action plan and monitoring and evaluation framework to ensure that progress is adequately measured.

Interventions in terms of prevention has moved gradually from general one size fits all messages to more targeted interventions albeit being conducted more by NGOs rather than the Ministry of Health. The latter has also partially succeeded in getting the nation and key stakeholders to see that HIV and AIDS are not the sole responsibility of the Ministry, but that the issue is a national one, with the potential to wreak havoc with national development goals.

The surveillance of the epidemic is conducted at sentinel points, such as the Communicable Disease Control Unit (CDCU), antenatal clinics, Occupational Health Unit (OHU) and the blood bank in the Ministry of Health and reveals that there is an increasing trend in HIV infections.

The study is being conducted to better understand the prevalence of HIV in Seychelles and to identify drivers of the epidemic for policy formulation and programmatic actions developments and adjustments, in line with the ***National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs in Seychelles 2012-2016***.

1.2 Justification

The information collected in this project was used to re-orientate, plan and implement targeted HIV prevention, care and treatment activities. IBBS among FSWs is being repeated because of the i**mportance of key populations for the HIV epidemic.** The Key Affected Populations (KAPs) such as Female Sex Workers (FSWs), PWIDs and Men Having Sex With Men (MSM), through sexual and drug-using partners, may provide a bridge for HIV transmission to the general population. They are highly stigmatized, criminalized, and their sexually transmitted infection (STI) and HIV risk often goes unrecognized contributing to the spread of the infection.

Chapter Two: Objectives

The primary objective of this project is to provide essential data to track HIV epidemic trends among FSW and to measure the outcomes and impact of the national HIV response. This was done through two sites from each country.

The primary objective of this project in Seychelles is to provide essential data to track HIV epidemic trends among FSW and to measure the outcomes and impact of the national HIV response.

Specific Objectives

- To follow the trend in the prevalence of HIV among FSWs in Seychelles
- To assess sexual and other risk behaviours associated with HIV transmission among FSWs.
- To assess health seeking behaviours, including harm reduction and VCT among FSWs.
- To describe demographic characteristics of FSWs and to note the changes in their behaviors.
- To estimate population size of FSWs in Seychelles using a variety of multiplier methods.
- To develop capacity to strengthen national HIV surveillance systems for key populations.
- To provide information about FSWs to inform public policy and services and to assist the Government of Seychelles, the cooperating partners, and other local organizations in strategic planning.
- To estimate the prevalence of the co-infections link to VIH, Syphilis and Hepatitis Band C in FSWs in Seychelles.

Expected Outcomes

The following results are expected to be attained.

1. The sample size is reached.
2. The National baseline prevalence of HIV, HBV, HCV and syphilis are established.
3. The socio-demographic characteristics of FSW are defined.
4. The knowledge, attitudes, and risky sexual behaviours, drug use among FSW are determined, as well as assessment of health seeking behaviours, including harm reduction and HTC.

It is also expected that data collected will assist with the development of targeted intervention programmes and the monitoring of trends.

Chapter Three: Methodology

Sex Workers are highly stigmatized and their behaviours are illegal in Angola, Mauritius and Seychelles. The Respondent-Driven Sampling survey (RDS) was shown to be effective in Zanzibar in 2007, in Mauritius in 2010 and in Seychelles in 2011. Moreover, it has been successfully used in several other countries to sample FSW. RDS is a chain referral sampling method designed to reduce biases generally associated with chain referral methods. Although sampling is initiated by purposively selected recruits ("seeds"), the composition of the ultimate sample is independent of those initial subjects and may be considered representative of the sampled population.

Sampling Size

The selected sampling frame is using the RDS methodology. The total sample size is one hundred and thirty-eight sex workers (N=138.)

Lead Organisation NAC/MOH

Technical Working Groups will provide technical guidance in survey design, implementation and dissemination. The HIV AIDS Technical Advisory Committee in Seychelles will provide oversight. Recruitment of consultancy wiil be done following the approval of the project by the Health Research and Ethics Committees from Member States.

Proposed Time line

Actual timeline depended on the date of official ethical clearance from all parties.
Estimates:
START DATE: 1st July 2014
END DATE: 1st February 2014 (8months)

2.1 Rationale for use of Respondent Driven Sampling

Sex Workers are highly stigmatized and their behaviours are illegal in Seychelles. RDS was shown to be effective in Zanzibar in 2007, in Mauritius in 2010 and in Seychelles in 2011 and has successfully been used in several other countries such as Vietnam, Brazil, Montenegro and Russia to sample FSWs. Thus, RDS is a chain referral sampling method designed to reduce the biases generally associated with chain referral methods. Although sampling is initiated by purposively selected recruits ("seeds"), the composition of the ultimate sample is independent of those initial subjects and may be considered representative of the sampled population.

The main methods to be used are a questionnaire to collect data on knowledge, attitudes, behaviours and practices and collection of a blood sample for testing. The questionnaire will look at demographics, knowledge, attitudes and behaviours about HIV and AIDS and STIs. The sampling method is snowballing with the use of initial contacts with seeds who will then seek out other people in their networks as participants. There will also be a biological sampling exercise to test blood for HIV and STIs, such as syphilis and hepatitis C.

All ethical and methodological guidelines for such a study was observed, namely informed consent, confidentiality, respect of the person, withdrawal and risks to the participants as well as the enumerators, nurses and laboratory technicians.

2.2 Sample size calculation

Sampling

The selected sampling frame is using the RDS methodology. The total sample size is one hundred and thirty eight female sex workers (n=138).

Sample size for general population

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

Where,
At 95 % Confidence Interval, Z0.05, α = 1.96 p = Prior information; for safest point, overall knowledge of female sex workers for HIV/AIDS/STIs is 90.0%,

so "p" =0.90 and 1-p = 0.10

d = Effect size (precision),

Assuming over knowledge of female sex workers in Seychelles must have fluctuated in between 5.0% point, i.e., (85.0% to 95.0%), if so, "d" is expressed as decimal (0.05).

$$\mathbf{n} = \frac{1.96^2 \times (0.9) \times (0.1)}{(0.05)^2} = 138.3 \text{(rounded up to)} = 138$$

2.3 Eligibility and non-eligibility

Inclusion Criteria

Inclusion criteria for all females include 15 years and older and living/working in Seychelles.

The FSW must have been born female and had been having penetrative anal and vaginal sex with a male or female partner in the past six months (active or passive). Potential study participants must meet the following eligibility criteria to enroll in the study:

(a) Female

(b) Age: 15 years or older (if under the age of 18 years, subject must be an emancipated minor)

(c) Exchanged sexual intercourse (vaginal or anal) for money in the past 6 months (IBBS)

Exclusion criteria

Persons who meet the eligibility criteria may be excluded from enrollment in the study on the following grounds:

- Unable to understand or provide informed consent: this includes recruits who are thought to be under the influence of alcohol or drugs.
- Already enrolled in the survey.
- Received coupon from a stranger (does not know recruiter). (At the discretion of the PI or project manager, such recruits may either be excluded or used as a seed to start a new wave, depending on the stage of sampling and sample size recruited at that time).
- All male sex workers, even if they are working as transgendered males.

2.4 Enrollment of Minors

The UN General Assembly indicators suggest reporting on HIV/AIDS indicators in many groups from ages 15-24. The Government of Seychelles is required to report on these rates. The age of majority in Seychelles is also 18 years of age. However, the legal age of marriage for in Seychelles is 16 years of age with parental consent.

The importance of this study for delivering prevention and services in the population of 15-17 year olds is considered a high priority by the Seychelles Ministry of Health, the Youth Health Centre, Family Planning and ANC. Surveillance from all these organisations and sites includes youth aged 15 and older. Given that most FSWs, PWIDs, and MSM are unlikely to live with or near their parents and understanding the risks related to identifying them to family members or spouses, we propose to include emancipated minors aged 15-17 years in this study. This information was self-reported and questions for verification are built into the survey tool.

The enrolment of minors was done only with the following procedures.
(i) The legal guardians or the parents were asked for permission to interview their child, in the presence of the child.
(ii) If the parents or legal guardians refuse, then the proceedings are ended.
(iii) If the parents or legal guardians give their consent, then the child was asked to give his or her consent. After both have given consent, the interview takes place in private with the child.
(iv) If a parent or legal guardian gives their consent for HIV testing, then the child was asked to give his or her consent. After both have given consent, then the drawing of blood takes place. If the parent or legal guardian refuses to give consent for the biological sample, then the proceedings are ended.

To further protect minors and all study participants, no identifying information was collected. All participation was confidential and anonymous with referrals to local resources provided to all study participants who wish to receive services and support.

2.5Survey Design, Methods and Procedures

Recruitment

Recruitment of seeds: 4 to 6 seeds were recruited and were selected from contacts made through the liaison officer of the AIDS Unit and NGOs working FSWs. Special recruitment criteria for seeds were considered:

a) Well-connected within their networks (among peers);
b) Well-regarded by their peers;
c) Interested in the objectives of the survey;
d) Diversity with regard to socioeconomic status, age, years of selling sex, type of work, self-identity, ethnicity, religion, and place of work/residence in Seychelles.

b) Recruitment of participants:

According to RDS methods, the first wave of participants was recruited by seeds. Thereafter, each person recruited and enrolled in the survey will receive up to three recruitment coupons to use for recruiting their peers into the survey. Participants were allowed to participate one time only in the study. Duplication of respondents is a concern in any survey. Study staff will ask participants to self-report if they have already participated in the study. In addition, the level of compensation was set based on formative research to discourage repeat enrollment.

c) Coupons:

Each recruitment coupon was uniquely coded to link recruiters with recruits. Each participant's coupon number will also link the participant's consent form, questionnaire, test results, incentive, and test voucher for receiving results. The size and design of the coupon were determined in formative research. Coupons were produced on heavy paper and designed so they cannot be easily duplicated. Coupon identification numbers were carefully recorded in a logbook. The coupon numbering system permits easy monitoring of recruitment waves and tracks recruitment patterns, information which is crucial for analysis of RDS data.

2.6 Survey procedures

The survey procedures were divided into two parts: 1) Questionnaire; and 2) Biological testing. Participants had to complete both the questionnaire and Rapid Testing for HIV. All interviews, testing, counseling and return of results were carried out at the study site. Criteria for study site selection ensured convenience, accessibility, confidentiality and comfort for participants.

Questionnaires

After providing informed consent, respondents were administered face-to-face questionnaires (described in detail below) in Creole by trained interviewers. All questionnaires were translated from English to Creole and pre-tested before implementation to assure that language, cultural and peer norms are considered. All documents used for data collection were linked by the participant's coupon number. The questionnaire probed for the following:

Surveillance assessment

All participants were asked questions about their demographic background, current drug use if any, sexual behaviors, experience of sexual and physical violence and stigma, HIV knowledge and risk perceptions and service utilization. This survey should be completed in 45 minutes or less.

Network questions: Questions about a network size are embedded in the questionnaire. For example, a network size question for an FSW can be "How many other women who have exchanged vaginal/anal sex for money or in kind in the past six months do you know, they know you (you know their name and they know yours), they are 15 years and older, and you have seen them in the past 30 days and they live in Seychelles?" No personal identifiers were collected and all information was linked to the participant's coupon number.

Non-response Form

(Appendix B) Participants who return to the study site to collect their test results and/or secondary incentive may be asked to provide some additional information to assess information about people to whom the participant tried to recruit but the person refused to accept the coupon. This measured some non-response bias. Questions included those about the characteristics of individuals whom the recruiter approached and refused to accept a coupon.

Biological testing

In accordance with national testing guidelines, we propose to test for HIV, Hepatitis B, Hepatitis C and syphilis infections among FSW. Following the face-to-face interview, all participants met with the VCT counselor. Those who did not want to provide blood when they enrolled in the study was given another opportunity to provide blood at this time. If the participant now chooses to provide blood for testing, the VCT counselor will update the consent form. If the participant is still not willing to provide venous blood for testing, he/she still had the option of providing a specimenof blood.

Participants who consent to biological testing will receive pre-test counseling in accordance with national guidelines. Seven milliliters of venous blood were collected for diagnostic serology (RPR and TPPA), Hepatitis B and C determination and HIV by the VCT counselor/nurse using veni-puncture.

Testing procedures

HIV

Specimens were collected by trained nurses using standard HTC guidelines and procedures. Universal precautions were observed during blood specimen collection. Ten milliliters 10 mls) of venous blood were collected (universal clotted Container) from participants using venipuncture. After the specimen is collected, the HTC nurse will label the specimen container with the questionnaire number and will record the numbers in the 'specimen log book' and linked with the participant's respondent number identification number.

Specimens collected on sites were transported (by car in a in a specimen box everyday to the clinical laboratory of the Ministry of Health where experienced laboratory technicians trained for the survey will process the samples

Collected blood specimen was tested in the clinical laboratory using RAPID screening/Alere. HIV1/2 determine as a first test if the first test is non-reactive the result was recorded as HIV- Negative.

If that first test was reactive a second test was done using HIV1/2 Acon strip test and if still reactive a third test which is a confirmatory test was done using Inno-lia HIV1/2 score and the result was recorded as final HIV status.

All reactive specimens from Praslin and La Digue were transported to the Clinical Laboratory of the Seychelles Hospital for confirmatory test.

All collected specimens should be accompanied with their corresponding data collection forms and laboratory request form to the clinical laboratory.

At the laboratory each blood sample was centrifuged for 5 minutes at 3000 rpm. Two 0.5-ml serum tubes were aliquoted for each sample by laboratory technicians into cryotubes from the vacutainer tube and the total number of cryotubes aliquoted was recorded.One aliquoted serumwas used for rapid HIV testing.

Quality assurance testing was performed on all positive samples using HIV Alere1/2 and Inno-LIA HIV1/2 score in parallel. The other aliquots were stored at -20^{o}c.At the time of testing only one aliquot per test was retrieved from storage and was documented.

The laboratory technician filled the testing worksheet which bore sample ID, date of specimen collection, assigned Lab number and initials of personnel receiving specimen. Manufacturers' instructions of individual test kit were followed to perform all the testing. Package inserts were included in standard operational procedures.

Proficiency testing was done at the beginning of testing period in each laboratory involved. Quality assurance confirmatory testing was performed on all Reactive samples using Inno-LIA hiv1/2 score (line immuno assay)

Specimens were tested using the national testing algorithms for HIV. Laboratory technicians and the counselors were trained on the receiving, documentation and standard operational procedures for this project prior to commencement.

The remaining serum was stored by the clinical laboratory technician of Seychelles Ministry of Health @-80^{0}C. All results were counterchecked and signed off by a senior Laboratory technician before dispatch. All test results were dispatched within 07 days (two calendar weeks) of sample receipt in the laboratory

Hepatitis B

Sampleswere tested in the clinical laboratory using monolisa.Hbs.ag ultra as the first test using Elisa technique,if the first test is non- reactive the result was recorded as Hepatitis B negative then if that first test is reactive a second test was done using Hbs.ag Determine Alere rapid strip and if still reactive a confirmatory test was done using HBs.Ag Ultra confirmatory test and result was recorded as final Hepatitis B status.

Hepatitis C

Sampleswere tested in the clinical laboratory by using Human Hexagon HCV rapid test as the first test and if found non- reactive at that stage result was recorded as Negative.

If that first result is found reactive it was duplicated by the same rapid strip(Human Hexagon HCV) then a confirmatory test was done using INNO-LIA HCV SCORE and result was recorded as the final Hepatitis C status.

Syphilis

Sampleswere tested in the clinical Laboratory by using RAPID HUMAN SYPHILLIS RPR TEST as the first test if test is non-reactive at that stage result was recorded as Negative, if test is reactive itwas duplicate twice and then a confirmatory test was done using BIO-RAD TPHA agglutination test and the final result was recorded as the final SYPHILLIS status.

Table 1: Specimen collection and laboratory tests

Test	Laboratory	Volume
Specimen: Serum		
Alere HIV-1/2 and HIV 1/2 ; Acon, HCV,Syphillis and Hepatitis B	Tests conducted in the Laboratory.	**10mls**
HIV,HCV Quality Assurance: Innolia Line Assay,	All Reactive samples for confirmatory test ran in the Clinical Laboratory	
HCV,SYPHILLIS,HEPATITIS B	Test done in the clinical laboratory	

Provision of test results

Each participant who consents to an HIV test will receive post-test counseling and their test results during their follow-up visit. After specimen collection, each participant will receive a test voucher with their coupon identification number and instructions for obtaining test results. Participants were able to receive test results at the study site, approximately two weeks after their interview on designated days. Post-test counseling for infections was provided by trained counselors in conjunction with the provision of results and referral for appropriate treatment or other services when applicable. All participants who receive positive HIV or STI test results will also be encouraged to refer their sexual partners for medical follow-up and treatment. If a participant loses their test voucher, they can be identified with their payment coupon number, if they have it (used to collect secondary incentive).

The study site was kept open for two weeksafter the last participant is enrolled and/or all test result appointments are completed to ensure that everyone has a chance to receive their test results if they want to. Study staff will monitor the proportion of participants returning who collect their test results as well as treatment for STIs or referrals for HIV or STI management.

Table 2: Survey steps and participant flow

Steps		Staff responsible	Comments
Initial visit to study site			
1.	Introduction to the survey	Site supervisor/Screener	
2.	Eligibility process	Screener	
3.	Informed consent	Screener	Informed Consent Form, Appendix A
4.	Face to face interview	Interviewer	Surveillance Assessment Questionnaire, Appendix B
5.	Pre-test HIV and infection counseling	VCT Counselor/Nurse	Participants were asked again at this time if they agree to be tested
6.	Collection of blood specimens	VCT Counselor/ Nurse	Only participants agreeing to provide specimens.
7.	Explanation of coupon recruitment process and provision of coupons	Screener	
8.	Provision of primary incentive	Screener	
Return visit to study site for results and secondary incentive (after 2 weeks)			
9.	Non-response questionnaire	Counselor or interviewer	Non-response form, Appendix C
10.	Post-test counseling and test results	VCT Counselor/Nurse	
11.	Provision of secondary incentive	Screener	Based on number of recruits who successfully enrolled in study

Compensation for participation

Compensation (i.e. "incentives") is an essential part of RDS methods. RDS relies on survey participants to identify, approach, and inform future recruits. Further, recruits must travel to the study site for their interview and are asked to return for a second visit. Recruits should be compensated for their effort, time and travel costs associated with participation (primary incentive) and recruitment of peers (secondary incentive).

The primary incentive is paid to eligible and consenting recruits at their initial visit as compensation for transport costs and time spent on survey participation. The primary incentive was estimated at USD25 (SR300) and was paid to all participants who enroll in the survey.

Secondary incentives are provided to compensate participants for their assumed costs and time to identify and recruit peers for participating in the survey and transport costs related to the second visit. Participants will receive approximately 12.5 USD (SR150) for each of their eligible recruits who enroll in the survey, up to a maximum of three recruits.

Possible total for participation and recruitment were USD37.50 or SR450 for each participant.

Ending RDS and Reaching Sample Size

As recruitment nears sample size, no new coupons were distributed and the duration of the expiration periods were narrowed to reduce the chances of persons trying to enroll in the study once it has ended. During every interview, all participants were informed that no more interviews were conducted once the sample size is reached. Furthermore, interview sites will have a protocol in place for explaining the termination of the survey to those who show up once the sample size is reached. Interview sites will remain open for at least one week after the last coupon is distributed in order to continue providing HIV education, secondary incentives and VCT. Office closing dates will also be explained to participants and posted outside project sites.

If necessary, once 75% of the sample size is reached, the study supervisor may inform study staff to reduce the number of recruitment coupons dispensed to participants from three coupons to two coupons to one coupon. Determining when to end RDS recruitment will take several factors into consideration including the number of recruits still need to reach the sample size, number of valid (unexpired) coupons still in the community, and average number of FSW enrolling at the study site every day.

Unique Identifier

The first approach for the multiplier would be the "unique object technique". This approach involves gathering the "first multiplier" component by distributing key chains or some other unique and memorable object to FSWs through existing peer outreach activities one week in advance of the study. The timeframe for passing out key chains of one week will limit in and out migration and minimize the possibility that FSWs give their key chain away.

Peer educators from multiple community outreach projects will distribute special "unique identifier" to people they identify as FSWs. Each person will receive only one "unique identifier", and were asked to keep the "unique identifier" because they may be asked about it the near future by another project staff. The peer outreach workers were meant to use log forms to keep track of when, where, and to whom they have distributed the "unique identifier" and will ask a series of questions to determine whether the participant had previously received a "unique identifier". Instead, the peer leader asked these questions for each respondent who came in for the interview. In an effort to test the validity of this method another unique item (e.g., cosmetic bags) was also meant to be distributed in the same manner described above on different days. However, it was not possible to do so.

The goal was to distribute as many of the unique identifiers as possible, but no fewer than the study sample size.

The RDS survey will ask each participant the following questions:

1) Have you received one of these in the past (time period)? Interviewer shows the "unique identifier".

2) From whom did you receive it (if they have received the "unique identifier" from someone other than a peer educator, they were eliminated from the multiplier)

3) Where did you receive it? (To verify the "unique identifier" was received in the catchment area).

Service Data

The second approach for the multiplier is through the use of "service data". This approach involves gathering the "first multiplier" component by using data of one time visits by population members in the previous six months to different services (NEP, outreach, visits to NGOs providing services to KAPs, etc.)

The second multiplier was enumerated during RDS among FSWs. The survey will ask each participant the following questions:

1) Did you have exposure to a particular service (name of service) at least one time during anytime between (put six month period prior to the start of the RDS study)?

2) When did you have exposure to this particular service? (Validation question)

Multiplier Calculation

By using the overlapping number of interviewed (encountered through both peer education contacts and respondent driven sampling) as a numerator, we were able to estimate the size of the FSW population.

The mathematical formula to calculate the total size of the population is:

$N=1/p * M$

Where:

N=Estimated Size

P=Proportion of FSW in survey corresponding to list or multiplier

M=Number of FSW who received key chains from outreach workers before the survey or those who had exposure to a particular service during the proposed six month period.

95% confidence intervals were constructed around the resulting number using the formula:

$95\% CI = N +/- 1.96 \sqrt{Var (N)}$

On-site and off-site study personnel and training

The following personnel were trained prior to the actual survey:

(i) Site Manager

(ii) Screener/Coupon Manager

(iii) Interviewers

(iv) VCT Counselor/Nurse

(v) Laboratory personnel

(vi) Data Manager

3.0 ETHICAL CONSIDERATIONS

3.1 Benefits to participants

Participants may receive the following benefits:

(a) VCT (including risk reduction counselling);
(b) For HIV-infected participants, referral to the treatment and care centre was provided. Antiretroviral therapy (ART) is available free of charge and easily accessible in Angola, Mauritius and Seychelles, hence it is expected that all eligible HIV-infected participants were able to receive ART.
(c) The project aims to inform HIV prevention activities among FFSWs, benefiting their population as a whole and hence all MARP members, including survey participants

Risks to participants

The blood draw involves minimal physical risks, including that of bleeding, bruising, fainting, light-headedness, and the rare risk of trauma and infection. The survey will hire only trained medical personnel and will ensure an adequate supply of new, sterile disposable needles.

There is inconvenience to participants due to the time required to complete the survey and collect samples. There is a psychological risk due to the sensitive nature of the questions in the structured questionnaire. The questionnaire will not contain personal identifiers (only an identification number), and the participants are informed they can refuse to answer any question.

There are also some psychological risks from learning that one has an infection or HIV, and the risk of inadvertent disclosure of HIV or other infection if positive. Every participant will receive pre and post-test counseling. Participants found to test positive for HIV, hepatitis B or C, and syphilis were referred to specialized care for further evaluation and treatment if available.

Participants were encouraged to notify their partners if they have been diagnosed with HIV or other infection. VCT counselors will discuss partner notification strategies during counseling sessions and for HIV-positive participants, referrals for couples counseling were made. Because the study deals with stigmatizing issues such as sex work and HIV status, participants may be at risk if their identity is revealed to persons other than survey staff or if the purpose of the study becomes known. However, we will attempt to keep this survey outside public awareness during data collection and we will not collect personal identifiers. All hard copy data, signed consent forms, and access for electronic data were stored in locked file cabinets. We will also employ a security guard at each survey office.

Informed consent

All participants must be aged 15 years or older and willing and able to provide verbal informed consent (Appendix A). Following careful explanation of the survey, study staff will give eligible participants the consent form which was available in English and Creole. For illiterate participants, the interviewer will read the consent form out loud and sign as witness of the informed consent process. Persons who are deemed by staff personnel to be under the influence of alcohol, drugs or other substances, or who do not fully understand the informed consent procedures, will not be enrolled in the study. Participants were informed that their participation is voluntary, that they may stop at any time, or refuse to answer any questions.

Participants were informed about their rights for medical care, including current antiretroviral ART available according to local standard of care. Every participant will receive pre- and post-test counseling regarding HIV and other infections from experienced and trained personnel.

3.2 Confidentiality and anonymity

All test specimens, results and behavioral data were linked through a unique number. No personal identifiers were collected.

Data security and privacy

Access to the recruit interview data was limited to the data/coupon manager, site manager, data analyst, and investigators. Data files were password protected. Any hard copy recruit data as well as signed consent forms were stored in locked file cabinets, as were access for electronic data.

4.0 Data management and analysis

4.1 Data management

Hard copies of the questionnaires were transported to the MOH for data entry. All data were double entered and backed-up daily in a Behavioral Surveillance Database to be created specifically for the study. Data were managed by the survey data manager who will run weekly cleaning and validation programs and will provide feedback to the field to carry out appropriate corrective actions.

Coupon information was collected on paper forms by the screener in the interview location. These forms were sent to the MOH office daily for entry and monitoring. A coupon database was maintained in Excel at the MOH office to monitor participants‟ date of enrollment, coupon expiration date, coupon number and the coupons provided to participants for purposes of recruitment.

Sample collection and transport were monitored through paper records. These forms were collected weekly by the MOH and were taken to their offices and entered into a database. Test results for HIV were recorded into an HIV results form at the testing sites and results for other infections were recorded at the laboratory and entered locally into a Lab Test Result Database. Double data entry was performed to minimize errors. Data errors and missing data were cross-checked against hard copy data where available.

Hard copy and back-up disks of all data were stored in locked file cabinets at the AIDS Unit. Databases containing this information, hard copy files and consent forms were destroyed five years after the completion of the survey.

4.2 Data Analysis

Data was analyzed with SPSS RDSAT, a software package that adjusts data collected with RDS for social network sizes and recruitment patterns. For instance, individual social network sizes for FSWwere measured by the response to the question: "How many other women do you know who have exchanged sex for money or kind in the past six months, are 15 years or older, living in Seychelles, you know them and they know you and you have seen them in the past 30 days?" The social network size sets up the probability of selection in the sample and provides weights for estimations. The recruitment patterns set up transition probabilities needed to calculate the pre-weighted estimators and account for homophily.

There was analysis of prevalence of HIV and other infections, sexual and drug-related risk behaviors, demographic characteristics and variables on the nature of high risk behaviors in Seychelles using breakpoint and partition analyses in RDSAT. Estimators and 95% confidence intervals for sexual and other risk factors associated with HIV and other infections transmission were analyzed using partition and then prevalence analysis. These analyses form the core of HIV surveillance among FFSW and were reported as such by the MOH.

Some data may be used for more advanced statistics to examine associations between HIV and other STIs and associated risk factors. If multivariate analyses are conducted, RDSAT was used to produce individualized weights on the dependent variable used in multivariate analyses. RDSAT-generated weights were exported into a standard statistical package (SPSS) for multivariate analysis.

5.0 Timeline

Actual timeline will depend on the date of official ethical clearance from all parties. Estimates are indicated in the tables below.**START DATE**: 1st July 2014 **END DATE:** 31st December 2015

6.0 Dissemination of Findings

After data analysis is completed, an oral debriefing was conducted with key stakeholders, including the MOH, FSWs, members of the study population and participating clinics/providers. Results from this survey were presented at national, regional and international meetings and submitted to international peer-reviewed journals.

7.0 Budget Summary

No.	Objectives	Amount in USD
Objective 1	To Prepare and undertake of desk review	114,975
Objective 2	To Prepare and develop Research Protocol	6,250
Objective 3	To seek ethical clearance from national Ethics Committee	00
Objective 4	To recruit and train of Research Team	57,535
Objective 5	To undertake data Collection	3,200
Objective 6	To enter and clean collected data	1,700
Objective 7	To analyse collected data	400
Objective 8	To disseminate data of Result	2,750
Objective 9	To Monitor and Evaluate the joint project in the 3 countries	49,733
TOTAL		**236,543**

8.0 Results

The expected sample size was 138. The number of participants exceeded expectation with 156 in total.

Demographics data

Age groups

The highest number of participants was in two age groups: the 20-24 years and the 30-34 years, with 32 or 20.5%, compared to three other age groups: the over 50 years, with 4 or 2.6%; the 45-49 years, with the 6 or 3.8% and 15-19 years, with 13 or 8.3%(Figure 1). Most respondents were between 16 and 34 years (107 or 68.6%).

The youngest and the oldest respondent were 16 and 57 years old, respectively. The age range was 41, whereas the mode was 30 and 33 years of age and the median was 30 years.

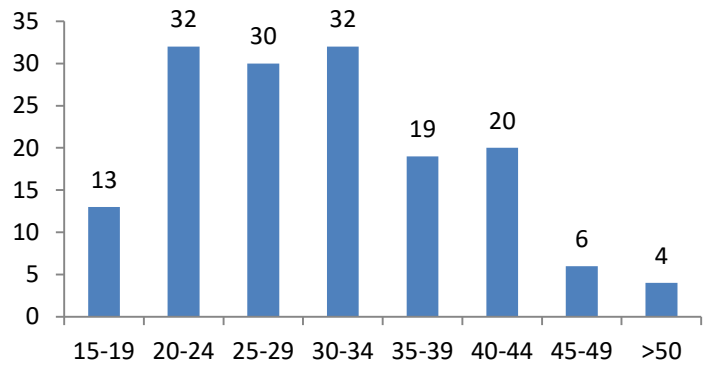


Figure 1: Age groups of respondents

There were 122 or 78.2% of respondents with children and 34 or 21.8% with none (Table 8.1). The older the respondents, the more of them had children compared with the younger ones (Figure 2). In the 15 to 19 age group, nearly half had children (6 or 46.2%; N=13) compared to 7 or 53.8% who did not have children. There was an even split in the 20 to 24 year age group, whereas in the 25 to 29, 30 to 34 and 35 to 39 age groups there were more respondents with children than those with none (23 or 76.7%, N=30; 29 or 90.6%, N=32; 18 or 94.7%, N=19).

From 40 years old onwards, all respondents had children.

Table 8.1: Respondents with children

Have children		
Yes	122	78.2
No	34	21.8
Total	**156**	**100**

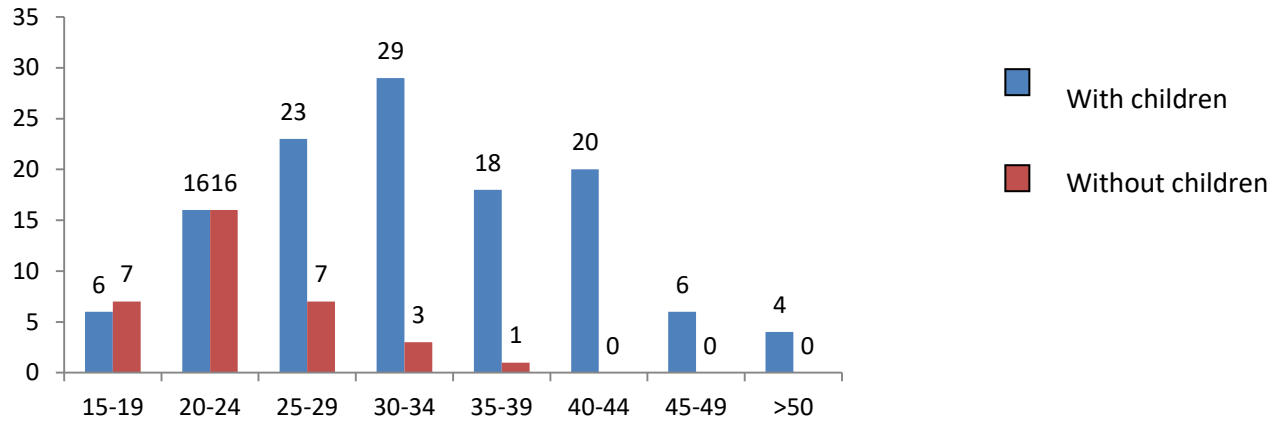


Figure 2: Comparing respondents with children and without children by age group

Most respondents (98 or 62.8%) had never married or had common-law husbands (29 or 18.6%), while there were 14 or 9.0% who were and had been married. There were 9 or 5.8% of respondents who were currently married (Table 8.2).

Table 8.2: Civil status of respondents

Civil status	Frequency	%
Currently married	9	5.8
Separated	12	7.7
Divorced	4	2.6
Widowed	1	0.6
Nevermarried	98	62.8
Common-law	29	18.6
Not recorded	3	1.9
Total	**156**	**100**

Most of the respondents (116 or 74.4%) had completed their secondary education, compared to 4 or 2.6% who had completed primary education, 25 or 16.0% who had finished post-secondary technical education and 9 or 5.7% who completed a post-secondary academic education programme.

Table 8.3: Highest level of education

Highest level of education	Frequency	%
Primary	4	2.6
Secondary	116	74.4
Post-sec. Tech.	25	16.0
Post-sec. Aca.	9	5.7
Diploma	2	1.3
Total	**156**	**100**

In terms of employment, 130 or 83.3% of respondents had worked before compared to 26 or 16.7% who had never worked before.

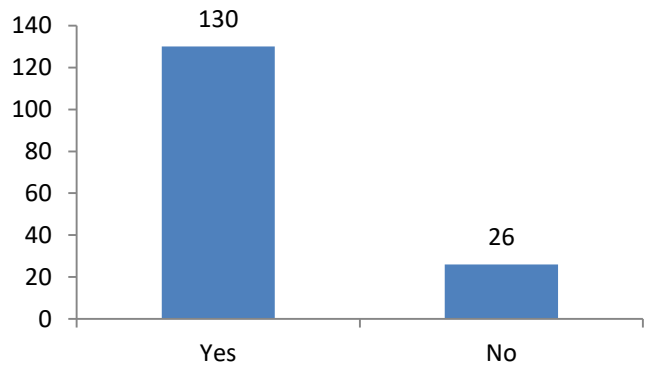


Figure 3: Lifetime employment

Earnings before and as a sex worker

The research also explored the respondents' earnings as a sex worker and in other employment. The highest earning was SR10,000 (the respondent had no children and was aged 24 years) compared to the lowest earning of SR600 (the respondent had no children and was aged 20 years). Most respondents (104 or 66.7%) indicated that there were earning less than SR5,000 per month when they were in employment. Twenty-six or 16.7% of respondents earned more than SR5,000 or had never worked before (Table 8.4).

Table 8.4: Monthly earnings

Monthly Earnings in rupees	Number of respondents	%
<1,000	3	1.9
1,000-1,999	9	5.8
2,000-2,999	28	18.0
3,000-3,999	41	26.2
4,000-4,999	23	14.8
5,000-5,999	10	7.4
6,000-6,999	6	3.8
7,000-7,999	5	3.8
8,000-8,999	3	1.9
9,000-9,999	1	0.6
>10.000	1	0.6
Did not work	26	16.7
Total	**156**	**100**

As for earnings in the last month, the highest earnerwas a 21 year old with no children (SR60,000) and the lowest earner was a 47 year old with one child. Thirty-three or 21.2% of respondents had a monthly income of over SR10,000 in July 2015 compared to 79 or 50.6% who earned less than SR5,000. Forty-one or 28.6% of participants earned between SR5,000 and SR9,900 in the last month (Table 8.5).

Table 8.5: Earning last month

Earnings last month (SR)	Number of respondents	%
<1,000	4	2.4
1,000-1,999	14	8.9
2,000-2,999	20	12.8
3,000-3,999	26	16.7
4,000-4,999	15	9.6
5,000-5,999	13	8.3
6,000-6,999	15	9.6
7,000-7,999	2	1.2
8,000-8,999	7	4.2
9,000-9,999	4	2.4
>10.000	33	21.2
Don't know	2	1.2
Not applicable	1	0.6
Total	156	**100**

Most respondents (91 or 58.1%) reported that they were paid between SR100 and SR500 for their last sexual encounter, compared to 36 or 23.0% who were paid from SR501 to SR1,000 and 25 or 16.0% who earned between SR1,001 and SR3,000 for their last sex with a client. Three or 1.8% of respondents reported getting over SR3,000 for their last sexual encounter (Table 8.6). Three respondents or 1.8% reported being given SR5,000, SR10,000 and SR15,000, respectively.

Table 8.6: Earning at last sex encounter

Earning at last sex (SR)	Number of respondents	%
<100	1	0.6
100-500	91	58.1
501-1000	36	23.0
1001-3000	25	16.0
>3000	3	1.9
Total	**156**	**100**

The smallest amounts ever received in the last six months are presented below in Table 8.7. Three respondents or 1.9% reported earning SR50, compared to 2 or 1.3% who indicated that they earned SR1,500. The most common smallest figure for sex was SR100 (33 or 21.2%), followed by SR200 (27 or 17.3%), SR500 (26 or 16.7%), SR300 (25 or 16.0%), and SR150 (24 or 15.4%).

However, 142 or 91.0% of respondents earned between SR100 and SR500 for the least amount of money received for sexual intercourse.

Table 8.7: Smallest amount of money paid for sexual intercourse

Amount (SR)	Number of respondents	%
50	3	1.9
100	33	21.2
150	24	15.4
200	27	17.3
250	5	3.2
300	25	16.0
400	2	1.3
500	26	16.7
600	1	0.6
800	3	1.9
900	1	0.6
1000	4	2.6
1500	2	1.3
Total	**156**	**100**

Table 8.8 shows the largest amount paid in the last six months for sexual intercourse. The most common amounts range from SR1, 001 to SR3, 000 with 69 or 43.9% of respondents reporting such. Thirty-five or 22.4% of respondents indicated that they received between SR501 to SR1,000, whereas 17 or 10.8% reported earning between SR3,001 and SR5, 000 and 16 or 10.2% with reports of SR100 to SR500.

Table 8.8: Largest amount of money paid for sexual intercourse

Amount	Frequency	%
100-500	16	10.2
501-1000	35	22.4
1001-3000	69	43.9
3001-5000	17	10.8
5001-7000	3	1.9
7001-9000	4	2.4
>10000	12	8.4
Total	**156**	**100**

Sexual behaviour

Age of first sexual encounter

The respondents reported that 19.2% of them had sex before the age of 15 years compared to 57.0% who had their first sexual encounter between the ages of 15 and 17 years and 19.2% who had their first sex between the age of 18 and 21 years (Figure 4).

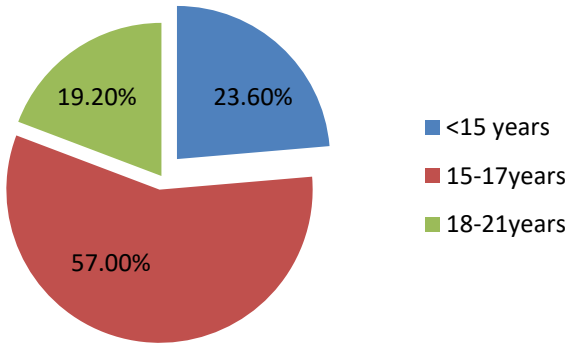


Figure 4: Age of first sex

The youngest age for first sex was reported at 9 years old (1 or 0.6%), followed by another one (0.6%) at 10 years, 3 (1.9%) at 11 years, 10 (6.4%) at 12 years, 8 (5.1%) at 13 years and 14 (9.0%) at 14 years. For those respondents, this situation constituted child sexual abuse (Table 8.9).

Table 8.9: Age of first sexual encounter

Age of first sex	Frequency	%
9	1	0.6
10	1	0.6
11	3	1.9
12	10	6.4
13	8	5.1
14	14	9
15	30	19.2
16	29	18.6
17	30	19.2
18	22	14.1
19	2	1.3
20	3	1.9
21	3	1.9
Total	156	100

A majority of respondents (113 or 32.4%) had between 2 and 5 and 6 and 10 partners in the last month, whereas 8 or 5.1% had one only compared to 13 or 8.3% who had 11 to 15 partners (Table 8.10). Twenty-two respondents (22 or 14.1%) had 16 or more sexual partners in the last month. One participant reported having 115 clients in the past month.

Table 810: Number of sexual partners in last month

Number of sexual partners in past month	Frequency	%
1	8	5.1
2-5	69	44.2
6-10	44	28.2
11-15	13	8.3
16-20	7	4.5
21-30	7	4.5
31-40	2	1.3
41-50	0	0
>51	6	3.8
Total	**156**	**100**

The study also enquired about sex with different types of partners. These were regular partners whoincluded a spouse, a live-in boyfriend or a steady partner, a casual partner, a one-time client, a tourist or foreigner or other types of clients.

Sexual behaviour with steady partners

The respondents indicated that the majority of them (85 or 54.5%) of them had sex with a steady partner in the past one month, compared to 71 or 45.5% who did not (Table 8.11).

Table 8.11: Sexual intercourse with steady partner in past month

Had sex with a steady partner	Frequency	%
Yes	85	54.5
No	71	45.5
Total	**156**	**100**

Most respondents (60 or 68.9%) did not use a condom with their steady partner in the past month, compared to 21 or 24.1% who always did so, and 3 or 3.4% who used one most of the time or occasionally (Table 8.12).

Table 8.12: Frequency of condom use with steady partner in past month

Frequency of condom use with steady partners in last month	Frequency	%
Always	21	24.1
Most of the time	3	3.4
Occasionally	3	3.4
Never	60	68.9
Total	**87**	**100**

However, the number of respondents who used a condom at the last sexual encounter with their steady partner was low, with only 25 or 16.0% who did so. The majority of the participants did not use a condom at their last sexual contact (Table 8.13).

Table 8.13: Use of condoms at last sexual encounter

Use of condoms at last sex	Frequency	%
Yes	25	16.0
No	62	39.7
Not recorded	1	0.6
Not Applicable	68	43.6
Total	**156**	**100**

For those who chose to use a condom (Figure 5), it was mostly (64.0%) the respondents themselves who suggested that one should be used, compared to a minority of them where it was the partner (8.0%) and where it was a mutual decision taken (28%).

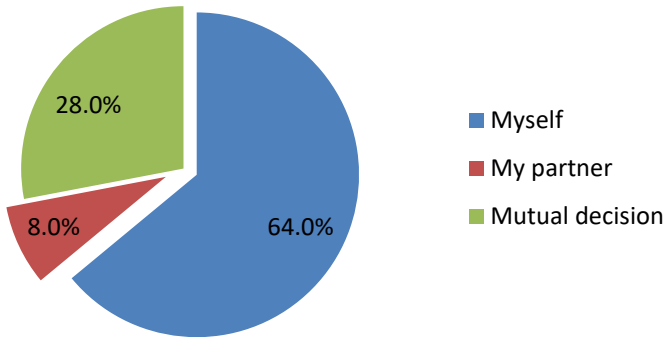


Figure 5: Initiator for condom use with a steady partner

As for those who chose not to use a condom, the majority of respondents (87.1%) indicated that they did not use a condom because they trusted their partner, whereas for 8.1% of them, the partner objected to their using one and for 1.6% of respondents, they were too drunk or high to use a condom (Figure 6).

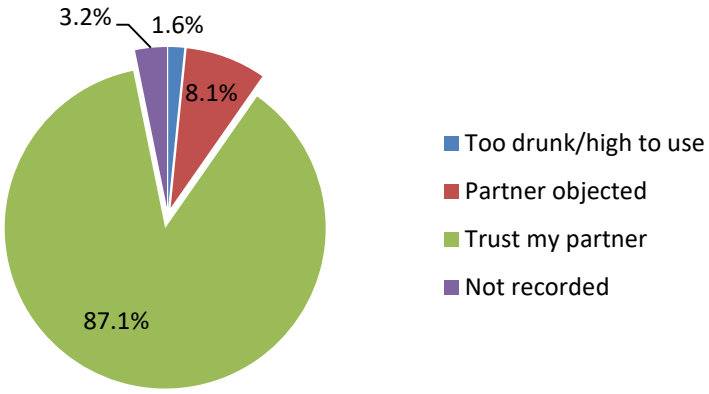


Figure 6: Reasons for non-use of condoms

Sex with a casual partner

Thirty-two respondents (20.5%) reported having sex with a casual partner in the last month, compared to 124 or 79.5% who did not. This category of sexual partner included people who did not pay for sex (Table 8.14).

Table 8.14: Sexual intercourse with a casual partner in last month

Had sex with acasual partner	Frequency	%
Yes	32	20.5
No	124	79.5
Total	**156**	**100**

Of the 32 respondents who had sex with a non-paying casual partner, there were 19 or 59.4% who always used a condom, compared to 7 or 21.8% and 2 or 6.2% who used one most of the time and occasionally, respectively (Table 8.15).

Table 8.15: Frequency of condom use with casual partner in last month

Condom use in past month	Frequency	%
Always	19	59.4
Most of the time	7	21.8
Occasionally	2	6.2
Not recorded	4	12.6
Total	32	100

When it came to condom use at the last sexual encounter with a casual non-paying partner, most of the respondents (26 or 81.3%) chose to have him wear a condom, compared to 5 or 15.6% who did not do so and 1 (3.1%) respondent whose answer was not recorded (Table 8.16).

Table 8.16: Use of condoms at last sex with casual partner

Use of condoms at last sex	Frequency	%
Yes	26	81.3
No	5	15.6
Not recorded	1	3.1
Total	**32**	**100**

There were 19 (59.4%) respondents who refused to have sex with a casual non-paying partner who refused to wear a condom, compared to 12 or 37.5% who accepted the situation (Table 8.17).

Table 8.17: Refusal to have sex for non-use of condoms

Refusal to have sex if condom not used	Frequency	%
Yes	19	59.4
No	12	37.5
NA	1	3.1
Total	**32**	**100**

For those who chose to use a condom (Figure 7), most (84.4%) of respondents did not answer this question. For those who respondent, 12.5% reported that they trusted their partner and 3.1% did not feel like using one at the time (N=32).

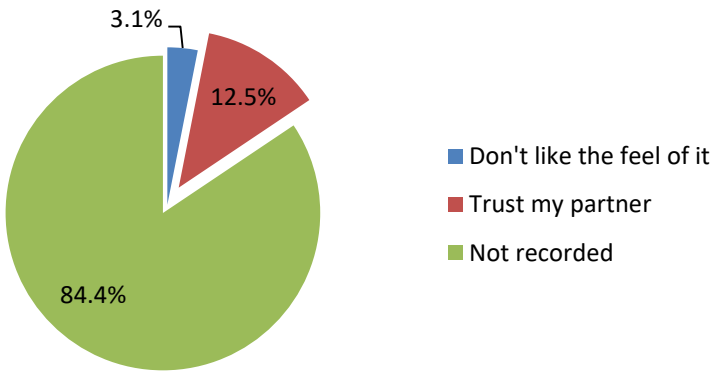


Figure 7: Reasons for non-use of condoms

Of those respondents who chose to use a condom at the last sexual encounter with a casual non-paying partner, 46.9% of them suggested using one themselves, whereas for 31.3% of them, it was a mutual decision with their partner and for 3.1%, it was the partner who proposed that a condom be used (Figure 8).

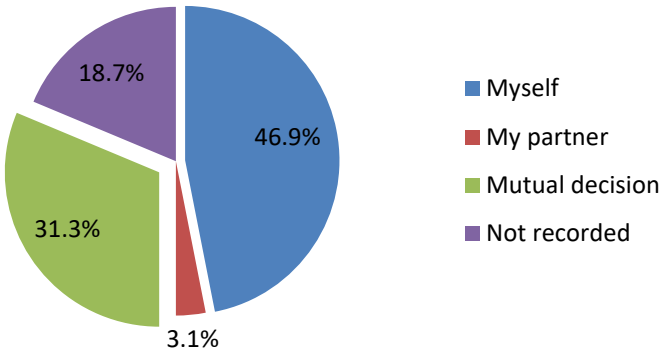


Figure 8: Initiator for condom use at last sex with casual partner

Sex with a one-time client

Ninety-five respondents or 60.9% reported having sex with a one-time client during the past month, compared to 61 or 39.1% who did not (Table 8.18).

Table 8.18: Sexual intercourse with one-time client in past month

Had sex with aone-time client in past month	Frequency	%
Yes	96	61.5
No	60	38.5
Total	**156**	**100**

Of those who had sex with a one-time client, 91 or 94.8% of respondents used a condom at the last sexual encounter with a one-time client, whereas 5 or 5.2% did not do so (Table 8.19).

Table 8.19: Use of condoms at last sex with one-time client

Condom use with aone-time client in past month	Frequency	%
Yes	91	94.8
No	5	5.2
Total	**96**	**100**

Most respondents (88 or 91.7%) reported always using a condom when they had sex with a one-time client, compared to 3 or 3.1% who did so most of the time or never did so. However, 2 respondents or 2.1% indicated that they used a condom occasionally during the last month when having sex with a one-time client (Table 8.20).

Table 8.20: Frequency of condom use in last month with one-time client

Frequency of condom use	Number	%
Always	88	91.7
Most of the time	3	3.1
Occasionally	2	2.1
Never	3	3.1
Total	**96**	**100**

Respondents refused to have sex with a one-time client for not wanting to use a condom; there were 69 or 71.9% of them who did so. There were, however, 27 or 28.1% of respondents who decided to have sex with a one-time partner without using a condom (Table 8.21).

Table 8.21: Refusal to have sex with one-time client for non-use of condom

Refusal to have sex if condom not used	Frequency	%
Yes	69	71.9
No	27	28.1
Total	**96**	**100**

There were 8 participants who did not use a condom at all times when having sex with a one-time client, and of those 2 or 25.0% did not do so because they trusted their partner and the others did not think about it or were too high or drunk or the partner objected to using a condom (all 1 or 12.5%). Three respondents' answers were not recorded (Figure 9).

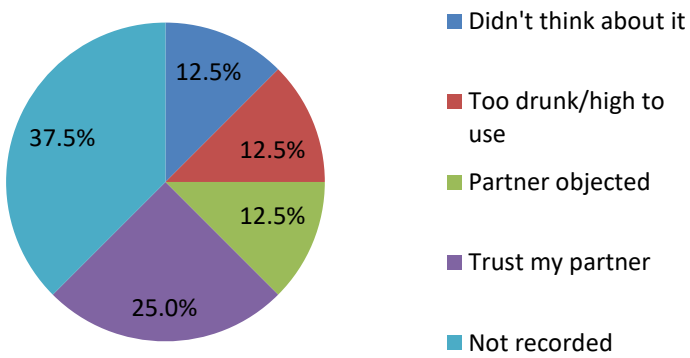


Figure 9: Reasons for not using a condom with a one-time client

Most respondents (54.2%) suggested the use of a condom themselves and for 39.6% of them, it was a mutual decision, compared with only 1.0% whose partner was the one to suggest using a condom (Figure 10). For 5.2% of respondents, the answers were not recorded.

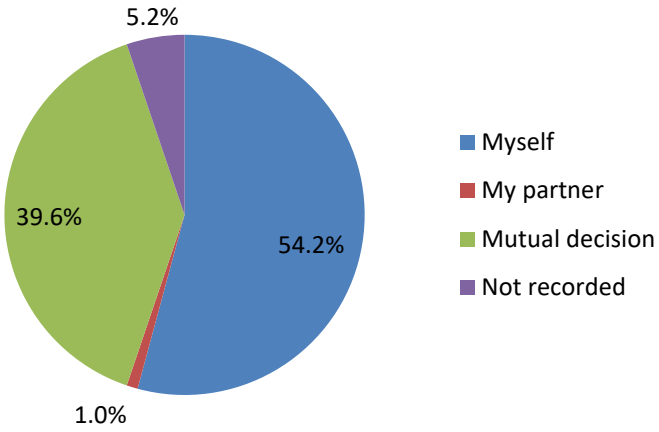


Figure 10: Initiator for condom use with a one-time client

Sex with regular clients

Nearly all respondents (143 or 91.7%) have had sex with a regular client in the last month, compared to a minority (13 or 8.3%) who did not (Table 8.22).

Table 8.22: Sex with regular client in last month

Had sex with aregular client	Frequency	%
Yes	143	91.7
No	13	8.3
Total	**156**	**100**

Most of the respondents (125 or 80.1%) always used a condom with a regular client, whereas 10 or 6.4% of them used one most of the time and 6 or 3.8% never used one (Table 8.23).

Table 8.23: Frequency of condom use with a regular client in last month

Frequency of condom use with aregular client	Frequency	%
Always	125	80.1
Most of the time	10	6.4
Occasionally	1	0.6
Never	6	3.8
Not recorded	1	0.6
Total	**143**	**100**

Most of the respondents (107 or 74.8%) indicated that they refused to have sex with a regular client if he did not want to use a condom, compared to 34 or 23.8% who did not refuse to have sex in these circumstances (Table 8.24).

Table 8.24: Refusal to have sex with regular client for non-use of condom

Refusal to have sex if condom not used	Frequency	%
Yes	107	74.8
No	34	23.8
Not recorded	1	0.7
Don't know	1	0.7
Total	**143**	**100**

One hundred and thirty-four or 93.7% of respondents reported using a condom at the time of the last sexual encounter with a regular client compared to 8 or 5.6% who did not do so (Table 8.25).

Table 8.25: Use of condom at last sex with a regular client

Use of condom at last sex with a regular client	Frequency	%
Yes	134	93.7
No	8	5.6
Not recorded	1	0.7
Total	**143**	**100**

There were 8 participants who did not use a condom at the last time they were having sex with a regular client, and of those 37.5% did not do so because they trusted their partner and the others did not think about it or found condoms uncomfortable because they itch (all 1 or 12.5%). Three respondents' answers were not recorded (Figure 11).

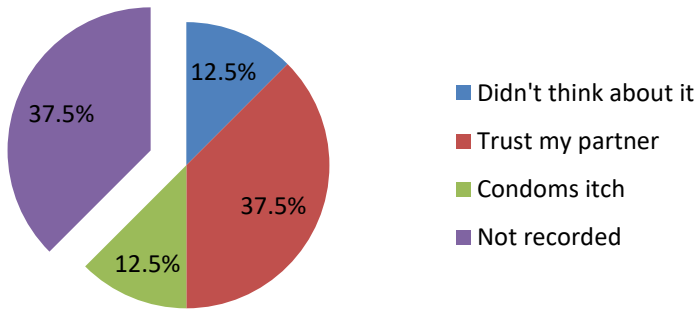


Figure 11: Reasons for non-use of condoms with regular client

For those who used a condom with a regular client, thedecision was mutual for 40.6% of respondents and 51.7% of participants took the initiative themselves.

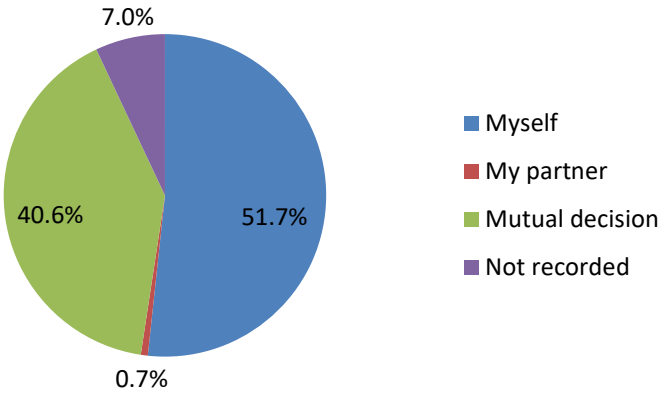


Figure 12: Initiator for condom use with a regular client

Sex with a tourist or a foreigner

Sixty-eight or 43.6% of respondents had sex with a tourist or a foreigner in the last month, compared to 87 or 55.8% who did not (Table 8.26).

Table 8.26: Sexual intercourse with a tourist or a foreigner in past month

Had sex with a steady partner	Frequency	%
Yes	68	43.6
No	87	55.8
Not recorded	1	0.6
Total	**156**	**100**

Respondents used a wide variety of arrangements and places to meet client. The preferred methods were the telephone (115 or 73.7%), chance meetings in the streets (77 or 49.4%) or discotheques (22 or 14.1%). A minority of respondents (6 or 3.8%) used agents and / or pimps or hotels or even pubs and bars (5 or 3.2%) and private houses (4 or 2.6%). Other means were even less popular, such as contacts on the highway, in shops or the beach or bush, with 1 or 0.6% of respondents reporting such methods (Table 8.27).

Table 8.27: Arrangements to meet clients

Where do you usually meet your clients?		
Place	**Frequency**	**%**
Telephone	115	73.7
Street	77	49.4
Disco	22	14.1
Hotel	6	3.8
Agent/Pimp	6	3.8
Pub/Bar	5	3.2
Private Houses	4	2.6
Guest House	3	1.9
Bush	1	0.6
Beach	1	0.6
Highway	1	0.6
Shop	1	0.6

Interestingly, in spite of using mobiles and telephones to contact potential clients, respondents reported the primary meeting places as the street (59 or 37.8%), guesthouses (38 or 24.4%), rented room in private houses (28 or 17.9%) and discotheques (6 or 3.8%). Other places such as cars, beaches, hotels and hidden places on the highway were less popular, with a minority of respondents choosing such places as primary meeting places (Table 8.28).

Table 8.28: Primary meeting places for clients

	Frequency	**%**
Street	59	37.8
Guesthouse	38	24.4
Private house (rented room)	28	17.9
Disco	6	3.8
At clients homes	5	3.2
Beach	3	1.9
In vehicles/transport	3	1.9
At home	3	1.9
Not recorded	3	1.9
Pub/Bar	3	1.9
Hotel	2	1.3
Hidden place on highway	2	1.3
Through an agent/pimp	1	.6
Total	156	100.0

Condom use and knowledge

Respondents (152 or 97.4%) reported that they have, for the most part, used a male condom with a partner before, compared to 4 or 2.6% who have never used a male condom (Table 8.29).

Table 8.29: Lifetime use of male condoms

	Frequency	%
Yes	152	97.4
No	4	2.6
Total	**156**	**100**

Respondents used a variety of places and / or persons to obtain male condoms in the past month. These included for the most part health facilities (145 or 92.9%), friends (20 or 12.8%), shops (17 or 10.9%), pharmacies (16 or 10.3%) and friends (8 or 5.1%). Two respondents or 1.3% of them obtained their condoms from bars or guesthouses or hotels, too (Table 8.30).

Table 8.30: Sites and persons from which to obtain condoms

Places or persons	Frequency	%
Health Facility	145	92.9
Friends	20	12.8
Shop	17	10.9
Pharmacy	16	10.3
Sex Partner	8	5.1
Bar/Guest House/Hotel	2	1.3

Since most respondents obtained their male condoms from health facilities, it was not surprising that for some of them (41 or 26.4%) paid nothing for these, whereas 53 or 33.9% paid between SCR1 to SCR5 for condoms. Other respondents (37 or 23.6%), however, paid over SCR10 for a pack of three male condoms (Table 8.31).

Table 8.31: Amount paid a pack of 3 male condoms

Amount paid	Frequency	%
0	41	26.4
1-5	53	33.9
6-10	7	4.5
11-20	7	4.5
21-50	23	14.6
>50	7	4.5
Not valid	18	11.6
Total	156	100

For those respondents who bought a pack of three male condoms in the past month, the most common time was the early evening from 6pm to 9pm (14 or 32.6%) and in the morning between 6am and 11am (Table 8.32). Late night was the rarest time recorded (9 or 20.9%).

Table 8.32: Time of purchase of pack of 3 male condoms

Time	Frequency	%
Morning(06H-11H)	12	27.9
Afternoon (12H-17H)	8	18.6
Evening (18H-20H)	14	32.6
Night (21H – 05H)	9	20.9
Total:	**43**	**100**

One hundred and forty-three (91.7%) respondents indicated that they could obtain a male condom at any time they needed one, compared to 10 or 6.4% who indicated the opposite (Table 8.33).

Table 8.33: Ease of obtaining male condoms

	Frequency	%
Yes	143	91.7
No	10	6.4
Not valid	3	1.8
Total:	**156**	**100**

Knowledge of HIV and AIDS and other sexually transmitted infections

More than half of the respondents (79 or 50.6%) could name at least one symptom of sexually transmitted infections (STIs), compared to 77 or 49.4%. The most commonly known symptom was urethral discharge (63 or 40.4%), followed by genital itching (49 or 31.4%) and pain when urinating (25 or 16.0%). Few respondents (fewer than 10) knew about other symptoms such as genital ulcers or sores (Table 8.34).

Table 8.34: Knowledge of STI symptoms

Knowledge of STIs symptoms	Frequency	%
Do not know any	77	49.4
Urethral discharge	63	40.4
Genital itching	49	31.4
Pain with urination	25	16.0
Abdominal pain	12	7.7
Fever/Cough	9	5.8
Genital ulcer/sore	7	4.5

Anal ulcer/sore	5	3.2
Headache/weakness	2	1.3

Seventeen or 10.9% of respondents had experienced an unusual genital discharge in the past six months compared to 137 or 87.8% who did not. Two respondents (1.2%) did not answer this question (Table 8.35).

Table 8.35: Had an unusual genital discharge in past 6 months

	Frequency	%
Yes	17	10.9
No	137	87.8
Not answered	2	1.2
Total	**156**	**100**

Only 7 or 4.5% of respondents reported having had a genital or anal sore or ulcer in the past six months, compared to 148 or 94.9% who did not report such (Table 8.36).

Table 8.36: Had a genital or anal sore or ulcer in past 6 months

	Frequency	%
Yes	7	4.5
No	77	49.4
Never had genital/anal sores/ulcer	71	45.5
Not recorded	1	0.6
Total	**156**	**100**

Of those participants who experienced a genital or anal sore, ulcer or discharge, half of them went to a state health facility for treatment, whilst a quarter chose not to do anything (Table 8.37). Other methods were treatment at home (8.3%) and using condoms during intercourse (4.2%).

Table 8.37: Actions taken following appearance of STIs symptoms

	Frequency	%
Went to govt. health facility for examination & treatment	12	50.0
Did not do anything	6	25.0
Treated myself at home	2	8.3
Used condoms when having sexual intercourse	1	4.2
Not recorded	3	12.5
Total	**24**	**100**

Participants generally had good knowledge of HIV transmission, understanding risk factors such as the sharing of injecting equipment (151 or 96.8%) and anal sex (125 or 80.1%). Protective factors such as using condoms every time during sexual intercourse (141 or 90.4%) and abstinence (117 or 75.0%) were also generally understood. The respondents for the most part (112 or 71.8%) also agree that buying fresh vegetables from a vendor who is a PLHIV is a very low risk activity (Table 8.38).

Table 8.38: Knowledge about HIV and AIDS

Knowledge about HIV and AIDS	Agree (%)	Disagree (%)
Sharing needles when injecting drugs will increase the risk of HIV infection	151 (96.8)	2 (1.3)
Cleaning needles and syringes with bleach between injections reduces the risk of HIV	54 (34.6)	86 (55.1)
One can avoid becoming infected with HIV by not having sex at all	117 (75.0)	34 (21.8)
Using a condom every time during intercourse prevents HIV transmission	141 (90.4)	9 (5.8)
Having anal sex is protective against HIV infection	11 (7.1)	125 (80.1)
Having oral sex reduces the risk of HIV infection	21 (13.5)	123 (78.8)
Buying fresh vegetables from a HIV positive shopkeeper or vendor	36 (23.1)	112 (71.8)

Drug use

Drug use by sexual partners

Respondents generally believed that their various types of sexual partners (casual non-paying partners, 15 or 9.6%; one-time clients 46 or 29.5% and regular clients 87 or 55.8%) were not using drugs(Table 8.39).

Table 8.39: Types of partners and use of drugs

Types of partners	Yes (%)	No (%)
Casual, non-paying partners	14 (9.0)`	15 (9.6)
One-time clients	31 (19.9)	46 (29.5)
Regular clients	40 (25.6)	87 (55.8)

For injecting drug use, respondents tended to believe that their various types of sexual partners were not using drugs (Table 8.40). The group with the highest level of trust on this issue was the regular (115 or 73.7%) and one-time clients (67 or 42.9%).

Table 8.40: Types of partners and use of drugs

Types of partners	Yes (%)	No (%)
Casual, non-paying partners	5 (3.2)`	24 (15.4)
One-time clients	9 (5.8)	67 (42.9)
Regular clients	7 (4.5)	115 (73.7)

Drug use by respondents

The majority of respondents (147 or 94.2%) had used drugs before (Table 8.41).

Table 8.41: Use of drugs

Use of drugs other than alcohol	Frequency	%
Yes	147	94.2
No	9	5.8
Total:	**156**	**100**

Respondents for the most part (135 or 86.5%) were currently using drugs other than alcohol, compared to 12 or 7.7% who reported that they had notused drugs in the last three months (Table 8.42).

Table 8.42: Use of drugs in last 3 months

Current use of drugs	Frequency	%
Yes	135	86.5
No	12	7.7
Not valid	9	5.7
Total:	**156**	**100**

Sixty-two respondents (39.7%) had injected drugs, compared to 86 or 55.1% who did not report such behaviours (Table 8.43).

Table 8.43: Injecting drug use

Injecting drug use	Frequency	%
Yes	62	39.7
No	86	55.1
Not valid	8	5.1
Total:	**156**	**100**

As for current injecting drug use, there were 48 (30.8%) of respondents who reported such compared to 15 or 9.6% who did not (Table 8.44).

Table 8.44: Current injecting drug use

Current injecting drug use	Frequency	%
Yes	48	30.8
No	15	9.6
Total:	**63**	

The most commonly injected drug was heroin, reported by 59 or 37.8% of respondents compared to 1 respondent (0.6%) who reported injecting ecstasy (Table 8.45).

Table 8.45: Drug injected in last three months

	Frequency	%
Heroin	59	98.3
Ecstasy	1	1.7
Total	**60**	**100**

Of those respondents who inject drugs, 8 or 12.9% used soiled needle or syringe the last time they injected drugs, compared to 52 or 83.9% who did not use equipment previously used by someone else (Table 8.46).

Table 8.46: Use of soiled needle or syringe

	Frequency	%
Yes	8	12.9
No	52	83.9
NA	2	1.2
Total	**62**	**100**

There were 14 or 22.6% of respondents who shared their needle or syringe after they had used it first, compared to 46 or 74.2% who did not do so (Table 8.47).

Table 8.47: Sharing soiled needle or syringe

	Frequency	%
Yes	14	22.6
No	46	74.2
NA	2	1.2
Total	**62**	**100**

There were 28 or 17.9% of respondents who injected on average from 2 to 4 times a day, whereas 14 or 9.0% did so more than 5 times as day (Table 8.48).

Table 8.48: Frequency of injecting drug use

	Frequency	Percent
More than 5 times a day	14	9.0
2-4 times a day	28	17.9
More than 5 times a week	3	1.9
Once a day	1	0.6
Once a week	1	0.6
Not recorded / answered	9	5.8
Total	**62**	**100**

There were 2 respondents or 1.3% who had used blood flushing as a means of administering drugs to them (Table 8.49). Fifty-four (34.6%) indicated that they had not.

Table 8.49: Flushing blood in past month

	Frequency	%
Yes	2	1.3
No	54	34.6
NA	4	2.4
Total	**62**	**100**

Attitudes about HIV and AIDS and STIs

There were still some negative attitudes amongst female sex workers about HIV and AIDS, with 45 or 28.8% who would be ashamed if they were HIV positive or 47 or 30.1% who believed that it was mostly promiscuous people who were infected with HIV or even that HIV was a punishment for bad behaviour (38 or 24.4%). However, most respondents had positive attitudes for all the statements about HIV and AIDS, with percentages ranging from 68.6% (HIV as a punishment for bad behaviour) to 91.7% for shame if a family member was HIV positive (Table 8.50).

Table 8.50: Attitudes about HIV and AIDS

Attitudes about HIV and AIDS	Agree (%)	Disagree (%)
People with HIV/AIDS should be ashamed of themselves	14 (9.0)	139 (89.1)
I would feel ashamed if someone in my family had HIV/AIDS	11 (7.1)	143 (91.7)
I would feel ashamed if I was infected with HIV	45 (28.8)	108 (69.2)
People with HIV/AIDS are promiscuous	47 (30.1)	103 (66.0)
It is female sex workers who spread HIV in the community	31 (19.9)	122 (78.2)
HIV/AIDS is a punishment for bad behaviour	38 (24.4)	107 (68.6)

Only 14.7% of respondents considered themselves to be at high risk of contracting HIV, whilst 31.4% thought they were at medium risk and 17.3% believed that that they had a low risk (Figure 13). Interestingly, 9.0% of respondents reported that they did not know their level of risk.

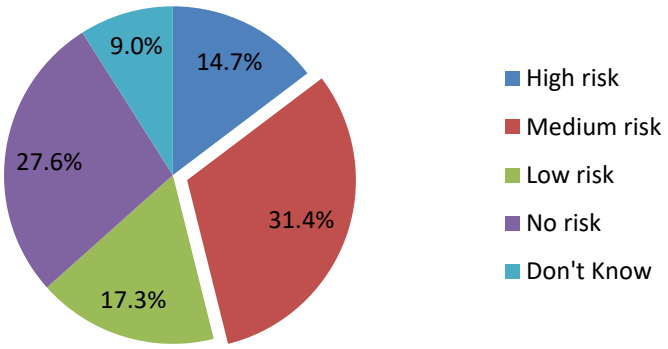


Figure 13: Respondents' views of their personal risk of contracting HIV

The most common reasons respondents believed that they were at risk of contracting HIV were that they were often changing partners (48.5%), they did not always use a condom (20.2%), condoms could break (18.2%) and that they were injecting drugs (10.1%). Other reasons were the partner was a PLHIV (2.0%) and sexual partners included PWIDs (3.0%) (Figure 14).

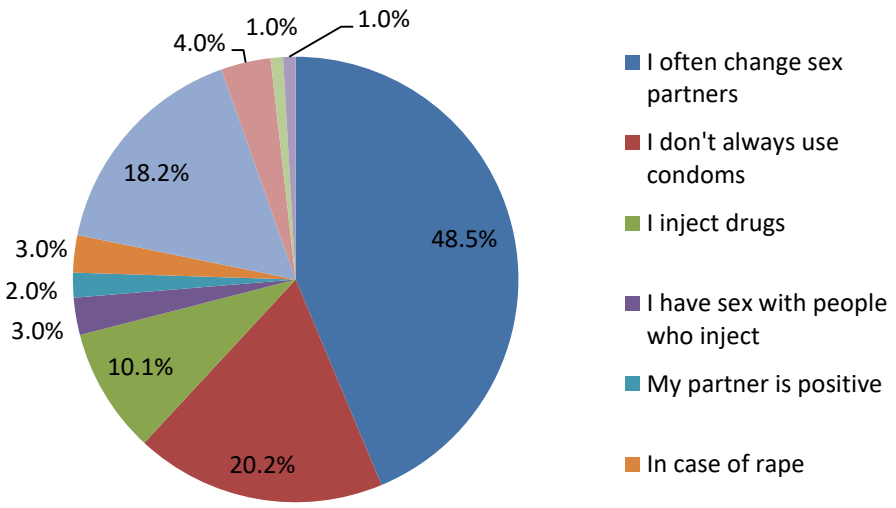


Figure 14: Reasons for thinking you are risk of contracting HIV

For those respondents who believed that they were not at risk for HIV infection, their main reasons were that they always used condoms and they considered themselves to be faithful partners (Figure 15). This is somewhat paradoxical given the nature of the respondents' work.

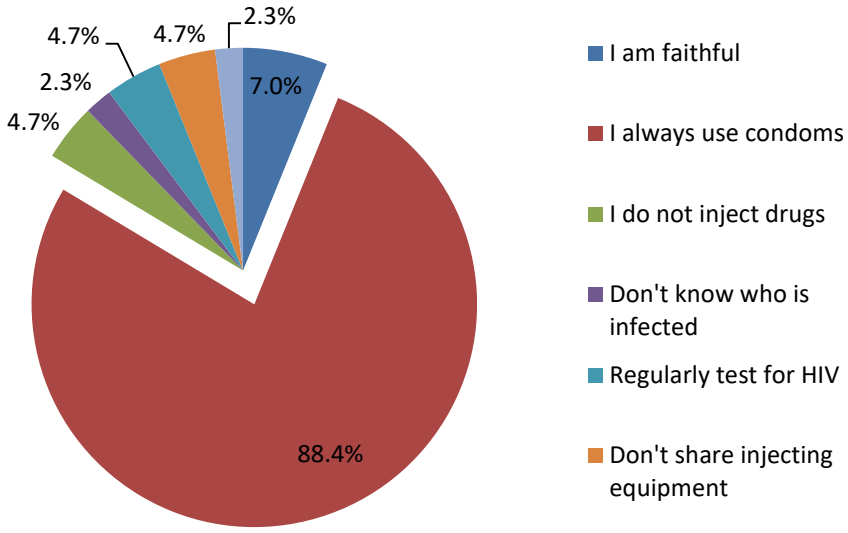


Figure 15: Reasons for low risk of HIV infection

Respondents reported that they spoke to people about HIV and AIDS (114 or 73.1%). However, 42 or 26.9% indicated that they did not do so (Table 8.51). Respondents discussed HIV and AIDS with their friends (91 or 79.8%), their relatives (55 or 48.2%) and their sexual partners (54 or 47.4%). Health professionals, religious leaders and their own children were the people respondents were less likely to talk to about HIV and AIDS (Table 8.52).

Table 8.51: Talking about HIV and AIDS

	Frequency	%
Yes	114	73.1
No	42	26.9
Total	**156**	**100**

Table 8.52: Persons with whom respondents talk about HIV and AIDS

Persons with whom HIV was talked to	Frequency	%
Friend	91	79.8
Relative	55	48.2
Sexual partner	54	47.4
Acquaintance	12	10.5
Health care professional	9	7.9
People you have just met	6	5.3
Religious leader	2	1.8
Children	1	0.9

Most respondents (138 or 88.5%) reported that they knew where to obtain a confidential HIV test, whereas 16 or 10.3% indicated that they did not know of such a place (Table 8.53).

Table 8.53: Knowledge of site for confidential HIV test

	Frequency	%
Yes	138	88.5
No	16	10.3
No response	2	1.3
Total	**156**	**100**

Most respondents (141 or 90.4%) had already done a HIV test, compared to 15 or 9.6% who had not (Table 8.54). Eighty-four or 53.8% had done the test in the past year whereas 57 or 36.5% had done it over a year ago (Table 8.55).

Table 8.54: Knowledge of site for confidential HIV test

	Frequency	%
Yes	141	90.4
No	15	9.6
Total	**156**	**100**

Table 8.55: Period of last HIV test

	Frequency	%
Past year	84	53.8
Over a year ago	57	36.5
Not answered	15	9.6
Total	**156**	**100**

The main reasons for the HIV test were as follows: to know the health status (82 or 58.2%), service provider driven (23 or 16.3%) and the respondent was pregnant at the time (15 or 9.6%). There were a variety of reasons which are listed in Table 8.56.

Table 8.56: Reasons for doing the HIV test

Decision to have a HIV test	Frequency	%
To know my health status	82	58.2
Doctor/nurse advised	23	16.3
A must for pregnant women	15	10.6
Felt sick/suspected	4	2.8
To get a clean syringe from CDCU	3	2.1
Infected partner	2	1.4
Did a test in prison	2	1.4
Premarital testing	1	0.7
Is a blood donor	1	0.7
Partner was a drug user	1	0.7
Has multiple partners	1	0.7
Workplace activity	1	0.7
Family/Relatives forced me to do a test	1	0.7%
I inject drugs	1	0.7
Was raped	1	0.7
Condoms break	1	0.7
Was brought in by the police	1	0.7

Stigma and discrimination

Fifty-eight respondents (37.2%) had experienced violence in the past year, whereas 32 (20.5%) had been forced to have sex against their will and 79 (50.6%) had been arrested (Table 8.57). Physical violence was most likely to be suffered at the hands of the steady boyfriend or the husband (20 or 34.5%), the one-time client (9 or 15.5%) and the police (8 or 13.8%). Respondents were just as likely to be assaulted by unknown persons as they were by the police (Table 8.58).

Table 8.57: Stigma and discrimination in past year

Discriminatory actions / stigma	Yes (%)	No (%)
Experienced physical violence	58 (37.2)	98 (62.8)
Forced to have sexual intercourse	32 (20.5)	29 (18.6)
Arrest	79 (50.6)	77 (49.4)

Table 8.58: Persons who assaulted respondents

Persons	Frequency	%
Boyfriend/Husband Steady	20	34.5
Client (One-Time or Regular)	9	15.5
Police	8	13.8
Unknown person	8	13.8
Family Member	6	10.3
Casual Sex Partner	6	10.3
Friend	6	10.3
Children's father	2	3.4
Co-worker	1	1.7
Sex Workers	1	1.7

Of those respondents who had been forced to have sex against their will, the most common perpetrators were one-time clients (9 or 28.1%), unknown persons (5 or 15.6%) and the steady partner or husband (4 or 12.5%). Other people included friends, casual sex partners and the children's father (Table 8.59).

Table 8.59: Persons who forced respondents to have sex

Persons	Frequency	%
Client (One-Time or Regular)	9	28.1
Unknown person	5	15.6
Boyfriend/Husband Steady	4	12.5
Friend	4	12.5
Casual Sex Partner	3	9.4
Children's father	2	6.3
Neighbour	1	3.1

In terms of arrests, the main reasons were loitering (25 or 16.0%), drug use (20 or 11.5%) and selling sex (11 or 7.1%). Table 8.60 shows the wide variety of reasons for arrests by the police.

Table 8.60: Reasons for arrests

	Frequency	Percent
Loitering	25	16.0
Drug use	20	11.5
Selling sex	11	7.1
Theft	9	5.8
Aggravated assault	6	3.8
Unpaid maintenance	3	1.9
Drinking alcohol public	2	1.3
A misunderstanding	2	1.3
Tribunal order	1	0.6
Personal	1	0.6
Total	**155**	**99.4**

Biological data

The results of the biological survey showed that there was a HIV prevalence of 4.5% with 7 respondents who had confirmed HIV positive results. This was relatively high compared to the prevalence in the general population (0.87%) and in the population of 15 to 19 year olds (0.76%). However, the results are comparable to those of PWIDs (5.8%) and less than half of that of MSMs (13.2%). The results are presented in Table 8.61 below.

Table 8.61: Comparative results for HIV prevalence

Populations	Sources	HIV Prevalence
15 to 64 years	IBBS, 2012	0.87%
15 to 19 years	IBBS, 2012	0.76%
MSM	IBBS, 2011	13.2%
PWID	IBBS, 2011	5.8%
FSW	IBBS, 2015	4.6%

There were no positive cases of blood results for syphilis and for Hepatitis B. however, there were 54 (34.6%) confirmed Hepatitis C positive results and 2 indeterminate results (1.3%). This result is comparable to the one obtained for other key populations such as MSM (41.9%) and PWID (46.5%) from the IBBS in 2011 (Table 8.62).

Table 8.62: Hepatitis C prevalence

Populations	Sources	HCV Prevalence
MSM	IBBS, 2011	41.9%
PWID	IBBS, 2011	46.5%
FSW	IBBS, 2015	34.6%

Population estimate

Participants reported that they took part in the survey to obtain an STI and HIV test (90 or 57.7%) and that the student seemed interesting and useful (33 or 21.2%). Other respondents (16 or 10.3% and 13 or 8.3%respectively) indicated that they had come for the incentive given or to get help to stop using drugs and to cease selling sex (Table: 8.63).

Table 8.63: Reasons for participating in the study

Reasons given	Frequency	%
For STI/HIV test results	90	57.7
Study seems interesting/useful	33	21.2
To get help to stop using drugs &selling sex	16	10.3
For incentive	13	8.3
Peer influence	4	2.6
Total	**156**	**100**

There are a variety of methods for population estimation, such as census and estimation, unique event multiplier or literature review, especially when previous studies had been done on the same population. The method chosen for this survey was the ***Unique Object Multiplier***.

A week prior to the start of the survey, 150 unique objects (white and red plastic key rings, with the HIV international logo – the red ribbon) were distributed to eligible FSW throughout Mahéby peers and key informants. During the month of thesurvey, 40 or 25.6%FSWs reported receiving the unique object. The calculation for the population size estimation using the unique identifier method is 150/.256 which provides a size estimation of 586 FSWs. Assuming that there were 32, 164 adult females (16+) in August 2015 (according to the mid-year population estimates of the National Bureau of Statistics), then FSWs comprise 1.8% (586/32164) of the adult female population.

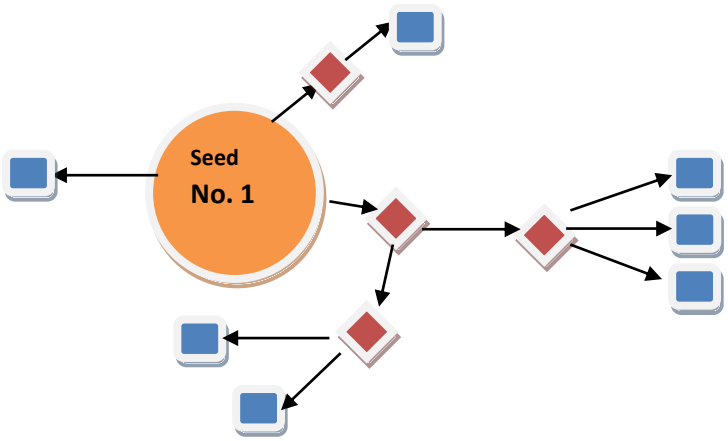
There were 6 seeds selected. The strongest was Seed No.2 who yielded a total of 56 respondents more than one-third (35.9%) of the sample compared to Seed No. 1 and Seed No. 4 who brought in 11 and 12 participants respectively. The strongest recruit was No. 23 who managed to further

recruit 40 respondents. Some recruits did not manage to further obtain other participants such as recruits 011, 021, 042, and 062.

Seed No. 1

Number of recruits =12

Seed No. 1 had few contacts within her area which was in the Central and Eastern regions of the main island, Mahé. She through her contacts recruited a total of 11 participants. The strongest recruit was 012.



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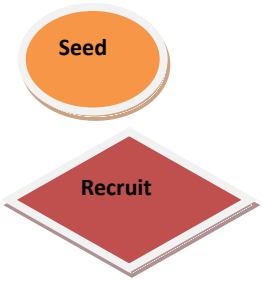
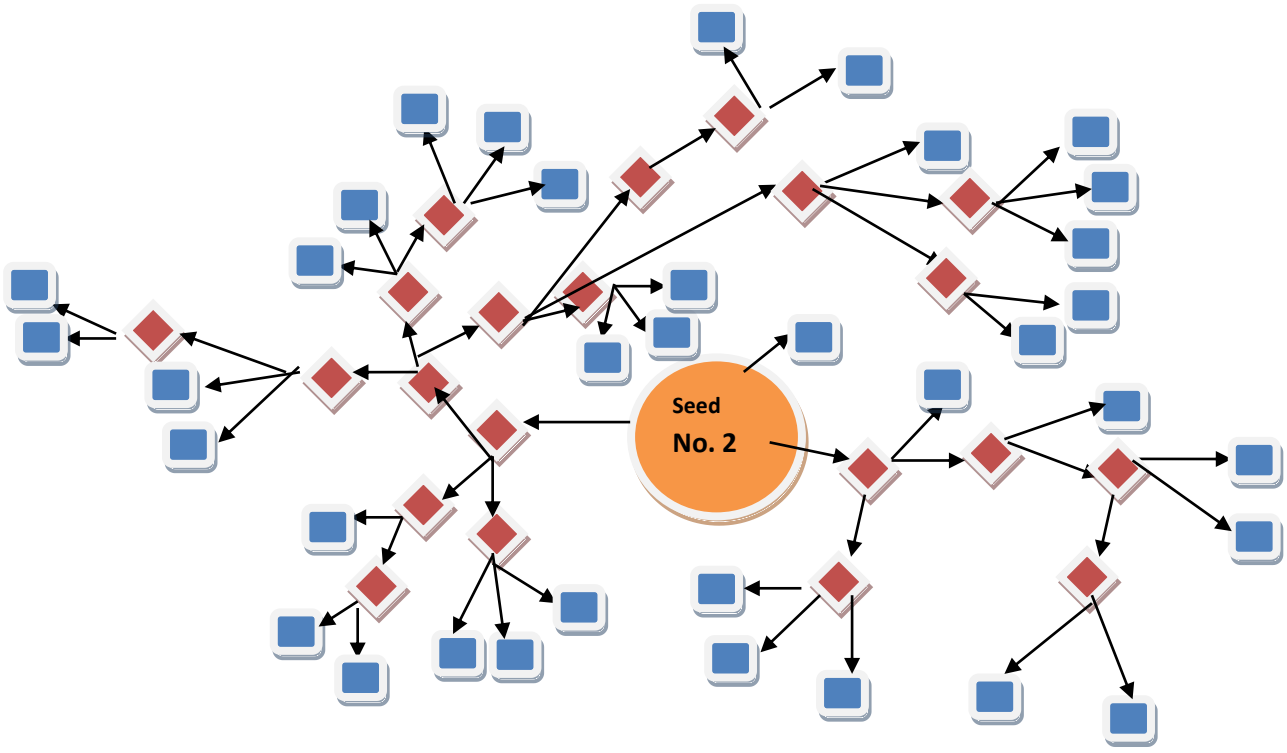



Indicates the last participant in the chain

Seed No. 2

Number of recruits = 57

The most prolific seed was No.2, with more than one third of the total sample.

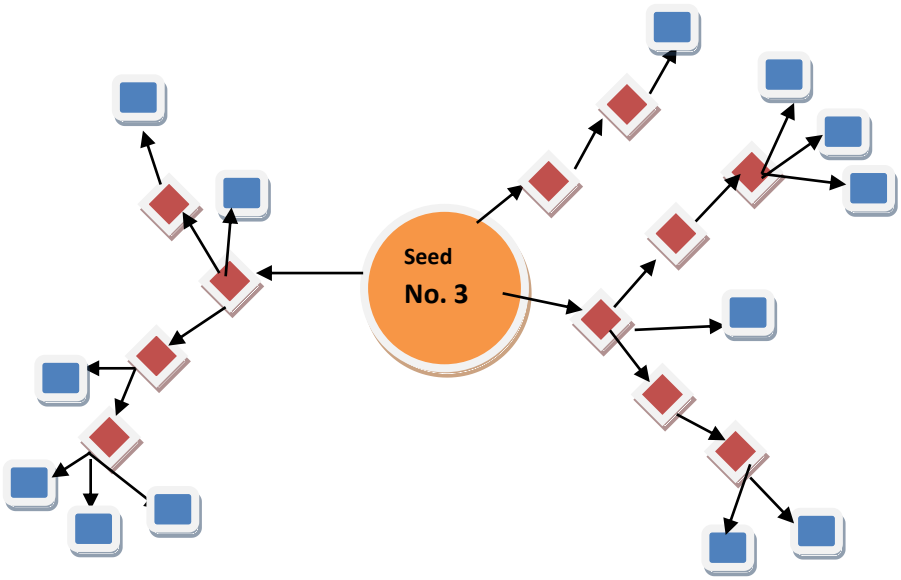


The two recruits with the most participants were 022 and 023, with the latter bringing in 40 respondents. The contacts varied from the Central and Easternn regions of Mahe, as well as the Northern districts. Recruit 231 on her own and through her contacts also managed to refer 31 FSWs for the survey, compared to Recuit 232 and 233 who brought in 3 or 4 participants.

At one point, the Coupon Manager was advised to reduce the number of coupons from 3 to 2 and then to 1 and finally, new recruits from the chain 23 were no longer given any coupons.

Seed No. 3

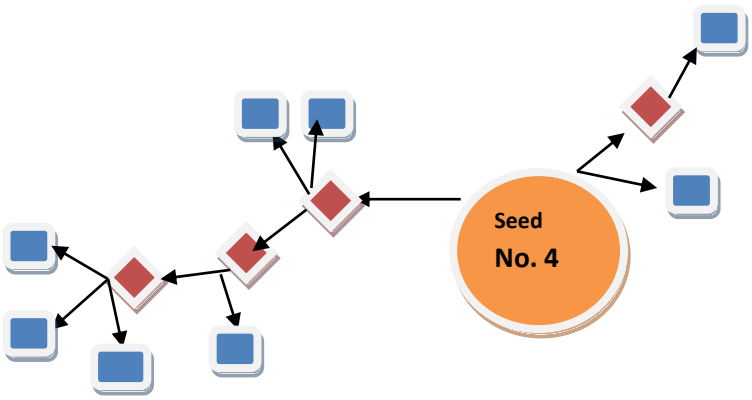
Number of recruits = 25. All three initial recruits from Seed No. 3 managed to obtain other respondents. Recruit 031 was the weakest with 2 participants compared to 032 and 033, who each managed to recruit 10 and 9 participants respectively.



Seed No. 4

Number of recruits = 13

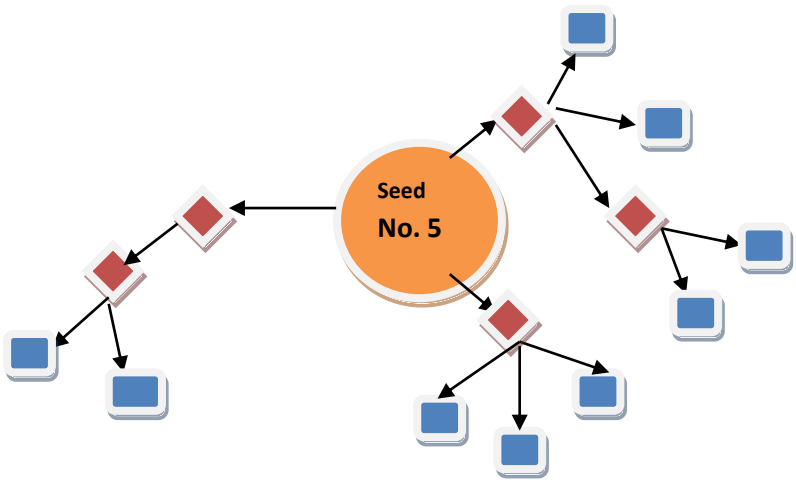
Seed No. 4 produced fewer participants with a total of 12. Recruit No. 42 did not manage to recruit other respondents, compared to recruit No. 43 who brought in a total of 8 other participants.



Seed No. 5

Number of recruits = 15

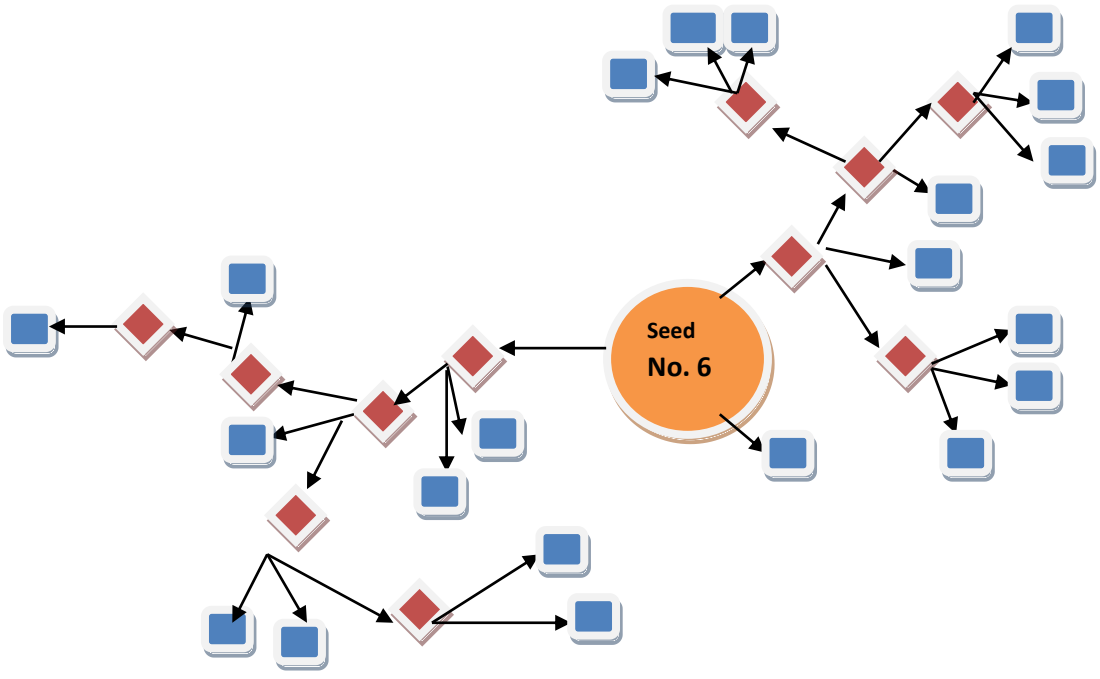
Seed No. 5 was also weak with a total of 15 participants recruited from her network. The recruit was No. 51 with 5 more respondents. The other two recruits No. 52 and No. 53 each managed to obtain three more participants for the survey.



Seed No. 6

Number of recruits = 34

Another prolific seed was No. 6 who enrolled 34 other participants through her network, with recruit No. 61 managing to recruit a further 16 respondents.



9.0 Discussion and recommendations

The study reached 156 respondents when there were 138 targeted. There were more than 256 coupons distributed. The final reached sample was beyond expectation.

Profile of Female Sex Workers

The profile of FSWs in Seychelles is a single woman who has never been married, aged about 24 years, with a secondary school education. Most (83.3%) have worked before doing work other than sex work, but they were earning less than SCR 9,000 a month or US$ 720 monthly. When they began sex work, their earnings increased. For example, only 0.6% reported earning more than SCR 10,000 monthly compared to 21.2% who reported such earnings with sex work. The age of first sex is between 15 and 17 years, with 23.6% having their first sexual experience below the age of 15 years.

Most of the FSW (78.2%) have children. Some (18.6%) have at least three children. This poses a particular problem for their work and perhaps, explains why most of the FSW work outside of their homes (see below). With some of the FSW (49.5%) having children as young as 10 years, there may be other problems with their line of work, such as supervision and child protection issues. Indeed, some of the respondents with babies came with them for the interviews. This also indicates a lack of facilities for child supervision especially at night when they are working.

Sexual behaviours of FSW

There were 54.5% of FSW who had steady partners and condom use was generally low (27.5%). The main reason for such low use was that the respondents reported trusting their partner. Having casual non-paying partners was low (20.5%) and for these kinds of partners, condom use was quite high (82.2%). It was also fairly common to have one-time partners (60.9%). With these partners, condom use was very high (94.8%). Nearly all FSW had regular clients (91.7%) and with these too, condom use was high (86.5%). Thus, it was more common for FSW to use condoms with clients compared to their steady partners who included boyfriends and live-in boyfriends.

Work arrangements

Most FSW (73.7%) made arrangements to meet partners by telephone and they tended to meet in the street (37.8%), in a guesthouse (24.4%) or in a private house (17.8%). Contrary to popular beliefs, other meeting places such as discos and clubs were quite rare compared to the other methods mentioned above.

Knowledge of HIV and AIDS and STIs

FSW's knowledge of STIs was fairly low with only 50.5% being able to name one symptom of STIs. Moreover, at the appearance of a symptom, only 50% actually went to a state medical facility and 25% did not do anything at all about their symptom. They were more open and accepting with the issue of HIV and AIDS happening to other people. However, when it came to them in a more personal way, such as themselves having HIV, the FSWs (28.8%) were less open-minded, indicating that they would be ashamed of the situation. Nearly a quarter of them (24.4%) also believed that HIV and AIDS were caused by bad behaviour. However, most of the respondents (percentages above 80% for all attitudinal statements) were aware of the risks involved in engaging in certain behaviours such as injecting drugs, sharing injecting equipment and engaging in certain types of sexual activities.

Drug use

Drug use is an issue, with 94.2% of the sample using illicit drugs. Current use stood at 86.5% whilst injecting drug use was at 39.7%. Moreover, 30.8% of the FSW in the sample were currently injecting drugs, such as heroin. This is an indication of the precariousness of the life of FSWs in Seychelles. Their work involving multiple partners combined with drug use and having young children at home make their daily life particularly difficult to handle and manage. Discussions with FSWs before or after their interviews showed that for many of them, there was desperation and difficulty to negotiate terms of their services with clients. This fact led to exploitation of the worst kind for some of them.

Status of the HIV epidemic

The prevalence of HIV in FSW is higher (4.6%) than in the general population (0.87%), as expected, but it is lower than for MSM and PWIDs. This is an important result as there is a general perception in the population that FSW are the main drivers of the epidemic in the country. Whilst FSW are important key populations and their needs must be adequately addressed, there are many other factors and issues that are affecting the epidemic in Seychelles. This is also further confirmation that the epidemic is concentrated within the three main key populations studied so far (See Table 8.61).

Recommendations

The following recommendations are made.

1. There is a need for NAC to give moreup-to-date and evidence-based informationto be given to service providers to ensure that they improve delivery of goods and services to key populations. There are clear misconceptions about the epidemic and key populations that the FSW IBBS 2015 can help to dispel and ensure that services are adapted and targeted.

2. The various activities concerning FSWs and other key populations from the ***National Strategic Framework for the Prevention and Control of HIV and AIDS and STIs in Seychelles 2012-2016***must be implemented as they provide for targeted service delivery and prevention work.

3. For key populations including FSWs to have greater access to services, there is a need to have a drop-in centre in Victoria and perhaps in other districts or on other islands. These can provide services such as shelter, laundry, counselling and legal advice, medical and health services to address numerous issues (bruises, skin care, and hygiene, HIV and AIDS, STIs) that FSWs may bring. The drop-in centre will also be distribution sites for condoms.

4. Given that many FSWs were leaving school at the secondary education level, there is a need for a comprehensive programme in secondary schools to identify girls at risk (difficult home situations and backgrounds, child abuse, poverty, low academic skills and early pregnancy) and to provide services for them to prevent school drop-out and to support those who are in need of special assistance. Social Services, CARE and NCC have a critical role to play to help these girls and their family to cope with their life situations.

5. Both male and female condoms should be made available to FSWs in the guesthouses that they use for their business as well as in clubs and discotheques. Private health facilities should also ensure that they are able to assist with condom distribution.

6. Some of the seeds showed signs of having extensive networks. They should be engaged in some meaningful way to ensure that they are able to provide information, education and behaviour change messages to their peers. Thus, a Peer Education Programme for FSWs should be implemented, using the most prolific seeds from the study. This task should be undertaken under the guidance of NAC and the programmatic actions should be undertaken by NGOs.

7. NGOs should become more involved in providing services to FSWs as this can improve access with outside normal working hours and extended services at night. NAC should consider engaging key NGOs to improve service delivery.

8. With only 50% of FSWs reporting to a medical facility when they notice a health issue and 24.4% choosing not to act on the symptoms seen, there is an urgent need to ensure that this key population has greater and more regular access to IEC and voluntary counselling and testing. This service would be better delivered through drop-in centres.

9. NGOs focusing on women empowerment and poverty alleviation need to be engaged to assist with alternative employment for FSWs who wish to stop such work. Training programmes such as Skills Development in collaboration with these NGOs (Alliance of Solidarity for the Family – ASFFand Women in Action and Solidarity Organisation – WASO) and the Ministry of Labour and Human Resource Development (MLHRD) should be instituted to assist these girls and women to train in marketable and employable skills for their own socioeconomic development.NAC and partners should use the UNAIDS programme for girls as a model for helping sex workers find alternative income-generating activities.

10. Drug treatment and rehabilitation centres (Wellness Centre, Centre Mont Royal and Centre d'Accueil de la Rosière) need to ensure that their services are provided for women and girls, organizing cohorts of women. Alternatively, facilities dedicated for women should be made available, too.

11. NAC should undertake a systematic review of all normative documents such as policies, regulations and legislation which inadvertently encourage violence against FSWs. NAC should advocate for decriminalization of sex work, as per previous recommendations from a variety of local and overseas studies on the matter.

12. Intervention programmes must be multifaceted and multisectoral, with every key stakeholder involved. NAC will spearhead this initiative.

10.0 References

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Annexes

Annex 1: Terms of Reference- National Consultant

1.0 BACKGROUND

The HIV and AIDS pandemic in Seychelles is a concentrated on, with a prevalence of 0.87% in the general population (KAPB Study Final Report, 2013).

Conducting a KAPB helped to better understand the HIV epidemic in Seychelles by providing two types of essential data: KAPB and biological surveillance of the general population. This is in line with the principles of Result-Based Management, which have also been incorporated into the national strategic plan for HIV and AIDS and STIs3. A key component of any action national prevention and control programme is to Know Your Epidemic. The KAPB Study 2012 has gone a long way in ensuring just that: Seychelles stakeholders and partners having comprehensive knowledge and understanding of the key drivers of the epidemic in the country.

The surveillance of the epidemic is conducted at sentinel points, such as the Communicable Disease Control Unit (CDCU), antenatal clinics, Occupational Health Unit (OHU) and the blood bank in the Ministry of Health and reveals that there is an increasing trend in HIV infections.

The study is being conducted to better understand the prevalence of HIV in Seychelles and to identify drivers of the epidemic for policy formulation and programmatic actions developments and adjustments, in line with the National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs in Seychelles 2012-2016.

Over the past 26 years since the first HIV case was diagnosed in Seychelles, a cumulative of 578 (334M/244F) HIV & AIDS clients which represents 58% males and 42% females have been reported. Currently, 376 (209M/167F) cases are living with HIV & AIDS representing 60% males and 40% females.

Seychelles is faced with a concentrated epidemic; HIV prevalence remains relatively low, with 0.87% in the general population. The pandemic is a concentrated one, as indicated from the IBBS 2011 conducted with two key populations (MSM and PWID) which showed prevalence rates of 14% and 4% respectively. The HIV prevalence among 15 to 24 years is also low (0.76%). This result was obtained from the IBBS 2012 conducted in the general population and tests at outreach activities.

The RDS study conducted in 2011, which focused on two key population including people who inject drugs (PWID) and Men who have sex with men (MSM) indicate HIV is currently concentrated among these two population groups with disproportionately higher prevalence of least 5 times and 14 times respectively than that found in the general population. The Respondent Driven Sampling (RDS) study report, 2011 indicate HIV prevalence of about 5.8% among PWIDs of which about 53.5% were infected with Hepatitis C. These are new dynamics in the trends of the epidemic and cause a major concern especially due to dramatic rise in prevalence particularly among the PWIDs and MSM.

2.0 RATIONALE FOR THE CONSULTANCY

Concerns about the representativeness and accuracy of HIV estimates derived from sentinel surveillance alone have led to an increased demand for more surveys and more data on the prevalence in the whole population including behavioral risk factors to gain a better understanding of the state of the epidemic. In many instances combining data from HIV Prevalence Survey and sentinel surveillance data including behavioural survey provide more accurate estimates and allow for comparing HIV transmission and population risk behaviours. Therefore, the study will add to the base of data and evidence for Sero-Prevalence surveillance and behavioural surveillance of HIV risk behaviours in the country. The data generated will add weight to data from sentinel surveillance systems and provide clearer picture of the

epidemic in Seychelles. Overall, the study will provide useful data for improving HIV/AIDS response strategies and programs including allocation of resources.

While the dynamics of concentrated epidemic among Injecting Drug Users and men Having Sex with men lead to suspect changes in population knowledge, behaviour and practices, it is not very clear to what extent HIV has spread to the general population from the sentinel surveillance data which are not as complete.

The information collected in this project will be used to re-orientate, plan and implement targeted HIV prevention, care and treatment activities. IBBS among FSWs is being repeated because of the importance of key populations for the HIV epidemic:

The Key Affected Populations (KAPs) such as Female Sex Workers (FSWs), PWIDs and Men Having Sex With Men (MSM), through sexual and drug-using partners, may provide a bridge for HIV transmission to the general population. They are highly stigmatized, criminalized, and their sexually transmitted infection (STI) and HIV risk often goes unrecognized contributing to the spread of the infection.

To realize these targets the Ministry of Health, National AIDS Council requires short term technical support of a specialist will act as the Principle Investigator (PI) to provide overall technical leadership and advise for the national HIV prevalence and behavioural survey.

3.0 THE GOAL OF THE STUDY

The primary objective of this project is to provide essential data to track HIV epidemic trends among FSW and to measure the outcomes and impact of the national HIV response.

3.01 Specific Objectives

1. To follow the trend in the prevalence of HIV among FFSWs in Angola, Mauritius and Seychelles

2. To assess sexual and other risk behaviours associated with HIV transmission among FFSWs.

3. To assess health seeking behaviours, including harm reduction and VCT among FFSWs

4. To describe demographic characteristics of FSWs and to note the changes in their behaviors.

5. To estimate population size of FSWs in Seychelles using a variety of multiplier methods.

6. To develop capacity to strengthen national HIV surveillance systems for key populations.

7. To provide information about FSWs to inform public policy and services and to assist the Government of Seychelles, the cooperating partners, and other local organizations in strategic planning.

8. To estimate the prevalence of the co-infections link to VIH, Syphilis and Hepatitis Band C in FSWs in Seychelles.

4.0 PURPOSE AND SCOPE OF ROLES AND RESPONSIBILITIES OF THE CONSULTANCY

Sex Workers are highly stigmatized and their behaviours are illegal in Angola, Mauritius and Seychelles. RDS was shown to be effective in Zanzibar in 2007, in Mauritius in 2010 and in Seychelles in 2011 and has successfully been used in several other countries such as Vietnam, Brazil, Montenegro and Russia to sample FSW. Thus, RDS is a chain referral sampling method designed to reduce the biases generally associated with chain referral methods. Although sampling is initiated by purposively selected recruits (“seeds”), the

composition of the ultimate sample is independent of those initial subjects and may be considered representative of the sampled population.

The main methods to be used are a questionnaire to collect data on knowledge, attitudes, behaviours and practices and collection of a blood sample for testing. The questionnaire looks at demographics, knowledge, attitudes and behaviours about HIV and AIDS and STIs. The sampling method is snowballing with the use of initial contacts with seeds who will then seek out other people in their networks as participants. There will also be a biological sampling exercise to test blood for HIV and STIs, such as syphilis and hepatitis C.

All ethical and methodological guidelines for such a study will be observed, namely informed consent, confidentiality, respect of the person, withdrawal and risks to the participants as well as the enumerators, nurses and laboratory technicians.

The purpose of the consultancy is to provide overall technical leadership and support as a Principle Investigator (PI) for the National HIV Prevalence and Behavioural Study of Female Sex Workers in close collaboration with a Technical Working Group (TWG). Through consultative process the Principle Investigator will provide technical support and advice on research design, methodology and tools, data collection, data management and analysis. The consultant will assume overall responsibility to ensure quality of the process and outcome of the research exercise.

Annex 2: Main roles and responsibilities of the Principal Investigator

TECHNICAL LEADERSHIP AND ADVISORY ROLES

Assume overall technical leadership for the HIV Prevalence and Behavioural Survey of Female Sex Workers to ensure development of research design, methods, tools, data collection, storage, entry, cleaning, analysis and report writing.

Specific tasks in under guidance of TWG will involve:

1. He will review and prepare the research protocol, including consent forms in close consultations with TWG.
2. Development of survey design, methods including appropriate methods for 'HIV prevalence survey ', research tools including Behavioral Survey questionnaire design
3. Planning and implementation of integrated HIV Prevalence and Behavioral Survey activities
4. Support identification and recruitment of study population(done) by Principal Investigator)
5. Piloting study procedures and survey tools/instrument
6. Overall supervision of data collection, data management, data analysis, and report writing
7. Provide technical support in developing appropriate procedures for collecting sample HIV testing and sample collection management
8. The consultant will be responsible to advise and monitor data quality including data cleaning and verification of information from the study
9. Preparing data analysis plan and techniques including a coding system and data screen input format. Data will be analyzed with RDSAT, a software package that adjusts data collected with RDS for social network sizes and recruitment patterns.
10. Prepare data analysis report
11. He/She will also provide technical support to analysis process and how to reconcile the results obtained from national surveys with those obtained from sentinel surveillance to produce an estimate of HIV prevalence in a country.
12. Reports on progress and communicates regularly with TWG on emerging needs among the field teams to ensure successful completion of all activities

COORDINATION SUPPORT ROLES

He/She will be responsible for coordinating the different research activities on a day to day basis and some tasks include:

1. Providing technical assistance to TWG and NAC in recruitment and training of research supervisors, research assistants and interviewers/enumerators
2. Ensure effective communication among different teams and persons at different levels.
3. Work in collaboration with TWG to support supervision of field teams ensuring high quality data collection, adherence of implementation to study protocol and procedures
4. He/She is expected to contribute to budget and operations planning to ensure smooth day to day operations
5. Write Report and present final findings to the NAC for validation
6. Dissemination workshop at the occasion of the ABCD of Safer Sex Week 2015

5.0 SUPERVISION

The Principal Investigator will be based at the Ministry of Health offices, reporting to the Steering Research committee and NAC secretariat. He will be working closely with Technical Working Group.

6.0 DELIVERABLES

1) Complete research protocol developed including research design, methods, ethical issues and how they will be addressed, data analysis plan.

2) Clearly outlined plans developed including data collection, management and analysis plan developed

3) Data collection tool/instrument is reviewed and finalized for behavioural survey

4) Sample collection procedures and tools for HIV prevalence survey developed

5) Preliminary analysis report outlining 1) analysis of proportion of target group with HIV positive results 2) level of Knowledge, attitudes, practices among the study population disaggregated by age, gender, level of education, marital status and other socio economic identifiers, 2) analysis of the prevalence of risk factors among the study population disaggregated by age, gender, level of education, marital status and other socio economic identifiers 3) estimation of association between HIV status and risk behaviours among different population groups.

6) Final complete research report with detailed analysis of both HIV prevalence data and behavioral data completed and associations.

7.0 QUALIFICATIONS AND EXPEREINCE

1. A Graduate qualification or other relevant degree in public health, epidemiology, demography, social sciences or related field with advanced skills in quantitative methods, statistical analysis, evaluation research design or equivalent years of experience.
2. Five years or more demonstrated experience in designing population based and quantitative studies, management and analysis of quantitative data. Experience with public health or HIV and AIDS programme environments is preferred

8.0 CONSULTANCY TIMELINE AND REPORTING

This consultancy will be for a maximum of 90 days with regular performance appraisal. The expected results should be achieved by the timeline

Annex 3: Information Sheet for RDS Research Participants (English)

Date_____

Integrated Biological and Behavioural Surveillance Survey on Female sex Workers in Seychelles

A survey of HIV prevalence and risk behavior among female sex workers in Seychelles is being conducted from August this year (2014).

Introduction (For participants with low reading skills, the paper will be read to them).
You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.
All information you provide for this study is confidential and anonymous. Names are not recorded anywhere, and nothing can be attributed to you personally.

Thank you for reading this.

What is the purpose of the study?

We are interested in finding out about the characteristics of people who engage in sex work, and measure HIV prevalence in these populations. The study will help us develop HIV prevention services for (insert group here) in (insert city and/or country here). It is part ofa collaborative project between the Ministry of Health and its partners, such as SADC.

Why have I been chosen?

You have been chosen because you have engaged in sex work in the last 6 months).

Do I have to take part?

You can decide not to take part. It is up to you. If you do decide to take part, you will be provided this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

1. You will be asked to take part in an interview which takes between 30 to 45 minutes. This interview will be conducted with an interviewer. You will be asked questions on sexual behavior, drug use, sharing of injecting equipment, use of health services, and contact with the police, imprisonment, etc.). You will be able to skip any questions that you do not want to answer.
2. You will be asked to give a venous blood. A staff member will counsel you before taking a blood sample through an injection and drawing of 7mls blood into a syringe. This blood will be tested for antibodies to HIV, Hepatitis A, B and C and syphilis. It may also be tested for other viruses in the future.
3. Your test results will be available in 2 weeks and you will be given a specific day to collect the results. A staff member will also be available for counselling before and after giving you the results.
4. If you agree, we will keep left-over samples at our laboratory. Later, we may do some more tests on your samples to know more about HIV infections and development of new laboratory tests for STIs. Your name will not be on any of the left over samples, so we cannot contact you with the results of any future tests.

Will the information I give you be kept confidential?

The questionnaires and the blood sample and results are confidential and anonymous. No names are recorded on the questionnaire or the specimens. What you say in the interview will not be linked to you personally, and any test results will be anonymous; this means they will not have your name on them and you will obtain the results of the tests through your unique identifier (number).

What will happen to the results of the study?

The results of the study will be written up into a report for the Ministry of Health and its other partners. These publications will be used to inform the development of HIV prevention services for female sex workers in Seychelles. No persons will be identified in any report or publication.

Who is organizing and funding the research?

The Ministry of Health, NAC and SADC

What should I do if I want to know whether I have HIV?

At the end of the interview and you giving the blood sample, you will be able to obtain the results in 2 weeks on a specific date. It is up to you whether you decide to have your results.

Contact for further information

You may speak with any member of the staff at this project. You may also contact CDCU.

We appreciate your participation.

Thank you for taking part in the study.

You will be given a copy of this information sheet.

Annex 4: Consent Form (English version) for RDS Research Participants

Coupon number _____Time Started _____

Site _____

(The following is to be read verbatim by the interviewer to the respondent):

"The Ministry of Health is conducting a survey of people in Seychelles to learn more about their risk for certain sexually transmitted diseases and HIV. This interview should take no longer than 45 minutes.

Some of these questions are personal. You are free to refuse to participate or to terminate the interview at any time. All answers are anonymous. I do not know your name and there is no way that anyone can learn how you answered these questions. Please be truthful in your responses. Your participation is very important and will help Seychelles to improve its health services for its people"

[PAUSE}

Do you want to participate?

YES□ *No□*

Signature of enumerator_____ Date: _____

Annex 5: Consent Form (Creole Version)

Form lo lenformasyon e konsantman pour bann partisipan resers

Dat_____

Serve lo lapse biolozik e konportmantal bann travayer seks madanm Sesel

En Out 2014, en serve lo prevalans HIV e konportman a risk parmi bann travayer seks madanm pe ganny fer dan Sesel.

Lentrodiksyon (Li sa form pour bann partisipan ki pa lir byen).

Ou pegannyenvite pour partisip dan en resers. Avan ou deside si ou oulepran par, i enportan pou ou konpran akoz nou pe fer sa resers e ki i pou enplike pour ou. Pran enpe letan pour lir (ekout) sa kilo sa papye e ou menm kapab diskit ek lezot dimoun si ou oule. Demann nou okenn kestyon pour tou sa ki pa kler. Pran ou letan e deside si ou pou partisipe oubyen non.

Tou lenformasy onki ou donnendan sa letid pou reste sekre e konfidansyel. Napa okenn non ki ganny mete okenn par dan bann rikord e napa nanryen ki kapab ganny idantifye konmkwa sa lenformasyon pe sorti kot ou.

Mersi pour (lir sa dokiman) ekoutmwan.

Akoznoupe fer sa letid?

Nou anvi konnen ki bann karakteristik bann dimoun ki fer travay seks e mezir nivo HIV dan sa popilasyon. Sa letid pou ed nou develop bann programm prevansyon lo HIV pour bann travayer seks dan Sesel. I form par bann travay kolaborasyon ki Minister Lasante Sesel pe fer avek de lezot pei – Moris e “Angola”.

Akozmon’ngannyswazir?

Ou’n ganny swazir akoz ou’n fer travay seks pandan lannen ki’n pase.

Eski mon bezwenpran par?

Ou kapab de side pour papran par. I depann lo ou. Si ou deside pour pran par dan sa letid, nou pou bezwen ou konsantman. Ou kapab arete reponn kestyon a okenn moman pandan sa letid e ou pa bezwen donn okenn rezon akoz ou pe arête.

Ki pou arrive ekmwan si mon pran par?

1. Ou pou ganny demande pour fer en ‘interview’ kip pran ant 30 a 45 minit. I annan en dimoun ki pou \interview’ ou. I pou demann ou kestyon lo ou konportman seksyel, si ou servi drog, si ou pik drog dan lavenn, si ou partaz sereng ek zegwir, kontaktek lapolis, prizon, eksetera.Serten bann kestyon i pou tre personnel. Me ou kapab deside pour pa reponn si ou oule.

1. Ou pou osi ganny demande pour donn en pedisan. Enn nou bann staf ava konsey ou aven pran ou disan. Set mililit disan pou ganny tire avek en zegwir e ganny met dan en sereng. Sa disanki ou donnen pou ganny teste pour viris HIV, Epatit A, B ekC e osi sifilis. Dan lavenir, nou osi kapab teste li pour lezot viris.
2. Our ezilta pou pare dan 2 semenn. Ou pou ganny en zour spesifik pour vin sers ou rezilta. Pou annan an staf pour konsey ou avan e apreki ou ganny ou rezilta.
3. Si ou dakor, nou pou gard ou disan ki reste dan laboratwar. Pli tar, nou kapab teste ou disan pour konn plis lo HIV (SIDA) e bann nouvo tes pour (HIV) SIDA. Ou non pa pou lo okenn sa bann tib disan ki’n reste e nou pa pou kapab kontakte ou pour okennn rezilta.

Eski bann lenformasyon pou konfidansyel?

Bann kestyoner, disan ek rezilta bann tes pou konfidansyel e sekre. Napa okenn non ki pou ganny met lo kestyoner e bann rikor. Sa ki ou dir dan 'interview' pa pou ganny asosye ek ou personelman. Tou tes pou anonim (sekre). Pou napa ou non. Ou rezilta pou ganny kolekte an servan en limero ki zis ou ki pou annan.

Ki pou arrive ekrezilta sa letid?

Rezilta sa letid pou ganny ekri dan en rapor pour Minister Lasante e son bann partner. Sa bann piblikasyon pou ganny servi pour donn lenformasyon lo ki mannyer nou kapab travay pli byen dan prevansyon HIV pour bann madanm ek fiy ki pe fer travay seks Sesel. Napa okenn non ki pou ganny asosye ek sa bann rapor ek piblikasyon.

Lekel kip e organize e peye pour fer sa letid?

Minister Lasante, NAC ek SADC

Ki mon devret fer si mon anvikonnen si mon annan HIV?

Alafen sa 'interview' e letan ou'n donn en 'sample' ou disan, ou pou kapab ganny rezilta dan 2 semenn lo en dat spesifik. Ou ki pou deside si ou oule ganny rezilta ou tes.

Kontakpour plis lenformasyon

Ou kapab koz avek okenn bann manm staf ki pe travay lo sa proze. Ou osi kapab kontakte …

Nou vreman apresye ou partisipasyon e ou led.

Mersi pour pran par dan sa letid.

Nou pou donn ou en kopi sa form lenformasyon.

Annex 6: Form lo lenformasyon (Creole) pour bannpartisipanresers

Form Konsantman Partisipan

Serve lo lapse biolozik e konportmantal bann travayer seks madanm Sesel

Silvouple met en tik

☐1. Mon konfirmenkimon'nlir e konpran sa bannlenformasyonkiannanlo sa papye date le _____ konsernan sa letid. Mon'nosiganny sans demannkestyon.

☐2. Mon konpranki mon partisipasyon ivolonter e ki mon lib pour sorti dan sa serve aokennmoman, sandonnokenrezon e sanki mon banndrwalokotelegal e medical i gannyafekte.

☐3. Mon dakor pour partisipdan sa letid.

_____ _____

Sinyatir sa zofisye kipe pran konsantman **Dat**

Annex 7: Information (English) for Parents / Guardians for RDS Research Participants FSW(English)

IMPORTANT NOTE TO INTERVIEWERS

Date:

IMPORTANT NOTE TO INTERVIEWERS

A parent, for purposes of consent, means either a minor's biological or adoptive parent. In some instances, the consent of a guardian may be used instead of parental consent. A guardian is an individual who is authorized under national law to consent on behalf of a minor (15 to 17 years) to important decisions, such as general medical care.

For the purposes of this research a ***guardian*** is:

1. ***A person appointed guardian of a minor, according to the Children Act as documented by a valid court order;***

2. A person having legal custody of a minor and as documented by court order;

3. A person (sister, brother, uncle, aunt, godfather, godmother, grandparents, parents-in-law) above 18 years, acting in loco parentis, regardless of whether such is documented by a court order. A person acts in loco parentis of a minor where the individual voluntarily assumes responsibility for the minor's custody, care, and maintenance even though no court order exists formally appointing the person as the guardian, legal custodian, or adoptive parent of the minor.

Integrated Biological and Behavioural Surveillance Survey on Female sex Workers in Seychelles

Coupon number _____ **Time Started** _____

Site _____

A survey of HIV prevalence and risk behavior among female sex workers in Seychelles is being conducted from August this year (2014). The study covers people aged 15 to 64 years. So, some minors (people under 18 years of age) may be selected to participate in this study

Introduction (For parent/guardian participants with low reading skills, the paper will be read to them).

Has the minor been interviewed already for this study?

(IF THE RESPONDENT HAS BEEN INTERVIEWED BEFORE, DO NOT INTERVIEW THIS PERSON AGAIN.

Tell them you cannot interview them a second time, thank them, and end the interview). If they have not been interviewed before, continue:

Explanations: "You are making a decision whether or not to have your …… (state the relationship) participate in this study. I will sign this document to show that you have verbally given your consent. This is done because we do not want your name or that of your _____ to be associated in any way with this research.

Would you like me to go on?

(IF THE PARENT OR GUARDIAN SAYS YES, PROCEED.

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HER OR THEM AND LEAVE)

IF PARENT/GUARDIAN SAY YES. Then continue

Your _____ has been selected to take part in this study. I amasking you for your permission to allow your _____ to take part in this study. I am going to ask her some personal questions that may she may find difficult to answer. Her answers are completely confidential- that means her name will not be written on this form or associated with it in any way, and her name or identity will never be used in connection with any of the information she tells me.

All the information we collect from over 133 interviews will be analysed together to give us a general picture of the situation in the country as a whole. Your _____ does not have to answer any questions that she does not want to answer, and she may end this interview at any time she wants to. However, her honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviours. We would greatly appreciate your help in allowing your _____ to respond to this survey. The survey will take about 45 minutes to ask the questions.

Your _____ will be interviewed alone to allow for her answers to remain confidential. I will not be able to share her answers with you as this is not the purpose of this study.

Introduction:

"My name is …… I'm working for the Ministry of Health, and we are interviewing people all over the Seychelles as part of a national survey on HIV and AIDS. We want to get a picture of how HIV might be spreading in Seychelles, and what we can do about it. The study covers people aged 15 to 64 years. So, some minors (people under 18 years of age) may be selected to participate in this study.

Would you like me to go on?

(**IF THE PARENT OR GUARDIAN SAYS YES, PROCEED.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

Do you have any questions you would like to ask me?

(QUESTIONS AND ANSWERS. SEE GUIDE)

Would you be willing to let your (_____) participate?

(**IF THE PARENT OR GUARDIAN SAYS YES, THANK THEM AND ASK TO BEGIN INTERVIEWING THE CHILD. GO OVER THE INSTRUCTIONS PRIVATELY WITH THE CHILD.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

Thank you for taking the time to learn about this study. It is up to you to decide if you want (will let your _____) to take part. If you decide to (let your _____) take part, we would like to get your consent. You (Your _____) are still free to withdraw at any time and without giving a reason.

Please tick box (Pay attention to Boxes 3 and 4)

1. ☐The respondent confirms that he/she have been read the informed consent sheet for the study and have understood the content. He or she also confirms that s/he have had the opportunity to ask questions. (***The parent / guardian confirms that s/he have been read the informed consent form and have understood the content. S/he hereby gives consent for her _____ to take part in this study.)***

2. ☐The respondent understands that his or her participation (***the participation of her*** _____) is voluntary and that s/heis free to withdraw at any time, without giving any reason, without her medical care or legal rights being affected.

3. ☐The respondent agrees to (***let her _____)*** take part in the above study by giving a blood sample for HIV, HBV, HEP C and syphilis.

4. ☐The respondent (***The parent or guardian***) does not agree to (***let her _____)*** take part in this study.

_____ _____

Name of Person taking consent Date Signature

Annex 8: Information (Creole) for Parents / Guardians RDS Research Participants FSW (Creole)

VERSYON KREOL– lenformasyon e form konsantman pou paran /gardyen

IMPORTANT NOTE TO INTERVIEWERS

A parent, for purposes of consent, means either a minor's biological or adoptive parent. In some instances, the consent of a guardian may be used instead of parental consent. A guardian is an individual who is authorized under national law to consent on behalf of a minor (15 to 17 years) to important decisions, such as general medical care.

For the purposes of this research a ***guardian*** is:

1. ***A person appointed guardian of a minor, according to the Children Act as documented by a valid court order;***

2. A person having legal custody of a minor and as documented by court order;

3. A person (sister, brother, uncle, aunt, godfather, godmother, grandparents, parents-in-law) above 18 years, acting in loco parentis, regardless of whether such is documented by a court order. A person acts in loco parentis of a minor where the individual voluntarily assumes responsibility for the minor's custody, care, and maintenance even though no court order exists formally appointing the person as the guardian, legal custodian, or adoptive parent of the minor.

Dat_____

Serve lo lapse biolozik e konportmantal bann travayer seks madanm Sesel

En Out 2014, en serve lo prevalans HIV e konportman a risk parmi bann travayer seks madanm pe ganny fer dan Sesel. Sa letid i kouver bann fanm aze ant 15-64 an. Alor detwa minor pou ganny selekte pou partisip dan sa letid. (dimoun anba 18 an)

Limero koupon _____ Ler komanse _____

landrwa _____

Entrodiksyon*: "Mon non i …… Mon pe travay pour Minister Lasante. Nou pe fer en lanket / serve nasyonal partou dan Sesel lo HIV ek SIDA. Nou anvi konpran ki mannyer HIV (SIDA) pe ganny transmet dan Sesel e ki nou kapab fer lo sa sitiasyon. Alors pou annan en pe miner, dimoun ki anba 18-t-an ki pou ganny swazir pour partisip ladan.*

Eski ou _____ i'n deza ganny "interview" pour sa letid?

Eksplikasyon: "*Ou pou deside si ou _____ pour partisip dan sa letid / lanket. Mwan pou sinny dan ou plas si ou dir wi / ou dakor / ou aksepte. Mon pou fer sa (sinny dan ou plas) akoz sa resers i konpletman konfidansyel / sekre e nou pa oule ou non e non ou _____ aparet dan okenn sa bann dokiman.*

Ou tia kontan plis lenformasyon?

(**IF THE PARENT OR GUARDIAN SAYS YES, PROCEED.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

Konfidansialite e konsantman: *"Mon pou demann ou _____plizyer kestyon personel ki kapab difisil pour li reponn. Son bann larepons i konpletman konfidansyel – savedir son non pa pe ganny ekri lo sa form oubyen ganny asosye avek sa form dan okenn fason. Son non ek son idantite pa pou ganny servi an koneksyon avek bann lenformasyon ki i donn mwan. Tou*

lenformasyon ki nou pou kolekte dan sa plis 133 form pou ganny analize ansanm pour nou ganny en portre kler lo sitiasyon SIDA parmi bann travayer seks dan sesel .

I pa oblize reponn okenn kestyon ki i pa anvi reponn. I kapab aret sa interview nenport ki moman i oule. Par kont (Selman) son bann larepons onnet pour sa bann kestyon pou ed nou konpran pli byen sa ki dimoun pe mazinen, pe dir e pe fer konsernan serten kalite konportman. Nou pou vreman apresye ou led si ou les li partisip dan sa lanket / serve. Sa bann kestyon pou pran apepre 45 minit pour reponn.

Ou (_____) pou ganny interview li tousel akoz i enportan ki son larepons i reste konfidansyel. Mon pa pou dir ou sa ki i'n dir nou.

Ou tia kontan plis lenformasyon?

(**IF THE PARENT OR GUARDIAN SAYS YES, PROCEED.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

Eski ou annan okenn kestyon pour demande?

(QUESTIONS AND ANSWERS. SEE GUIDE)

Eski ou aksepte pou ou (_____) partisip dan sa serve / lanket?")

(**IF THE PARENT OR GUARDIAN SAYS YES, THANK THEM AND ASK TO BEGIN INTERVIEWING THE CHILD. GO OVER THE INSTRUCTIONS PRIVATELY WITH THE CHILD.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

Entrodiksyon

*Bonzour, mon non i (_____). Nou pe kontinny nou travay lo sa lanket / serve lo konesans, latitid, pratik e konportman an relasyon ek HIV (SIDA) e lezot maladi transmit par seks. Sa voyaz, nou anvi konnen ki kantite HIV (SIDA) i anna dan popilasyon an zeneral. Avan ou deside (**les ou _____)** partisipe, i enportan pour ou konnen akoz nou pe fer sa letid e ki mannyer ou pou pran par, si ou dakor.*

Mon pou donn ou lenformasyon lo sa letid e donn ou letan pour reflesir. A nenport ki moman, si en keksoz pa kler, aret mwan si ou anvi plis lenformasyon.

Mersi pour letan ki ou'n donnen pour aprann plis lo sa letid. Ou ki deside si ou (_____) pou pran par. Si ou deside (les ou _____) partisipe, nou pou demann ou konsantman. Ou kapab arete a nenport ki moman san donn okenn rezon.

Met en tik (✓) dan bwat (Vey byen Bwat 3 ek 4)

1. ☐ *Partisipan i konfirmen ki i'n ganny lir sa form konsantman pour sa letid e ki i'n konpran sa bann lenformasyon. I konfirmen ki i'n ganny sans demann kestyon.* ***Paran oubyen gardyen sa miner i konfirmen ki i'n ganny lir sa form konsantman e ki i'n konpran sa bann lenformasyon. I'n pare pour les son _____ partisip dan sa letid.***

2. ☐ *Partisipan (**Paran oubyen gardyen**) i'n konpran ki son partipasyon (**son _____)** i volonter e ki i lib pour arete a nenport ki moman, san perdi son drwa ganny swen medikal oubyen ki son drwa legal i ganny afekte.*

3. ☐ *Partisipan (**Paran oubyen gardyen)** i'n dakor pour (**les son _____)** partisip dan sa letid e tir disan pour teste HIV (SIDA).*

4. ☐ *Partisipan pa'n dakor pour partisip dan sa letid.*

Paran oubyen gardyen sa miner pa'n dakor pour les son _____ partisip dan sa letid.

_____	_____	_____
Name of Person taking consent	**Date**	**Signature**

Annex 9: Questionnaire Surveillance Risk Behaviour Assessment of Female Sex Worker (English)

Section 1: Background characteristics - *First I would like to ask you a few questions on your background, including information on your age, education, jobs and income*

No.	Questions and filters	Coding categories	Skip to
1.	How old are you? (In completed years)	Years____	
2.	Do You have children?	Yes 1 No 2	→ **4**
	If Yes , How old are they (state age)	Years……	
3	Were you born in Seychelles?	Yes 1 No 2 NA / DK 99	
4	***What is your marital status?***	Currently married 1 Divorced/separated/widowed 2 Never married NA / DK 99	
5	***Currently***, with whom are you living? *Read out the possible answers* *Circle one only*	Alone 1 Boyfriend 2 Husband 3 With mother / father 4 With friends 4 No fixed address (unsettled) 5 Other sex workers 6 NA / DK 99 Other (specify) _____	
6	What is the **highest level of education** have you attained / finished schooling? ***Post-Secondary Classification***: Technical = Seychelles Institute of Technology (SIT), Maritime Training Centre (MTC), Seychelles Horticulture and Agriculture Training Centre (SHATC), Seychelles Tourism Academy (STA) and School of Visual Arts, School of Business Studies General: School of Advanced Level Studies (SALS) and	Primary 1 Secondary 2 Post-secondary (Technical) 3 Post-secondary (Academic) 4 Diploma 5 Bachelor 6 Masters 7 Ph. D 8 NA / DK 99	
7	What was your total income in the <u>past month</u>?	_____ NA / DK 99	

8 How much did you contribute towards the total household income earned in the <u>past month</u>?

TS _____
NA / DK 99

9 Other than sex work, what kinds of things do you do to earn money?

READ OUT LIST – CIRCLE ALL MENTIONED

Private Business (own or for wage) 1
Government 2
Service/Tourism 3
Teaching 4
Student 5
Petty trading 6
Illegal activities 7
No other income besides sex work 8
Others (specify)_____88
NA / DK 99

Section 2: FSW Network -*Now I would like to ask you some questions about other FSWs that you may know. Please remember that no one will be able to find out what you tell me so please be truthful.*

No.	Questions	Coding categories	Skip to
10	How many FSWs do you know personally (i.e., who are living in Seychelles, are 15 years and above, you know their name, you know who they are and they know you)?	|__|__|__|	
		NA / DK 99	
11	How many of these (repeat the number in Question 9) FSW have you seen during the past one month?	|__|__|__|	
		NA / DK 99	
12	Would you have given a coupon to the same person who gave this coupon to you?	Yes 1 No 2 NA / DK 99	
13	What is the primary reason you decided to accept a coupon and enroll in the study? ***MARK ONE RESPONSE ONLY***	For incentive 1 For STI/HIV test results 2 Peer influence 3 Study seems interesting/useful 4 Had time to spend 5 Others _____88 NA / DK 99	

Section 3: **General Sex Work and Stigma Questions** -Now I will ask you some general questions about sex work *and stigma that may affect you because of sex work.Your responses are anonymous and completely private.*

14	Where do you usually meet your clients? <u>*Do not read responses*</u>*.*	Pub / Bar 1 Street 2 Disco 3 Private houses [rented room] 4 Guesthouse 5 Hotel 6 By telephone 7 Through an agent / pimp 9 Internet 10 Other_____88 NA / DK 99	

15 Where is your <u>primary</u> place to meet clients?

SELECT ONE.

Pub / Bar	1
Street	2
Disco	3
Private houses [rented room]	4
Guesthouse	5
Hotel	6
By telephone	7
Through an agent / pimp	9
Internet	10
Other_____	88
NA / DK	99

16 The <u>last time</u> you had sexual intercourse with a client, how much were you paid cash or in kind? _____

NA / DK 99

17 What is the smallest amount you have been paid for sexual intercourse in the past six months? _____

NA / DK 99

18 What is the largest amount you have been paid for sexual intercourse in the past six months? _____

NA / DK 99

19 On the <u>last day</u> you worked, how many clients did you have? _____ *(write the number)*

NA / DK 99

20 On the last day you worked, did you use a condom with the last client you had?

Yes	1	→ **22**
No	2	
NA / DK	99	

21 If not used, why didn't you and your partner use a condom that time?

DO NOT READ RESPONSES; MARK ONE RESPONSE ONLY*)*

Didn't think about it	1
Don't like the feel of it	2
Didn't have any condoms	3
Too drunk/high to use	4
Things happened too fast	5
Wanted to get pregnant	6
Partner objected	7
Trust my partner	8
Too expensive	9
Condoms don't work	10
Other reasons given _____	88
NA / DK	99

22 Do you have someone who helps you meet clients or acts as an 'agent'?

Yes 1
No 2
NA / DK 99

23 Does anyone in your family know about your sex work/that you sell sex?

Yes 1
No 2
NA / DK 99

24 Please answer yes or no to the following statements that refer to your experience as a sex worker.

	Yes	No	DK / NA
a. I have experienced name calling, teasing and insults.	1	2	99
b. I have been excluded from a social gathering.	1	2	99
c. I have been gossiped about.	1	2	99
d. Other people have lost respect for me.	1	2	99
e. I have been abandoned by my partner or put out from my family. 1 299	1	2	99
f. Physical violence			

Section 4: Sexual History and Sex Work Practices- *Now I will ask you some questions about your sexual history, sex partners, and use of condoms. Please remember that your answers are completely anonymous.*

25. How old were you when you had sexual intercourse (vaginal or anal sex) for the first time?

_____ years
Don't remember 99

26. How old were you when you sold sex for the first time?

_____ years
Don't remember 99

27. When you started having sex for money/materials/services/gifts, what was the most important reason?

(**CHOOSE ONLY ONE RESPONSE**)

Need money to help family 1
Need money to pay a debt 2
Was forced 3
Like to do it/pleasure 4
Friends/family were doing it 5
Good income 6
Abandoned by husband/family 7
To buy drugs 8Abandoned by partner/husband/Partner 9
Unemployed 10
Others_____88
NA / DK 99

28. In the past one month, how many different sexual partners have you had sexual intercourse with?

(**INCLUDE HUSBAND, BOYFRIENDS, CLIENTS, ETC**.*)*

_____ (**WRITE IN NUMBER**)

NA / DK 99

29. In the past one month have you had sex with:
(Read each category; check yes or no for each)

	Yes	No	DK / NA
a. A spouse, live-in boyfriend (steady partner)	1	2	99
b. A casual, non-paying partner	1	2	99
c. A one-time client	1	2	99
d. A regular client	1	2	99
	1	2	99
e Tourist/Foreigner	1	2	
f. Others _____			

***Steady Partner**- Now I will ask you questions about sex with your husband/boyfriend or steady partner. A steady partner is someone with whom you regularly have sex with any time???. Please be truthful.*

30. In the past one month, how many times did you have sexual intercourse with your steady partner?

_____ (**WRITE IN NUMBER**)
None 00 → **33**
Never had sex with husband / boyfriend/partner 1 → **38**

31. In the past one month, how often have you used condoms with your steady partner?

Always 1
Most of the time 2
Occasionally 3
Never 4
NA / DK 99

32. In the past one month, did you refuse to have sex with a steady partner if a condom was not used?

Yes 1
No 2
NA / DK 99

33. Do you think your husband/boyfriend/partner has ever used drugs?

Yes 1
No 2
NA / DK 99

34. Do you think your husband/boyfriend/partner has ever injected drugs?

Yes 1
No 2
NA / DK 99

35. The last time you had sex with your steadypartner, did you use a condom?

Yes 1 → **37**
No 2
NA / DK 99

36. If not used, what was the primary reason you and your partner did not use a condom that time?

*(**DO NOT READ RESPONSES; MARK ONE RESPONSE ONLY**)*

Didn't think about it	1	→ **38**
Don't like the feel of it	2	→ **38**
Didn't have any condoms	3	→ **38**
Too drunk/high to use	4	→ **38**
Things happened too fast	5	→ **38**
Wanted to get pregnant	6	→ **38**
Partner objected	7	→ **38**
Trust my partner	8	→ **38**
Too expensive	9	→ **38**
Condoms don't work	10	
Other _____	88	
NA / DK	99	

37. If used, who suggested condom use?

Myself	1
My partner	2
Mutual decision	3
NA / DK	99

Casual, non-paying partner-*Now I will ask you about sex you have with casual, non-paying partners. Again, these matters are personal, but they are important to us. Please be truthful. (this question is fine have serched in literature)*

38. In the past <u>one month</u>, how many casual, non-paying partners did you have sexual intercourse with? (*Number can't be larger than the number in 28 and must take into account inclusion of husband/boyfriend)*

_____ (*write in number*)		
None	00	→**41**
Never had sex with a casual non-paying partner	1	→**46**

39. In the past <u>one month</u>, how often have you used condoms with your casual, non-paying partners?

Always	1
Most of the time	2
Occasionally	3
Never	4
NA / DK	99

40. In the past <u>one month</u>, did you refuse to have sex with a casual, non-paying partner if a condom was not used?

Yes	1
No	2
NA / DK	99

41. Do you think any of your casual, non-paying partners have ever used drugs?

Yes	1
No	2
NA / DK	99

42. Do you think any of your casual, non-paying partners have ever injected drugs?

Yes	1
No	2
NA / DK	99

43. The <u>last time</u>you had sex with a casual, non-paying partner, did you use a condom?

Yes	1	→ **45**
No	2	
NA / DK	99	

44. If not used, what was the primary reason you and your partner did not use a condom that time? *(Do not read responses; Mark one response only)*

Didn't think about it	1	→ **46**
Don't like the feel of it	2	→ **46**
Didn't have any condoms	3	→ **46**
Too drunk/high to use	4	→ **46**
Things happened too fast	5	→ **46**
Wanted to get pregnant	6	→ **46**
Partner objected	7	→ **46**
Trust my partner	8	→ **46**
Too expensive	9	→ **46**
Condoms don't work	10	
Other _____	88	
NA / DK	99	

45. If used, who suggested condom use?

Myself	1
My partner did	2
Mutual decision	3
NA / DK	99

One time Clients*- Now I will ask you about sex you have with one-time time clients in exchange for money and/or gifts. Again, these matters are personal, but they are important to us. Please be truthful.*

46. In the past one month, how many one-time clients did you have sexual intercourse with? (*Number can't be larger than the number in 28 and must take into account inclusion of husband/boyfriend/partner)*

_____ (**WRITE IN NUMBE*R***)		
None	00	→ **49**
Never had a one-time client	1	→**53**

47. In the past one month, how often have you used condoms with your one-time clients?

Always	1
Most of the time	2
Occasionally	3
Never	4
NA / DK	99

48. In the past one month, did you refuse to have sex with a one-time client if a condom was not used?

Yes	1
No	2
NA / DK	99

49. Do you think any of your one-time clients have ever used drugs? 425

Yes	1
No	2
NA / DK	99

50. Do you think any of your one-time clients have ever injected drugs?

Yes	1
No	2
NA / DK	99

51. The last timeyou had sex with a one-time client, did you use a condom?

Yes	1	→ **53**
No	2	
NA / DK	99	

52. If not used, what is the primary reason you and your partner did not use a condom that time? *(Do not read responses; Mark one response only)*

Didn't think about it	1	→ **54**
Don't like the feel of it	2	→ **54**
Didn't have any condoms	3	→ **54**
Too drunk/high to use	4	→ **54**
Things happened too fast	5	→ **54**
Wanted to get pregnant	6	→ **54**
Partner objected	7	→ **54**
Trust my partner	8	→ **54**
Too expensive	9	→ **54**
Condoms don't work	10	
Other _____	88	
NA / DK	99	

53. If used, who suggested condom use?

Myself	1
My partner did	2
Mutual decision	3
NA / DK	99

Regular Clients*-Now I want to ask you about regular clients you have sex with in exchange for money and/or gifts/services. Again, these matters are personal, but they are important to us. Please be truthful.*

54. In the past one month, how many regular clients did you have sexual intercourse with? (*Number can't be larger than the number in 28 and must take into account inclusion of husband/boyfriend/partner)*

_____ (**WRITE IN NUMBER**)		
None	99	→ **57**
Never had sex with a regular client	1	→ **62**

55. In the past one month, how often have you used condoms with your regular clients?

Always	1
Most of the time	2
Occasionally	3
Never	4
NA / DK	99

56. In the past one month, did you refuse to have sex with a regular client if a condom was not used?

Yes	1
No	2
NA / DK	99

57. Do you think any of your regular clients have ever used drugs?

Yes	1
No	2
NA / DK	99

58. Do you think any of your regular clients have ever injected drugs?

Yes	1
No	2
NA / DK	99

59. The last time you had sex with a regular client, did you use a condom?

Yes	1	→**61**
No	2	
NA / DK	99	

60. If not used, what was the primary reason you and your partner did not use a condom that time?
(<u>Do not read responses</u>; Mark one response only)

Didn't think about it	1	→ **62**
Don't like the feel of it	2	→ **62**
Didn't have any condoms	3	→ **62**
Too drunk/high to use	4	→ **62**
Things happened too fast	5	→ **62**
Wanted to get pregnant	6	→ **62**
Partner objected	7	→ **62**
Trust my partner	8	→ **62**
Too expensive	9	→ **62**
Condoms don't work	10	→ **62**
Other _____	88	
NA / DK	99	

61. If used, who suggested condom use? 437

Myself	1
My partner did	2
Mutual decision	3
NA / DK	99

Section 5:Male and Female Condoms

Now I would like to ask you questions about using male condoms and female condoms. Your answers are anonymous.

62. Have you ever used a male condom with a partner?

Yes	1
No	2
NA / DK	99

63. Which places or persons have you obtained male condoms from in the last <u>one month</u>?

Multiple answers possible

DO NOT READ OUT

(CIRCLE WHAT IS MENTIONED)

Shop	1
Pharmacy	2
Health facility	3
Bar/Guest House/Hotel	4
Friends	5
Taxi drivers	6
Saloon	7
NGO	8
Public office	9
Did not buy condom in last month	10
Never used condom	11
Did not get condom	12
Sex partner	13
Other	88
NA / DK	99

64. How much did you pay for a pack (3-pieces) of male condoms last time you got one?

SR_____		
Free	0	→**66**
Never used condom	1	
NA / DK	99	

65. What time of day did you purchase the male condoms? *(Use 24 hour time)*

_____

66. Can you obtain a male condom every time you need one?

Yes	1	→**68**
No	2	
NA / DK	99	

67. Why can't you get a male condom every time you need one?

MULTIPLE ANSWERS POSSIBLE

DO NOT READ OUT

Costs too much	1
Shop too far away	2
Shops closed	3
Pharmacy too far away	4
Pharmacy closed	5
Embarrassed to buy condom	6
Don't know where to obtain	7
Things happen too fast	8
Don't need condom	9
Other_____	10
NA / DK	99

68. What lubricant did you use the last time you used it during vaginal or anal sex?

Did not use lubricant 1
Saliva 2
Vaseline / other petroleum based lubricant 3
Oil 4
Water based condom lubricant 5
Normal lotion 6
KY Jelly 7
Water 8
Other_____88
NA / DK 99

69. Have you ever used a female condom?

Yes 1
No 2 **→72**
NA / DK 99

70. Where did you obtain your last female condom? When?

Shop 1
Pharmacy 2
Health facility 3
Bar/Guest House/Hotel 4
Friends 5
Taxi drivers 6
Saloon 7
NGO 8
Sex Partner 9
Other _____ 88
NA / DK 99

71. What are your reasons for using a female condom?

Multiple answers possible
Do not read out

Protection from pregnancy 1
Protection from HIV/STIs 2
Partner requests me to use it 3
Gives me more control than male condom for protection 4
It was free 5
Other _____ 88
NA / DK 99

72. What are your reasons for not using female condom?

Multiple answers possible
Do not read out

Not available 1
Too big 2
Clients don't like them 3
Too difficult to insert into vagina 4
Don't want to insert into vagina 5
Too expensive 6
Never heard of it 7
Prefer male condoms 8
Too noisy 9
Allergic reation10
Use other birth control method 11
Other _____ 88
NA / DK 99

73. How much did you pay for a pack (3-pieces) of female condoms last time you got one?

SR_____
Free 0
Never used condom 1
NA / DK 99

74. The last time you used a female condom; did you use a single condom with more than one sexual partner?

Yes 1
No 2
Don't remember 97
No response 98

75; Did you re-used the same condom with another partner

Yes 1
No 2
Never used 3
Don't remember 97
No response 98

Section 6: Drug Use- *Now I would like to ask you some questions about drug use in the past three months, with and without a needle. Please remember that the answers to your questions are anonymous and completely private.*

75. Some people take drugs for fun or to get high. Have you ever taken any drugs other than alcohol? ***(By drugs I mean marijuana, hashish, prescription drugs, cocaine, heroin, ecstasy, others)***

Yes 1
No 2 → **84**
Never taken drugs 3
NA / DK 99

76. Have you taken any drugs other in the <u>last three months</u>?

Yes 1
No 2
Never taken drugs 3
NA / DK 99

77. Some people have tried injecting drugs for fun or to get high. Have you EVER injected drugs? (By drugs I mean heroin, cocaine, prescription drugs/medicine, and ecstasy)

Yes 1
No 2 → **84**
NA / DK 99

78. Have you injected drugs in the <u>last three months</u>?

Yes 1
No 2
Never injected drugs 3 → **84**
NA / DK 99

79. <u>Last time</u> you injected, what drugs did you use?

(**DO NOT READ RESPONSES**.)

Heroin 1
Ecstasy 2
Cocaine 3
Never injected drugs 4
Other _____88
NA / DK 99 → **84**

80. <u>Last time</u> you injected drugs, did you use a needle or syringe after someone else had used it?

Yes 1
No 2
NA / DK 99

81. Last time you injected drugs, did you pass your syringe or needle on to someone else after you used it?

Yes 1
No 2
NA / DK 99

82. During the past one month, on average, how often did you inject drugs?
(Do not read responses; Mark one response only)

Once a day 1
3-4 times a day2
More than 5 times a day3
Once a week 4
3-4 times a week 5
More than 5 times a week6
NA / DK 99

83. During the past one month,did you inject blood from someone who had taken drugs? (Flashblood / flushing)

Yes 1
No 2
NA / DK 99

Section 7: Violence- *Now I will ask you some questions on violence and history of incarceration. These questions are very personal and may make you uncomfortable. You can choose to not answer any question. Please remember that your responses are very important and will remain completely private*

84. In the past 12 months, have you ever experienced physical violence? 701
(by physical violence, I mean being slapped or having something thrown at you, being pushed or shoved, having your arm twisted or hair pulled, hit with a fist or something else that could hurt, kicked, dragged or beat up, choked or burnt, threatened or actually having a knife, gun or other weapon used against you.)

Yes 1
No 2 **→86**
NA / DK 99

85. Who was the person (or people) who physically hurt you?

MULTIPLE ANSWERS POSSIBLE

(DO NOT READ OUT)

Police	1
Family member	2
Client (one-time or regular)	3
Casual sex partner	4
Boyfriend/husband (steady)	5
Friend	6
Unknown person	7
Agent/Pimp	8
School mate/Teacher	9
Co-worker	10
Others_____	88
NA / DK	99

86. Have you ever been forced to have sexual intercourse when you didn't want to? 703

Yes	1	
No	2	→**89**
NA / DK	99	

87. In the <u>past 12 months</u>, have you been forced to have sexual intercourse when you didn't want to?

Yes	1	
No	2	→**89**
NA / DK	99	

88. The last time you were forced to have sex, who forced you?

MULTIPLE ANSWERS POSSIBLE

(DO NOT READ OUT)

Client (one-time or regular)	1
Casual sex partner	3
Boyfriend/husband (steady)	4
Friend	5
Unknown person	6
Agent/Pimp	7
Others_____	88
NA / DK	99

89. During the past <u>12 months</u>, have you been arrested? 706

Yes	1	
No	2	→**91**
NA / DK	99	

90. If yes, what were you arrested for?

Drug use	1
Aggravated assault	2
Theft	3
Selling sex	4
Loitering	5
Other _____	88
NA / DK	99

Section 8: STIs (Sexually Transmitted Infections)- Now will ask you some questions about STIs and whether you *have had an STI in the past.*

91. Can you tell me symptoms of diseases that can be transmitted through sexual intercourse?

DO NOT READ LIST. JUST PROMPT FOR MORE RESPONSES.
CIRCLE ALL APPROPRIATE RESPONSES

Do not know of any	1	
Abdominal Pain	2	
Urethral Discharge	3	
Pain with urination	4	
Genital ulcer/sore	5	
Genital itching	6	
Anal ulcer/sore	7	
Other (detail)	88	
NA / DK	99	

92. During the past six months, have you had unusual genital discharge?

Yes	1	
No	2	
NA / DK	99	

93. During the past six months,have you had genital/anal sores or ulcers?

Yes	1	
No	2	
Never had genital/anal sores/ulcer	3	→**95**
NA / DK	99	

94. The last time you had a genital/anal sore, ulcer or unusual discharge what did you do?

DO NOT READ LIST. CIRCLE ALL ANSWERS MENTIONED.

Did not do anything	1	
Went to government health establishment for examination and treatment	2	
Went to private health establishment for examination and treatment	3	
Went to pharmacy to buy drugs	4	
Went to traditional healer for examination/treatment	5	
Treated myself at home	6	
Told my sexual partner about the symptoms	7	
Stopped having sexual intercourse when having the symptoms	8	
Used condoms while having sexual intercourse	9	
NA / DK	10	
	99	

95. Have you ever been told by a physician or nurse that you had a sexually transmitted infection (STI)? 805

Yes	1	
No	2	→**97**
NA / DK	99	

96. The <u>last time</u> you were told by a physician or nurse that you had a STI, what was it (were they?)
    a.

Gonorrhea 1
Chlamydia 2
Syphilis 3
Herpes 4
Hepatitis 5
Genital Warts 6
HIV 7
Others _____ 88
NA / DK 99

Section 9: HIV knowledge, stigma, risk and testing history- *In this last section, I will ask you some questions about your knowledge of HIV and whether or not you have been tested for HIV in the past. Please do not tell me the results of your HIV test, but please be truthful in answering these questions.*

97. Have you <u>ever</u> heard of HIV/AIDS before this interview?

Yes 1
No 2
NA / DK 99 **→END**

98. In your opinion, can you tell if someone is infected with HIV just by looking at him/her?

Yes 1
No 2
NA / DK 99

99. *Now I will read some statements about HIV/AIDS. Some of them are true and some are not true. These are general statements and do not refer to your own experience or behavior. Please tell me whether you agree or disagree with each of the statements*.

Statements	**Responses**		
	Agree	**Disagree**	**Don't know**
a. Having sex with only one faithful uninfected partner reduces the risk of HIV transmission.	1	2	99
b. One can get HIV if one uses public toilets.	1	2	99
c. Using a condom every time during vaginal sex prevents HIV transmission.	1	2	99
d. Mosquitoes and other insect bites transmit HIV.	1	2	99
e. Sharing needles when injecting drugs will increase the risk of HIV infection.	1	2	99
f. Cleaning needles and syringes with bleach between injections reduces the risk of HIV.	1	2	99
g. One can avoid becoming infected with HIV by not having sex at all.	1	2	99
h. Using a condom every time during intercourse prevents HIV transmission.	1	2	99

i. Having anal sex is protective against HIV infection.	1	2	99
j. Oral Sex	1	2	99
k. Buying fresh vegetables from a HIV positive shopkeeper or vendor			

100. *Now I will ask some questions about stigma related to HIV/AIDS that you may have experienced in the last twelve months. Please tell me whether you agree or disagree with each of the statements.*

Statements	**Agree**	**Disagree**	**No response**
a. People with HIV/AIDS should be ashamed of themselves	1	2	99
b. I would feel ashamed if someone in my family had HIV/AIDS	1	2	99
c. I would feel ashamed if I was infected with HIV	1	2	99
d. People with HIV/AIDS are promiscuous	1	2	99
e. It is female sex workers who spread HIV in the community	1	2	99
f. HIV/AIDS is a punishment for bad behavior	1	2	99

101. With your current behaviors, how do you think about your risk of HIV infection?

High risk 1
Medium risk 2
Low risk 3
No risk 4 →**103**
NA / DK 99 →**104**

102. *<u>If you feel you are at risk for HIV infection</u>*, can you tell me the reasons/why?
(Multiple responses possible, but do not read choices aloud)

I often change sex partners 1 →**104**
I don't always use a condom 2 →**104**
I inject drugs 3 →**104**
I have sex with people who inject 4 →**104**
Other(s), specify _____ 88
NA / DK 99

103. *If you feel you are NOT at risk for HIV infection*, why do you feel that you are not at risk?
(Multiple responses possible, but do not read choices aloud)

I am faithful 1
I always use condoms 2
I'm convinced my partner is HIV-neg 3
I don't have anal sex 4
I don't have vaginal sex 5
I never have sex with sex workers 6
Do not inject drugd 7
Others, specify _____ 88
NA / DK 99

104. Do you ever talk to people about HIV/AIDS?

Yes 1
No 2 →**107**
NA / DK 99

105. With whom do you talk about HIV/AIDS?

MULTIPLE ANSWERS POSSIBLE

Friend 1
Acquaintance 2
Sexual Partner 3
Relative 4
People you have just met 5
Health care professional 6
Religious leader 7
I don't talk with people about HIV 8

106. How often do you discuss HIV/AIDS?

DO NOT READ RESPONSE.

MARK ONLY ONE.

Once a month 1
Once a week 2
More than once a week 3
Less than once a month 4
Once a year 5
Never 6
Other _____ 88
NA / DK 99

107. Do you know of a place where people can go to have a confidential test to find out if they are infected with HIV?
(Confidential means that nobody will know the test result unless you want them to know)

Yes 1
No 2
No response 99

108. Please do not tell me the result, but have you ever had an HIV test?

Yes 1
No 2 →**113**
No response 99

109. When did you last request an HIV test for which you got the results?

In the past year 1
Over one year ago 2
Never 3
NA / DK 99

110. Did you receive pre-test counseling when you took your last HIV test?

Yes 1
No 2
NA / DK 99

111. Did you receive post-test counseling when you took your last HIV test?

Yes 1
No 2
Did not get results 3

NA / DK 99

112. Why did you decide to get your <u>last</u> HIV test?

Doctor/nurse advised	1	
Felt sick/suspected	2	**END**
Infected partner	3	**END**
Premarital testing	4	**END**
Peer educator advised	5	**END**
To know my health status	6	**END**
Others _____	88	**END**
NA / DK	99	**END**

113. *<u>If you NEVER had an HIV test</u>*, why have you never chosen to get an HIV test?

Circle all that apply.

Didn't know where to go	1
Don't feel at risk	2
Concerned about confidentiality	3
Negative attitude of health care workers	4
Cost	5
Distance	6
Fear of knowing status	7
Not important for me	8
Others _____	88
NA / DK	99

This is the end of the interview. Thank you very much for your kind cooperation and spending your valuable time with me.

NAME OF INTERVIEWER: _____ **Signature _____**

DATE OF INTERVIEW: ____/ ____ / 2014 **Time Ended _____**

CHECKED BY SUPERVISOR: Name: _____Signature _____

DATE **CHECKED**: ____/ ____ / 2014

Limero Koupon _____ **Ler Konmanse** _____

Sit _____

Annex 10: Questionnaire Surveillance Risk Behaviour Assessment of Female Sex Worker (creole)

(The following is to be read verbatim by the interviewer to the respondent):

"Bonzour / Bonswar, mon apel _____. Minister Lasante pe fer en serve lo dimoun Sesel pour konn plis lo zot bann risk pour ganny serten maladi ki transmet par seks e osi HIV. Sa "interview" pa devret pran plis ki 45 minit.

Serten sa bann kestyon i personnel. Ou lib pour ou refize partisipe e osi aret sa "interview" a okenn moman. Tou ou larepons i konfidansyel e sekre. Mon pa konn ou non e napa personn ki pou konnen ki mannyer ou'n reponn sa bann kestyon. Silvouple, koz laverite. Ou partisipasyon i vreman enportan e zot pou ed Sesel amelyor bann servis ki i ofer son dimoun / pep.

[PAUSE}

Eski ou dakor pour partisipe?

Wi ☐ *Non* ☐

Sinyatir lanketer _____ Dat: _____

Seksyon 1: Lenformasyon debaz – *Premyerman, mon pou demann ou detrwa kestyon lo "background", enkli lenformasyon lo ou laz, ou nivo ledikasyon,ou travay e ou reveni.*

No.	Kestyon e bann "filters"	Kategori bann kod	Al lo
1	Ke laz ou annan? (Dan lannen ki'n konplet)	Lannen ____	
		Wi 2	
2.	Eski ou annan zanfann	Non 3	→ **4**
		Larz :……..	
3.	Si Wi , Ki larz		
4.	Eski ou ti ne Sesel?	Wi 1 No 2 NA / DK 99	
5.	Ki ou sitiasyon sivil konmela (Eski ou'n marye)***?***	Marye konmela 1 Divorse/separe/Vev 2 Pa'n zanmen marye 3 NA / DK 99	
6.	***Pour konmela***, ek ki ou pe reste? *Read out the possible answers* *Circle one only*	Tousel 1 Boyfriend 2 Mari 3 Avek manman / papa 4 Avek zanmi 4 Napa landrwa reste 5 Avek lezot travayer seks 6 NA / DK 99 Lezot (spesifye) _____ 88	
7.	Ki pli o nivo ledikasyon ou'n fini konplete? ***Post-Secondary Classification***: Technical = Seychelles Institute of Technology (SIT), Maritime Training Centre (MTC), Seychelles Horticulture and Agriculture Training Centre (SHATC), Seychelles Tourism Academy (STA) and School of Visual Arts Academic = School of Advanced Level Studies (SALS) and School of Business Studies	Primer 1 Segonder 2 Pos-segonder (Teknik) 3 Pos-segonder (Akademik) 4 Diploma 5 Premye degre 6 'Masters' 7 'Ph. D' 8 NA / DK 99	
8.	Konbyen ou ti gannyen totalman konman reveni <u>sa dernyen mwa</u>?	SR _____ NA / DK 99	
9.	Konbyen ou ti kontribye anver reveni total sa lakour kot ou reste <u>sa dernyen mwan</u>?	SR _____ NA / DK 99	

10. Apart travay seks, ki lezot fason ou ganny larzan?

READ OUT LIST – CIRCLE ALL MENTIONED

Biznes Prive (pour mwan menm oubyen pour en saler) 1
Travay dan gouvernman 2
Servis/Tourism 3
Ansennyan 4
Etidyan 5
Vann bann keksoz 6
Aktivite ilegal 7
Napa ankor reveni apart travay seks 8
Lezot (spesifye)_____88
NA / DK 99

Seksyon 2: serk sosyal bann travayer seks –*Naprezan, mon pou demann ou detrwa kestyon lo bann lezot travayer seks ki petet ou konnen. Mazin byen ki personn pa pou konnen ki bann larepons ou pe donnen. Alor, koz laverite.*

11. Konbyen travayer seks ki ou konnen personelman (set-a-dir, ki reste Sesel, ki annan 15-an ou parlao 15-an, ou konn zot non, ou konn lekel zot e zot konn ou osi)? |__|__|__|

NA / DK 99

12. Konbyen parmi sa bann (**repet sa limero ki zot l'n donnen dan Kestyon 9**) travayer seks ki ou'n vwar dan sa dernyen mwan? |__|__|__|

NA / DK 99

13. Eski ou ti pou donn en koupon sa menm dimoun ki'n donn ou enn?

Wi 1
Non 2
NA / DK 99

14. Ki rezon presipal ou'n deside pran en koupon e partisip dan sa resers?

MARK ZIS EN LARESPONS SELMAN

Pour sa larzan ki zot pe donnen 1
Pour ganny rezilta bann tes HIV e MTS 2
Lenflians zanmi 3
Sa letid i paret enteresan / bon 4
Mon annan letan 5
Lezot _____88
NA / DK 99

Seksyon 3: Kestyon lo travay seks an zeneral ek stigma –Aprezan, mon pu demann ou detrwa kestyon zeneral lo travay seks ek diskriminasyon ki ou kapab petet eksperyanse. Ou larepons i konfidansyel e sekre.

15. Labitid, kote ou zwenn ou bann kliyan?

PA LIR BANN LAREPONS.

Bar 1
Lo semen 2
Disko 3
Bann lasanm lwe dan lakaz prive 4
Guesthouse 5
Lotel 6
Par telefonn 7
A traver en lazans / en 'pimp' 9
Internet 10
Lezot _____ 88
NA / DK 99

16. Ki landrwa pli <u>komen (ou annan pli abitye)</u> zwenn ou bann kliyan?

SELECT ONE.

Bar 1
Lo semen 2
Disko 3
Bann lasanm lwe dan lakaz prive 4
Guesthouse 5
Lotel 6
Par telefonn 7
A traver en lazans / en 'pimp' 9
Internet 10
Lezot _____ 88
NA / DK 99

17. <u>Dernyen fwa</u> ou ti fer seks ek en kliyan, konbyen I ti pey ou oubyen ki valer larzen sa ki i ti donn?

SR _____

NA / DK 99

18. <u>Dan sa dernye 6 mwan</u>, ki pli ti git larzan ou'n ganny peye pour fer seks ek en kliyan?

_____

NA / DK 99

19. <u>Dan sa dernye 6 mwan</u>, ki pli gran kantite larzan ou'n ganny peye pour fer seks ek en kliyan?

_____

NA / DK 99

20. <u>Dernye zour</u> ki ou ti travay, konbyen kliyan ou ti annan?

_____ *(***EKRI SA LIMERO***)*

NA / DK 99

21. Dernye zour ki ou ti travay, eski ou ti servi en kapo tek sa dernye kliyan ki ou ti annan?

Wi 1 → **22**
Non 2
NA / DK 99

22. Si ou pa ti servi en kapot, akoz ou ek ou partner pa ti servi en kapot sa fwa-la?

DO NOT READ RESPONSES; MARK ONE RESPONSE ONLY*)*

Pa ti mazin servi enn 1
Pa kontan mannyer kapot I 'fil' 2
Ti napa okenn kapot 3
Tro sou / tro 'high' pour servi enn 4
Keksoz nariv sitan vit 5
Mon ti anvi tonm ansent 6
Partner pa ti oule 7
Ti annan konfyans dan mon partner 8
Tro ser 9
Kapot pa marse 10
Lezot rezon _____ 88
NA / DK 99

23. Ou annan en dimoun ki ed ou zwenn bann kliyan?

Wi 1
Non 2
NA / DK 99

24. Eski i annan bann manm ou fanmiy ki konnen ki ou vann seks?

Wi 1
Non 2
NA / DK 99

25. Reponn 'Wi' oubyen 'Non' sa bann stetment swivan lo get en pe ou leksperyans koman en travayer seks.

	Wi	Non	DK / NA
e. Mon'n eksperyans dimoun sikann mwan, donn mwan bann non e ensilte mwan.	2	2	99
f. Mon'n deza ganny met dekote letan ti annan en aktivite sosyal.	2	2	99
g. Dimoun i'n koz lo mwan.	1	2	99
h. Lezot dimoun napa respe pour mwan.	1	2	99
i. Mon partner oubyen mon fanmiy i'n deza pous mwan.	1	2	99
j. Violans fizik	1	2	99

Seksyon 4: Listwar e Pratik seksyel- *aprezan, mon pou demann detrwa kestyon lo ou listwar seksyel, bann partner seksyel e lo kapot. Mazinen ki ou bann larepons i sekre e konfidansyel.*

26. Ki laz ou ti annan letan ou ti fer seks (penetrasyon dan vazen oubyen dan deryer) pour premye fwa?

_____ lannen
Pa mazinnen 99

27. Ki laz ou ti annan letan ou ti vann seks pour premey fwa?

_____ years
Pa mazinnen 99

28. Letan ou ti konmans fer seks pou larzan, ki rezon ki ti pli enportan pour ou?

(**CHOOSE ONLY ONE RESPONSE***)*

Bezwen larzan pour ed mon fanmiy 1
Bezwen larzan pour pey en det 2
Mon ti ganny forse 3
Mon ti anvi fer li par plezir 4
Annan fanmiy e zanmi ki ti p fer 5
Ou ganny en bon reveni 6
Mon ti'n ganny abondonnen 7
Pour aste drog 8
Abandonnen par fanmiy, mari, partner 9
Pa travay10
Lezot _____88
NA / DK 99

29. Dan sa dernye mwan, konbyen dimoun ou'n fer seks avek?

_____ (**EKRI LIMERO**)

(**ENKLI MARI, BOYFRIEND, KLIYAN**.*)*

NA / DK 99

30. Dan sa dernye mwan, eski ou'n fer seks avek:
(lir sak kategori, met en tik kot WI oubyen NON pour sa larepons)

	Wi	NoN	DK / NA
a. Mari, boyfriend (partner labitid)	1	2	99
b. Partner "casual", ki pa ti peye	1	2	99
c. En kliyan ki ou zwenn zis en fwa	1	2	99
d. En kliyan labitid	1	2	99
f.Touris/Etranger	1	2	99
k. Lezot _____	1	2	99

Partner atitre *– Aprezan, mon pou demann ou detrwa kestyon lo ou partner atitre (ou boyfriend oubyen ou mari). Ou partner atitre i sa dimoun ki ou fer seks avek regilyerman,nenport ler menm si zot pa reste ansanm. Silvouple, dir mwan laverite.*

31. Dan sa dernye mwan, konbyen fwa ou'n fer seks ek ou partner regilye?

_____ (**EKRI LIMERO**)
Zero 00 → **32**
Pa'n zanmen fer seks ek li 1 → **37**

32.	Dan sa <u>dernye mwan</u>, konbyen fwa ou'n servi en kapot?	Toultan 1 Laplitr ditan 2 Tanzantan 3 Zanmen 4 NA / DK 99	
34.	Dan sa <u>dernye mwan</u>, eski ou'n refize fer seks ek ou partner regilye si i pa pou servi en kapot?	Wi 1 Non 2 NA / DK 99	
35.	Eski ou kwar ki ou mari / boyfriend/partner i'n deza servi drog?	Wi 1 Non 2 NA / DK 99	
36.	Eski ou mari / boyfriend/partner i'n deza pik drog dan lavenn?	Wi 1 Non 2 NA / DK 99	
37.	<u>Dernyen fwa</u> ou ti fer seks ek ou partner regilye (mari / boufriend), eski ou ti servi en kapot?	Wi 1 Non 2 NA / DK 99	→ **37**
38.	Si zot pa ti servi en kapot, pour ki rezon ou ek ou partner pa ti servi enn sa fwa si? *(***DO NOT READ RESPONSES; MARK ONE RESPONSE ONLY***)*	Pann mazin servi enn 1 Pa ti anvi servi enn 2 Ti napa kapot 3 Nou ti tro sou / tro 'high' 4 Keksoz n'ariv tro vit 5 Mon ti anvi tonm ansent 6 Partner pa ti dakor 7 Mon trust mon partner 8 Tro ser 9 Kapot pa marse, pa bon 10 Lezot _____ 88 NA / DK 99	→ **38** → **38** → **38** → **38** → **38** → **38** → **38** → **38**
39.	Si zot ti servi en kapot, lekel ki ti sizere ki zot servi enn?	Mwan menm 1 Mon partner 2 Nou toulede 3 NA / DK 99	

Bann partner ki pa peye, 'casual' – *Aprezan, mon pou demann ou detrwa kestyon lo seks avek ou bann partner ki pa peye (bann ki ou tap tape avek san demann peyman oubyen en kado, en keksoz an retour.) Ankor, ou ava remarke ki sa bannn kestyon pou personnel, me selman i enportan pour nou konpran. Silvouple, koz laverite.*

40	Dan sa <u>dernye mwan</u>, konbyen partner casual, non-peyan ki ou'n fer seks avek? (*Number can't be larger than the number in 28 and must take into account inclusion of husband/boyfriend)*	_____ (*Ekri limero*) Personn 00 Zanmen mon'n fer seks ek en partner casual 1	→**41** →**46**

41 Dan sa dernye mwan, konbyen fwa ou'n servi en kapot ek en partner 'casual', non-peyan?

Toultan 1
Laplipar ditan 2
Tanzantan 3
Zanmen 4
NA / DK 99

42 Dan sa dernye mwan, eski ou'n refize fer seks avek en partner 'casual', non-peyan si zot pa servi en kapot?

Wi 1
Non 2
NA / DK 99

43 Eski ou kwar ki ou'n annan partner 'casual', non-peyan ki'n deza servi drog?

Wi 1
Non 2
NA / DK 99

44 Eski ou'n annan partner 'casual', non-peyan ki'n deza pik drog dan lavenn?

Wi 1
Non 2
NA / DK 99

45 Dernyen fwa ou ti fer seks ek en partner 'casual', non-peyan, eski ou ti servi en kapot?

Wi 1 → **45**
Non 2
NA / DK 99

46 Si zot pa ti servi en kapot, pour ki rezon ou ek ou partner pa ti servi enn sa fwa si?
(Do not read responses; Mark one response only)

Pann mazin servi enn 1 → **46**
Pa ti anvi servi enn 2 → **46**
Ti napa kapot 3 → **46**
Nou ti tro sou / tro 'high' 4 → **46**
Keksoz n'ariv tro vit 5 → **46**
Mon ti anvi tonm ansent 6 → **46**
Partner pa ti dakor 7 → **46**
Mon trust mon partner 8 → **46**
Tro ser 9 → **46**
Kapot pa marse, pa bon 10
Lezot _____ 88
NA / DK 99

47 Si zot ti servi en kapot, lekel ki ti sizere ki zot servi enn?

Mwan menm 1
Mon partner 2
Nou toulede 3
NA / DK 99

Kliyan ki ou'n vwar zis en fwa– *Aprezan, mon pou demann ou kestyon lo seks avek bann lkiyan ki ou'n vwar zis en fwa. Ankor, ou ava remarke ki sa bannn kestyon pou personnel, me selman i enportan pour nou konpran. Silvouple, koz laverite.*

48 Dan sa dernye mwan, konbyen kliyan ki ou'n fer seks avek zis en fwa? (*Number can't be larger than the number in 28 and must take into account inclusion of husband/boyfriend)*

_____ (**WRITE IN NUMBE*R***)
Personn 00 → **49**
Napa sa kalite kliyan 1 →**53**

49	Dan sa dernye mwan, konbyen fwa ou'n servi en kapot ek en kliyan ki ou'n fer seks avek zis en fwa?	Toultan 1 Laplipar ditan 2 Tanzantan 3 Zanmen 4 NA / DK 99	
50	Dan sa dernye mwan, eski ou'n refize fer seks ek enn sa bann kliyan si i pa servi en kapot?	Wi 1 Non 2 NA / DK 99	
51	Eski ou kwar ki ou'n annan sa kalite kliyan ki'n deza servi drog?	Wi 1 Non 2 NA / DK 99	
52	Eski ou'n annan sa kalite kliyan ki'n deza pik drog dan lavenn?	Wi 1 Non 2 NA / DK 99	
53	Dernyen fwa ou ti fer seks ek en kliyan ki ou'n vwar zis en fwa, eski ou ti servi en kapot?	Wi 1 Non 2 NA / DK 99	→ **53**
54	Si zot pa ti servi en kapot, pour ki rezon ou ek ou kliyan pa ti servi enn sa fwa si? *(Do not read responses; Mark one response only)*	Pann mazin servi enn 1 Pa ti anvi servi enn 2 Ti napa kapot 3 Nou ti tro sou / tro 'high' 4 Keksoz n'ariv tro vit 5 Mon ti anvi tonm ansent 6 Partner pa ti dakor 7 Mon trust mon partner 8 Tro ser 9 Kapot pa marse, pa bon 10 Lezot _____ 88 NA / DK 99	→ **54** → **54** → **54** → **54** → **54** → **54** → **54** → **54**
55	Si zot ti servi en kapot, lekel ki ti sizere ki zot t servi enn?	Mwan menm 1 Mon partner 2 Nou toulede 3 NA / DK 99	

Kliyan regilye *– Aprezan, mon pou demann ou kestyon lo ou bann kliyan labitid, regilye. Parey avan, bann kestyon i personnel, me sa bann larepons i enportan pour nou. Koz laverite, silvouple.*

56	Dan sa dernye mwan, konbyen kliyan regilye ki ou'n fer seks avek zis en fwa? (*Number can't be larger than the number in 28 and must take into account inclusion of husband/boyfriend)*	_____ (**EKRI LIMERO**) Personn 00 Napa kliyan regilye 1	→ **57** → **62**

57	Dan sa dernye mwan, konbyen fwa ou'n servi en kapot ek ou bann kliyan regilye?	Toultan	1	
		Laplipar ditan	2	
		Tanzantan	3	
		Zanmen	4	
		NA / DK	99	
58	Dan sa dernye mwan, eski ou'n refize fer seks ek enn ou bann kliyan regilye si i pa servi en kapot?	Wi	1	
		Non	2	
		NA / DK	99	
59	Eski ou kwar ki okenn ou bann kliyan regilye ki'n deza servi drog?	Wi	1	
		Non	2	
		NA / DK	99	
60	Eski ou'n annan kliyan regilye ki'n deza pik drog dan lavenn?	Wi	1	
		Non	2	
		NA / DK	99	
61	Dernyen fwa ou ti fer seks ek en kliyan regilye, eski ou ti servi en kapot?	Wi	1	**→61**
		Non	2	
		NA / DK	99	
62	Si zot pa ti servi en kapot, pour ki rezon ou ek ou kliyan regilye pa ti servi enn sa fwa si? *(Do not read responses; Mark one response only)*	Pann mazin servi enn	1	**→ 62**
		Pa ti anvi servi enn	2	**→ 62**
		Ti napa kapot	3	**→ 62**
		Nou ti tro sou / tro 'high'	4	**→ 62**
		Keksoz n'ariv tro vit	5	**→ 62**
		Mon ti anvi tonm ansent	6	**→ 62**
		Partner pa ti dakor	7	**→ 62**
		Mon trust mon partner	8	**→ 62**
		Tro ser	9	**→ 62**
		Kapot pa marse, pa bon	10	**→ 62**
		Lezot _____	88	
		NA / DK	99	
63	Si zot ti servi en kapot, lekel ki ti sizere ki zot t servi enn?	Mwan menm	1	
		Mon partner	2	
		Nou toulede	3	
		NA / DK	99	

Seksyon 5:Kapot zonm ek kapot pour madanm

Aprezan, mon pou demann ou kestyon lo kapot pour zonm e madanm. Ou bann kestyon i reste konfidansyel.

64 Eski ou'n deza servi en kapot zonm avek ou parner (klyen)?

Wi 1
Non 2
NA / DK 99

65. Ki bann landrwa ou ti ganny kapot zonm dan sa <u>dernye mwan</u>?

Multiple answers possible

DO NOT READ OUT

(CIRCLE WHAT IS MENTIONED)

Laboutik 1
Farmasi 2
Klinik gouvernman 3
Klinik prive 4
Bar/Guest House/Lotel 5
Zanmi 6
Drayver taksi 7
Dan salon fer seve 8
NGO 9
En biro gouvernman 10
Pa'n aste okenn kapot sa dernye mwan 11
Pa'n zanmen servi kapot 12
Pa ti ganny kapot 13
Partner zonm 14
Lezot larepons 88
NA / DK 99

66. Dernye fwa ki ou ti aste en pake kapot zonm (ki annan 3 ladan), konbyen ti koute?

SR_____
Pour nanryen 0 **→66**
Pa'n zanmen servi en kapot 1
NA / DK 99

67. Ki ler ou ti aste en kapot zonm? *(Use 24 hour time)*

_____

68. Eski ou kapab ganny en kapot nenport ler ou bezwen enn?

Wi 1 **→68**
No 2
NA / DK 99

69. Akoz ou pa kapab ganny en kapot nenport ler ou bezwen enn?

MULTIPLE ANSWERS POSSIBLE

DO NOT READ OUT

Tro ser 1
Laboutik tro lwen 2
Laboutik ti fermen 3
Farmasi tro lwen 4
Farmasi ti fermen 5
Anbarase pour aste en kapot 6
Pa konnen kote mon kapab ganny enn 7
Keksoz ti pe pas tro vitman 8
Mon pa bezwen kapot 9
Lezot_____ 10
NA / DK 99

70. Ki kalite gel ou ti servi dernye fwa ou ti fer seks (devan / deryer)?

Pa ti servi gel / lubricant	1
Lakras	2
Vazlin / Lezot gel ki servi petrol konman baz	3
Delwil	4
Lubricant / gel pour kapot	5
Bann losyon normal	6
Ky jelly	7
Delo	8
Lezot_____	88
NA / DK	99

71. Eski ou'n deza servi en kapot madanm?

Wi	1	
Non	2	→**72**
NA / DK	99	

71. Kote ou ti ganny en kapot madanm?

Laboutik	1
Farmasi	2
Klinik gouvernman	3
Klinik prive	4
Bar/Guest House/Lotel	5
Zanmi	6
Drayver taksi	7
Dan salon fer seve	8
NGO	9
En biro gouvernman	10
Pa'n aste okenn kapot sa dernye mwan	11
Pa'n zanmen servi kapot	12
Pa ti ganny kapot	13
Lezot larepons	88
NA / DK	99

72. Ki rezon ou servi en kapot madanm?

Multiple answers possible
Do not read out

Pa tonm ansent	1
Proteksyon kont HIV/STIs	2
Partner ti demande ki mon servi enn	3
Donn mwan plis control pour proteksyon	4
I ti 'free'	5
Lezot rezon _____	88
NA / DK	99

73. Ki rezon ou pa servi en kapot madanm?

Multiple answers possible
Do not read out

Napa 1
Tro gran 2
Kliyan pa kontan 3
Tro difisil pour mete 4
Mon pa oule met li dan vazen 5
Tro ser 6
Pa ti konnen i annan 7
Prefer male condoms 8
Mon servi lezot metod kontraseptiv 9
I fer tro tapaz 10
Reaksyon alerzi 11
Lezot _____ 88
NA / DK 99

74. Dernye fwa ou ti aste pake kapot madanm (3 dan 1 pake), konbyen ti kout ou?

SR_____
Free 0
Pa zanmen servi kapot madanm 1
NA / DK 99

75. Dernyen fwa ou ti servi en kapot madanm, eski ou ti servi en sel kapot pour plizyer partner seksyel?

Wi 1
Non 2
Pa mazinen 97
NA / DK 99

76. Eski ou ti servi sa menm kapok kiin oun déjà servi avek en lot klyen ?

Wi 1
Non 2
Pa mazinen 97
NA / DK 99

Seksyon 6: Lizaz drog – *Aprezan, mon pou demann ou detrwa kestyon lo lizaz drog dan sa dernye 3 mwan, swa avek piker oubyen on. Bann larepons i toultan prive e konpletman anonym.*

I annan dimoun ki pran drog pour ganny en high oubyen pour anmize.Eski ou'n deza servi okenn drog apart lalkol?
(Par drog, mon oule dir mariwana, asis, latizann dokter ki pann ganny preskir pour ou, kokain, eroin, ekstazi, lezot)

Wi 1
Non 2 → **84**
Pa'n zanmen pran drog 3
NA / DK 99

77. Eski ou'n servi okenn drog dan sa dernye <u>trwa mwan</u>?

Wi 1
Non 2
Pa'n zanmen pran drog 3
NA / DK 99

78. I annan dimoun ki servi pikir pour anmize oubyen ganny en high. Eski ou'n DEZA pik drog dan lavenn?
(Par drog, mon oule dir mariwana, asis, latizann dokter ki pa;n ganny preskir pour ou, kokain, eroin, ekstazi, lezot)

Wi 1
Non 2 → **84**
NA / DK 99

79. Eski ou'n pik drog dan ou lavenn dan sa <u>dernye 3 mwan</u>?

Wi 1
Non 2
Pa'n zanmen servi pikir pour pran drog 3 → **84**
NA / DK 99

80. <u>Dernyen fwa</u> ou ti pik drog dan ou lavenn, ki drog ou ti servi?

(**DO NOT READ RESPONSES**.)

Eroin 1
Ekstazi 2
Kokain 3
P'n zanmen pike 4
Lezot drog _____88
NA / DK 99 → **84**

81. <u>Dernyen fwa</u> ou ti pik drog dan ou lavenn, eski ou ti servi en zegwir oubyen en sereng apre ki en lot dimoun ti'n servi li?

Wi 1
Non 2
NA / DK 99

82. <u>Dernyen fwa</u> ou ti pik drog dan ou lavenn, eski ou ti pas ou sereng oubyen ou zegwir ek en lot dimoun apre ki ou ti'n servi li?

En fwa par zour 1
3-4 fwa par zour2
More than 5 times a day3
Once a week 4
3-4 times a week 5
More than 5 times a week6
NA / DK 99

83. <u>Dan sa dernye mwan,</u> labitid / an mwayenn, ki kantite fwa ou pik ou pour servi drog?
(Do not read responses; Mark one response only)

Enn fwa1
Plizyer fwa par mwan 2
Enn fwa par semenn 3
Plizyer fwa par semen 4
Enn fwa par zour 5
Plizyer fwa par zour 6
NA / DK 99

84. <u>Dan sa dernye mwan,</u> eski ou'n servi disan en lot dimoun ki ti'n pran drog? (Flashblood / flushing)

Wi 1
Non 2
NA / DK 99

Seksyon 7: Vyolans – ***aprezan, mon pou demann ou detrwa kestyon lo vyolans e listwar ou lanprizonnman. Sa bann kestyon zot personnel e zot kapab fer ou enkonfortab. Ou kapab swazir pour pa reponn si ou oule. Me, mazinen ki ou bann larepons zot enportan, zot konfidansyel e sekre. Ou'n pare?***

85. Dan sa dernye <u>12 mwan</u>, eski ou'n deza eksperyans okenn vyolans fizik ?
(Par vyolans fizik, mon oule dir ganny kalote, en keksoz anvoye ek ou, ganny pouse, ou lebra devire, seve rise, ganny koudpwen oubyen okenn lot keksoz ki fer ou dimal parey koudpye, trennen, bate, trangle, brile e en dimoun servi kouto oubyen lezot zouti ek

Wi 1
Non 2 →**86**
NA / DK 99

ou.)

86. Lekel sa dimoun ki ti fer ou dimal fizikman?

MULTIPLE ANSWERS POSSIBLE

(DO NOT READ OUT)

Lapolis	1
Manm fanmiy	2
Kliyan (one-time or regular)	3
Casual sex partner	4
Boyfriend/mari (steady)	5
Zanmi	6
Dimoun ki ou pa konnen	7
Gay	8
Koleg kot lekol / ansennyan	9
Koleg travay	10
Lezot dimoun _____	88
NA / DK	99

87. Eski ou'n **DEZA** ganny forse pour fer seks kan ou pa ti anvi?

Wi	1	
Non	2	→**89**
NA / DK	99	

88. In the <u>past 12 months</u>, Eski ou'n ganny forse pour fer seks kan ou pa ti anvi?

Wi	1	
No	2	→**89**
NA / DK	99	

89. Dernye ou ti ganny forse pour fer seks ler ou pa ti anvi, lekel ki ti fors ou?

MULTIPLE ANSWERS POSSIBLE

(DO NOT READ OUT)

Kliyan (labitid oubyen zis 1 fwa)	1
Casual sex partner	3
Boyfriend/Mari (steady)	4
Zanmi	5
Dimoun ki ou pa konnen	6
Gay	7
Lezot _____	88
NA / DK	99

90. Dan sa <u>dernye 12 mwan</u>, eski ou'n deza ganny arete par lapolis?

Wi	1	
Non	2	→**91**
NA / DK	99	

91. Si wi, pour ki lofans ou ti ganny arete?

Posesyon drog	1
Trafik drog	2
Bat dimoun, fer li dimal	3
Vole	3
Vann seks	4
"Idle & disorderly"	5
Lezot _____	88
NA / DK	99

Seksyon 8: MTS (Maladi Transmet par Seks) – Aprezan, mon pou demann ou kestyon lo Maladi Transmet Par Seks e si ou'n deza atrap enn dan lepase.

92. Ki bann sinny bann Maladi ki Transmet Par Seks?

DO NOT READ LIST. JUST PROMPT FOR MORE RESPONSES.
CIRCLE ALL APPROPRIATE RESPONSES

Pa konnen okenn bann sinny 1
Douler dan ba vant 2
Desarz 3
Douler ler ou pise 4
Boubou lo parti prive 5
Grate lo parti prive 6
Boubou lo ou dan deryer 7
Lezot (detaye) 88
NA / DK 99

93. <u>Dan sa dernye 6 mwan,</u> eski ou'n ganny en desarz ki paret drol / pa korekt?

Wi 1
Non 2
NA / DK 99

94. <u>Dan sa dernye 6 mwan,</u> eski ou'n ganny boubou dan parti prive oubyen dan deryer?

Wi 1
Non 2
Pa'n zanmen annan boubou lo parti prive / deryer 3 →**95**
NA / DK 99

95. <u>Dernye fwa</u> ou ti annan en boubou lo parti prive oubyen ou deryer, ouswa en desarz ki pa normal, ki ou ti fer?

DO NOT READ LIST. CIRCLE ALL ANSWERS MENTIONED.

Mon pa ti fer nanryen 1
Al kot klinik gouvernman pour teste / tretman 2
Al kot klinik prive pour teste / tretman
Al kot farmasi pour aste latizann 3
Al kot en bonnonm dibwa pour teste / tretman 4
Tret mon lekor dan lakour mon menm 5
Eksplik mon partner bann sinny 6
Aret fer seks pandan ki mon ti annan sa bann sinny 7
Servi kapot ler mon fer seks 8
NA / DK 99

96. Eski en ners oubyen dokter I'n DEZA dir ou ki ou annan en Maladi ki Transmet Par Seks?

Wi 1
Non 2 →**97**
NA / DK 99

97. Dernye fwa ki en ners oubyen en dokter ti dir ou ki ou annan en Maladi ki Transmet Par Seks, ki ou'n ti'n gannyen?

Gonore 1
Chlamydia 2
Sifilis / Solpis 3
Herpes 4
Epatit 5
Genital Warts 6
HIV 7
Lezot _____ 88
NA / DK 99

Seksyon 9: Konesans lo HIV, stigma, bann risk listwar lo teste pour HIV – *Dan sa dernye seksyon, mon pou demann ou kestyon lo ou konesans lo HIV e si ou'n deza fer tes pour HIV dan lepase. Pa donn mwan rezilta ou tes, me koz laverite ler ou reponn sa bann kestyon.*

116	Eski ou ti'n deza tann nonm HIV / SIDA avan sa 'interview'?	Wi 1 Non 2 NA / DK 99	→**END**
117	Dapre ou, eski ou kapab konnen si en dimoun i annan virus HIV zis par get li?	Wi 1 Non 2 NA / DK 99	

118 *Apresan, mon pou lir bann stetment lo HIV e SIDA. En bann zot vre e lot bann pa vre. Sa bann stetment zeneral pa refer lo ou leksperyans e konportman. Dir mwan si ou dakor oubyen pa dakor avek sakenn sa bann stetment*.

Stetment / Remark	**Larepons Dakor**	**Pa dakor**	**Pa konnen**
l. Fer seks avek en partner fidel e ki pa enfekte i redwir ou risk ganny enfekete ou menm.	1	2	99
m. Ou kapab ganny HIV si ou servi kabinen piblik.	1	2	99
n. Servi en kapot letan ou pe fer seks par devan (dan vazen) i rediwir ou risk ganny HIV.	1	2	99
o. Pike moustik e lezot zensek i transmet HIV.	1	2	99
p. Partaz zegwir ler ou pik drog dan lavenn i ogmant ou risk ganny enfekte ek HIV.	1	2	99
q. Si ou netway sereng e zegwir avek bleach / javel ant bann pike i redwir ou risk atrap HIV.	1	2	99
r. Ou kapab evite ganny enfekte avek HIV si ou pa fer seks ditou.	1	2	99
s. Servi en kapot sak fwa ou fer seks i anpes tranmisyon HIV.	1	2	99
t. Fer seks dan deryer i protez ou kont lenfeksyon HIV .	1	2	99
a. Oral Sex	1	2	99
b. Buying fresh vegetables from a HIV positive shopkeeper or vendor	1	2	99

117. *Aprezan, mon pou demann ou detrwa kestyon lo stigma ki ou'n kapab eksperyanse pandan sa dernye 12 mwan konsernan HIV ek SIDA. Dir mwan si ou dakor oubyen pa dakor ek sakenn sa bann stement swivan.*

Stetment / Remark	**Dakor**	**Pa Dakor**	**Pa konnen**

g.	Dimoun ki annan HIV oubyen SIDA devret onte	1	2	99
h.	Mon ti pou kanmi si ti annan en dimoun dan mon fanmiy ki annan HIV oubyen SIDA	1	2	99
i.	Mon ti pou kanmi si mon ti annan HIV oubyen SIDA	1	2	99
j.	Dimoun ki annan HIV oubyen SIDA zot i'n fer seks banavini	1	2	99
k.	Bann fanm-de-vi ki propaz SIDA	1	2	99
l.	HIV ek SIDA en pinisyon pour bann move konportman	1	2	99

Dapre ou bann konportman la-konmela, ki ou risk atrap viris HIV?

O risk 1
Mwayenrisk 2
Ba risk 3
Okenn risk 4 →**103**
NA / DK 99 →**104**

119. *Si ou santi ou annan risk atrap viris HIV*, eksplik mwan akoz ou kwar sa?

*(***MULTIPLE RESPONSES POSSIBLE, BUT DO NOT READ CHOICES ALOUD***)*

Mon sanz partner seks souvan 1 →**104**
Mon pa toultan servi en kapot 2 →**104**
Mon pik drog dan mon lavenn 3 →**104**
Mon fer seks ek dimoun ki pe pike 4 →**104**
Lezot, Spesifye _____ 88
NA / DK 99

120. *Si ou santi ou napa risk atrap viris HIV, eksplik mwan akoz ou kwar sa?*

*(***MULTIPLE RESPONSES POSSIBLE, BUT DO NOT READ CHOICES ALOUD***)*

Mon senser 1
Mon toultan servi kapot 2
Mon asire mon partner napa viris HIV 3
Mon pa fer seks dan deryer 4
Mon pa fer seks dan vazen / devan 5
Zanmen mon fer seks ek travayer seks 6
Mon pa pik drg dan lavenn 7
Lezot , Spesifye _____ 88
NA / DK 99

121. Eski ou'n deza koz ek dimoun lo viris HIV ek SIDA?

Wi 1
No 2 →**107**
NA / DK 99

122. Ek ki ou koz lo viris HIV ek SIDA?

MULTIPLE ANSWERS POSSIBLE

Zanmi 1
Bann konesans 2
Partner Seksyel 3
Manm fanmiy 4
Dimoun ki mon'n fek zwenn 5
Bann travayer lasante 6
Bann sef relizye 7
Mon pa koz ek dimoun lo HIV 8
NA / DK 99

123. Ki kantite fwa ou koz ek dimoun lo HIV ek SIDA?

DO NOT READ RESPONSE.

MARK ONLY ONE.

Enn fwa par mwan	1
Enn fwa par semenn	2
Plis ki en fwa par semenn	3
Mwens ki en fwa par	4
Once a year	5
Never	6
Lezot _____	88
NA / DK	99

124. Eski ou konn oken ladrwa kot dimoun i kapab fer en tes konfidansyel pour konne si zot annan HIV?
(Konfidansyalite savedir person pa pou konn rezilta ou test amwen ki ou ou anvi les zot konnen)

Wi	1
Non	2
NA / DK	99

125. Silvouple, pa donn mwan ou rezilta. Me, eski ou'n deza fer en tes pour viris HIV?

Wi	1	
Non	2	**→113**
NA / DK	99	

126. Ki dernye fwa ou ti demann pour fer en tes pour HIV e ou ti osi ganny sa rezilta?

Lannen pase	1
Plis ki en an pase	2
Zanmen	3
NA / DK	99

127. Eski ou ti ganny counselling <u>avan</u> ou fer ou tes pour viris HIV?

Wi	1
Non	2
NA / DK	99

128. Eski ou ti ganny counselling <u>apre</u> ou fer ou tes pour viris HIV?

Wi	1
Non	2
Pa ti ganny rezilta	3
NA / DK	99

129. Akoz ou ti deside fer en tes?

Dokter/ners ti rekomande	1	
Ti malad / ti kwar mon annan viris	2	**END**
Partner i annan viris HIV	3	**END**
Bann tes avan maryaz	4	**END**
Zanmi ti rekomande	5	**END**
Mon ti anvi konn mon leta lasante	6	**END**
Lezot rezon _____	88	**END**
NA / DK	99	**END**

130. *Si ou pa'n zanmen fer en tes pour viris HIV*, ki rezon ou pa'n fer sa tes?

ANSERKLE TOU SA KI APLIKE.

Pa ti konne kot pour ale 1
Pa ti santi sa risk 2
Mon ti konserne lo size konfidansyalite 3
Latitid negative bann travayer lasante
Kou / pri 5
Distans 6
Mon ti per rezilta 7
Pa enportan pour mwan 8
Lezot rezon _____88
NA / DK 99

Nou'n ariv lafen sa 'interview'. Mersi bokou pour ou korperasyon e pour pas enpe letan avek nou.

NAME OF INTERVIEWER: _____ Signature _____

DATE OF INTERVIEW: ____/ ____ / 2014 Time Ended _____

CHECKED BY SUPERVISOR: Name: _____Signature _____

DATE CHECKED : ____/ ____ / 2014

Annex 11: Information introduction Sheet for RDS Research Participants (English)

Date_____

Integrated Biological and Behavioural Surveillance Survey on Female sex Workers in Seychelles

A survey of HIV prevalence and risk behavior among female sex workers in Seychelles is being conducted from August this year (2014).

Introduction (For participants with low reading skills, the paper will be read to them).

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

All information you provide for this study is confidential and anonymous. Names are not recorded anywhere, and nothing can be attributed to you personally.

Thank you for reading this.

What is the purpose of the study?

We are interested in finding out about the characteristics of people who engage in sex work, and measure HIV prevalence in these populations. The study will help us develop HIV prevention services for (insert group here) in (insert city and/or country here). It is part ofa collaborative project between the Ministry of Health and its partners, such as SADC.

Why have I been chosen?

You have been chosen because you have engaged in sex work in the last 6 months).

Do I have to take part?

You can decide not to take part. It is up to you. If you do decide to take part, you will be provided this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

1. You will be asked to take part in an interview which takes between 30 to 45 minutes. This interview will be conducted with an interviewer. You will be asked questions on sexual behavior, drug use, sharing of injecting equipment, use of health services, and contact with the police, imprisonment, etc.). You will be able to skip any questions that you do not want to answer.

2. You will be asked to give a venous blood. A staff member will counsel you before taking a blood sample through an injection and drawing of blood into a syringe. This blood will be tested for antibodies to HIV, Hepatitis A, B and C and syphilis. It may also be tested for other viruses in the future.

3. Your test results will be available in 2 weeks and you will be given a specific day to collect the results. A staff member will also be available for counselling before and after giving you the results.

Will the information I give you be kept confidential?

The questionnaires and the blood sample and results are confidential and anonymous. No names are recorded on the questionnaire or the specimens. What you say in the interview will not be linked to you personally, and any test results will be anonymous; this means they will not have your name on them and you will obtain the results of the tests through your unique identifier (number).

What will happen to the results of the study?

The results of the study will be written up into a report for the Ministry of Health and its other partners. These publications will be used to inform the development of HIV prevention services for female sex workers in Seychelles. No persons will be identified in any report or publication.

Who is organizing and funding the research?

The Ministry of Health, NAC andSADC

What should I do if I want to know whether I have HIV?

At the end of the interview and you giving the blood sample, you will be able to obtain the results in 2 weeks on a specific date. It is up to you whether you decide to have your results.

Contact for further information

You may speak with any member of the staff at this project. You may also contact CDCU.

We appreciate your participation.

Thank you for taking part in the study.

You will be given a copy of this information sheet.

Annex 12: Form loentrodiksyon lenformasyon RDS of Female Sex Worker (Creole Version) pour bann partisipan resers

Dat _____

Serve lo lapse biolozik e konportmantal bann travayer seks madanm Sesel

En Out 2014, en serve lo prevalans HIV e konportman a risk parmi bann travayer seks madanm pe ganny fer dan Sesel.

Lentrodiksyon (Li sa form pour bann partisipan ki pa lir byen).

Ou pe ganny envite pour partisip dan en resers. Avan ou deside si ou oule pran par, i enportan poyr ou konpran akoz nou pe fer sa resers e ki i pou enplike pour ou. Pran enpe letan pour lir (ekout) sa ki lo sa papye e ou menm kapab diskit ek lezot dimoun si ou oule. Demann nou okenn kestyon pour tou sa ki pa kler. Pran ou letan e deside si ou pou partisipe oubyen non.

Tou lenformasyon ki ou donnen dan sa letid pou reste sekre e konfodansyel. Naoa okenn non ki ganny mete okenn par dan bann rikord e napa nanryen ki kapab ganny idantifye konm kwa sa lenformasyon pe sorti kot ou.

Mersi pour (lir sa dokiman) ekout mwan.

Akoz nou pe fer sa letid?

Nou anvi konnen ki bann karakteristik bann dimoun ki fer travay seks e mezir nivo HIV dan sa popilasyon. Sa letid pou ed nou develop bann progranm prevansyon lo HIV pour bann travayer seks dan Sesel. I form par bann travay kolaborasyon ki Minister Lasante Sesel pe fer avek de lezot pei – Moris e “Angola”.

Akoz mon’n ganny swazir?

Ou’n ganny swazir akoz ou’n fer travay seks pandan lannen ki’n pase.

Eski mon bezwen pran par?

Ou kapab deside pour pa pran par. I depann lo ou. Si ou deside pour pran par dan sa letid, nou pou bezwen ou konsantman. Ou kapab arete reponn kestyon a okenn moman pandan sa letid e ou pa bezwe donn okenn rezon akz ou pe arête.

Ki pou arrive ek mwan si mon pran par?

1. Ou pou ganny demande pour fer en ‘interview’ kip ran ant 30 a 45 minit. I annan en dimoun ki pou \interview’ ou. I pou demann ou kestyon lo ou konportman seksyel, si ou servi drog, si ou pik drog dan lavenn, si ou partaz sereng ek zegwir, kontakt ek lapolis, prizon, eksetera. Serten bann kestyon i pout re personnel. Me ou kapab deside pour pa reponn si ou oule.

2. Ou pou osi ganny demande pour donn en pe disan. Enn nou bann staf ava konsey ou aven pran ou disan. Disan pou ganny tire avek en zegwir e ganny met dan en sereng. Sa disan ki ou donnen pou ganny teste pour viris HIV, Epatit A, B ek C e osi sifilis. Dan lavenir, nou osi kapab teste li pour lezot viris.

3. Ou rezilta pou pare dan 2 semenn. Ou pou ganny en zour spesifik pour vin sers ou rezilta. Pou annan an staf pour konsey ou avan e apre ki ou ganny ou rezilta.

Eski bann lenformasyon pou konfidansyel?

Bann kestyoner, disan ek rezilta bann tes pou konfidansyel e sekre. Napa okenn non ki pou ganny met lo kestyoner e bann rikor. Sa ki ou dir dan 'interview' pa pou ganny asosye ek ou personelman. Tou tes pou anononim (sekre). Pou napa ou non. Ou rezilta pou ganny kolekte an servan en limero ki zis ou ki pou annan.

Ki pou arrive ek rezilta sa letid?

Rezilta sa letid pou ganny ekri dan en rapor pour Minister Lasante e son bann partner. Sa bann piblikasyon pou ganny servi pour donn lenformasyon lo ki mannyer nou kapab travay pli byen dan prevansyon HIV pour bann madanm ek fiy ki pe fer travay seks Sesel. Napa okenn non ki pou ganny asosye ek sa bann rapor ek piblikasyon.

Lekel ki pe organize e peye pour fer sa letid?

Minister Lasante, NAC ek SADC

Ki mon devret fer si mon anvi konnen si mon annan HIV?

Alafen sa 'interview' e letan ou'n donn en 'sample' ou disan, ou pou kapab ganny rezilta dan 2 semenn lo en dat spesifik date. Ou ki pou deside si ou oule ganny rezilta ou tes.

Kontakt pour plis lenformasyon

Ou kapab koz avk okenn bann manm staf ki pe travay lo sa proze. Ou osi kapab kontakte AIDS Control Programme

Nou vreman apresye ou partisipasyon e ou led.

Mersi pour pran par dan sa letid.

Nou pou donn ou en kopi sa form lenformasyon.

Annex 13: Coupon Rejecter Respondent Driven Sampling Survey of Female Sex Worker (English)

Instructions: *Collect this information face-to-face from returning recruiters each time they come to collect their compensation*.

Questionnaire Identification Number: |___|___|___|___|___|___|___|___|

Name of Interviewer: _____ **Date of Interview**: __ __ / __ __ / __ __

1. Is this the first time you have been here to collect compensation?

☐ Yes *If yes, continue.*

☐ No *If no, answer questions for the period of time between when the participant was last here and filled out this same questionnaire and now.*

2. How many coupons did you give out? _____ (*Between the last time you came here to receive compensation and now. If 1 or more, complete coupon rejecter questionnaire.)*

3. How many people refused to accept coupons? _____ *(If zero, do not complete the rest of this questionnaire. If 1 or more, continue.)*

Ask These Questions for Each Individual Who Refused to Accept a Coupon

Question	Responses to question	Responses for each person who refused to accept a coupon
1	**What is your relationship to this person?** *(Check only one)* a. A stranger, someone you met for the first time b. Someone you knew, but not closely c. A close friend, someone you knew very well d. A sexual partner e. A family member or relation f. A dealer	**Person 1 _____** **Person 2 _____** **Person 3 _____** **Person 4 _____** **Person 5 _____** **Person 6 _____**
2	**How long have you known this person?**	**Person 1 _____**

	(Check only one) a. Less than 6 months b. 6 months to 1 year c. 1-2 years d. 3-6 years e. More than 6 years	**Person 2 _____** **Person 3 _____** **Person 4 _____** **Person 5 _____** **Person 6 _____**

Question	Responses to question	Responses for each person who refused to accept a coupon
3	**Why do you think this person refused to accept a coupon?** *(Do not read. Ask for each individual who refused to accept the coupon.)* 1. Too busy 2. Already had a coupon/already participated in the study 3. Not a sex worker 4. Younger than 15 years 5. Did not sell sex in past month 6. Fear of being identified as sex worker 7. Site is too far away 8. Not interested 9. Incentive is not worth the time	**Person 1 _____** **Person 2 _____** **Person 3 _____** **Person 4 _____** **Person 5 _____** **Person 6 _____**

Annex 14: Coupon Rejecter - Respondent Driven Sampling Survey of Female Sex Worker (Creole Version)

Koupon Bann Refi Partisipasyon pour Kestyoner

Lenstriksyon: *Kolete sa lenformasyon fas-a-fas ek bann partisipan ki ti pe rod lezot partisipan sak fwa ki zot vin kolekte zot bann konpansasyon*.

Limero Idantite Kestyoner: |___|___|___|___|___|___|___|___|

Non zofisye resers: _____ **Dat 'Interview'**: __ __ / __ __ / __ __

1. Eski i fer premye fwa ki ou vin sers ou konpansasyon?

☐ Wi Si wi, kontinnyen.

☐ Non *Si non, reponn bann kestyon pour sa peryod letan kan sa partisipan ti la dernye fwa e ti ranpli sa menm kestyoner e la-konmela.*

2. Konbyen koupon ou'n donnen? _____ (*Ant dernye fwa ou ti la pour ganny ou konpasasyon e la-konmela. Si 1 ou plis, konplet sa koupon refi pour kestyoner.)*

3. Konbyen dimoun ki'n refize asepte koupon?_____ *(Si zero, pa konplet sa kestyoner. Si 1 ou plis, kontinyen.)*

Demann sa bann kestyon pour sak dimoun ki'n refize pran enn sa bann koupon.

Kestyon	Larepons	Larepons pour sak dimoun ki'n refize aksepte en koupon
1	**Ki ou relasyon ek sa dimoun?** *(Tik zis enn)* a. En diomoun ki mon pa konnen, mon ti'n zwenn li pour premye fwa b. En dimoun ki mon konnen, me nou pa pros c. En bon zanmi, nou konn kanmarad byen d. En partner seksyl e. En manm mon fanmiy f. En dealer	**Dimoun 1 _____** **Dimoun 2 _____** **Dimoun 3 _____** **Dimoun 4 _____** **Dimoun 5 _____** **Dimoun 6 _____**
2	**Depi konbyen letan ou konn sa dimoun?** *(Tik zis enn)* a. Mwens ki 6 mwan b. 6 mwan a 1 an c. 1-2 an d. 3-6 an e. Plis ki 6 an	**Dimoun 1 _____** **Dimoun 2 _____** **Dimoun 3 _____** **Dimoun 4 _____** **Dimoun 5 _____** **Dimoun 6 _____**

Kestyon	Larepons	Larepons pour sak dimoun ki'n refize aksepte en koupon
3	**Akoz ou kwar ki sa dimoun ti refize aksepte en koupon?** *(Pa lir. Demann pour sak dimoun ki'n refize pran en koupon.)* 1. Tro busy 2. I ti deza annan en koupon e i ti'n fini partisipe 3. I pa en travayer seks 4. I mwens ki 15 an 5. I pa'n travay (vann seks) sa dernye mwan 6. Per i ava ganny idantifye konman en travayer seks 7. Site I tro lwen pour li vini 8. Pa enterese 9. Sa incentive pa vo lapenn	**Dimoun 1 _____** **Dimoun 2 _____** **Dimoun 3 _____** **Dimoun 4 _____** **Dimoun 5 _____** **Dimoun 6 _____**

Annex 15: Workplan

Task No.	Deliverables	Deadlines
1.0	**Phase 1 Preparation Desk reviews**	**July 2014**
1.1	Conduct meeting of research Committee	**1st week of July to 2nd week of July 2014 (2 weeks)**
1.2	Advocacy meeting with NAC/TAC/CMT Committee	
1.3	Develop concept note for consultancy International	
1.4	Develop TOR for National consultancy	
1.5	Advertise post in national written media	
1.6	Develop TORs for survey team	
1.7	Develop TOR for Technical Working Group	
1.8	Develop first draft of sampling method	
1.9	Draw up selection panel	
1.10	Advocacy meeting with national stakeholders advocacy & awareness	
1.11	Select International and national consultant with panel based on TOR	
1.12	Recruit consultant	
1.13	Introduce consultant & discuss on project to Research team/TAC through one day meeting	
2.0	**PHASE 2: Research Protocol**	**2nd Week of August 2014**
2.1	Research design	**3rd Week of July To 1st Week of August 2014 (2 weeks)**
2.2	Methodology	
2.3	Sampling method finalized	
2.4	Validation meeting of draft questionnaires	
2.5	Drafting protocol for biological surveillance	
	Develop training modules for Enumerators/Nurses/Lab Technicians/Data Managers	
2.6	Meeting with national Ethical Committee for approval of proposal	
2.7	Develop Data analysis plan	
3.0	**PHASE 3: Health Research and Ethics Committee Application and Approval**	**4th Week Sept**
3.1	Application to the Health and Research Ethics Committee completed and approval obtained	**2nd Week of August to 4th week of Sept 2014 (2 weeks)**
3.2	Application submitted to the HREC	
3.3	Presentation done to the HREC	
4.0	**PHASE 4: Piloting of research**	**4th week of August**
4.1	Recruitment of site staff/interviewers	**1st week Oct To 4th week of Oct 2014 (4 weeks)**
4.2	Recruitment of nurses	
4.3	Recruitment of laboratory technicians	
4.4	Media and Communication Plan for pilot & survey	
4.5	Pre-testing of questionnaire and procedures	
4.6	Analysis of results	
4.7	Drafting of new questionnaire	
4.8	Sample collection procedures and tools for HIV prevalence survey developed	
4.9	Final sample procedures adopted	
4.10	Review of HIV prevalence survey done	
4.11	Training of site staff and supervisors (Mahé	
4.12	Training of nurses	
4.13	Training of laboratory technicians	
4.14	Training of data management Officers	
Task No.	**Deliverables**	**Deadlines**
5.0	**PHASE 5: Data Collection**	**3rd Week Nov**

5.1	Development of Data collection, management and analysis plan	**1st week Nov to 4th week of Nov. 2014 3 weeks**
5.2	Data collection begin	
5.3	Monitoring of data collection	
6.0	**PHASE 5: Data Entry**	**3 weeks**
6.1	Data Coding	**4th week Nov to 3rd Week of Dec 2014**
6.2	Data entry/cleaning	
7.0	**PHASE 7: Data Analysis**	**4 weeks**
7.1	Production of Data analysis tables / data sets	**4th Week Dec to 4th Week Jan 2015**
7.2	Preliminary analysis report: behavioural surveillance data	
7.3	Preliminary analysis report: biological surveillance data	
7.4	Review of data sets	
7.5	Interpretation of data	
8.0	**PHASE 8: Dissemination**	**4 weeks**
8.1	Final complete research report with detailed analysis of both HIV prevalence data and behavioral data completed and associations	**4th Week of Feb 2015**
8.2	Presentation of results to NAC during the ABCD of Safer Sex Week March 2015)	
8.3	Communication of data results –Mass media/Airing/	
8.4	Printing of reports	
8.5	Dissemination of results to all stakeholders	