REGIONAL SUMMARY OF FINDINGS OF AN ASSESSMENT OF HIV SERVICES PACKAGES FOR KEY POPULATIONS IN SELECTED COUNTRIES IN WEST AND CENTRAL AFRICA

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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
</tr>
<tr>
<td>BBFWSS</td>
<td>Brothel-based females who sell sex</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
</tr>
<tr>
<td>CDC</td>
<td>Centre for Disease Control</td>
</tr>
<tr>
<td>CSLS</td>
<td>Sectorielle de lutte contre le SIDA du Ministere de la Sante, Mali</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>GAM</td>
<td>UNAIDS Global AIDS Monitoring reports</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HIVST</td>
<td>HIV Self-Testing</td>
</tr>
<tr>
<td>HTA</td>
<td>High Transmission Area</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counseling</td>
</tr>
<tr>
<td>IBBS</td>
<td>Integrated Bio-Behavioral Surveillance</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication materials</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender, Intersex</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MSHP</td>
<td>Ministere de la Sante et de l’Hygiene, Mali</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NBBFWSS</td>
<td>Non Brothel-based females who sell sex</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NSP</td>
<td>Needle and Syringe Program</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The United States President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission of HIV</td>
</tr>
<tr>
<td>PR</td>
<td>Principal Recipient (of Global Fund funds)</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-Exposure prophylaxis</td>
</tr>
<tr>
<td>PSE</td>
<td>Population Size Estimates</td>
</tr>
<tr>
<td>PWID</td>
<td>People Who Inject Drugs</td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreements</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
</tr>
<tr>
<td>SR</td>
<td>Sub-Recipient (of Global Fund funds)</td>
</tr>
<tr>
<td>SRH(R)</td>
<td>Sexual Reproductive Health (and Rights)</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SW</td>
<td>Sex Workers</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TG</td>
<td>Transgender people</td>
</tr>
</tbody>
</table>
Assessment of HIV Service Packages for Key Populations
West and Central Africa

UIC Unique Identifier Code
UNAIDS Joint United Nations Programme on HIV/AIDS
WCA West and Central Africa
WHO World Health Organization
EXECUTIVE SUMMARY

In its *Consolidated Guidelines for HIV prevention, diagnosis, treatment and care for key populations*, the World Health Organization (WHO) has clearly outlined the comprehensive package of services which should be available for men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW), transgender people (TG) and prisoners (WHO 2016, 2017). The Global Fund contracted APMG Health to review the design, implementation and monitoring of national HIV service packages for key populations against the *WHO Consolidated Guidelines* in 65 countries in which the Global Fund has provided HIV grant funds, across six regions.

These are the results of this assessment in West and Central Africa. This report is based on five country-specific desk reviews and on five further country reports the cover an initial desk review and an in-country assessment. The Global Fund Country Team for each country provided data sources used for completing the desk reviews. For those countries with in-country assessments, fieldwork was conducted over the course of five days. For each of these five countries, two key populations and two sites were selected, with guidance from Global Fund Country Teams and Country Coordinating Mechanisms (CCM). An exception was Sierra Leone, where four key populations and three sites were selected and Mali, where three sites were selected.

Table ES1. West and Central Africa Key Population and Site Selection

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Selected</th>
<th>Sites Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>FSW, MSM</td>
<td>Bohicon, Cotonou</td>
</tr>
<tr>
<td>Cameroon</td>
<td>FSW, MSM</td>
<td>Yaounde, Douala</td>
</tr>
<tr>
<td>Mali</td>
<td>FSW, MSM</td>
<td>Kouremalé, Ségou, Kati</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>MSM, FSW, PWID, TG¹</td>
<td>Freetown, Makeni, Lakka</td>
</tr>
<tr>
<td>Togo</td>
<td>MSM, FSW</td>
<td>Lome, Tsevie</td>
</tr>
<tr>
<td>Desk Review Only: Burundi, Cape Verde, Côte d’Ivoire, Ghana, Nigeria</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data were collected through document review, interviews with national stakeholders responsible for design of packages, visits to at least two sites where services were being provided, including observation of service delivery, interviews with service delivery staff, focus groups discussions (FGD) with people from key populations, interviews with monitoring staff and examination of monitoring forms, methods and databases. It should be noted that the primary method of assessing quality of

¹ Limited attention to PWID and TG where possible
services was through FGD with key populations. To support the development of this report, a literature review was subsequently conducted on recent literature related to key populations in the region.

There were several limitations in conducting this assessment process, including during the initial desk review portion of country assessments. For the ‘desk review only’ countries, APMG Health did not conduct an in-country assessment to collect data and information which could verify information found in the initial desk review. Data for these five countries have been included in this summary, however it should be noted that the desk review assessments were limited to those data provided by the Global Fund up to and including quarter four of 2017.

Due to time restrictions of in-country visits, only 2-3 sites were selected for observation (see Table ES1). It is important to note that because of this, country assessments are not nationally representative and reports only speak to the data available in the regions, districts and cities which were visited or were assessed within other reports reviewed. Also, due to time restrictions, only two out of the five key populations were focused on during data collection in most countries. Finally, this regional analysis is based on a non-representative selection of countries within the region, and therefore the results of this analysis may not be applicable to or representative of every country in the region.

**DESIGN**

National HIV strategic plans were available for review in all countries assessed. In the case of Cape Verde, the most recent national HIV strategic plan provided was out of date. A major issue across countries assessed – linked to implementation and monitoring as well as design – is the limited and sometimes evidently inaccurate data on the size of each key population, making it difficult to plan accurately and to adequately justify resources for targeted key populations programming. For example, population size estimates (PSE) for MSM among the assessed countries vary from 0.01% of the population (Nigeria), 0.03%-0.07% (Sierra Leone, Benin, Mali and Ghana), 0.26% in Cote d’Ivoire and 0.29% in Cameroon – a range which is unlikely to reflect actual population sizes, based on accepted international norms.

All ten countries identify MSM as a key population in their national strategies. Sex workers are identified in all national strategies as a key population, with the majority of countries focusing on female sex workers (FSW). There are many similarities between the service packages for SW and MSM across the countries. When compared with the *WHO Consolidated Guidelines*, the majority of countries include most of the called-for interventions.

Nine of the ten countries assessed identify people who inject drugs (PWID) as a key population in their national strategies, however, few of these countries include the full range of harm reduction interventions, with five countries including neither needle-syringe programs (NSP) nor opioid substitution therapy (OST) in their service packages. Mali is the only country which does not include PWID as a key population. Only four out of the ten countries identify prisoners as a key population.
Assessment of HIV Service Packages for Key Populations
West and Central Africa

(Benin, Côte d’Ivoire, Ghana and Togo). Program designs in these countries generally match the WHO Consolidated Guidelines, with the exception of harm reduction interventions, which are only included in Ghana.

Very few countries provide definitions of KP. Where they are available, they are quite consistent across the countries assessed, though often vague. For example, a PWID is considered a PWID regardless of whether they last injected today or a year ago. The biggest area of difference is in sex work, where some countries evidently (through their programming and guidance documents) restrict their focus to female sex workers while others assume sex workers could be female, male or transgender.

Structural interventions are present in most national service package designs. Of the 10 countries assessed, only three (Cape Verde, Cameroon and Côte d’Ivoire) have not included any critical enabler activities in any KP service packages. However, none of the countries include all critical enabler activities called for by the WHO Consolidated Guidelines, for all key populations. There is a lack of sensitivity to sex and gender across the full range of strategic information gathered, including PSE and epidemiological monitoring, design, implementation and service monitoring.

All of the assessed countries have taken the opportunity to formally recognize some key populations in their national plans and strategies and have acknowledged the importance of designing service packages for key populations based on the WHO Consolidated Guideline, other WHO guidance documents and national studies of HIV epidemiology. The exception is for transgender people (TG), for whom there are very limited data and lack of inclusion in any of the national strategies assessed.

Recommendations are presented below. Many of these accord with current WHO guidance.

RECOMMENDATIONS: DESIGN OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Defined packages of services should include services for all key populations which have been identified in the country. There may be minor variations depending on local epidemiology and behavior patterns.

2. All countries in the region require at least the basic services for each key population to be in the designed service packages. All key population packages should contain condoms and lubricant distribution, with female condoms at least included in all SW programs and needles and syringes included in at least all PWID programs.

3. Needs-based services should also be included in service packages for all key populations, including the offer of post-exposure prophylaxis (PEP), sexually transmitted infection (STI), tuberculosis (TB) and hepatitis B and C services. Pre-exposure prophylaxis (PrEP) should be included to be offered to at least MSM, SW and TG.

4. Critical enabler activities for each key population should be specified in all service packages. Assessments of human rights related barriers to key population access to HIV services have been carried out in some of the assessed countries (Benin, Sierra Leone, Cameroon and Côte d’Ivoire). Similar exercises should be carried out in all countries. All countries should have a strategy to address ongoing human rights related barriers that impact key population access to HIV and
broader health services. This strategy should be explicitly linked to national HIV strategies and plans.

5. All countries should continue to progress towards clear definitions of coverage for all elements of service packages.

6. In order to assure that investments in mental health are cost-effective, there is need for greater understanding of the mental health needs of different key populations, as well as more thoughtful, realistic and well-described approaches and interventions included in service packages. Adequate resourcing of these services is required.

7. The development of minimum standards for behavioral interventions, which are attuned to population needs, would ensure that the intent of the design of this intervention carries over into appropriate resource mobilization and implementation.

IMPLEMENTATION

In West and Central Africa, the range and quality of services delivered under KP service packages differs considerably from country to country. In all countries assessed, KP (and therefore the burden of HIV among KP) are not evenly distributed across the country, so decisions need to be made about geographical distribution of services. In most countries, services are concentrated (along with populations) in the urban centers of the jurisdictions with the highest prevalence. This has led to some under-servicing, and sometimes no dedicated servicing, of KP in rural areas or in lower-prevalence provinces.

Across the countries assessed, service packages along the HIV continuum are mostly delivered by civil society and government providers. Private clinics play less of a role in the delivery of HIV services for key populations. Prevention services are provided primarily by NGOs and CBOs (including faith-based ones), often utilizing peer educators or peer navigators to conduct outreach or drop-in services in ‘hot spots’ where PWID, MSM and FSW are found in the greatest density. Services are provided through mobile outreach (e.g. through mobile units) or at static locations (e.g. drop-in centers). A common issue with outreach services in the region is the threat of abuse or violence towards outreach workers, particularly among MSM. Counseling and testing is provided in both community and clinic settings to varying degrees.

The point of intersection between government and non-government service providers tends to be at either HIV testing or at linkage to treatment and care. In some cases, NGOs or CBOs deliver community-based rapid testing on site (either mobile or static) and provide passive or accompanied referrals to care for people who test positive to HIV. In other environments, clients are referred or accompanied to care facilities to initiate testing. Support from NGOs and CBOs beyond the point of HIV diagnosis may or may not continue, depending on models employed and resources available. Government service providers, in government facilities, then generally provide HIV treatment and care. For prevention, treatment and management of opportunistic infections, mainly tuberculosis,
NGOs and CBOs play a significant role in screening, bringing potential TB patients to government facilities for testing and supporting patients with treatment adherence.

Coverage of key populations with defined service packages varies widely across the region, as does the definition of coverage. The key indicator should be the number of members of a key population reached with the defined package of services on a regular basis (with the regularity of reach also being defined). Due to variable descriptions and monitoring processes for coverage, it is difficult to state what the real coverage levels are for interventions and it is impossible to state the coverage of the full, defined package for each key population. Coverage appears to be generally low for prevention services, for HIV testing among key populations and for linkage to care. Quality issues were also raised in most focus groups among key populations. Stock outs of ART due to inadequate planning and lack of communication and coordination at all levels of government are also responsible for low treatment coverage. Uneven access to STI services appears to be a major issue in most countries for FSW and MSM.

All countries assessed have made efforts to provide services matching the designed package of services, but the results are highly variable and difficult to assess with current monitoring tools. As an example, all five countries in-country assessment countries identify MSM as a key population, however service coverage data are only available for condom and lubricant programming and HIV prevention programs. Data on other interventions are mostly not available and are not included in reporting on the service package. For all interventions, Cameroon has the most complete data, yet coverage is low across all interventions. One positive feature of the implementation assessments is that some countries are moving towards implementing programming for TG despite there being no national service package for this KP. For example, a situational analysis of the context of HIV risk and impact among TG was carried out in 2017 in Benin, and Cameroon is also looking to expand services for this group.

In addition, some countries have begun to increase attention to critical enablers, despite their uneven inclusion in KP packages in the region. In Benin, the 2018 baseline assessment of human rights related barriers to HIV services reported many barriers experienced by KP that affect their access to HIV prevention, treatment and care services. To address these barriers a watchdog committee has been strengthened to document cases of gender-based violence (GBV), stigma and discrimination against MSM and SW and to provide psychological and legal support to people who have experienced human rights violations. In addition, the capacity of rights-based organizations has been strengthened, journalists and lawyers have been trained to create KP-friendly networks among those professions, healthcare personnel have been sensitized to the rights of KP and radio campaigns have been organized to promote the rights of KP.

In Togo, the 2013 Analysis of Policies for KP at Risk of HIV Infection describes a range of inhibiting factors to delivering services to KP. Responses to these issues, including training of media personnel, police and the legal sector on the rights of KP are reported to have brought about positive changes in
the environment for key populations. Members of KP in focus groups in Togo expressed the view that the situation for most KP had improved in the past five years.

RECOMMENDATIONS: IMPLEMENTATION OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Service packages need to be implemented as designed, with particular emphasis on ensuring a sufficient supply of condoms and lubricant to MSM, TG and SW and of needles and syringes to PWID.
2. STI services for FSW and MSM need to be made more accessible, including assuring they are affordable (or free of charge) to key populations.
3. Differentiated service delivery should be developed to assist in expanding reach of key interventions among KP. Innovations include: self-testing, lay provider testing, community-based testing, assisted partner notification, community-based initiation and distribution of ART for KP.
4. Community empowerment activities, particularly community monitoring of HIV service packages by key population networks, need to be scaled up in the region. This is a key strategy for improving service quality.
5. Outreach and support service models need to be reviewed to ensure that there are sufficient resources to ensure linkage to treatment for newly-diagnosed PLHIV and case-management models in place to cover at least the first three months following diagnosis.
6. Community HIV testing and self-testing models in the region need to be assessed and guidance for expanding access and improved quality developed.
7. Strategies to engage countries in transition planning for the outreach (demand-creation) workforce for KP need to be strengthened.
8. Key population (KP) NGOs need to be assisted to secure resources to pursue broad health goals for their constituents, including reduction of stigma and discrimination, responses to KP-related violence, gender-based violence and other issues that increase service access obstacles for people from KP.
9. Technical support agencies, in collaboration with regional KP organizations should work to develop a set of regional guidelines for e-outreach, covering safety and security for e-outreach workers, ethics, privacy and effective messaging.
10. Critical enabler activities have very low levels of coverage and the range of activities implemented is generally much smaller than needed. As Sierra Leone, Cameroon, Benin and Cote d’Ivoire work to reduce human rights related service access barriers for KP, other countries in the region should study the activities implemented and their results for possible replication.
11. In collaboration with regional KP organizations, UN agencies should work to develop a set of regional guidelines for e-outreach, covering safety and security for e-outreach workers, ethics, privacy and effective messaging.
12. Safety of outreach workers, particularly among MSM, needs to be addressed through the use of written security protocols, which are the subject of training and supervision for outreach staff.

13. Male sex workers are hardly mentioned throughout the region, yet men who have sex with men report buying and selling sex at significant frequency. Implementers of MSM and SW programs need to work together to ensure that the needs of male SW are met.
MONITORING

Table ES2. UIC System Scores by Country in West and Central Africa

0: No data/evidence
1: Monitoring contacts, which disallow de-duplicated reporting
2: Partially using UIC, which disallow de-duplicated reporting. This includes scenarios where UICs are used in some regions of the country or different UICs are used in the country but not harmonized.
3: Nationally using UIC, which allow de-duplicated reporting. This includes the scenario where different UICs are used but harmonized.

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>2</td>
<td>There is a clear monitoring system in place and standard tools have been developed, but they are not harmonized across all programs targeting key populations. The country has set up various coding systems for key populations programs, however, they are not generated in the same manner and not all of them are actually identifying codes.</td>
</tr>
<tr>
<td>Cameroon</td>
<td>2</td>
<td>Global Fund and PEPFAR-funded service providers now use the same UIC codes. There is no consistent UIC between community-based prevention and linkage services and the medical system, making it difficult to measure retention in care by key populations beyond the key populations served by PEPFAR.</td>
</tr>
<tr>
<td>Mali</td>
<td>1</td>
<td>Each local non-governmental partner uses its own data collection system for monitoring contacts, which is not unified at national level. Local stakeholders have agreed to implement a UIC from 2018 onwards.</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>2</td>
<td>A UIC has been partially implemented to improve monitoring of key populations and link them to other services for HIV, but the code does not adhere to international best practice guidelines and may need some adjustment to truly prevent duplication and improve monitoring.</td>
</tr>
<tr>
<td>Togo</td>
<td>3</td>
<td>A UIC was introduced by USAID-funded programs and has been adopted by all government and civil society service-delivery institutions working with key populations, including the principal recipients (PR) and sub-recipients (SR). Unable to link with hospital patient data.</td>
</tr>
</tbody>
</table>

*For countries that only received a desk review, there was not enough information available to adequately and reliably assess the existence and use of a UIC. Therefore, details are not included here.

Four of the in-country assessment countries are currently using a Unique Identifier Code (UIC) system. Mali is not but has plans to implement one in 2018. Among the countries that do have UIC systems, problems are apparent. Systems in Benin, Cameroon and Sierra Leone face a set of issues, such as lack

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2 Score has been assigned based on available information from country assessments. Score may not apply to all key populations (MSM, FSW, PWID and prisoners) in WCA. Please see notes for specifications.
of harmonization due to different UIC systems implemented by different organizations, partial systems that track some services but not others, or different systems operating for different services. None of the countries is able to follow KP from prevention services (where a UIC is used) through testing to treatment for those who are HIV-positive (where usually a government-issued patient number is used to record service use). This makes cascades of prevention and care for each KP problematic, if not impossible.

Data on KP are often not included in Health Management Information Systems (HMIS) at the national level or are not fully included, with significant data remaining only in systems operated by Global Fund PR and PEPFAR-funded entities.

**RECOMMENDATIONS: MONITORING OF SERVICE PACKAGES FOR KEY POPULATIONS**

1. For accurate coverage calculations, countries need to follow established guidelines to develop population size estimates, including a national consensus processes involving substantial representation from the KP concerned. From these processes, more accurate and agreed-upon PSE should be derived.

2. Mapping of KP size and characteristics, including the involvement of community networks, should be carried out nationally where possible to aid in verifying each PSE and in planning, implementing and measuring adequate coverage of KP programs.

3. Countries should continue to progress towards a national UIC and determine whether case-based surveillance and harmonizing of health databases can assist in following KP from prevention and testing programs through ART and viral load suppression, while maintaining sensitivity to confidentiality in criminalized environments.

4. Tracking of service use and health outcomes for KP needs to be integrated into national e-health and unique patient record initiatives, where this can be done without compromising safety of KP.

5. Mechanisms or systems should be developed so that data collected by donor-funded programs, including by SR and PR of the Global Fund, is fed into national-level data.

6. It is important to stress that none of these data are useful unless they are utilized for decision-making – whether at the policy or the implementation level. Capacity building is required to help staff see the value in not merely collecting, but analyzing service data and using this information as the basis for suggesting changes to services.

7. Intervention data should be routinely collected with vital demographic (sex, gender and age) data included, so that data may be analyzed in a disaggregated manner to show relative access and outcomes for sub-populations, as well as to support advocacy for more attention to under-served groups.

8. Documenting, mapping activities and results related to reducing human rights related access barriers should be a priority for learning and generating best practice on what works to create a more enabling environment for KP. As much as possible, this documentation should be specific to each key population. Mapping and reporting on
activities to these barriers for each KP should become part of regular monitoring processes.

9. International organizations working on HIV should assist countries to develop low-cost, non-intrusive methods to measure quality of HIV services for KP and for reporting on KP access to non-HIV specific services provided by the health system and communities.

FINANCING

Due to the limited time available for the assessments, financing of KP programs was not a major focus of these assessments. However, some trends were observed. The Global Fund has become the major donor for key population services in several countries. From the data available through Global Fund, PEPFAR and National AIDS Spending Assessments, it appears that most countries are spending increasing amounts on ART programming, including increased domestic funding. However, very little or no domestic funding is being spent on programming specifically for KP.

The lack of substantial growth in PEPFAR and Global Fund funding for KP activities in most assessed countries means that there has been a struggle to take KP programs to scale. This is exacerbated by the unwillingness of most countries to apply domestic funding to these programs. The recent introduction of Matching Funds programs by the Global Fund – both for activities specifically to scale up KP programming and to reduce human rights related access barriers for KP to HIV services – offers an opportunity to improve quality and scale of KP programming.

Regionally, UNAIDS reports that resources for HIV are alarmingly insufficient to reach the Fast Track targets. This was confirmed in the five in-country assessment countries where large funding gaps remain. Funding for services for key populations is even more underfunded, especially for MSM and FSW, the two key populations with the highest HIV prevalence among all key population groups.
### Table ES3. Summary of Key Findings in West and Central Africa

Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O)

*Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Benin</th>
<th>Burundi*</th>
<th>Cameroon</th>
<th>Cape Verde*</th>
<th>Côte d’Ivoire*</th>
<th>Ghana*</th>
<th>Mali</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Size Estimate (% of total population)</td>
<td>MSM</td>
<td>5,846 (0.05%)</td>
<td>9,346 (0.08%)</td>
<td>66,842 (0.29%)</td>
<td>694 (0.13%)</td>
<td>59,040 (0.26%)</td>
<td>18,700 (0.07%)</td>
<td>32,084 (0.18%)</td>
<td>26,013 (0.01%)</td>
<td>20,000 (0.03%)</td>
<td>27,978 (0.3%)</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>700 (&lt;0.01%)</td>
<td>N/A</td>
<td>N/A</td>
<td>2,192 (0.42%)</td>
<td>129 (&lt;0.01%)</td>
<td>5,500 (0.02%)</td>
<td>749 (&lt;0.01%)</td>
<td>44,515 (0.02%)</td>
<td>1,500+ (0.02%+)</td>
<td>2,289 (0.03%)</td>
</tr>
<tr>
<td></td>
<td>Prisoner</td>
<td>7,890 (0.07%)</td>
<td>10,093 (0.07%)</td>
<td>29,341 (0.1%)</td>
<td>1542 (0.3%)</td>
<td>16,127 (0.05%)</td>
<td>15,063 (0.04%)</td>
<td>5,209 (0.03%)</td>
<td>75,176 (0.04%)</td>
<td>4519 (0.06%)</td>
<td>4,839 (0.06%)</td>
</tr>
<tr>
<td></td>
<td>SW</td>
<td>16,219 (0.15%)</td>
<td>51,482 (0.46%)</td>
<td>115,000 (0.49%)</td>
<td>1,665 (0.32%)</td>
<td>9,211 (0.04%)</td>
<td>63,475 (0.23%)</td>
<td>35,903 (0.2%)</td>
<td>103,506 (0.06%)</td>
<td>240,000 (3.7%)</td>
<td>14,833 (0.14%)</td>
</tr>
<tr>
<td></td>
<td>TG</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>500 (&lt;0.01%)</td>
<td>N/A</td>
</tr>
<tr>
<td>HIV Prevention Programming</td>
<td>MSM</td>
<td>43.6% (P)</td>
<td>18% (P)</td>
<td>7.8% (P)</td>
<td>98% (P)</td>
<td>18.4% (S)</td>
<td>54.7% (S)</td>
<td>73.1% (P)</td>
<td>34% (P)</td>
<td>27.4% (P)</td>
<td>58.7% (P)</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>112.3% (P)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>61.4% (P)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

---

3. All data sources are provided in footnotes to tables for each KP in Implementation

4. Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSEs as denominators

5. Coverage with prevention package as defined in national design documents
### Assessment of HIV Service Packages for Key Populations
#### West and Central Africa

<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Benin</th>
<th>Burundi*</th>
<th>Cameroon</th>
<th>Cape Verde*</th>
<th>Côte d’Ivoire*</th>
<th>Ghana*</th>
<th>Mali</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoners</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>79.5% (O)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SW</td>
<td>73.2% (P)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>79.5% (O)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TG</td>
<td>94.3% (O)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Knowledge of HIV status(^7)</td>
<td>MSM</td>
<td>20.9% (P)</td>
<td>32% (S)</td>
<td>44.5% (P)</td>
<td>50% (S)</td>
<td>54.9% (S)</td>
<td>26.3% (S)</td>
<td>26% (P)</td>
<td>38% (P)</td>
<td>92.2% (S)</td>
<td>31.6% (O)</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>57.8% (O)</td>
<td>10.0% (P)</td>
<td>55.1% (S)</td>
<td>98.0% (P)</td>
<td>9.9% (P)</td>
<td>N/A</td>
<td>48.8% (P)</td>
<td>45.5% (P)</td>
<td>31.1% (O)</td>
<td>N/A</td>
</tr>
<tr>
<td>Prisoners</td>
<td>101.1% (P)</td>
<td>66.7% (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>23.2% (O)</td>
</tr>
<tr>
<td>SW</td>
<td>81.6% (S)</td>
<td>42.6% (S)</td>
<td>59.1% (S)</td>
<td>45.1% (S)</td>
<td>47% (P)</td>
<td>66.7% (S)</td>
<td>N/A</td>
<td>4.4% (P)</td>
<td>20.9% (P)</td>
<td>94.1% (S)</td>
<td>N/A</td>
</tr>
<tr>
<td>TG</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>MSM</td>
<td>N/A</td>
<td>17% (P)</td>
<td>10.3% (P)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1.4% (O)</td>
</tr>
</tbody>
</table>

---

6 Not possible to estimate – PSE given as GF and PEPFAR reached more than 36,000 FSW in 2016
7 Percentage of KP that have received an HIV test in the past 12 months and know their results
<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Benin</th>
<th>Burundi*</th>
<th>Cameroon</th>
<th>Cape Verde*</th>
<th>Côte d’Ivoire*</th>
<th>Ghana*</th>
<th>Mali</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiretroviral therapy*</td>
<td>PWID</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0.4% (O)</td>
</tr>
<tr>
<td></td>
<td>Prisoners</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0.02% (O)</td>
</tr>
<tr>
<td></td>
<td>SW</td>
<td>N/A</td>
<td>31.8% (P)</td>
<td>N/A</td>
<td>28% (P)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2% (O)</td>
</tr>
<tr>
<td></td>
<td>TG</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Proportion of KP who report currently being on ART
BACKGROUND

In 2017, approximately 40% of new HIV infections were among key populations and their sexual partners (UNAIDS, 2018). A range of policy and legal barriers and harmful social factors increase the HIV vulnerability of key populations and undermine their access to HIV and other services. The criminalization of sex between men, sex work, drug use and HIV transmission, as well as high rates of incarceration, homophobia, transphobia, violence and social marginalization all serve to influence risk practices and undermine access to services. Women in key populations face specific challenges and barriers, including gender-based violence and poorly tailored services. These factors further intensify their vulnerability to HIV. Male KP also face high levels of violence.

The World Health Organization (WHO) has outlined the comprehensive package of services which should be available for men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW), transgender people (TG) and prisoners (WHO, 2016). However, these populations rarely have access to the full range of recommended services (UNAIDS, 2015).

The Global Fund contracted APMG Health to review the design, implementation and monitoring of national HIV service packages for key populations in 65 countries in which the Global Fund has provided HIV grant funds, across six regions. Out of the 65 countries assessed, 55 countries were selected based on the Global Fund KPI2 (2014-2016) results, where key population size estimations were classified as ‘nationally adequate’ by 2016. An additional ten countries were selected based on discussions with the Global Fund regional teams and consultation with global partners. The specific objectives of this assessment were:

1. To determine whether HIV service packages as designed in the national guidelines or supported by Global Fund programs are in line with international standards and guidelines (e.g. WHO Consolidated Guidelines for Key Populations, Key Populations Implementation Tools, amongst others) and are appropriate to epidemiological context, available, accessible and utilized by relevant key population groups;
2. To examine the implementation of HIV service packages in reaching intended target groups, taking into account specific needs and vulnerabilities within sub-groups of key populations (e.g. age, sex), along with the coverage and reported quality of these programs;
3. To assess whether the monitoring framework, tools and other mechanisms set up by implementation partners are appropriate to local contexts and are used effectively to regularly report on programmatic coverage;
4. To examine the enabling environment and other factors facilitating and inhibiting the availability, accessibility and utility of intervention services; and,
5. To determine the degree to which financial resources are made available and used accountably for funding the implementation of service packages for key populations.
These objectives were completed through a mix of desk review and in-country visits, as further described below. This report is one of six regional reports produced to summarize the assessment findings. A global summary report has also been produced.

9 Regional reports are available for East and Southern Africa, West and Central Africa, Middle East and North Africa, Asia and the Pacific, Latin American and the Caribbean, and Eastern Europe and Central Asia.
METHODOLOGY

COUNTRY ASSESSMENT PROCESS

Each of the country assessments consisted of an initial desk review of documents provided by the GF Country Teams. The main data sources provided for desk reviews in West and Central Africa were:

- Global Fund Performance Framework
- Integrated Bio-behavioral Surveillance Survey Reports (IBBS Reports)
- National Strategic Plans
- Monitoring and Evaluation Plans
- Global Fund Funding Request Reports & Concept Notes
- Global AIDS Monitoring Reports (GAM)
- Global Fund Program Update data
- Programmatic Spot Checks
- Cross checking of findings at a debrief with PR and other stakeholders

A desk review was conducted for all 10 countries selected for the West and Central Africa region. Out of the 10 countries, five of the countries included a follow-up in-country visit to verify and expand data collected during the initial desk review process.

Each field assessment was conducted over the course of five working days. For each country, key populations and two to three sites were selected, with guidance from The Global Fund Country Teams and Country Coordinating Mechanism (CCM).

Table 1. West and Central Africa Key Population and Site Selection during In-Country Visits

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Selected</th>
<th>Sites Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>FSW, MSM</td>
<td>Bohicon, Cotonou</td>
</tr>
<tr>
<td>Cameroon</td>
<td>FSW, MSM</td>
<td>Yaounde, Douala</td>
</tr>
<tr>
<td>Mali</td>
<td>FSW, MSM</td>
<td>Kouremalé, Ségou, Kati</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>MSM, FSW, PWID, TG</td>
<td>Freetown, Makeni, Lakka</td>
</tr>
</tbody>
</table>

Limited attention was devoted to PWID and TG, where possible; MSM and FSW were the primary focus of the in-country assessment
One International consultant and one local consultant carried out each country assessment. The majority of the data collected during each country assessment were collected through:

- An initial meeting with representatives of CCM, PR and SR working with key populations and other key informants to discuss design and enabling environment issues.
- Visits to at least two sites for observation of package delivery.
- Visits to SR/SSR to discuss implementation issues and to examine M&E forms and systems.
- Additional key informant interviews.
- Focus group discussions (FGD) with key populations: in each country, focus groups were held with individuals from each of the two selected key populations in each site visited, except in Mali where three FGD were held.

**REPORTING PROCESSES**

Country reports for both desk-review only and in-country assessment countries have been produced and used to prepare each regional report. Countries were grouped by UNAIDS regions. This report provides summary and analysis of the ten countries assessed in the West and Central Africa region, as displayed in Table 2. A literature review was also conducted on recent literature related to key populations in the region.

**Table 2. West and Central Africa Countries Assessed**

<table>
<thead>
<tr>
<th>Desk Review and Country Assessment</th>
<th>Benin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cameroon</td>
</tr>
<tr>
<td></td>
<td>Mali</td>
</tr>
<tr>
<td></td>
<td>Sierra Leone</td>
</tr>
<tr>
<td></td>
<td>Togo</td>
</tr>
<tr>
<td>Desk Review Only</td>
<td>Burundi</td>
</tr>
<tr>
<td></td>
<td>Cape Verde</td>
</tr>
<tr>
<td></td>
<td>Côte d’Ivoire</td>
</tr>
<tr>
<td></td>
<td>Ghana</td>
</tr>
<tr>
<td></td>
<td>Nigeria</td>
</tr>
</tbody>
</table>

It should be noted that the countries selected for this region were not selected on the basis of being a regionally representative sample. While this report will present trends observed across these ten
countries, extrapolation of the findings to other countries in the region should be done with caution. The findings of this assessment may be instructive for development of policy or practice across the region, but any country-level decisions should always be grounded in the reality of the specific country context.
FINDINGS

PART I: REGIONAL PROFILE AND KEY POPULATIONS CONTEXT

KEY POINTS

- In West and Central Africa, HIV is higher among key populations, MSM SW (mostly female), and to a lesser extent among PWID and possibly TG.
- Not enough is known about the sizes of key populations: in particular, few countries have a TG PSE, prisoner numbers are not provided in all countries and PSE of MSM may be greatly under-estimated.

Cascade data in the UNAIDS 2018 Data Report estimate that, among the 6.1 million people living with HIV in West and Central Africa at the end of 2017, 48% were aware of their HIV status, an increase from 43% in 2016. The gap to achieving the first 90 of the 90–90–90 targets in 2017 was 2.6 million people living with HIV who did not know their HIV status. About 2.4 million people living with HIV in the region were accessing antiretroviral therapy in 2017, or 40% of all people living with HIV, with a gap to achieving the first and second 90 of the 90–90–90 targets of 2.5 million people. The estimated percentage of people living with HIV in the region who achieved viral suppression increased from 26% in 2016 to 29% in 2017, with a gap to achieving the all three 90s of 2.7 million people. These gaps represent a significant challenge to the goal of ending AIDS by 2030 for countries in the region.

Figure 1. HIV Testing & Treatment Cascade, West & Central Africa 2017 (UNAIDS Special Analysis 2018)
In West and Central Africa, HIV prevalence is higher among key populations, namely MSM, PWID, SW (mostly female) and prisoners. Data on transgender people (TG), an identified key population in other regions, are not available for any of the countries except for Sierra Leone (which has a population size estimate, only) and Benin. Therefore, further details on TG are not included in this regional report.

**Figure 2. Distribution of New HIV Infections, by Population Group, West & Central Africa 2017 (UNAIDS Special Analysis 2018)**

Recent literature on key populations and HIV in the region provides evidence for the central role that KP play in epidemics and responses to HIV. Djomand et al (2014) reviewed data on MSM and SW in West Africa, finding that HIV prevalence varied from 15.9% in The Gambia to 68% in Benin among female sex workers, whereas it ranged from 9.8% in The Gambia to 34.9% in Nigeria for MSM. The authors noted that, “because of sociocultural, legal, political and economic challenges, exacerbated by a poor health system infrastructure, the HIV response is not strategically directed toward programs for key populations in countries with concentrated epidemics. Noteworthy is the low coverage of prevention, care and treatment interventions offered to key populations.”

In its Catch-Up Plan for the region UNAIDS (2017) notes that major barriers for KP in accessing services include high levels of stigma and discrimination, high rates of gender-based violence (including in conflict and emergency situations) and gender inequities. Punitive laws and policies also deter key populations from fully using available services. Laar and DeBruin (2017) and the draft Baseline Assessment reports on human rights barriers to HIV service access by key populations funded by the
Global Fund in Benin, Cameroon, Cote d’Ivoire and Sierra Leone (carried out in 2017/18) provide clear evidence to support this view (Global Fund, 2019, in press).

**Population Size Estimates and HIV Prevalence in West and Central Africa**

**Table 3a. Population Size Estimation and HIV Prevalence, by Key Population for In-Country Assessment Countries**

<table>
<thead>
<tr>
<th>Key Population</th>
<th>Benin 11</th>
<th>Cameroon 12</th>
<th>Mali 13</th>
<th>Sierra Leone 14</th>
<th>Togo 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM PSE</td>
<td>5,846</td>
<td>66,842</td>
<td>32,084</td>
<td>20,000</td>
<td>27,978</td>
</tr>
<tr>
<td>MSM Prevalence</td>
<td>8.2%</td>
<td>20.6%</td>
<td>13.7%</td>
<td>14.0%</td>
<td>22.0%</td>
</tr>
<tr>
<td>PWID PSE</td>
<td>700</td>
<td>N/A</td>
<td>749</td>
<td>1,500+</td>
<td>2,289</td>
</tr>
<tr>
<td>PWID Prevalence</td>
<td>2.2%</td>
<td>N/A</td>
<td>5.1%</td>
<td>8.5%</td>
<td>2.8%</td>
</tr>
<tr>
<td>FSW PSE</td>
<td>16,219</td>
<td>115,000</td>
<td>35,903</td>
<td>240,000</td>
<td>14,833</td>
</tr>
<tr>
<td>FSW Prevalence</td>
<td>8.5%</td>
<td>24.3%</td>
<td>24.2%</td>
<td>7.0%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Prisoner PSE</td>
<td>7,890</td>
<td>29,341</td>
<td>5,209</td>
<td>4,519</td>
<td>4,639</td>
</tr>
<tr>
<td>Prisoner Prevalence</td>
<td>0.6%</td>
<td>3.96% 16</td>
<td>1.4%</td>
<td>2.2%</td>
<td>4.3%</td>
</tr>
<tr>
<td>TG PSE</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>500</td>
<td>N/A</td>
</tr>
<tr>
<td>TG Prevalence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>General population prevalence</td>
<td>0.6%</td>
<td>2.2%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

---

11 UNAIDS (2018a) except PWID and SW PSE (PSE 2017), and prisoner PSE from World Prisons Brief 2016
12 UNAIDS (2018a) except MSM population size estimations and prevalence (2015 IBBS), SW PSE (GAM 2015), prisoner prevalence (Cameroon 2018-2022 NSP), and prisoner PSE from World Prisons Brief 2016
13 UNAIDS (2018a) except SW prevalence (GAM 2009) and MSM PSE (PSE/Mapping 2015)
14 All data from GARPR 2016, except TG PSE (2017 GF Performance Framework), general population data (UNAIDS 2019a) and prisoner PSE from World Prisons Brief 2016
15 UNAIDS (2018a) except prisoner prevalence (National policy for prevention and comprehensive treatment, care & support of STIs and HIV in Key Populations in Togo 2013), prisoner PSE from World Prisons Brief 2016, and MSM and SW PSEs (JHU/USAID 2014)
16 Cameroon 2018-2022 NSP
Table 3b. Population Size Estimation and HIV Prevalence, by Key Population for Desk Review Only Countries

<table>
<thead>
<tr>
<th>Key Population</th>
<th>Burundi17</th>
<th>Cape Verde18</th>
<th>Côte d’Ivoire19</th>
<th>Ghana20</th>
<th>Nigeria21</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM PSE</td>
<td>9,346</td>
<td>694</td>
<td>59,040</td>
<td>18,700</td>
<td>26,014</td>
</tr>
<tr>
<td>MSM Prevalence</td>
<td>4.8%</td>
<td>6.1%</td>
<td>12.3%</td>
<td>17.5%</td>
<td>23%</td>
</tr>
<tr>
<td>PWID PSE</td>
<td>N/A</td>
<td>2,192</td>
<td>129</td>
<td>5,500</td>
<td>44,515</td>
</tr>
<tr>
<td>PWID Prevalence</td>
<td>10.2%</td>
<td>39%</td>
<td>5.3%</td>
<td>11.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>FSW PSE</td>
<td>51,482</td>
<td>1,445</td>
<td>9,21112</td>
<td>63,475</td>
<td>103,506</td>
</tr>
<tr>
<td>FSW Prevalence</td>
<td>21.3%</td>
<td>4.6%</td>
<td>12.2%</td>
<td>6.9%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Prisoner PSE</td>
<td>10,093</td>
<td>1542</td>
<td>16,127</td>
<td>15,063</td>
<td>75,176</td>
</tr>
<tr>
<td>Prisoner Prevalence</td>
<td>3.0%</td>
<td>N/A</td>
<td>1.2%</td>
<td>2.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>TG PSE</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TG Prevalence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>General population prevalence</td>
<td>0.7%</td>
<td>0.4%</td>
<td>2.1%</td>
<td>1.1%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

Men who have Sex with Men (MSM)

Of the 10 countries assessed, HIV prevalence among MSM was lowest in Burundi (4.8%) and highest in Nigeria (23%). National prevalence estimates can hide significant regional variation. For example, in Togo, according to the 2017 IBBS, the prevalence rate of HIV in the region of the capital, Lomé, (29.8%) is much higher than the general HIV prevalence among MSM (22%).

17 All data from PLACE study (2013), except prisoner PSE (World Prisons Brief 2016) and general population data and prisoner prevalence (UNAIDS 2018a)
18 All data from IBBS (2013), except SW (IBBS 2017), prisoner PSE (World Prisons Brief 2016), and general population data, SW PSE and prisoner prevalence (UNAIDS 2018a)
19 UNAIDS (2018a) except MSM PSE (IBBS 2016), PWID and FSW PSE (IBBS 2013), and prisoner PSE (World Prisons Brief 2016)
20 All data from The Global Fund PSE by KP, Spreadsheet; GAC, 2015-2016, except PWID (UNAIDS Modes of Transmission Study 2010), prisoner PSE (World Prisons Brief 2016), prisoner HIV prevalence (2016 data from Prison Service) and general population data (UNAIDS 2018a)
21 UNAIDS (2018a) except prisoner PSE (World Prisons Brief 2016)
12 As footnote 7 in ES 3 notes, 36,000 SW were reached in 2016, this figure is a PSE for Abidjan only.
Among the five countries assessed with country visits, there were wide variations in condom use and risk behaviors. In Mali, the TERIYA study from 2014-2015 in Bamako, found that 40.7% of the MSM had unprotected anal intercourse in the previous six months, 59.2% used lubricant in the past six months and 10.3% sold sex in exchange for money or goods in the past 12 months (APMG Health Mali Country Report). These data are consistent with the focus group feedback obtained during the field portion of the Mali assessment. In Sierra Leone, 47.0% of MSM reported using a condom the last time they had anal sex with a male partner (APMG Health Sierra Leone Country Report). Condom use among MSM in Benin was found in the 2017 IBBS to have has risen from 21.1% in 2015 to 44.1%. Knowledge about HIV prevention and modes of transmission remained high (97.2% in 2015 and 99.2% in 2017).

Most MSM in the countries surveyed meet partners in areas of cities known to be frequented by MSM. However, most MSM in Mali use online services and Apps (mostly Facebook, but also Badoo, Drage.net or Gay Romeo) to meet other men for sex, although a smaller proportion also use physical locations like cafes and bars. Of the latter, a significant proportion (46%) have been selling sex to other men for money (APMG Health Mali Country Report).

**People Who Inject Drugs (PWID)**

The estimated HIV prevalence among PWID varies across the 10 countries with the lowest in Benin (2.2%) and the highest in Ghana (11.4%). Cape Verde reported 39.0% HIV prevalence among PWID, but these data are from 2013 and based on a very small study population (eight individuals). Data were not available for Burundi and Cameroon. For Benin, there has been a decrease in HIV prevalence among PWID since 2013 from 6.7% to 2.2% in 2017 (IBBS, 2017). Data specifically on the injecting-drug using population are limited in this region and are sometimes captured in data for a broader group of people who use drugs (PWUD).

Côte d’Ivoire has identified people who use both injection and non-injection drugs (PWUD) as a key population – data in the country report are for PWUD. It is only very recently that Côte d’Ivoire has focused more attention and resources on PWUD and it remains a very hard to reach population. HIV prevalence is 9.5% according to the Médecins du Monde report for PWUD in the capital, Abidjan (2014), although infection is thought to be related to sexual transmission (as an MSM or SW) rather than injecting practices. Most PWUD smoke heroin and cocaine and injecting is not common. Only 3.6% had injected in the last month (APMG Health, Cote d’Ivoire Country Report).

**Sex Workers (SW)**

In West and Central Africa, most data on sex work relate to female sex workers. PSE data on male sex workers are unavailable or non-existent. Throughout this report, information on sex workers refers to

23 95% confidence intervals for the 2017 study 1.01%-3.63%
female sex workers (FSW). In this region based on available data, HIV prevalence among FSW was lowest in Cape Verde (4.6%) and highest in Cameroon (24.3%) and Mali (24.2%). Country-specific characteristics, terminology and population data for sex workers are provided in national reference documents in several of countries that identify sex workers as a key population.

In Benin, waitresses are considered as being high risk for HIV, together with the FSW population in both IBBS and service packages. According to a 2017 mapping report, 81% of FSW are clandestine – they work at night in well-hidden sex work sites. Forty-nine percent (49%) of FSW are not from Benin, migrating mainly from Togo.

Female sex workers were one of the first key populations to be identified and serviced in Côte d'Ivoire, which is probably one of the contributing factors to the current high rate of condom use with clients (81% in most recent IBBS, 2014).

Sex workers in Ghana are often categorized into two groups: seaters and roamers. Seaters are based in a brothel or home, while roamers actively seek clients on the streets, in bars, hotels or other public spots, moving from one site to another in search of clients (GAC & FHI360, 2011). Studies show that HIV prevalence is decreasing among seaters, who are estimated to be of a smaller population size, while roamers, with a larger population size, are not experiencing decreased prevalence (The Global Fund, 2014).

In Mali, documents available vary greatly in their estimation of the FSW population size (range: 35,903-127,643). There have been efforts to better estimate HIV prevalence in this group, which has apparently shown a decline in prevalence over time (2003: 31.9%; 2006: 35.3%; 2009: 24.2%; CSLS/MSHP/CDC); despite this, FSW are still the most affected population in the country. Female sex workers are divided in two categories: ‘official’ and ‘clandestine’. ‘Official’ FSW activity is mostly venue-based (night clubs, bars, massage parlors) followed by open-space pick-up (streets, parks, shopping centers), and to a minor extent operating in hotels and lodges, brothels or from home and residential places. Women doing sex work or transactional sex only occasionally, typically when travelling to the city to sell farm products, and minors (14 – 18 years) are considered ‘clandestine’ and are commonly out-of-reach from the HIV services. In border cities, the proportion of foreign FSW and mobile FSW is very high (up to 80%).

In Nigeria, the term Female Sex Worker (FSW) has been replaced in the previous National Strategic Framework by Females Who Sell Sex (FWSS). According to the National HIV Epidemic and Response Analysis for 2017 from Nigeria, a FWSS is defined as any woman 15 years or older who has received money or valuable gifts or incentives in exchange for sexual services. Women who sell sex are generally categorized as either Brothel-Based Females Who Sell Sex (BBFWSS) or Non-Brothel-Based Females Who Sell Sex (NBBFWSS). Within the category of NBBFWSS are women who operate in clubs, restaurants, gardens, hotels, nightclubs, on the street or in a residence. The majority of FWSS in the country are NBBFWSS and those NBBFWSS are, on average, younger than brothel-based women (mean age of 25.8 years versus 28.3 years) (IBBS, 2014).
Prisoners

Seven out of the 10 countries assessed have available data on the prisoner population, with no data available for Cameroon, Cape Verde or Nigeria. Out of the seven countries with data, Ghana reports the highest number of prisoners – 13,580. Benin and Mali report the lowest HIV prevalence rate among prisoners with both at 1.4%. Togo reports the highest HIV prevalence (4.3%). For Togo and Burundi, data show that female prisoners have a much higher HIV prevalence (14.3%, 5.0% respectively) compared to male prisoners (4.0%, 2.0% respectively).

In Benin, the proportion of female to male prisoners is 1:5. According to the 2015 IBBS only 29.3% have a proficient level of information about HIV. In 2014, the country recorded 7,656 prisoners, despite the fact that the total capacity of the prisons is set at 3,600 (212% above capacity). The health services in prison are known to be underequipped and this affects HIV services (Concept Note 2015).

Little else is known about the prisoner population and HIV prevalence rate among prisoners in the other countries.

Transgender People

Transgender people are not included as a key population in this regional report. Data on TG were not available for any of the countries except for Sierra Leone, which reported a TG population of 500 and Benin where a situation assessment has recently been carried out. No country reports national estimates of HIV prevalence among TG.

The Benin study included both transgender men and women. The study clearly shows that the MSM peer education programs have been successfully reaching out to TG: 91.1% of TG in the study had ever had an HIV test, 94.3% of them had benefited from HIV prevention sessions in the past six months and 86.6% used a condom the last time they had sex. Around 72% of those surveyed had good knowledge about how to prevent sexual transmission of HIV. Although 75.6% of TG know of a public healthcare center where they can be treated for an STI, 57% prefer going to a private healthcare center even if it costs more and the quality of service is not always good. This mitigates exposure to potential stigma and discrimination.

ANALYSIS: DO WE KNOW WHAT WE NEED TO KNOW ABOUT KEY POPULATIONS IN WEST AND CENTRAL AFRICA?

Overall, the answer is no. It is true that population size data for key populations are available for MSM, PWID and FSW in most of the assessed countries. This was not the case several years ago when the size of key populations was largely unknown. However, in most countries assessed, there are problems with population size estimates (PSE). As these are the denominators from which all other key data is derived – including coverage figures, prevalence of HIV among KP and the need of testing and
treatment – it is important to ensure that PSE are as accurate as they can be under local conditions. The stigma and discrimination experienced by KP in the countries of the region (see Implementation section) appears to play a strong role in under-estimating KP population sizes. For example, the percentages of national populations estimated to be men who have sex with men are remarkably low by global standards. Work by Johns Hopkins University has provided much larger population estimates in 13 countries by using social media for sampling (Baral et al, 2018), and this work suggests that these expanded estimates can be extrapolated to other countries.

Another important issue is the lack of available data on prisoners in some countries. This is likely to be an issue of vertical control of information in which prisons data held by the Ministry of Justice (or similar) is not shared with the Ministry of Health. Likewise, the almost complete lack of data on TG in the region is problematic.

Understanding the size and epidemiology of key populations is critical for appropriate design, implementation and monitoring of services. Given the diversity of country definitions for different key populations, different data sources, survey designs and years of administration, it should be noted that all further findings from these assessments should be viewed with caution. Underestimates of population sizes will produce artificially inflated statistics on service reach and may give the impression of coverage that reaches epidemiologically significant levels, when in reality a significant, hidden portion of the population at risk remains unreached.

However, it should be noted that the lack of a sufficiently robust PSE is not an excuse for inaction. Programs can start in the absence of a PSE and the programmatic staff can assist in developing a size estimate over time. It should also be noted that there are inherent limitations in measuring an epidemic by its prevalence alone. Prevalence measures the proportion of the people with HIV in the population. This can drop sharply if treatment access or uptake drops and more PLHIV die. It is important to also have access to high-quality, up-to-date incidence data – how many new people from the population are becoming infected – and to ensure universal access to HIV testing so that incidence figures are accurate. It may be possible by disaggregating prevalence data by age to use the number of young members of HIV-positive KP as a proxy for new infections.
PART II: DESIGN AND DOCUMENTATION OF SERVICE PACKAGES

KEY POINTS

- National strategies and plans were available for most countries in this assessment, except for Côte d’Ivoire.
- Service packages were found to be similar for all identified key populations (except for harm reduction interventions for PWID) with minimal variation across packages and, generally, a lack of specific interventions that are tailored to meet the unique needs of each population.
- The KP for whom national service package designs are available vary across the region.
- Service packages were found to be similar for MSM and SW, but there was a lack of inclusion of several key interventions including widespread availability of lubricant and several countries’ designs included few or no critical enabler activities.
- Where PWID are included in designs, most countries have only very limited harm reduction interventions.
- Little detail is available on prisoner programming and virtually none on TG programming.

For the countries assessed, consultants were able to review national strategies and plans in order to understand the service packages designed for key populations. In two countries, other documents were examined. In Sierra Leone, the most recent service package for key populations is described in the Program Implementation Plan Global Fund HIV Grant Continuation (PIP) 2018-2020, developed by the National AIDS Secretariat (NAS) of Sierra Leone. In Côte d’Ivoire, service packages for FSW, MSM and TG were described in PEPFAR (LINKAGES) documents and in Global Fund PR documents for SW, MSM, people who use drugs (PWUD) and prisoners. These service packages are referenced in the national strategy.

For the other countries, not all of the national strategies and plans were found to be current. Table 5 details the national documents reviewed for all ten countries and, among these, seven had timeframes that ended in 2017 or earlier. In some cases, national strategies were still in use and extended for a period of time. For example, in Cape Verde, the National Strategic Plan 2017-2020 was not yet available at the time of the assessment. Until the new plan was made available, the previous plan (2011-2015) had been extended for another two years.

Table 5 below summarizes the key populations identified in national reference documents where packages are documented. Table 6 summarizes which key populations are officially acknowledged in each country.
Table 4. Key Populations Identified in Countries Assessed
*Notes desk-review only country

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Identified in Nationally Endorsed HIV Strategies/Plans</th>
<th>Document(s) Defining Service Packages for Key Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>FSW, MSM, PWID, prisoners(^\text{24})</td>
<td>Minimum Service Package for Key Populations in Benin, 2016</td>
</tr>
<tr>
<td>Burundi(^*)</td>
<td>MSM, FSW, PWID</td>
<td>National Strategic Plan to Fight AIDS 2014-2017</td>
</tr>
<tr>
<td>Cameroon</td>
<td>FSW, MSM, PWID, prisoners</td>
<td>National Strategic Plan to Fight Against HIV, AIDS and STIs 2014-2017</td>
</tr>
<tr>
<td>Cape Verde(^*)</td>
<td>MSM, SW, PWID</td>
<td>National Strategic Plan 2011-2015</td>
</tr>
<tr>
<td>Côte d’Ivoire(^*)</td>
<td>MSM, FSW, PWUD(^\text{25}), prisoners</td>
<td>National Strategic Plan 2016-2020 (service packages elaborated in PEPFAR and Global Fund documents)</td>
</tr>
<tr>
<td>Nigeria(^*)</td>
<td>FSW, PWID, MSM</td>
<td>National HIV and AIDS Strategic Framework 2017-2021</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>MSM, PWID, FSW</td>
<td>Program Implementation Plan Global Fund HIV Grant Continuation 2018-2020</td>
</tr>
<tr>
<td>Togo</td>
<td>PWID, SW and their clients, MSM, prisoners</td>
<td>National Policy—Prevention, TCS of KP, 2013</td>
</tr>
</tbody>
</table>

Table 5. Key Population Identified in National Strategies for 10 assessed countries
*Notes desk-review only country

<table>
<thead>
<tr>
<th>Country</th>
<th>MSM</th>
<th>PWID</th>
<th>SW</th>
<th>Prisoners</th>
<th>TG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Burundi(^*)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

\(^{24}\) Identified as a “vulnerable population”, but interventions similar to those for other identified key populations

\(^{25}\) Including PWID
The process to develop key populations packages is described in many national strategies and plans. Below are examples:

- In Togo, the national prevention policy was endorsed in a validation meeting in July 2013 with 50 participants from the public sector and civil society, including representatives from key population NGOs, mainly SW peer educators.
- In Sierra Leone, key population representatives are included in the CCM and during interviews many key population leaders felt meaningfully included in the Global Fund Program Implementation Plan design, implementation and ongoing monitoring. Opportunities exist to improve the meaningful involvement of TG, prisoners and PWID.
- In Benin, a series of validation meetings took place in which three members of key populations NGOs (2 MSM and 1 FSW) participated out of a total of 25 local participants and endorsed the minimum service package for key populations. Key populations were consulted through individual and group discussions during the development of the minimum service package.
- In Burundi, representatives of key population CSOs were involved in the participatory process of developing the Plan Stratégique National de Lutte Contre le SIDA (2014-2017), which was developed in response to the mid-term evaluation of the 2012-2016 strategic plan.
- In Nigeria, the National HIV and AIDS Strategic Framework (2017-2021) was developed through participatory and consultative processes towards the vision of having an “AIDS-free Nigeria with zero new infections and zero AIDS-related discrimination and stigma”.

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26 Is identified as People Who Use Drugs (PWUD) to include injecting and non-injecting drug users.
Attention to critical enablers is not described absent in several countries’ package designs and, where present, often refers to all KP as a single group. Below are set out specific critical enabler activities for each KP. The following apply to all KP in Ghana, Mali, Nigeria and Togo related to laws and policies:

- **Ghana**: Legal protections for KP rights to access services; advocacy to lawmakers on finalizing the Ghana HIV and AIDS Bill; review of legislation that discriminates against and enacting laws that reduce discrimination against KP; technical and material assistance for Law Enforcement Agencies to ensure respect of rights of KP and protection from harassment and abuse by the general public and by the Services themselves.
- **Mali**: Evaluation of cases of violations of the rights of KP; provision of legal support to KP.
- **Nigeria**: Development of national policies, regulations, protocols and laws regarding provision and access of target populations to friendly HIV prevention services; support for organizations to advocate for the revision and repeal of laws, policies and programs that hinder access of key and vulnerable population to HIV prevention services; promote access to justice for KP through use of community-based and institutionalized mechanisms; education of PLHIV about HIV and AIDS Anti-discrimination Act and how to seek justice.
- **Togo**: Advocacy for rights of KP and against GBV, and for an environment conducive to support of PLHIV and KP including advocacy for the adoption of a legal framework favorable to prevention and care of KP.

The following apply to all KP in Ghana, Nigeria and Sierra Leone related to stigma and discrimination:

- **Ghana**: Partner with the media to ensure visibility of critical issues including *Know Your Status* campaign and reducing stigma and discrimination against KP campaign; engage with traditional authorities and religious leaders to reduce HIV and AIDS stigma and discrimination; reduce stigma and discrimination in health settings; involve PLHIV in anti-stigma and discrimination activities.
- **Nigeria**: Strengthen interventions targeted at reducing stigma and discrimination against PLHIV, vulnerable and key populations; advocate for health care institutions to institute punitive measures for health care providers who stigmatize PLHIV; educate PLHIV of existing support mechanisms to address stigma and discrimination; conduct awareness and sensitization at community level for prevention of HIV stigma and discrimination.
- **Sierra Leone**: For all KPs: The goal is to see "PLHIV, EVDS and Key Populations at most risk of HIV that are empowered and participating effectively in advocacy and program interventions to eliminate stigma and discrimination increased from 2015 level to twice that level by 2020".

The following apply to all KP in Ghana, Nigeria and Togo related to community empowerment:

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27 Ebola Virus Disease Survivors
Ghana: Identify and develop effective partnerships with community level actors (CBOs, NGOs and faith-based organizations (FBOs)), spearheading behavior change interventions for KP; support meaningful involvement of PLHIV in the national response.

Nigeria: Improve community participation, support and uptake of HIV prevention services through engagement of existing and new community structures; strengthen community structures for provision of equitable HIV prevention interventions; build linkages and partnerships between PLHIV networks, key populations, community-based organizations and other community actors, and strengthen the coordination mechanisms for optimal impact; build the knowledge and capacity of community actors, service providers and CBOs, and support them technically to function effectively in HIV prevention, treatment and care services.

Togo: Encourage the establishment of organizations of KP; establish a national coordination system involving community organizations recipients; take into account KP-specific needs in the development of interventions targeting KP.

The following apply to all KP in Ghana related to interventions to reduce violence: Work with stakeholders to address GBV and for PLHIV, create an enabling environment for justice for survivors of sexual violence. Togo calls for advocacy against GBV across all KP.
Men who have Sex with Men (MSM)

All 10 countries identify MSM as a key population in their national strategies. In Côte d’Ivoire, the service package for MSM is described in PEPFAR and Global Fund grant documents and subsequently referenced in the national strategy.

Two countries (Burundi and Cape Verde) do not include lubricant along with condom programming in their service packages for MSM. Three countries (Benin, Burundi and Nigeria) conduct social marketing of condoms. Seven countries include information, education and communication (IEC) and behavior change communication (BCC) materials targeted to MSM and six countries nominate peer education as a strategy to reach out to MSM. HIV testing and counseling as well as ART provision or referral is included in the service packages specific to MSM for all countries, although it is not explicit in the national strategy for Mali. All countries except for Mali include TB services. Benin and Ghana also include viral hepatitis testing and treatment. Mental health services are only included in Benin. All countries except for two include STI screening, testing and treatment (or referral).

Only Ghana and Togo include activities in all four critical enabler categories (namely supportive legislation and policy, addressing stigma and discrimination, community empowerment, addressing violence against people from key populations), but these are for all KP and are not specified separately to MSM. Critical enabler activities specifically for MSM in designs are noted below. Several countries have few or no critical enabler activities in their MSM package designs.

Table 6. Comparison of HIV Services for MSM as Defined in WHO Global Guidance versus National Packages of Services

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>All countries except for Burundi and Cape Verde include lubricant along with condom promotion and distribution in their service package for MSM. Benin, Burundi and Nigeria conduct social marketing of condoms. In Benin, Côte d’Ivoire and Togo, activities are conducted to promote the correct and systematic use of condoms and lubricant, such as through the use of IEC materials, demo kits and pictograms (Benin). Nigeria plans to conduct a condom needs assessment to identify barriers and aims to strengthen logistics and supply chain management including improving variety of condoms.</td>
</tr>
<tr>
<td>2. Behavioral interventions</td>
<td>Service packages in all countries except for Cameroon and Mali explicitly include BCC and IEC materials for MSM. The range of topics varies by country, including HIV and STI prevention, evaluating the risk of contamination, risk reduction, testing, treatment, condom demonstration,</td>
</tr>
</tbody>
</table>
family planning, human rights, life skills, promotion of healthy lifestyles. Several countries, including Benin, Burundi, Cameroon, Côte d’Ivoire, Ghana and Togo, include peer education. Activities include individual or group sessions, support groups, film projections and debates, based on peer education on prevention of STI and HIV transmission. Social media and mobile phone applications also play a role in disseminating information in Benin and Ghana. Cameroon focuses on community-based interventions such as Pride and other human rights campaigns and outreach at MSM hotspots.

3. HIV testing and counseling (HTC)

All countries include HIV testing and counseling. In Cameroon and Sierra Leone, this includes promotion of disclosure of HIV status to regular sexual partners. HTC is to be promoted and provided at all levels – community-based (Benin, Burundi, Cameroon), provider and client-initiated (Cameroon), private sector (Burundi) and mobile clinics (Cameroon, Cape Verde).

4. HIV treatment and care

All countries include ART, although for Mali, provision or referral to ART is not explicit in the service package design. In some countries, ART initiation is combined with community-based outreach and support (e.g. home visits) to ensure treatment adherence, monitoring and overall case management (includes addressing side effects of ART). Care includes support groups, treatment adherence clubs, psychological support, social support (nutritional, economic, legal, hygiene and sanitation advice), palliative care including symptom management, grief care, home-based care and literacy on self-care. In Côte d’Ivoire, other services include GBV screening, PEP and referral to clinical or GBV services or legal aid, treatment literacy and access to viral load testing. Benin also provides PrEP. In Ghana, PEP is specified in cases of rape and sexual assault. Nigeria is developing policies and guidelines for PrEP and PEP.

5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions

All countries except for Mali include coordination for TB screening, testing, diagnosis and referral for treatment. Benin and Ghana also include preventing and testing for hepatitis B and C and referral to treatment. Benin, Cameroon and Ghana service packages include vaccination against hepatitis B. Benin and Nigeria also include services for the prevention of malaria and referral to specialized service provider for mental health issues.
### 6. Sexual and reproductive health interventions

All countries except for Mali and Nigeria include STI services, including STI information, screening, diagnosis and referral for treatment as part of the service package for MSM. The service package for MSM in Burundi also includes the promotion of male circumcision; Burundi and Côte d'Ivoire, include the prevention and management of sexual violence based on gender (GBV).

### 7. Supportive laws and policies

Not mentioned in designs in Benin, Cameroon, Cape Verde and Côte d’Ivoire. Burundi includes a general statement on strengthening the protection of the rights of MSM. Mali includes legal support for MSM. No specific MSM activities mentioned for Ghana, Togo and Sierra Leone.

### 8. Addressing stigma and discrimination

Not mentioned in designs in Benin, Burundi, Cameroon, Cape Verde, Côte d’Ivoire or Mali. No specific MSM activities mentioned in other countries’ designs.

### 9. Community empowerment

Not mentioned in designs in Cameroon, Côte d’Ivoire, Mali or Sierra Leone. The Benin and Burundi designs include strengthening collaboration with MSM associations and building the skills of MSM peer educators. Cape Verde mentions capacity building of peer educators. No specific MSM activities mentioned in other countries’ designs.

### 10. Addressing violence

Not mentioned in designs in Benin, Burundi, Cameroon, Côte d’Ivoire, Mali, Nigeria, Sierra Leone or Togo. No specific MSM activities mentioned in Ghana’s design.

**Sex Workers (SW)**

There are many similarities between the service package for SW and MSM across the 10 countries. SW are identified in all national strategies as a key population with the majority of countries focusing on female sex workers (FSW). In Sierra Leone, a sex worker is usually referred to in documents as FSW, and transgender women are sometimes captured in MSM data. There are limited data available on male sex workers.

In terms of comparison of country service packages to the WHO Consolidated KP Guidance, the majority of countries include most interventions. Again, Burundi and Cape Verde do not include lubricant along with condom programming in their service packages. Only five countries are explicit that they include both male and female condoms. Seven out of the 10 countries include IEC and BCC materials on a range of topics, which are used by peer educators in outreach activities. Individual and group sessions, films, debates, social media are all strategies identified to disseminate information as behavioral interventions. All countries include HTC and provision or referral to ART – although in Mali, the provision/referral to ART is not explicit. The majority of countries, except for Mali, include coordination with TB services while only a couple of countries include viral hepatitis screening, testing.
and treatment. Sexually-transmissible infection services are included in all countries except for Mali and Nigeria. Other sexual and reproductive health interventions that may be found in some countries include family planning, cervical cancer screening, promotion of male circumcision, PMTCT, gender-based violence (GBV) prevention and related services.

Only Ghana includes activities in all four critical enabler categories, but these are for all KP and are not restricted to SW. Critical enabler activities specifically for SW in designs are noted below. Several countries have few or no critical enabler activities in their SW package designs.

Table 7. Comparison of HIV Services for SW as Defined in WHO Global Guidance versus National Packages of Services

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<thead>
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<th>SW</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>All countries except for Burundi and Cape Verde include lubricant with condom promotion and distribution in their service package for SW. Service packages in Burundi, Cameroon, Cape Verde, Nigeria and Togo are all explicit in promoting and providing both female and male condoms. Benin, Burundi and Nigeria conduct social marketing of condoms. In Benin, Côte d’Ivoire and Togo, activities are set out to promote the correct and systematic use of condoms and lubricant, such as through the use of IEC materials, demo kits and pictograms (Benin). Nigeria plans to conduct a condom needs assessment to identify barriers and aims to strengthen logistics and supply chain management including improving variety of condoms.</td>
</tr>
<tr>
<td>2. Behavioral interventions</td>
<td>Service packages in all countries except for Nigeria, Cameroon and Mali explicitly include BCC and IEC materials for SW. The range of topics varies by country, including HIV and STI prevention, evaluating the risk of contamination, risk reduction, testing, treatment, condom demonstration, family planning, human rights, life skills and promotion of healthy lifestyles. Several countries, including Benin, Burundi, Cameroon, Côte d’Ivoire, Ghana and Togo, identify peer education. Activities include individual or group sessions, support groups, film projections and debates. Cameroon also includes community-based support through drop in centers and hotspot outreach. Social media and mobile phone applications are also identified as a means of disseminating information in Benin and Ghana.</td>
</tr>
</tbody>
</table>
3. HIV testing and counseling (HTC)  
All countries include HIV testing and counseling. In Cameroon and Sierra Leone, this includes promotion of disclosure of HIV status to regular sexual partners. HTC is promoted at all levels – community-based (Benin, Burundi, Cameroon), provider and client-initiated (Cameroon), private sector (Burundi) and mobile clinics (Cameroon, Cape Verde).

4. HIV treatment and care  
All countries include ART, although for Mali, provision or referral to ART is not explicit in the service package design. In some countries, ART initiation is combined with community-based outreach and support (e.g. home visits) to ensure treatment adherence, monitoring and overall case management (includes addressing side effects of ART). Care includes support groups, treatment adherence clubs, psychological support, social support (nutritional, economic, legal, hygiene and sanitation advice), palliative care including symptom management, grief care, home-based care and literacy on self-care. 
In Côte d’Ivoire, other services include GBV screening, PEP and referral to clinical or GBV services or legal aid, treatment literacy and access to viral load testing. Benin also provides PrEP.
In Ghana, PEP is provided in cases of rape and sexual assault. Nigeria is developing policies and guidelines for PrEP and PEP.

5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions  
All countries except for Mali include coordination for TB screening, testing, diagnosis and referral for treatment. Benin and Ghana also include preventing and testing for hepatitis B and C and referral to treatment. Benin, Cameroon and Ghana service packages include vaccination against hepatitis B. Benin and Nigeria also provide services for the prevention of malaria and referral to specialized service provider for mental health issues.

6. Sexual and reproductive health interventions  
All countries except Mali set out STI services including STI information, screening, diagnosis and referral for treatment as part of the service package for SW. Other services include:
- Benin: Social marketing of contraceptive methods and cervical cancer screening
- Nigeria and Cameroon: Family planning
- Burundi: Prevention of unintended pregnancies in HIV-positive women; prevention of mother-to-child transmission (PMTCT)
- Burundi, Côte d’Ivoire: Prevention and management of sexual violence based on gender (GBV).
7. Supportive laws and policies

Not mentioned in designs in Cameroon, Cape Verde, Cote d’Ivoire. Benin calls for advocacy for politico-administrative authorities, public security forces and health workers towards regulation of the sex industry; while Burundi includes a general statement on strengthening the protection of the rights of SW. No specific SW activities mentioned in other countries’ designs.

8. Addressing stigma and discrimination

Not mentioned in designs in Benin, Burundi, Cameroon, Cape Verde, Cote d’Ivoire and Mali. No specific SW activities mentioned in other countries’ designs.

9. Community empowerment

Not mentioned in designs in Benin, Cameroon, Cote d’Ivoire and Mali. The Burundi design includes strengthening collaboration with SW associations and building the skills of SW peer educators. Cape Verde mentions capacity building of peer educators. No specific SW activities mentioned in other countries’ designs.

10. Addressing violence

Only Ghana and Togo mention activities, but not specific to SW.

**People who Inject Drugs (PWID)**

Out of the 10 countries assessed, nine identified people who inject drugs (PWID) as a key population in their national strategies. Mali is the only country that does not include PWID as a key population.

Despite PWID being included as a key population, many of the national strategies either do not define a package of services (Cameroon, Côte d’Ivoire) or only include some of the interventions (Burundi) as recommended by WHO. In Burundi, services for PWID are limited to preventing sexual transmission of HIV, with no harm reduction strategies in the country’s designed package. In Côte d’Ivoire, the service package is described in Global Fund grant documents but not described in the national strategy. In Ghana, there is a notable lack of harm reduction services targeted to PWID because, according to the National HIV & AIDS Strategic Plan (2016-2020), “Injecting drug use is thought to be low” (GAC, 2016). In Nigeria, there are no needle syringe programs (NSP) or opioid substitution (OST) programs set out. In Sierra Leone, the package does not include access to NSP, OST and overdose prevention.

Seven out of the nine countries include both condoms and lubricant for PWID. Provision of both male and female condoms is explicit in four out of the nine countries – Burundi, Cape Verde, Nigeria and Togo. Needle and syringe programs and OST are offered in four countries (Benin, Cameroon, Ghana, Togo). Materials on IEC and BCC are to be made available and disseminated to PWID except in Nigeria where the national strategy is not explicit in its informational outreach to this key population. Peer education is a key strategy in all countries. Both HIV testing and counseling and provision or referral to ART are included in the service package for PWID in all countries. Tuberculosis services are included
in all countries except for Côte d’Ivoire and just two countries (Benin, Ghana) provide viral hepatitis testing and treatment as well as the hepatitis B vaccine. Mental health services are not included in the majority of countries. Finally, STI screening, testing, diagnosis and treatment is included, with the exception of Nigeria.

Table 8. Comparison of HIV Services for PWID as Defined in WHO Global Guidance versus National Packages of Services

<table>
<thead>
<tr>
<th>PWID</th>
<th>WHO Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>All nine countries except for Burundi, Cape Verde and Côte d’Ivoire include lubricant along with condom promotion and distribution in their service package for PWID. Service packages in Burundi, Cape Verde, Nigeria and Togo are all explicit in promoting and providing both female and male condoms. Benin, Burundi and Nigeria conduct social marketing of condoms. In Benin and Togo, activities are conducted to promote the correct and systematic use of condoms and lubricant, such as through the use of IEC materials, demo kits and pictograms (Benin). Nigeria plans to conduct a condom needs assessment to identify barriers and aims to strengthen logistics and supply chain management including improving variety of condoms.</td>
</tr>
<tr>
<td>2. Harm reduction interventions for substance use (in particular, NSP and OST)</td>
<td>Among the nine countries, five do not include NSP or OST in their service packages for PWID. These countries are Burundi, Cape Verde, Côte d’Ivoire, Nigeria and Sierra Leone. Benin promotes NSP using a fixed and outreach strategy for PWID, an OST program in health structures close to PWID and an addictology center for treatment and care of PWUD. Togo also promotes NSP, OST and treatment of addictions. Sierra Leone promotes safe injection practice (avoidance of needle sharing) among peers. Nigeria’s harm reduction strategies focus on reducing the re-use of needles by PWID and encourage safer sex practices. Finally, in Ghana, if injecting drug use increases, the national strategy includes the provision of safe injection kits, OST, overdose management, drug detoxification and drug dependence treatment.</td>
</tr>
<tr>
<td>3. Behavioral interventions</td>
<td>Service packages in all countries except for Nigeria explicitly include BCC and IEC materials for PWID.</td>
</tr>
</tbody>
</table>
The range of topics varies by country, including HIV and STI prevention, evaluating the risk of contamination, risk reduction, testing, treatment, condom demonstration, family planning, human rights, life skills, promotion of healthy lifestyles. Several countries, including Benin, Burundi, Côte d’Ivoire, Ghana and Togo, identify peer education. Activities include individual or group sessions, support groups, film projections and debates, based on peer education on prevention of STI and HIV transmission. Social media and mobile phone applications are identified to play a role in disseminating information in Benin and Ghana.

4. HIV testing and counseling (HTC)
All countries include HIV testing and counseling. In Sierra Leone, this includes promotion of disclosure of HIV status to regular sexual partners. HTC is to be promoted and provided at all levels – community-based (Benin, Burundi), private sector (Burundi) and mobile clinics (Cape Verde).

5. HIV treatment and care
All countries include ART. In some countries, ART initiation is to be combined with community-based outreach and support (e.g. home visits) to ensure treatment adherence, monitoring and overall case management (includes addressing side effects of ART). Care includes support groups, treatment adherence clubs, psychological support, social support (nutritional, economic, legal, hygiene and sanitation advice), palliative care including symptom management, grief care, home-based care and literacy on self-care. Nigeria is developing policies and guidelines for PrEP and PEP and aims to establish centralized care (one-stop-shop) for service delivery for PWID.

6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions
All countries except for Côte d’Ivoire include coordination for TB screening, testing, diagnosis and referral for treatment. Benin and Ghana also include preventing and testing for hepatitis B and C and referral to treatment as well as vaccination against hepatitis B. Benin and Nigeria also include services for the prevention of malaria and referral to specialized service provider for mental health issues. Ghana includes injection site care.

7. Sexual and reproductive health interventions
All countries except for Nigeria include STI services including STI information, screening, diagnosis and referral for treatment as part of the service package for PWID.

8. Supportive laws and policies
Not mentioned in designs in Burundi, Cameroon, Cape Verde, Côte d’Ivoire. Benin calls for organizing advocacy.
sessions for politico-administrative authorities. While Mali does not list PWID as a KP in its NSP, there is a provision for legal support to PWID. In addition to its overall KP activities related to laws and policies, Nigeria calls for a review of policies where available or development of policies to facilitate an enabling environment for implementing harm reduction packages for PWID. No specific PWID activities mentioned in other countries’ designs.

9. Addressing stigma and discrimination
Not mentioned in designs in Benin, Burundi, Cameroon, Cape Verde and Cote d’Ivoire. No specific PWID activities mentioned in other countries’ designs.

10. Community empowerment
Not mentioned in designs in Burundi, Cameroon, Cote d’Ivoire and Sierra Leone. The Benin and Cape Verde designs include building the skills of PWID peer educators. No specific PWID activities mentioned in other countries’ designs.

11. Addressing violence
The service package for PWID in Côte d’Ivoire, includes the prevention and management of sexual violence based on gender (GBV). Ghana and Togo mention activities, but not specific to PWID.

Prisoners
Only five out of the 10 countries identified prisoners as a key population. These countries were Benin, Cameroon, Côte d’Ivoire, Ghana and Togo. Côte d’Ivoire does not include condoms and lubricant; Togo includes both male and female condoms. Harm reduction interventions are not included in any of the service packages except for Ghana, which is contingent on an increased need among prisoners. Materials for IEC and BCC are included in all country packages as well as HIV testing and counseling and provision of ART in prison infirmaries or referrals to a specialized health facility. All ten countries except for Côte d’Ivoire include the offer of services for the prevention, diagnosis and treatment of opportunistic infections including TB and viral hepatitis. Services for STI are also included for prisoners in all countries.

Table 9. Comparison of HIV Services for Prisoners as Defined in WHO Global Guidance versus National Packages of Services

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Prisoners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Three (Benin, Ghana, Togo) out of the five countries include condoms and lubricant to prisoners although it was noted for both Benin and Ghana, that advocacy is</td>
</tr>
</tbody>
</table>
required to ensure this service is realized. Togo includes both male and female condoms and also calls for the correct and systematic use of condoms and lubricant.

2. Harm reduction interventions for substance use (in particular, NSP and OST)

Ghana is the only country that includes some harm reduction interventions although very limited to bleach/decontamination for safer injection and tattooing, and if the numbers of PWID are high or levels of drug dependency are identified, safe injection kits, OST and drug detoxification and dependence treatment are provided.

3. Behavioral interventions

All five countries identify behavioral interventions. These include IEC/BCC materials in the form of leaflets, demo kits for condoms, pictograms, films and other visual displays.

The range of topics varies by country, including HIV and STI prevention, evaluating the risk of contamination, risk reduction, testing, treatment, condom demonstration, family planning, human rights, life skills, promotion of healthy lifestyles, individual hygiene and prevention of violence.

All five countries call for peer education. Activities include individual or group sessions, support groups, films projections and debates.

4. HIV testing and counseling (HTC)

All five countries include HTC access. In Benin: HTC is to be offered in the prison infirmary and systematically proposed at each medical visit and during testing campaigns. In Togo, HTC is included at entry and periodically.

5. HIV treatment and care

All countries except for Côte d’Ivoire include ART in prisons or referral to a health facility. Care includes psychological support and social support (nutritional, economic, legal, family reinsertion), palliative care including symptom management and grief care.

6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions

In all countries except for Côte d’Ivoire, prisoners are to be offered services for the prevention, diagnosis and treatment of opportunistic infections including TB, viral hepatitis, including vaccination against hepatitis B, although for Togo, the national strategy is not explicit and indicates “treatment of opportunistic infections and co-morbidities related to HIV.” In Benin, prisoners are also to be offered specialized medical consultations (dermatology, pneumatology, psychiatry etc.).

7. Sexual and reproductive health interventions

All five countries include STI screening, testing, diagnosis and treatment.
8. Supportive laws and policies

Not mentioned in designs in Burundi or Cote d’Ivoire. Benin calls for advocacy towards penitentiary authorities. No specific prisoner-related activities mentioned in other countries’ designs.

9. Addressing stigma and discrimination

Not mentioned in designs in Benin, Burundi, Cameroon, Cape Verde, Cote d’Ivoire. No specific prisoner-related activities mentioned in other countries’ designs.

10. Community empowerment

Not mentioned in designs in Burundi, Cameroon, Cote d’Ivoire and Sierra Leone. The Benin and Cape Verde designs includes building the skills of PWID peer educators. No specific prisoner-related activities mentioned in other countries’ designs.

11. Addressing violence

Ghana and Togo mention activities, but not specific to prisoners.

ANALYSIS: ARE PACKAGE DESIGNS MEETING INTERNATIONAL STANDARDS?

All of the assessed countries have taken the opportunity to formally recognize some key populations in their national plans and strategies and have acknowledged the importance of designing service packages for key populations based on the WHO Global Guidance. However, this is not the case for TG, who are not substantively discussed in this regional report due to the lack of data on and/or lack of inclusion of this key population in national strategies. It should be acknowledged that transgender people have been addressed in many countries as a subset of MSM, but the point being made here is that there are no service packages in the assessed countries specifically designed for TG. Only five countries identified prisoners as a key population in their national strategies.

The majority of service packages for the identified key populations are similar in their design with slight deviations mostly related to interventions for people who inject drugs (PWID) and some related to female sex workers (FSW). Overall, key interventions recommended in the WHO Global Guidance are mostly included in service packages for key populations including condom and (in most cases) lubricant programming, behavioral interventions, HIV testing and counseling, ART provision and referral, coinfection and comorbidity (specifically TB) management and STI services.

It is of concern that Burundi and Cape Verde do not include lubricant along with condoms in service packages for MSM and FSW, and only five of the 10 assessed countries explicitly include both male and female condoms for FSW. Similarly, of nine countries that identified PWID as a key population, only four are providing NSP and OST, and only Benin and Ghana provide viral hepatitis testing and treatment as well as the hepatitis B vaccine.

A key issue is where male sex workers fit into key populations programming. Recalling that several countries in the region have found substantial groups of MSM who sell and pay for sex, it should be
expected that either SW or MSM programming would ensure that needs of male sex workers and their clients are taken into account, but this does not seem to be the case across the countries assessed.

While behavioral interventions, primarily BCC and IEC materials are universally included in packages, it is unclear what exactly is produced, whether the materials and products have impact or whether the means of dissemination is the most effective.

The absence of mental health services in all countries is noteworthy as well as the absence of PrEP and PEP. The majority of countries do not include PrEP or PEP in their service packages with a few exceptions (PrEP in Benin, PEP in Côte d’Ivoire and Ghana).

Country and regional data on the prison population are scarce and therefore little attention is given to the needs of prisoners in national strategies. Service packages offered mostly follow the WHO Global Guidance with the exception of harm reduction interventions, which are not identified in any of the five countries.

Prevention and treatment of co-infections are inconsistent across countries. While linkage to TB services is identified in nearly all countries, it is not included in the service package for all key populations. This includes the lack of opportunistic infection prevention and management for prisoners in Côte d’Ivoire and TB services for MSM and SW in Mali. Sexual and reproductive health interventions, namely STI prevention and treatment services are included in all countries with the exception of two countries not identifying these services to PWID.

For the critical enablers, the situation is bleaker but, again, it is likely that most of the assessed countries had few or no such activities in their previous strategic plans relating specifically to KPs. Some of the major issues noted in these activities were:

- Lack of most critical enabler activities in several countries (Burundi, Cameroon, Cote d’Ivoire and Sierra Leone) though it should be noted that all these countries except Burundi have recently participated in Baseline Assessments of human rights barriers to HIV service access and are planning to scale up their critical enabler interventions over the next few years.
- An apparent lack of understanding around the term ‘community empowerment’ which in several countries, seems to be restricted to training peer educators. Exceptions to this were the much more comprehensive references to community empowerment activities in Ghana, Nigeria and Togo.
- An almost complete lack of attention to violence and GBV towards KP.

RECOMMENDATIONS: DESIGN OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Defined packages of services should include services for all key populations which have been identified in the country. There may be minor variations depending on local epidemiology and behavior.
2. All countries in the region require at least the basic services for each key population to be in the designed service packages. All key population packages should contain condoms and lubricants distribution; with female condoms at least included in all SW programs; and needles and syringes included in at least all PWID programs.

3. Needs-based services should also be included in service packages for all key populations, including the offer of PEP, STI, TB and hepatitis B and C services. Pre-exposure Prophylaxis should be included to be offered to at least MSM, TG and SW.

4. Critical enabler activities should be specified in all KP packages. Assessments on human rights barriers to KP access to HIV services have been carried out in some of the reviewed countries (Benin, Sierra Leone, Cameroon and Cote d’Ivoire). Similar exercises should be carried out in all countries. All countries should have a strategy to address ongoing human rights issues that impact key populations’ access to HIV and broader health services. This strategy should be explicitly linked to overall national HIV strategies and plans.

5. All countries should continue to progress towards clear definitions of coverage of all elements of service packages.

6. Where mental health interventions are to continue to be included in service packages, there is a need for greater understanding of the mental health needs of different key populations and therefore more thoughtful and well-described interventions included in service packages and adequate resourcing of these services.

7. The development of minimum standards for behavioral interventions, which are attuned to population needs, would ensure that the intent of the design of this intervention carries over into appropriate resource mobilization and implementation as well as impact.
PART III: IMPLEMENTATION AND SERVICE USAGE

KEY POINTS
- There is a deviation from the design in many countries.
- Extremely variable coverage across the five in-country assessment countries.
- For MSM, key issues include concerns about the numbers of condoms and amount of lubricant distributed; types and methods of education; and particularly linkage to care for HIV-positive MSM. PrEP is only being implemented at a very low level in the region.
- FSW in all five in-country assessment countries complained about the number of condoms and amounts of lubricant provided and reported dissatisfaction at quarterly HIV testing.
- Little emphasis has been placed on services for PWID to date.
- Prisoner programming and programs for TG have little coverage data.

In West and Central Africa, the range and quality of services delivered under KP service packages differs considerably from country to country. In all countries assessed, KP (and therefore the burden of HIV among KP) are not evenly distributed across the country, so decisions have to be made about geographical distribution. In most countries, services are concentrated (along with populations) in the urban centers of the jurisdictions with the highest prevalence. This has led to some under-servicing (and sometimes no dedicated servicing of KP in rural areas or in lower-prevalence provinces).

In this region, mostly civil society and governmental providers deliver service packages along the HIV continuum. Private clinics play less of a role in the delivery of HIV services for key populations. Prevention services are provided primarily by NGOs and CBOs (including faith-based), often utilizing peer educators or peer navigators to conduct outreach or drop-in in ‘hot spots’ where PWID, MSM and FSW are found in the greatest density. Services may be provided through mobile outreach (e.g. through mobile units) or at static locations (e.g. drop-in centers). A common issue with outreach services in the region is the threat of abuse or violence towards outreach workers, particularly among MSM. Counseling and testing is provided in both community and clinic settings to varying degrees.

The point of intersection between government and non-government service providers tends to be either HIV testing or linkage to care. In the five countries visited, NGOs or CBOs are able to deliver community-based rapid testing on site (either mobile or static) and conduct referrals or accompaniment to care only for those who test positive. In sites where community testing is not available, clients are passively referred or accompanied to care facilities to initiate testing for HIV. Support provided by NGOs and CBOs beyond the point of HIV diagnosis may or may not continue, depending on models employed and resources availability. Government service providers, in government facilities, then generally provide HIV treatment and care, though NGOs provide ART to 38% of patients in Togo and at least one NGO provides ART to KP in Cameroon. A range of KP NGOs in
Sierra Leone and Benin also provide ART. For prevention, treatment and management of opportunistic infections, mainly tuberculosis, NGOs and CBOs play a significant role in screening, bringing potential TB patients to government facilities for testing and supporting patients with treatment adherence.

Coverage of KP with defined service packages varies widely across the region, as do the definitions of coverage. The key indicator should be the number of members of a key population reached with the defined package of services on a regular basis (with the regularity of reach also being defined). Due to variable descriptions and monitoring processes for coverage, it is difficult to state what the real coverage levels are for interventions and it is impossible to state the coverage of the full, defined package for each key population. Coverage appears to be generally low for prevention services, for HIV testing among key populations and for linkage to care. Quality issues were also raised in most focus groups among key populations. Stock outs of ART due to inadequate planning, lack of communication and coordination at all levels of the government are also responsible for low treatment coverage. Uneven access to STI services appears to be a major issue in most countries for FSW and MSM.

In addition, some countries have begun to increase attention to critical enablers, despite their uneven inclusion in KP packages in the region. In Benin, the 2018 baseline assessment of human rights barriers to HIV services details many barriers experienced by KP, which affect their access to adequate HIV prevention, treatment and care services. To address these barriers, a watchdog committee has been strengthened to document cases of gender-based violence (GBV), stigma and discrimination against MSM and SW and to provide psychological and legal support to those who have been victims of human rights violations. The capacity of rights-based organizations has been strengthened, journalists and lawyers have been trained to create KP-friendly networks among those professions, healthcare personnel have been sensitized to the rights of KP and radio campaigns have been organized to promote the rights of KP.

In Togo, the 2013 Analysis of Policies for KP at Risk of HIV Infection in Togo describes a range of inhibiting factors to delivering the services to KP. Responses to these issues, including training of media personnel, the police force and the legal sector on the rights of KP have brought about positive changes in the environment for key populations. The focus groups in Togo expressed the view that the situation for most KP has improved during the past five years. Finally, the dependence on international funding for HIV programming and HIV programming for key populations in particular also impacts coverage, as funding levels fluctuate from year to year. Scaling up of services, and therefore coverage, becomes impossible to plan or sustain in this ever-changing funding environment.

A more detailed assessment of the implementation of packages is presented below by key population (with the exception of TG, for which no packages have been designed), with an emphasis on the five countries that included an in-country assessment, where implementation was able to be directly verified.
MSM Package Implementation

All five countries with in-country assessments identify MSM as a key population. However, service coverage data are only available in all five countries for condom and lubricant programming and HIV prevention programs. Data on other interventions are inconsistent. For all interventions, Cameroon has the most complete data, yet coverage is low across all interventions.

In all five countries, outreach is the primary method of accessing and providing services to MSM. In all countries, at least some of the outreach is carried out by peer educators. In Benin, peer educators are part of two recently-created lesbian, gay, bisexual and transgender (LGBT) networks (created in 2010 and 2014, respectively). In Togo, services in Lome are delivered by a peer network, but the rural services visited in Tsiévé are provided by a mainstream NGO using MSM as peer educators. In Sierra Leone, the current Global Fund grant funds 48 MSM peer educators, mostly through MSM-led organizations. Peer educators need to stay discreet while conducting their activities out of fear of being physically or verbally attacked.

There are also group education sessions in all countries, including in settings where MSM gather and, in most countries, in drop-in centers operated by MSM-led NGOs. Leaflets, posters and other educational materials are regularly distributed. In focus group discussions, MSM suggest that that BCC interventions need more innovative approaches to attract more peers, such as information on substance use and recreational drugs, hepatitis and STI identification. It should be noted that there appears to be a lack of resources aimed at MSM living with HIV. The assumption behind most BCC materials was that HIV-negative MSM were trying to protect themselves against infection. Some MSM reported that the staff members even in NGO-run services demonstrated stigmatizing and discriminating behavior, such as saying their religion prevents them from touching MSM.

Across the five countries, coverage with condoms and lubricant is quite high, with Benin reporting 99.1% of respondents reached with condoms and Cameroon, Mali and Togo all reporting service coverage levels of above 50%. Coverage in Sierra Leone based on programmatic data is 47%. Focus group discussions with MSM expressed general satisfaction with the quality of condoms provided but brought up some issues about the quantities provided through outreach:

- In Sierra Leone, condoms were said to be more available from NGOs in Yaoundé and Douala than in regions outside these cities.
- In Benin, peer educators at monthly meetings with clients distribute 16 condoms and 32 lubricant packs to each MSM. At the time of the consultant’s visit, there was no access to condom or lubricant from peer educators other than during these information sessions. Some MSM reported to consultants that they come to education sessions simply to obtain condoms and lubricant, and others complained that the stock is not enough to cover their sexual activity for a month.
Focus group participants in Mali also complained that the number of condoms provided was insufficient.

MSM in focus group discussions in Togo, Benin, Mali and Cameroon reported that the amount of lubricant distributed is insufficient, with focus groups in Cameroon suggesting that bottles of lubricant would be more appropriate than sachets.

Voluntary HTC was reported for all countries except Mali. In Benin, HIV testing is promoted every three months and peer educators refer clients to MSM-friendly services and sometimes accompany the MSM upon request. Outreach testing and information sessions conducted through recreational evenings target MSM who are more than 30 years old. There are no specific strategies for younger MSM. In Cameroon, focus group participants that receive services from two MSM-friendly CBOs agreed that HIV testing services were accessible and acceptable. In Togo, certain services such as HIV testing (as well as STI testing), are only offered a few days each week at a drop-in center which is accessed by an estimated 80-200 MSM per month.

Data are limited for all countries regarding linkage to enrolment and care, ART coverage and STI services. An important issue in Benin was that MSM interviewed reported not knowing exactly what tests and treatments were free of charge and there seemed to be a lot of misconception about the cost of health services (STI treatment and ART are both supposed to be free of charge if the country does not have a stock out). In Mali, the public health system is responsible for giving access to (free of charge) ART or TB treatment, and to (paid) treatment and care for other co-infections and comorbidities. Key populations in focus group discussions demanded that comprehensive healthcare, including access to ART, malaria and hepatitis treatment, is provided by key population-specific clinics outside the overall public health system.

A key finding from focus group discussions with MSM was a need for more comprehensive psychosocial support, with particular attention to issues resulting from family rejection. Some participants suggested a telephone hotline as a way to deliver this service. There was no evidence of supportive programs and harm reduction services for substance-using MSM despite observations at hotspots and informal discussions with MSM at venues stressing the need for these services.

Overall, all five countries have to varying degrees identified the barriers for MSM in their access to HIV services. Countries are trying to address these barriers, but most activities are at the planning or developmental stage.

Law and policy initiatives have included:

- A watchdog committee in Benin that has been strengthened to document cases of GBV, stigma and discrimination against MSM and SW (328 cases recorded in 2017) and to provide psychological and legal support to those who have been victims of human rights violations;
Assessment of HIV Service Packages for Key Populations
West and Central Africa

- Plans in Cameroon, based on the recent Baseline Assessment of human rights barriers to HIV service access, to undertake: sensitization opportunities to lawmakers and law enforcement agents; legal literacy; HIV-related legal services and access to justice; and, improvements to monitoring practices that can support reforms of laws and policies;
- A consortium of KP organizations in Sierra Leone collaborating on human rights activities to train police and policy makers in response to the findings of the 2017 UNDP legal and human rights assessment and plans to increase efforts to address legal and policy issues based on the recent Baseline Assessment of human rights barriers to HIV service access.

Stigma and discrimination are at the center of plans developed after the Baseline Assessments in Cameroon, Cote d’Ivoire and Sierra Leone. Community empowerment is demonstrated by the establishment of three rights-based NGOs in Togo, which have emerged to fight for the rights of gay men, who have grouped together to form the Cupidon Network. They are hosted in the MSM-led drop in center in Lomé, which is considered a safe space for MSM to gather and interact and an ideal space to offer services and community mobilization activities.

There are several interventions, which are included in the WHO Guidelines for packages of services for MSM, which, regardless of inclusion or exclusion in national packages, did not have any data on coverage for the countries assessed. These interventions include:

- PEP
- ART-related prevention
- Community based testing and counseling
- ART drug interactions
- Hepatitis prevention and management of co-infections
- TB prevention and management of co-infections
- Mental health services and management of co-morbidities
- Nutrition services
- Reproductive health issues
- Anal cancer treatment
### Table 10. Summary of Service Coverage for MSM

Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O); (*) Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Benin</th>
<th>Burundi*</th>
<th>Cameroon</th>
<th>Cape Verde*</th>
<th>Côte d’Ivoire*</th>
<th>Ghana*</th>
<th>Mali</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming²⁹</td>
<td>99.1%²⁸ (S)</td>
<td>45.1%³¹ (S)</td>
<td>81.6%³² (S)</td>
<td>57.5%³³ (S)</td>
<td>83.7%³⁴ (S)</td>
<td>60%³⁵ (S)</td>
<td>76.9%³⁶ (G)</td>
<td>82.6%³⁷ (S)</td>
<td>47%³⁸ (P)</td>
<td>50.7%³⁹ (S)</td>
</tr>
</tbody>
</table>

²⁸ Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSEs as denominators

²⁹ Percentage of men reporting using a condom the last time they had anal sex with a male partner

³⁰ IBBS 2017
³¹ IBBS 2011
³² IBBS 2016
³³ IBBS 2017
³⁴ IBBS 2016
³⁵ PSE/ mapping 2016
³⁶ GARPR 2015
³⁷ IBBS 2010
³⁸ GF Performance Framework 2016
³⁹ IBBS 2017
### Assessment of HIV Service Packages for Key Populations

**West and Central Africa**

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Benin</th>
<th>Burundi*</th>
<th>Cameroon</th>
<th>Cape Verde*</th>
<th>Côte d'Ivoire*</th>
<th>Ghana*</th>
<th>Mali</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of HIV prevention programs among MSM(^{40})</td>
<td>43.6(^{41}) (P)</td>
<td>18%(^{42}) (P)</td>
<td>7.8%(^{43}) (P)</td>
<td>98%(^{44}) (P)</td>
<td>18.4%(^{45}) (S)</td>
<td>54.7%(^{46}) (S)</td>
<td>73.1%(^{47}) (P)</td>
<td>34%(^{48}) (P)</td>
<td>27.4%(^{49}) (P)</td>
<td>58.7%(^{50}) (P)</td>
</tr>
<tr>
<td>Knowledge of HIV status(^{51})</td>
<td>20.9%(^{52}) (P)</td>
<td>32%(^{53}) (S)</td>
<td>55.1%(^{54}) (S)</td>
<td>50%(^{55}) (S)</td>
<td>54.9%(^{56}) (S)</td>
<td>26.3%(^{57}) (S)</td>
<td>N/A</td>
<td>26%(^{58}) (P)</td>
<td>38%(^{59}) (P)</td>
<td>92.2%(^{60}) (S)</td>
</tr>
</tbody>
</table>

\(^{40}\) Coverage with prevention package as defined in national design documents  
\(^{41}\) GF PUDR 2017  
\(^{42}\) GF PUDR 2016  
\(^{43}\) Program data GF and PEPFAR reviewed by APMG  
\(^{44}\) GF Concept Note 2015  
\(^{45}\) IBBS 2016  
\(^{46}\) National Strategic Plan 2016-2020  
\(^{47}\) Programmatic Results Plan Mali, July-October 2016  
\(^{48}\) GF PUDR 2016  
\(^{49}\) GF Performance Framework 2016  
\(^{50}\) Program data reviewed by APMG  
\(^{51}\) Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results  
\(^{52}\) GF PUDR 2017  
\(^{53}\) IBBS 2011  
\(^{54}\) IBBS 2016  
\(^{55}\) IBBS 2017  
\(^{56}\) IBBS 2016  
\(^{57}\) PSE/mapping 2016  
\(^{58}\) GF PUDR 2016  
\(^{59}\) GF Performance Framework 2016  
\(^{60}\) IBBS 2017
Assessment of HIV Service Packages for Key Populations  
West and Central Africa

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Benin</th>
<th>Burundi*</th>
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<th>Mali</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART coverage(^{61})</td>
<td>N/A</td>
<td>17%(^{62}) (P)</td>
<td>10.3%(^{63}) (P)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1.4%(^{64}) (O)</td>
</tr>
</tbody>
</table>

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\(^{61}\) Percentage of the people living with HIV in a key population receiving antiretroviral therapy in the past 12 months  
\(^{62}\) USAID/PEPFAR LINKAGES, Programmatic monitoring excel sheet. 2017  
\(^{63}\) Program data GF and PEPFAR reviewed by APMG  
\(^{64}\) PNLS-IST annual report, 2016
SW Package Implementation

All five countries identified sex workers as a key population with a focus on female sex workers. None of the countries provided disaggregated figures for male and female sex workers. Overall, Cameroon had the most complete data on service coverage for key interventions – it was the only country that had any coverage data on behavioral interventions (17.3% IBBS), knowledge of HIV status (48.3% IBBS) and STI prevention, screening and treatment (8.2% IBBS).

Similar to the situation with MSM, peer educators are used in all five countries to reach sex workers. During the in-country assessment, peer educators requested better working conditions, including identification badges, to be more official and protect against police harassment and work insurance in case of accidents.

Coverage data is available for all five countries for condom and lubricant programming and HIV prevention programs. Access levels vary between countries.

- In Benin, FSW receive information on contraception other than condoms during information sessions, however currently only condoms are available free of charge. Female condoms are only given upon request. FSW are not satisfied with the limited access to female condoms and the number of lubricant sachets distributed.
- In Cameroon, findings from focus group discussions with FSW in Yaoundé and Douala identified several barriers to accessing condoms, including hours of NGO operation and a lack of availability of condom and lubricant.
- In Togo and Mali, FSW reported that the number of condoms and lubricant provided per person per month is insufficient.
- In Sierra Leone, reported condom use was high among FSW but FSW living in poverty report re-using condoms and during focus groups many stated they did not have regular access to condoms or lubricant. Stock outs were reported as well as restricted access to a small number of condoms only after participating in a group-based IEC activity.

Community testing was preferred where it was available. In Sierra Leone and Cameroon, during focus group discussions, SW reported high satisfaction with HIV testing in community settings, but they experienced stigma and discrimination, long wait times and high costs for affiliated services when linked to care at some government-run hospitals. In Benin and Togo, FSW report a growing dissatisfaction with a focus by peer workers and services only on HIV testing and want a broader approach to testing (including hepatitis) and additional information on family planning and harm reduction.

In Sierra Leone, many SW report satisfaction with the quality of HIV care received at community-based ART treatment dispensaries, as well as NGO-delivered HIV care (by AIDS Healthcare Foundation (AHF)) and in smaller government facilities in Makeni with AHF oversight. At AHF, SW express high satisfaction at the one-stop shop model where they could receive free family planning, STI treatment
and HIV treatment. Family planning options for FSW are not universally available and many women from focus group discussions report paying significant out-of-pocket expenses for this service.

All five countries have to varying degrees identified the barriers for SW in their access to HIV services. Countries are trying to address these barriers, but most activities are at the planning or developmental stage. The activities described in the MSM section in Benin, Cameroon and Sierra Leone are also working on behalf of SW.

There are several interventions, which are included in the WHO Guidelines for packages of services for SW, which, regardless of inclusion or exclusion in national packages, did not have any data on coverage for the countries assessed. These interventions include:

- PEP
- Community-based testing and counseling
- ART drug interactions
- Hepatitis prevention and management of co-infections
- TB prevention and management of co-infections
- Mental health and management of co-morbidities
- Nutrition services
- Safe abortion and post abortion care and other sexual and reproductive health issues
- Cervical cancer screening and treatment
### Table 11. Summary of Service Coverage for SW
Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O)

*Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Benin</th>
<th>Burundi*</th>
<th>Cameroon</th>
<th>Cape Verde*</th>
<th>Côte d'Ivoire*</th>
<th>Ghana*</th>
<th>Mali</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming*</td>
<td>92.6%67 (S)</td>
<td>41.2%68 (S)</td>
<td>77.5%69 (S)</td>
<td>73.8%70 (S)</td>
<td>81%71 (S)</td>
<td>92%72 (S)</td>
<td>98.1%73 (S)</td>
<td>91.8%74 (S)</td>
<td>83.9%75 (P)</td>
<td>96.3%76 (S)</td>
</tr>
</tbody>
</table>

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65 Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSEs as denominators
66 Percentage of sex workers reporting the use of a condom with their most recent client
67 IBBS 2015
68 IBBS 2011
69 IBBS 2016
70 IBBS 2017
71 IBBS 2014
72 PSE/ mapping 2016
73 GARPR 2015
74 IBBS 2010
75 GF Performance Framework 2016
76 IBBS 2017
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<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Benin</th>
<th>Burundi*</th>
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<th>Mali</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of HIV prevention programs among sex workers&lt;sup&gt;77&lt;/sup&gt;</td>
<td>17.7%&lt;sup&gt;78&lt;/sup&gt; (P)</td>
<td>26%&lt;sup&gt;79&lt;/sup&gt; (P)</td>
<td>6.7%&lt;sup&gt;80&lt;/sup&gt; (P)</td>
<td>92%&lt;sup&gt;81&lt;/sup&gt; (P)</td>
<td>N/A&lt;sup&gt;82&lt;/sup&gt;</td>
<td>48%&lt;sup&gt;83&lt;/sup&gt; (O)</td>
<td>52.3%&lt;sup&gt;84&lt;/sup&gt; (P)</td>
<td>5.5%&lt;sup&gt;85&lt;/sup&gt; (P)</td>
<td>15%&lt;sup&gt;86&lt;/sup&gt; (P)</td>
<td>108.9%&lt;sup&gt;87&lt;/sup&gt; (P)</td>
</tr>
</tbody>
</table>

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<sup>77</sup> Coverage with prevention package as defined in national design documents  
<sup>78</sup> GF PUDR 2017 (excludes data related to waitresses)  
<sup>79</sup> GF PUDR 2016  
<sup>80</sup> Program data GF and PEPFAR reviewed by APMG  
<sup>81</sup> GF Concept Note 2015  
<sup>82</sup> No national PSE. GF and PEPFAR reached more than 36,000 FSW in 2016  
<sup>83</sup> PEPFAR/ GF (2017) Assessing the scope and effectiveness of key population interventions in the response to the HIV and AIDS Epidemic in Ghana  
<sup>84</sup> Programmatic Results Plan Mali, July-October 2016  
<sup>85</sup> GF PUDR 2016  
<sup>86</sup> GF Performance Framework 2016  
<sup>87</sup> Program data GF reviewed by APMG against nationally accepted PSE
## Assessment of HIV Service Packages for Key Populations
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<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Benin</th>
<th>Burundi*</th>
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<th>Côte d’Ivoire*</th>
<th>Ghana*</th>
<th>Mali</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of HIV status**</td>
<td>81.6%*89 (S)</td>
<td>42.6%*90 (S)</td>
<td>59.1%*91 (S)</td>
<td>45.1%*92 (S)</td>
<td>47%*93 (P)</td>
<td>66.7%*94 (S)</td>
<td>N/A</td>
<td>4.4%*95 (P)</td>
<td>20.9%*96 (P)</td>
<td>94.1%*97 (S)</td>
</tr>
<tr>
<td>ART coverage**</td>
<td>N/A</td>
<td>31.8%*99 (P)</td>
<td>28%*100 (P)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2% (O)*101</td>
</tr>
</tbody>
</table>

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** Percentage of sex workers that have received an HIV test in the past 12 months and know their results

*89 IBBS 2015
90 IBBS 2011
91 IBBS 2016
92 IBBS 2017
93 GF PUDR 2017
94 PSE/ mapping 2016
95 GF PUDR 2016
96 GF Performance Framework 2016
97 IBBS 2017
98 Antiretroviral therapy coverage among sex workers living with HIV
99 USAID/PEPFAR LINKAGES, Programmatic monitoring excel sheet. 2017
100 Program data GF and PEPFAR reviewed by APMG
101 PNLS-IST annual report, 2016
PWID PACKAGE IMPLEMENTATION

Out of the five in-country assessment countries, all but Mali identified PWID as a key population in their national strategies and plans. Data on service coverage for key interventions for PWID were available for three countries (Benin, Sierra Leone and Togo) with Benin and Togo offering the most complete data. However, PWID were not the focus of any of the in-country assessments in this region.

In-country visits revealed a more detailed picture of the interventions available:

- In Benin, PWID have access to a monthly NSP service, which provides injecting kits. Every month they are provided with 10 clean needles and syringes and they can return the dirty equipment to access more. There are no referrals between other KP programs and the NSP program. Interviewees in health care centers report having no PWID patients due to issues with management accepting the presence of PWID in their premises and the disruption this can cause among other patients. Overall, it was noted during the country visit that PWID seem to have significant barriers to accessing health services compared to FSW and MSM. Individuals from focus groups were frustrated by the limited services. However, a recent satisfaction survey was carried out in which 73% of clients referred to the services as appreciable or superior (Ahouansou, 2017).

- Sierra Leone’s 2013 KP PSE report highlighted that most PWID reported using opiates, however no exact number was reported. During key informant interviews at a PWID NGO several staff reported a high rate of opioid overdoses and that naloxone was not routinely available. A needle-syringe program was due to open in Freetown in 2018.

- In Togo, PWID are very hard to reach. There are no harm reduction programs (NSP/OST) being implemented for PWID but the country has requested funding for NSP under their prioritized above allocation request from the Global Fund.

Data were not available for any of the countries for the prevention and management of co-infections including TB and viral hepatitis. No data were found on the implementation of critical enabler activities for this population.

There are several interventions, which are included in the WHO Guidelines for packages of services for PWID, which, regardless of inclusion or exclusion in national packages, did not have any data on coverage for the countries assessed. These interventions include:

- PEP
- OST
- Overdose prevention and treatment, including naloxone
- Other drug dependence treatment
- Behavioral interventions
- Linkage and enrolment in care
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- ART drug interactions
- Mental health services and management of co-morbidities
- ART-related prevention
- Community based testing and counseling
- Nutrition services
- STI prevention, screening and treatment
Table 12. Summary of Service Coverage for PWID
Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O)
*Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Benin</th>
<th>Côte d’Ivoire*</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming(^{103})</td>
<td>75.2%(^{104}) (S)</td>
<td>50.5%(^{105}) (S)</td>
<td>83.2%(^{106}) (S)</td>
<td>N/A</td>
<td>56.1% (O)(^{107})</td>
</tr>
<tr>
<td>Coverage of HIV prevention programs among PWID(^{108})</td>
<td>112.3%(^{109}) (P)</td>
<td>N/A</td>
<td>61.4%(^{110}) (P)</td>
<td>28%(^{111}) (P)</td>
<td>N/A</td>
</tr>
<tr>
<td>Harm reduction - NSP(^{112})</td>
<td>66.6%(^{113}) (P)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Harm reduction - Safe injection practices(^{114})</td>
<td>94.6% (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>25.2%(^{115}) (P)</td>
<td>80.7%(^{116}) (S)</td>
</tr>
</tbody>
</table>

\(^{101}\) Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSEs as denominators
\(^{102}\) Percentage of PWID who report the use of a condom at last sexual intercourse
\(^{103}\) MDM 2014: Santé des personnes usagères de drogue à Abidjan en Côte d’Ivoire - Prévalence et pratiques à risque d’infection par le VIH, les hépatites virales, et autres infections.
\(^{104}\) IBBS 2010
\(^{105}\) Mapping & PSE 2014
\(^{106}\) Coverage with prevention package as defined in national design documents
\(^{107}\) GF PUDR 2017. Coverage calculated by APMG consultants, based on program statistics and nationally accepted PSE.
\(^{108}\) GF PUDR 2016
\(^{109}\) GF Performance Framework 2016
\(^{110}\) Number of needles and syringes distributed per person who injects drugs
\(^{111}\) GF PUDR 2017. Coverage calculated by APMG consultants, based on program statistics and nationally accepted PSE.
\(^{112}\) Percentage of PWID who reported using sterile injecting equipment the last time they injected
\(^{113}\) GF Performance Framework 2016
\(^{114}\) IBBS 2017
### Assessment of HIV Service Packages for Key Populations
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<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Benin</th>
<th>Côte d’Ivoire*</th>
<th>Nigeria*</th>
<th>Sierra Leone</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of HIV status¹¹⁷</td>
<td>57.8%¹¹⁸ (O)</td>
<td>23.2%¹¹⁹ (S)</td>
<td>48.8%¹²⁰ (P)</td>
<td>45.5%¹²¹ (P)</td>
<td>31.1% (O)¹²²</td>
</tr>
<tr>
<td>ART coverage¹²³</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0.4% (O)¹²⁴</td>
</tr>
</tbody>
</table>

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¹¹⁷ Percentage of PWID that have received an HIV test in the past 12 months and know their results
¹¹⁸ Mapping & PSE 2017
¹¹⁹ MDM 2014: Santé des personnes usagères de drogue à Abidjan en Côte d’Ivoire - Prévalence et pratiques à risque d’infection par le VIH, les hépatites virales, et autres infections.
¹²⁰ GF PUDR 2016
¹²¹ GF Performance Framework 2016
¹²² Mapping & PSE 2014
¹²³ Proportion of PWID who report currently being on ART
¹²⁴ PNLS-IST annual report, 2016
**PRISONER PACKAGE IMPLEMENTATION**

Among the ten countries selected for the West and Central Africa region, only five identified prisoners as a key population in their national strategies. Of these, two were in-country assessment countries, Benin and Togo. This section focuses on the data from the Benin and Togo, though prisoners were not the official focus of these assessments.

Coverage on service package interventions for prisoners is very limited. Among the interventions, the countries reported on the following:

- **Benin only**: Coverage of HIV prevention programs (65.6% IBBS; 73.2% programmatic)
- **Benin and Togo**: Voluntary HIV testing and counseling (101.1% programmatic and 23.2% national HIV program, respectively)
- **Benin and Togo**: Knowledge of HIV status (72.8% and 34.7% respectively, both IBBS)
- **Togo only**: ART coverage (0.2% National AIDS Program)

In Benin, according to the 2015 IBBS, only 29.3% of prisoners have a proficient level of information about HIV. The programs for prisoners are managed by the Programme Santé de Lutte contre le Sida (PSLS) through 10 NGOs that intervene in all the prisons of the country. Services offered include BCC interventions, promotion of HIV testing, testing in the infirmary services, and ART and STI treatment although service coverage data on the latter two interventions are not available. The PSLS also indicated that 16 nurses from the prisons were trained in HIV for testing and treatment services.

In Togo, the 2014 PSE and mapping report lists six prisons with HIV programming and four NGOs working within the prison system, although overall, prisons were found to be extremely underserved by HIV programming in terms of package of services, coverage, frequency of interventions and available resources.

No data were found on the implementation of critical enabler activities with this population.

**TG PACKAGE IMPLEMENTATION**

Data on service coverage for TG are very limited. The only data available are from Benin and Côte d’Ivoire regarding condom and lubricant programming (coverage of 86.6% and 66.1% respectively), and for Benin only, on coverage of HIV prevention programs (94.3%) and knowledge of HIV status (91.1%).

**ANALYSIS: ARE PACKAGES BEING IMPLEMENTED AS DESIGNED?**

All countries assessed have made efforts to provide services matching the designed package of services. But the results are highly variable and difficult to assess with current monitoring tools. As an
example, all five countries visited identify MSM as a key population. However, service coverage data are only available in these countries for condom and lubricant programming and HIV prevention programs. Data on other interventions are mostly not available and are not included in reporting on the service package. For all interventions, Cameroon has the most complete data, still coverage is low across all interventions. It should also be noted that HIV services for KP in Ghana were assessed separately in 2017 (Global Fund 2017). The assessment found that the current package of health sector services available to KP are consistent with global guidance provided by WHO. However, passive referrals to other facilities for clinical services such as HIV testing and STI testing and treatment represent an important mode of service delivery in many places, which may reduce utilization of some services through people not acting on the referral they are provided with. Currently, all KP PLHIV must initiate treatment at sites open to the general population.

One positive feature of implementation assessments is that some countries are moving towards implementing programming for TG despite there being no national service package for this KP. For example, in Benin, a situational analysis on TG was carried out in 2017 and Cameroon is looking to expand services for this population.

Overall, countries appear to be trying to implement packages as designed, in terms of interventions delivered. Though many interventions are not captured in regular reporting data, in-country assessments confirm that services are available at some level.

For MSM and SW in all countries, condom and lubricant programming is available, although the number of condoms and lubricant provided were reported to be insufficient. Peer educators play an important role for both MSM and SW populations by sharing information, creating support groups and safe spaces and encouraging HIV testing. Reports in several countries point to the value of the work of peer educators, but also note the need for more, updated and comprehensive information.

It should be noted that a PEPFAR/Global Fund (2018) joint stocktaking exercise related to MSM and SW in Democratic Republic of Congo, a similar exercise in Cote d’Ivoire (PEPFAR/ Global Fund 2017) and in Cameroon (PEPFAR/Global Fund 2016) have developed a long list of recommendations that echoes many of the issues highlighted below (see Annex 1).

For PWID, service coverage data are incomplete for many interventions, including ART coverage and prevention and management of co-infections including TB and viral hepatitis despite these being part of the package design. In-country visits confirm that harm reduction interventions are being implemented by countries that include them in their service packages, though mostly at low levels of coverage. Sierra Leone is the only country out of the five that does not include NSP and OST in its package. On the other hand, Togo includes harm reduction interventions in its design but is not implementing them.
For all countries, ART coverage data among KP are largely un-reported, unavailable or both. This is a major component of the HIV cascade and can indicate progress (or lack thereof). Advocacy and support are needed to ensure reporting of this very critical indicator.

Little evidence was found of large-scale implementation of critical enabler activities among key populations in the five countries assessed. (This is borne out in the Baseline Assessments of human rights barriers to HIV services carried out in Cameroon, Cote d’Ivoire and Sierra Leone.)

Ultimately, data gaps are quite large across all key populations and countries in the West and Central Africa region for the major elements of key populations service packages – condom and lubricant programming, harm reduction interventions, behavioral interventions, HTC and ART. It is also important to highlight that for countries assessed, many interventions, which are included in the WHO Guidelines for packages of services for MSM, SW and PWID, which, regardless of inclusion or exclusion in national packages, did not have any data on coverage for any of the countries assessed.

Table 13. Interventions included in the WHO Guidelines with no coverage data for MSM, SW and PWID

<table>
<thead>
<tr>
<th>MSM</th>
<th>SW</th>
<th>PWID</th>
</tr>
</thead>
<tbody>
<tr>
<td>● PEP</td>
<td>● PEP</td>
<td>● PEP</td>
</tr>
<tr>
<td>● ART-related prevention</td>
<td>● Community based testing and counseling</td>
<td>● OST</td>
</tr>
<tr>
<td>● Community based testing and counseling</td>
<td>● ART drug interactions</td>
<td>● Overdose prevention and treatment, including naloxone</td>
</tr>
<tr>
<td>● ART drug interactions</td>
<td>● Hepatitis prevention and management of co-infections</td>
<td>● Other drug dependence treatment</td>
</tr>
<tr>
<td>● Hepatitis prevention and management of co-infections</td>
<td>● TB prevention and management of co-infections</td>
<td>● Behavioral interventions</td>
</tr>
<tr>
<td>● TB prevention and management of co-infections</td>
<td>● Mental health and management of co-morbidities</td>
<td>● Linkage and enrolment in care</td>
</tr>
<tr>
<td>● Mental health services and management of co-morbidities</td>
<td>● Nutrition services</td>
<td>● ART drug interactions</td>
</tr>
<tr>
<td>● Nutrition services</td>
<td>● Safe abortion and post abortion care</td>
<td>● Mental health services and management of co-morbidities</td>
</tr>
<tr>
<td>● STI prevention, screening and treatment</td>
<td>● Cervical cancer screening and treatment</td>
<td>● ART-related prevention</td>
</tr>
<tr>
<td>● Anal cancer treatment</td>
<td></td>
<td>● Community based testing and counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Nutrition services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● STI prevention, screening and treatment</td>
</tr>
</tbody>
</table>
RECOMMENDATIONS: IMPLEMENTATION OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Service packages need to be implemented as designed, with particular emphasis on ensuring a sufficient supply of condoms and lubricant to MSM, TG and SW; and of needles and syringes to PWID.

2. Peer education and peer navigation are key to reaching and providing services to KP. The recommendations contained in PEPFAR/Global Fund 2017 and 2018 for Cote d’Ivoire and Democratic Republic of Congo related to peer educators should be considered by all countries in the region (see Annex 1).

3. Services for STI diagnosis and treatment among FSW and MSM need to be made accessible, including assuring they are affordable (or free of charge) to key populations.

4. Differentiated service delivery should be developed to assist in expanding reach of key interventions among KP. These include: self-testing; lay provider testing; community-based testing; assisted partner notification; community-based initiation; and, distribution of ART for KP.

5. Community empowerment activities, particularly community monitoring of HIV service packages by key population networks, need to be scaled up in the region. This is a key activity in improving service quality.

6. Critical enabler activities have very low levels of coverage and the range of activities implemented is generally much smaller than needed. As Sierra Leone, Cameroon, Benin and Cote d’Ivoire work to reduce human rights barriers for KP, other countries in the region should study the activities implemented and their results for possible replication.

7. Outreach and support service models need to be reviewed to ensure that there are sufficient resources to ensure linkage to treatment for newly diagnosed PLHIV and case-management models in place to cover at least the first three months following diagnosis.

8. Community HIV testing and self-testing models in the region need to be assessed and guidance for expanding access and improved quality developed.

9. Strategies to engage countries in transition planning for the outreach (demand-creation) workforce for KP need to be strengthened.

10. Key population NGOs need to be assisted to secure resources to pursue broad health goals for their constituents, including reduction of stigma and discrimination, responses to KP-related violence, gender-based violence and other issues that increase service access obstacles for people from KP.

11. In collaboration with regional KP organizations, UN agencies should work to develop a set of regional guidelines for e-outreach, covering safety and security for e-outreach workers, ethics, privacy and effective messaging.

12. Safety of outreach workers, particularly among MSM, needs to be addressed through the use of written security protocols which are the subject of training and supervision for outreach staff.
13. Male sex workers are hardly mentioned throughout the region, yet men who have sex with men report buying and selling sex at significant frequency. Implementers of MSM and SW programs need to work together to ensure that the needs of male SW are met.
PART IV: MONITORING SYSTEMS

KEY POINTS

- All countries assessed have some sort of monitoring system in place. Both Togo and Cameroon now have single national UIC allow de-duplication, including between providers funded by different funders.
- No assessed country in the region can monitor the delivery of the full package of services for any KP. Mostly, this is due to the difference between the ways HIV prevention activities are monitored (using a UIC) and the ways medical treatment is monitored (using national ID or patient numbers).
- Monitoring of critical enabler activities is haphazard and there is generally no monitoring of quality of services or of KP access to non-HIV-specific health interventions contained in the designed packages.

The process of monitoring the implementation of packages of services against their design (as shown in the Design section) is multi-faceted.

As noted in the beginning of this report, there are significant problems relating to population size estimations for some key populations in some countries. In addition, the way that coverage is compiled and analyzed varies across countries. In some countries, a mixture of programmatic and IBBS data are used as if the figures are interchangeable. However, the differences between IBBS results and programmatic data findings can be very large (see Tables 11-13). Given what has been reported below on monitoring systems, some of these problems may be attributed to issues in program reporting, but it seems likely that many IBBS studies continue to have sampling problems that over-represent the behavior of people who are regular clients of HIV prevention services, or that suffer from changing definitions of numerators and denominators from one study to another.

It should also be noted that monitoring of program results and progress towards targets should not pose a risk to the health (including the lives) of KP. The human rights-related barriers to accessing services for some KP in some countries are so great that there is a real risk of causing harm by asking for and retaining data of certain behaviors. For example, homosexuality is criminalized in most countries assessed and this can lead to under-reporting of the population size as well as reluctance among MSM clients to reveal their sexual practices or come forward for services. Even when MSM access services, they may be reluctant to provide data unless they can be assured of complete confidentiality.

As part of this assessment process, there was a requirement to rate the systems used to monitor key populations service packages. The results of this process (Table 14) show that four out of the five in-country assessment countries have unique identification code (UIC) systems.
Table 14. UIC System Scores by Country in West and Central Africa

0: No data/evidence
1: Monitoring contacts, which disallow de-duplicated reporting
2: Partially using UIC, which disallow de-duplicated reporting. This includes scenarios where UICs are used in some regions of the country or different UICs are used in the country but not harmonized.
3: Nationally using UIC, which allow de-duplicated reporting. This includes the scenario where different UICs are used but harmonized.

<table>
<thead>
<tr>
<th>Country*</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>2</td>
<td>There is a clear monitoring system in place and standard tools have been developed, but they are not harmonized across all programs targeting key populations. The country set up various coding systems for key populations programs; however, they are not generated in the same manner and not all of them are actually identifying codes.</td>
</tr>
<tr>
<td>Cameroon</td>
<td>2</td>
<td>Global Fund- and PEPFAR-funded service providers now use the same UIC codes. There is no consistent UIC between community-based prevention and linkage services and the medical system, making it difficult to measure retention in care by key populations beyond the key populations served by PEPFAR.</td>
</tr>
<tr>
<td>Mali</td>
<td>1</td>
<td>Each local non-governmental partner uses its own data collection system for monitoring contacts, which is not unified at national level. Local stakeholders have agreed to implement a UIC from 2018 onwards.</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>2</td>
<td>A UIC has been partially implemented to improve monitoring of key populations and link them to other services for HIV; however, the code does not adhere to international best practice guidelines and may need some adjustment to truly prevent duplication and improve quality of care.</td>
</tr>
<tr>
<td>Togo</td>
<td>3</td>
<td>A UIC was introduced by USAID-financed programs and has been adopted by all government and civil society service-delivery institutions working with key populations, including the Global Fund PR and SR.</td>
</tr>
</tbody>
</table>

*For countries that only received a desk review, there was not enough information available to adequately and reliably assess the existence and use of a UIC. Therefore, details are not included here.

In Benin, the FSW program has the most robust monitoring system, with monitoring of prevention, referral, STI and HIV testing, as well as a standard monthly medical check-up through a medical card and referral coupons between NGOs and medical centers. Other key population programs also use a referral coupon system. It is possible to de-duplicate within each key population program, however

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125 Score has been assigned based on available information from country assessments. Score may not apply to all key populations (MSM, FSW, PWID, and prisoners) in WCA. Please see notes for specifications.
no key populations living with HIV can be tracked for treatment and care services because a PLHIV code is assigned which is not connected with the KP UIC.

Benin also has various tools that include recording identifying personal information along with the UIC, which could be a threat to the safety of the clients. In addition, during the country visit, the national biometric census was mentioned as being a means towards obtaining more precise data on PLHIV (including KP), which is also potentially problematic in terms of confidentiality and security for KP.

The utilization of prevention and testing services by MSM and FSW in Cameroon is monitored using a UIC. The in-country visit found that a majority of beneficiaries interviewed were aware of the UIC and could recall their code from memory. Organizations primarily use paper-based recording methods to track service utilization by key population. However, evidence suggests that a PEPFAR-supported digital platform for tracking key population service usage, called ComCast, may be adopted by Global Fund-supported agencies in the near future, which could improve their quality and efficiency in reporting program indicators. Global Fund and PEPFAR-funded service providers now use the same UIC, making it easier to accurately detect duplication. There is no consistent UIC across community-based prevention and linkage services and the medical system, making it difficult to measure retention in care of key populations beyond the small number of programs supported by PEPFAR that monitor retention. Treatment for HIV in Cameroon is administered through a separate system from prevention services and efforts are needed to harmonize data systems in order to generate better data to inform progress towards the 90-90-90 targets for key populations in Cameroon.

In Mali, there is a range of programs to address the needs of key populations. Accuracy of data collection varies from site to site, with the lowest quality identified in the data collected by peer educators, especially FSW. Peer educators are extremely valuable as behavior change agents but are often illiterate or lack the basic skills to fill in the required registers. Local stakeholders have agreed to implement a UIC from 2018 onwards, and discussions are ongoing to begin utilizing project managers in place of peer educators to deliver services, which may increase data quality but will likely decrease outreach effectiveness.

In Sierra Leone, HIV prevention data are disaggregated by gender and age and by KP for prevention. Data are not disaggregated by KP for linkage or for treatment. A UIC has been partially implemented to improve monitoring of KP and link them to other services for HIV.

It should be noted that a PEPFAR/Global Fund (2018) joint stocktaking exercise related to KP in Democratic Republic of Congo has recommended that a UIC be developed for use of programs there.
**CASE STUDY: Effectively tracking service-delivery to key populations throughout the whole continuum of care in Togo**

Countries that introduce a Unique Identifier Code (UIC) to monitor KP programming often face challenges in tracking the members of KP throughout the whole continuum of care, especially linkage to care.

Togo introduced a simple UIC, composed of only components, that was adopted by all government and civil society service-delivery institutions working with key populations. The system is used at grassroots levels by peer educator programs that are usually the first entry point to HIV services for key populations, all the way through to healthcare personnel for the initiation on ART and follow-up of KP living with HIV. This enables a robust tracking system of KP interventions throughout the continuum of care.

Routine surveillance data collected by the health services through standardized tools includes key population data. This means that the country can produce detailed HIV reports that disaggregate data by key population. However, the country has not yet produced a national KP database that merges raw data from the two main implementing blocs (USAID-funded and GF-funded programming).

Merging the two existing databases would enable a more effective tracking at micro-level, such as detecting migration of KP from one region to the other; effective planning of interventions between all implementers; and, a higher potential to react rapidly and re-program interventions in a more efficient manner to respond to changes the environment.

One factor that enables tracking of interventions targeting KP through the whole continuum of care is the high involvement of civil society in linkage to care. HIV testing, treatment, and care and STI diagnosis and treatment through adapted services. Adapted services are health care structures that are KP-friendly and provide services to them without any stigma or discrimination towards them. There are currently eight authorized NGO-run HIV treatment centers and 33 public adapted services across the country. The latter dedicate special hours to receive key populations and their staff collaborate with NGOs to conduct outreach testing and ensuring that people testing HIV positive are linked to care in the adapted service.

The other factor that enables this robust monitoring system is the fact that the adoption of the UIC by all implementers was supported at the highest policy level (Prime Minister’s Office), leading to a consistent use of the system by all stakeholders.

Togo is a relatively small country. The replication of this system would probably be more challenging in bigger countries where the integration of a UIC in routine data collection in a larger healthcare system may meet with more resistance and the creation of adapted services may be a geographical challenge.
**Analysis: Do We Really Have Enough Information to Determine How Well Packages Are Implemented?**

The use of a national UIC is of great importance as it is one of the cornerstones of coverage calculations. Just as the PSE is the important denominator, the UIC leads to the construction of the national coverage numerator. Countries can have excellent programs but, without a way to accurately report de-duplicated client numbers, no statements about coverage of the programs can be made with any certainty. It should be noted that the UIC also allows programs to distinguish between unique individuals (clients) and visits (occasions of service), a confusion that has plagued key population programs for many years. Examples of coverage levels above 100% in the Implementation section show the importance of the UIC. Without it, duplicated figures can lead to wildly inaccurate results.

None of the in-country assessment countries have sufficiently developed ways to determine whether a client has received a defined package of services. Most countries assessed are currently using a UIC system and Mali has plans to implement one in 2018. Among the four countries that do have UIC systems, problems are apparent. Systems in Benin and Sierra Leone face varying issues, such as lack of harmonization due to different UIC systems implemented by different organizations, or partial systems that track some services but not others, or different systems operating for different services. Togo and Cameroon are the only countries where a UIC is used across the entire HIV prevention system and is used by all stakeholders.

Even so, no country has a system by which KP can be tracked across the full continuum of care, making it impossible to determine whether key populations are accessing ART and achieving viral suppression at levels equivalent to the general population of PLHIV. This is problematic from a strategic information perspective, making it impossible to monitor progress against 90-90-90 targets amongst KP, but also worrisome given the high levels of stigma and resultant avoidance of care reported by several key population focus groups.

In addition, little work has been done to date on monitoring quality of services and on monitoring of critical enabler activities. As shown in the Implementation sections for each KP, a substantial number of other activities – mostly provided by the health system – are not monitored for KP in any country.

**Recommendations: Monitoring of Service Packages for Key Populations**

1. For accurate coverage calculations, countries need to follow established guidelines to develop PSE, together with national consensus processes involving substantial representation from the key populations concerned. From these processes, more accurate, agreed-upon PSE should be derived.

2. Mapping of KP, including the involvement of community networks in mapping, should be carried out nationally where possible to aid in verifying each PSE and to aid in planning, implementing and measuring coverage of KP programs.
3. Countries should continue progress towards a national UIC and determine whether case-based surveillance and harmonizing of databases can assist in following KP from prevention and testing programs through ART and viral load suppression, while maintaining sensitivity to confidentiality in criminalized environments.

4. Tracking of service use and health outcomes for KP need to be integrated into national e-health and unique patient record initiatives, where this can be done without compromising safety of KP.

5. Mechanisms or systems should be developed so that data collected by donor-funded programs, including by SRs and PRs of the Global Fund, is fed into national-level data.

6. It is important to stress that none of these data are useful unless they are utilized for decision-making – whether at the policy or the implementation level. Capacity building may be needed to help staff see the value in not merely collecting but analyzing service data and using this information as the basis for suggesting changes to services.

7. Intervention data should be routinely collected with vital demographic (sex, gender and age) data included, so that data may be analyzed in a disaggregated manner to show relative access and outcomes by sub-groups, as well as to support advocacy for more attention to certain sub-populations.

8. Documenting and mapping activities and results related to reducing human rights barriers should be a priority for learning and generating best practice on what works to create a more enabling environment for KP. As much as possible, this documentation should be specific to each key population. Mapping and reporting on activities to reduce human rights barriers for each KP should become part of regular monitoring processes.

9. International organizations working on HIV should assist countries to develop low-cost, non-intrusive methods to measure quality of HIV services for KP and for reporting on KP access to non HIV-specific services provided by the health system.
PART V: FINANCING

KEY POINTS

- Data on funding for KP programming were available for all countries except for Mali. In the four remaining in-country assessment countries, domestic funding is either decreasing or remains stagnant.
- The Global Fund has become the major donor of KP services in several countries.
- Regionally, UNAIDS reports that resources for HIV are insufficient to reach the Fast Track targets. This was confirmed in the five in-assessment countries where large funding gaps remain.
- Funding for services for KP is even more underfunded especially for MSM and FSW, the two KP with the highest HIV prevalence among all KP in the region.

Resource needs for HIV in West and Central Africa will need to nearly double in order for the region to reach the Fast Track targets by 2020 (UNAIDS Update 2017). Figure 3 shows that while domestic resources, US bilateral funding and Global Fund support have all increased over the last decade, a substantial funding gap remains.

Figure 3. Substantial Funding Gap in West and Central Africa

[Graph showing funding trends over time]

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126 UNAIDS Global AIDS Update 2017: Ending AIDS – Progress towards the 90-90-90 targets – covers all HIV response, not just KP
Financing of KP programs was not a major focus of these assessments. However, some trends were observed. The Global Fund has become the major donor of KP services in several countries. From the data available through Global Fund, PEPFAR and National AIDS Spending Assessments, it appears that most countries are spending increasing amount on ART programming, including increased domestic funding. However, very little or no domestic funding is being spent on programming specifically for KP.

The lack of substantial growth in PEPFAR and Global Fund funding for KP activities in most assessed countries mean that there has been a struggle to take KP programs to scale. This is exacerbated by the unwillingness of most countries to apply domestic funding to these programs. The recent introduction of Matching Funds programs by the Global Fund – both on activities specifically to scale up KP programming and to reduce human rights barriers for KP to HIV services – offers an opportunity to improve quality and scale of KP programming.

**ANALYSIS: ARE COUNTRIES PREPARED TO ADEQUATELY FINANCE PACKAGES OF SERVICES FOR KEY POPULATIONS?**

Regionally, UNAIDS reports that resources for HIV are insufficient to reach the Fast Track targets. This was confirmed in the five in-country assessment countries where large funding gaps remain. Funding for services for key populations is even more underfunded.

The in-country assessments did not include a detailed review of the funding landscape, but from the data and information collected, it appears that the Global Fund has become the major donor for key population programming in a few of the countries (Benin and Togo). The reality of increasing dependence on the Global Fund to fill the funding gaps for KP programming is not sustainable. However, advocacy should not work to decrease the dependence of HIV and key population programming on resources from the Global Fund or to reduce the proportion that comes from the Global Fund, but instead advocacy should work towards an increase. At the same time, advocacy to increase domestic funding allocations for the entire HIV budget as well as specific funding for KP services is ever important.127

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PART VI: LIMITATIONS

There were several limitations in conducting this assessment process, including during the initial desk review portion of country assessments. Because not all of the assessment questions identified could be answered through desk review, five countries out of the 10 desk-reviewed countries in WCA were followed up with an in-country visit to obtain further information and answer any outstanding questions about the package of services for key populations. For the ‘desk review only’ countries, this meant that APMG Health did not conduct an in-country assessment to collect data and information that could verify that information found in the initial desk review. Data for these five countries has been included throughout this review; however, it has been noted that consultants were limited to those data provided by the Global Fund in quarter four of 2017.

One major limitation of the initial desk review was the above-mentioned list of available documents provided by the Global Fund. Due to the limited time available, desk reviews were a brief scan of relevant documents provided by the Global Fund to desk reviewers.

It is important to note, that for both ‘desk review only’ countries and for those countries that were visited, many have not acknowledged all five key populations identified by the Global Fund (PWID, MSM, FSW, prisoners and TG). This means that limited, if any, data were available for one or more of the key populations.

Due to time restrictions of country visits, only 2-3 sites were selected for visiting (see Table 2). It is important to note that because of this, country assessments are not national and reports only speak to the data available in the regions, districts and cities that were visited or within other reports reviewed. Also due to time restrictions, only two out of the five key populations were observed during in-country data collection. This has therefore limited the amount of data and information about the other key populations that were not selected for the in-country data collection.

Consultants conducting the in-country visits relied on implementing agencies to gather people from key populations for the focus groups. Therefore, respondents may not have been representative of key populations more broadly, particularly of those not accessing services. Focus group participants could have experienced peer pressure or pressure from program staff to give biased answers to the moderator’s questions. Focus group discussions also seemed to be made up of program participants who sought services fairly regularly or were even peer educators themselves. Therefore, the viewpoints of those members of key populations who do not receive services, or face more barriers in receiving services, are not represented. Focus group discussions were often conducted in local languages and therefore at times, were translated for the international consultant. One limitation of this is that only some of the information participants gave were actually recorded and presented in the country report.
It is important to add that another limitation of this regional analysis is that it is based on a selection of countries within a region and therefore, it is not representative of the entire region. Within the group of countries selected, significant diversity exists.
Assessment of HIV Service Packages for Key Populations
West and Central Africa

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ANNEXES

ANNEX 1: SUMMARY TABLE, WHO CONSOLIDATED GUIDELINES

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV prevention (condoms, lubricant, PrEP, PEP, VMMC)</td>
</tr>
<tr>
<td>2. Harm reduction interventions for substance use, in particular needle and syringe programs (NSP), opioid substitution therapy (OST) and naloxone for overdose management</td>
</tr>
<tr>
<td>3. HIV testing and counselling</td>
</tr>
<tr>
<td>4. HIV treatment and care</td>
</tr>
<tr>
<td>5. Prevention and management of co-infections and other comorbidities, including viral hepatitis, TB and mental health conditions</td>
</tr>
<tr>
<td>6. Sexual and reproductive health interventions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Critical enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supportive legislation, policy and financial commitment, including decriminalization of behaviors of key populations</td>
</tr>
<tr>
<td>2. Addressing stigma and discrimination</td>
</tr>
<tr>
<td>3. Accessible, available and acceptable health services</td>
</tr>
<tr>
<td>4. Community empowerment</td>
</tr>
<tr>
<td>5. Addressing violence against people from key populations</td>
</tr>
</tbody>
</table>
ANNEX 2 RECOMMENDATIONS FROM PEPFAR/GF COUNTRY KP STUDIES


The key recommendations for reach are:
- Increase the ratio of peer educators to beneficiaries served, with an ideal target of one peer educator to every 50 peers.
- Design new social and behavior change messages to promote linkages across the HIV continuum and specifically to promote the benefits of early treatment for key populations living with HIV (KPLHIV) and their partners.
- Use information and communication technology, including the unique identifier code (UIC) and mobile technology, to strengthen links between program elements, such as outreach, testing, treatment and sexually transmitted infections (STIs).

The key recommendations for testing are:
- Support all drop-in center (DIC) programs to provide HIV testing onsite and at hot spots, using lay community testers.
- Integrate HIV testing with STI screening and treatment.
- Improve messaging and information and education communication on testing and treatment literacy; explore the feasibility and acceptance of introducing pre-exposure prophylaxis (PrEP) with KP.

The key recommendations for linkage to treatment are:
- Implement one-stop-shop service delivery at DIC: expand HIV services, limit out-referrals, reduce or eliminate the barriers to care and treatment for key populations (e.g. paying for every visit and stigma and discrimination).
- Improve reach and linkage to care and treatment for broader MSM populations and FSW who are not willing to receive services at the DIC or KP-friendly public treatment centers.
- Strengthen case management: sensitize and train providers to work with key populations, including the provision of psycho-social support at all HIV testing and treatment entry points (including mobile campaigns) for beneficiaries who are HIV positive.

The key recommendations for HIV treatment are:
- Maximize opportunities for DIC-level antiretroviral (ARV) drug distribution following ARV prescriptions from partner ART centers.
- Accredit certain DICs as ART centers to prescribe and monitor patients with appropriate, continuous quality improvement.

The key recommendations for retention on ART are:
- Implement differentiated models of service delivery through expansion of multi-month ART delivery.
Promote treatment literacy among health care workers (HCWs) and sex workers to ensure that safe and efficacious regimens are selected and individualized, and that patients are properly educated on side effects.

Optimize and enhance approaches to ensure retention, including minimal wait times, phone-SMS reminders, reduction or elimination of fees, and the sending of samples (not people) to laboratories.

The key recommendations on crosscutting issues are:

- Increase knowledge and use of post-exposure prophylaxis.
- Build capacity of CBOs to provide laboratory services (especially rapid HIV testing) and to transfer specimens to other laboratories instead of sending patients.
- The National AIDS Program should monitor commodities after they are distributed (rather than before distribution) to avoid bottlenecks and stock-outs.
- Train peer educators and lay care providers to recognize the signs and symptoms of STIs, TB and common opportunistic infections. The peer educators and providers should provide immediate referrals back to the facility to ensure that those at higher risk are tested and referred for ART if necessary.
- Train health care providers on clinical and cultural competency with MSM and FSW; engage CBOs in a hospital catchment area in sensitizations and trainings.
- Recognize CBOs and KP community members as leaders and experts, and invest in further development of their technical capacity.
- Provide children of FSWs with HIV testing and Orphans and Vulnerable Children (OVC) services, either directly or through referrals.

The key recommendations for M&E are:

- Use multiple strategies to improve safety, privacy and confidentiality.
- Strengthen the monitoring of linkages from community programs (service delivery) for STIs and HIV care and treatment. The system should be able to monitor self-transfer of beneficiaries between ART centers.
- Continue to align The Global Fund and PEPFAR monitoring systems using UIC in order to track services received by each individual.
Assessment of HIV Service Packages for Key Populations
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The key recommendations for reach are:

- Harmonize across donors/implementers in several areas such as peer educator (PE) allowances, use of updated IEC materials and number of condoms and lubricants distributed per beneficiary based on a risk assessment.
- Increase the ratio of PEs to beneficiaries to around 1:40 for MSM and 1:60 for FSWs.
- Increase the frequency of PE visits to hot spots.
- Increase PE allowances for transport and communications.
- Increase the professional motivation of peer educators (e.g., establish a process for professional advancement and distribute t-shirts, blouses, badges and caps).
- Utilize and update existing IEC materials based on the newly updated national KP package of services for sex workers to increase their understanding and awareness of such topics as PEP, treatment adherence and viral load (VL).
- Provide kits for PEs that include updated IEC materials and a sufficient number of lubricants and condoms for peers’ needs.
- Encourage CBOs to support innovations based on staff and beneficiary experiences, and follow the impact of these innovations.
- Develop targeted social media and Internet platforms to reach unengaged KP members and to provide social and behavior change communication (SBCC) and health services.
- Create social activity spaces to better attract beneficiaries.
- Include clients of FSWs in programming so that FSWs do not bear the burden of condom negotiation alone.

The key recommendations for testing are:

- Train all PEs and Peer navigators (PNs) in HIV testing.
- Reinforce the supply system for HIV test kits.
- Plan for the provision of more than one container of dilution liquid per 100 HIV tests (to allow more PEs to conduct HIV testing at the same time).
- Evaluate risk more effectively before retesting KPs, based on agreed-on criteria.
- Reinforce the testing of stable partners of KPs living with HIV.
- Try new testing approaches (including oral self-testing, partner referral/index testing).
- Provide job aids and other tools as well as request a webinar on the PEPFAR monitoring, evaluation and reporting (MER) indicators for a more standardized understanding of the KP_PREV indicator.
- Improve targeting.

The key recommendations for linkage to treatment are:

- Improve education, counseling and demand creation for treatment among KP to reduce denial of positive status among KP members who have newly tested positive.
- Provide financial assistance for transport of beneficiaries to HIV care and treatment services.
- Have health providers on site in the community for immediate antiretroviral therapy (ART) initiation (mobile enrollment).
Assessment of HIV Service Packages for Key Populations
West and Central Africa

- Harmonize the definition and role of PNs and PEs in national policies as well as with Implementing Partners (IP).
- Reinforce the active referral of KP members newly tested positive in the community to ART service centers.

The key recommendations for HIV treatment are:
- Revise the national policy for ARV dispensation (provide a three-month ARV supply to stable patients after six months of treatment adherence).
- Expand fast-track ARV treatment services for stable KP.
- Assure provider supervised community-level initiation and distribution of ARVs for beneficiaries.
- Assure stock availability for three months or more for ARV dispensation to patients.

The key recommendations for treatment retention and adherence are:
- Initiate a model that permits stable beneficiaries to receive their medication every three months after six months of treatment adherence and with a suppressed VL.
- Reinforce treatment education, psychosocial support and mental health to increase retention/adherence.
- Cover transport allowances to care and treatment services for KP members in need who are living with HIV.
- Support the provision of income-generating activities.
- Provide wraparound services such as family planning, malaria, cervical cancer prevention and clinical services for children of KP.
- Reinforce the technical competency of implementing partner staff to provide services to transgender people and those who inject drugs.
- Commence supervised community initiation and distribution of ARV.
- Harmonize and improve upon the tracking of KP among and across IPs to more effectively gauge treatment success and reduce loss to follow-up if KP move from one implementer to another or move to another region/site.

The key recommendations for VL testing are:
- Improve understanding and importance of VL among PEs, peers and staff within the health facilities to promote demand creation for VL testing.
- Improve the availability of VL testing supplies.
- Increase the use of dried blood spot (DBS) testing.
- Increase demand creation for VL testing among providers to ensure patients receive tests when eligible.
- Use GenXpert for VL testing (subject to the approval of the protocol by CDC).
- Establish memos of understanding (MOUs) between community partners and clinics to facilitate receipt of VL testing results by community partners.
- Encourage the pursuit of decentralization of VL testing.
- Establish an anonymous electronic platform that permits the transmission of VL testing results in real time.
- Strengthen systems to help patients whose VL tests return unsuppressed to reach suppression (VL registers, peer navigation, case management, adherence counseling, switch committees).
The key recommendations on crosscutting issues are:

**Gender-based violence:**
- Strengthen the partnership between law enforcement and KP communities and implementers.
- Develop a comprehensive package of services for violence prevention and response for victims including post-exposure prophylaxis (PEP), psychosocial services and treatment of injuries and ensure the systematic use of the national GBV case documentation forms.

**Stigma and discrimination:**
- Capacity building for KP individuals and organizations to advocate against stigma, discrimination and violence.
- Train providers and KPs on how to effectively advocate for anti-stigma and antidiscrimination policies and practices within different settings.

**Other services:**
- Ensure that IPs collaborate to co-locate KP-friendly orphans and vulnerable children (OVC) programs and prevention of mother-to-child transmission (PMTCT) programs with KP programs.
- Promote partnerships to integrate family planning, cervical cancer prevention and STI services within the KP program.
- Ensure the provision of psychosocial services for KPs.
- Ensure adequate stock of STI drugs, of condoms and lubricants, HIV testing kits, VL reagents and other essential commodities at all sites.

The assessment team also recommends the piloting of certain innovations and best practices:
- Pilot innovative prevention and testing strategies such as pre-exposure prophylaxis (PrEP) for those at higher risk and HIV self- and/or assisted- oral testing.
- Increase technical exchanges among the three IPs through a national level technical working group (TWG), coalition meetings, during the country coordinating mechanism meetings, or other forum.
- Encourage CBOs to implement innovative interventions and monitor the impact of those interventions.

The key recommendations for M&E are:
- Review and reconcile/triangulate currently existing data to obtain KP size estimates.
- Use size estimation data collected by community partners when setting site level annual targets.
- Produce standardized national tools for programmatic mapping and size estimation of KPs at the site level.
- Reduce and harmonize the number and type of community data collection tools.
- Provide support and build partner capacity for use of PEPFAR and custom indicators and HIV cascade construction.
- Strengthen the current UIC reference document to reduce duplication.
Establish a mechanism for sharing program data with key stakeholders.


The key recommendations for reach are:
- Ensure the operationalization of micro planning in all sites.
- Standardize the peer education approach to establish a national standard.
- Standardize the incentives for PEs across all partners.
- Establish a professional advancement process (promote a quota of KP individuals).
- Produce and use social and behavior change communication (SBCC) materials (e.g., strategies for prevention, treatment compliance, viral load).
- Integrate new targeted testing strategies (enhanced peer outreach approach [EPOA], respondent-driven sampling and index testing) into the workflow.
- Strengthen capacities and funding of the KP community-based organization (CBO).
- Make available other services such as pre-exposure prophylaxis (PrEP).

The key recommendations for testing are:
- Expand targeted testing strategies to increase sero-positivity rate.
- Try new approaches for testing (including HIV self-testing).
- Develop a risk assessment tool at the national level and ensure its use.
- Include and formalize awareness for partner notification (index testing) in post-test counseling for HIV-positive key population members.
- Harmonize the operationalization of KP_PREV.

The key recommendations for HIV treatment are:
- Ensure the distribution of antiretroviral drugs (ARVs) in the community for KP.
- Disseminate and ensure the implementation of the service package for PWID.
- Use routine data to improve the cascade (e.g., linkage to treatment).

The key recommendations for treatment retention are:
- Establish a tracking protocol between partners and health facilities.
- Provide income generating activities (IGAs) to KP PLHIV.
- Improve marketing of services offered.
- Strengthen therapeutic education, psychosocial support and mental health.
- Disseminate and display the national tracking protocol for PLHIV in all sites.

The key recommendations for VL testing and monitoring are:
- Reinforce the staff of the national laboratories (hire contractors/consultants to address the bottleneck).
- Consider using undetectable viral load instead of viral suppression level to reach 90-90-90.
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- Improve the supply system for viral load commodities.
- Strengthen the results reporting system between the laboratory and the sites.
- Reinforce the contract for the maintenance of laboratory equipment.

The key recommendations on crosscutting issues are:

**Gender-based violence:**
- Strengthen links between law enforcement and KP communities.
- Integrate the full package of services for GBV victims in all KP programs (including psychosocial services and treatment of injuries).

**Violence, stigma, and discrimination:**
- Raise awareness of and train service providers in sensitization regarding KP.
- Involve politico-administrative authorities in the mechanisms of response to violence.
- Strengthen the capacity of KPs on knowledge of their human rights.

**Other KP services:**
- Consider expanding the package of services for KPs (non-HIV services, nutritional support, vocational support, orphans and vulnerable children (OVC) care, pre-exposure prophylaxis (PrEP) provision, etc.).

The key recommendations for the monitoring and evaluation system are:

- **Mapping and size estimation studies:** Finalize and publish the current national mapping study being led by PNLS.
- Share the results of studies on KP size estimates.
- **Validation of hot spots:** Regularly update hot spots to reflect KP sizes.
- **Annual targets and indicators:** Formalize indicators that capture the provision of services to non-KP populations.
- Develop process indicators to demonstrate key program strategies.
- Update integrated biological and behavioral surveillance (IBBS) data.
- **Data collection:** Harmonize data collection tools across partners and agencies.
- **Data management, analysis and use:** Conduct planning and make course corrections based on strategic information collected.
- **Data quality assurance:** Organize regular evaluation and routine data quality assessments.
- **Data security and storage:** Establish a UIC system.
- Secure individual client files.
- Require M&E staff to sign a confidentiality agreement if they have access to confidential information.
- **Provide sites with secure facilities for data storage** (e.g., cabinets locked and/or affixed to the wall for sites at risk of flooding).
- **M&E organization and capacity building:** Reinforce the referral and counter-referral system.
- Assign one or two members of facility staff to conduct M&E tasks and reinforce their M&E capacities.
- **Client tracking systems:** Document a referral’s effectiveness in the program database.
- Put in place a database with aggregate and individual-level data for client tracking.