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ACTION FOR WEST AFRICA REGION II (AWARE II)

An Assessment of Policy toward Most-at-Risk Populations for HIV/AIDS in West Africa

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Executive Summary

Context

The region of West and Central Africa is the most populous on the continent, totaling 340 million people. Countries in the region suffer significant HIV epidemics, which require a continued and comprehensive response. However, a current plateau in funding for HIV is juxtaposed with increasing needs for coverage and imperatives due to the shifting nature of the epidemic. These pose great challenges for policymakers in the region. In this context, the importance of most at-risk populations (MARPs) for HIV has been mentioned repeatedly.

For mixed and concentrated epidemics, a prevention focus on MARPs is requisite and cost-effective, and the focus involves enhanced surveillance as well as targeted interventions. These are essential from the “know your epidemic—know your response” perspective, as well as for “smart investments.” However, much is uncertain about how HIV policy in the West and Central African region responds to the epidemiological and programmatic evidence on MARPs. These questions remain. Are countries aware of what is needed? Are they doing it? What is working? This report is concerned with the first two issues, i.e., sharing a policy perspective on what is needed for MARPs in the region and producing an inventory of what is being done. One of our main concerns is providing evidence on the situation of a “continuum of response” for MARP that also includes treatment, care, and structural change to fully capture all potential benefits.

This report represents the second volume of the overall situation assessment of MARPs in West and Central Africa by the Action for West Africa Region II (AWARE II) Project. This volume focuses on the subject of policy, which involves, among other elements, laws, regulations, and programs. The broadening of a definition of policy beyond these familiar elements in the context of MARPs is an outcome of this report. Overall, this report has two objectives. The primary objective is to create a framework for policy related to MARPs and to use this framework to assess the situation in the AWARE II region. The assessment involves taking an inventory of existing laws, regulations, and programs in the region. The secondary objective is to interpret the inventory and data in order to identify barriers to effective prevention and treatment/care programming for MARPs in the region.

A Framework for MARP Policy

We frame the idea of a policy space for HIV/AIDS, building on prior work. We see three conceptual areas within the space: the *Determinants of the Policy Environment*, i.e., ideas and agreements among stakeholders; the *Formal Policies*; and *Policy Implementation*, i.e., the programmatic response. We highlight several policy “inputs” that affect one or more of the conceptual areas. These inputs can be considered “building blocks” for the policy areas.

Within the broad concept of MARPs, we focus on **female sex workers** (FSWs), **men who have sex with men** (MSM), **clients of sex work** (clients) and, where they are present, **injecting drug users** (IDUs). We defend our selection of these groups as central to MARP-related policy by explicitly considering epidemiological data and definitions of risk and vulnerability. Our selection follows other studies that also focus on these groups. We also consider epidemiological data in the context of a classification of epidemics in the AWARE II region, which helps in setting policy. Overall, epidemiology is one of the most crucial determinants of the HIV policy space.

Determinants of Policy

We frame our discussion of these determinants under the rubric “Do MARPs matter for HIV policy?” and “What matters for MARPs?”

Do MARPs matter? Our review suggests that MARPs matter for prevention success, given the epidemiology of HIV/AIDS in the region. Many of the countries in the AWARE II region of West and Central Africa have mixed or concentrated epidemics. The established guidance, following two decades of experience with the epidemic in sub-Saharan Africa, suggests that in such contexts, a prevention focus on MARPs is essential for halting transmission and reversing annual levels of incidence. There are proven prevention interventions for each of the four MARP groups (we briefly summarize these below), and while more research is needed into their effectiveness in the West and Central African context, our primary hypothesis is that these proven interventions are applicable.

Based on risk of infection from HIV, we consider four groups as “most at risk”—FSWs, MSM, clients, and IDUs. They are part of a category of the population with higher than average risk of infection. This category can together be termed “vulnerable,” but not all who are vulnerable belong to our definition of “most at-risk.” An example of a vulnerable group is prisoners. For the four key MARP groups, there is evidence from the AWARE II region of relatively high levels of HIV prevalence. Modes-of-transmission studies indicate that these groups contribute greatly to overall HIV incidence.

These groups also matter because together they constitute a significant target group for the delivery of key HIV/AIDS services, such as treatment, care, and mitigation. Our analysis of Demographic and Health Survey (DHS) and epidemiological data shows significant numbers of FSWs and clients in AWARE II countries; this furthers the credibility of a MARPs focus and adds to the finding that targeting these populations for HIV services other than prevention can have significant overall health benefits for the country.

What matters for MARPs? Stigma and discrimination matters, and may prevent access and utilization for services. Within an overall context of stigma and discrimination for people living with HIV (PLHIV), MARPs are more heavily affected because the four marginalized groups also experience other sources of stigmatization. The presence of stigma and discrimination can prevent MARPs from adequately accessing treatment, care, and mitigation services, rendering such groups “hidden” or hard-to-reach in the context of prevention services. Such a climate of stigma and discrimination can severely hamper the success of an overall HIV strategy for the countries of the region. For this reason, a lack of appreciation for stigma and discrimination faced by MARPs, within an overall lack of a MARP focus, could lead to avoidable morbidity and mortality in these countries. There are effective ways to counter stigma and discrimination—we will consider the policy space in this context in the following chapters—but from both a human rights and a program effectiveness point of view, a MARP focus is important. Focusing prevention on MARPs in mixed and concentrated epidemics is also efficient.

However, the AWARE II region is neither spending enough on prevention nor directing it appropriately toward MARPs. Given resource constraints for HIV/AIDS strategies, such a focus would produce smarter investments, allowing more prevention with fixed resources.

A sub-Framework for Formal Policy and Policy Implementation

We use a subordinate framework to examine inputs flowing into the areas of Formal Policies and Policy Implementation. This leads to the methodology we use to guide data collection. Our focus is on laws, regulations, and programs. In developing the framework, we review existing categorizations of policies in the HIV literature.

A common typology distinguishes between structural and other factors. Structural factors shape the environment in which MARPs face the risk of HIV infection and develop vulnerability to the progress of HIV disease after infection. Such structural factors are extremely important in defining the legal, social, political, and sometimes the physical environment in which individuals are exposed to HIV risk. In contrast, there are individual-level factors

that primarily affect the intensity of transmission risk via an individual's risky behavior, such as unprotected anal intercourse, and the frequency of such behavior.

Both structural and individual levels have associated interventions aimed at modifying HIV-related risk factors, and these can have a specific MARPs focus or an outcome of interest to MARP groups.

We used the structural vs. individual distinction in developing a framework for categorizing key policy inputs into the areas of Formal Policies and Policy Implementation. The framework divides policy inputs across *Individual/Direct*, *Individual/Indirect*, *Structural/Direct*, and *Structural/Indirect* categories; this division merges the distinctions in terms of level of intervention (location of interventions and target) as well as the causal and temporal distance to the effects of interest, whether risk or morbidity and mortality.

Using the four categories as a basis for seeking mutually exclusive and exhaustive inputs, we identified 24 *policy inputs* that are key individual and structural factors in the policy space for MARPs. They cover mostly laws, regulations, and programs, which are our focus.

There are several types of laws relevant to both the HIV sphere and MARPs. These include those defining the public health responsibilities of government, which can require funding or access to drugs. There are laws authorizing government agencies to prohibit or require certain HIV-related interventions. Others criminalize or prohibit certain HIV-related behaviors, including HIV transmission itself under certain contexts. Such laws have a particular significance for MARPs, who tend to be associated in a stigmatizing way with these behaviors. However, laws also can be protective for MARPs and can help to dissipate associated stigma, especially when legislation intends to prohibit discrimination. A review of recent literature suggests that these various legal aspects have been adopted in several AWARE II countries of West and Central Africa through "model" or specific HIV/AIDS legislation that followed from a process beginning with a meeting of policymakers and legislators in N'djamena.

Our framework for Formal Policies and Policy Implementation, which includes 24 policy inputs, has broad coverage across these aspects of law and the regulations flowing from legislation. We used the framework to guide secondary data collection using literature review as well as field-level interviews and document review.

Summary of Findings Across the 24 Policy Inputs

We collected findings in response to four main questions.

1. Is HIV prevention policy in the region appropriately responsive to the importance of MARPs?

Based on the data reported to United Nations Joint Program for HIV/AIDS (UNAIDS) and the epidemic classification, it appears that for many countries in the AWARE II region, prevention spending on MARPs is too low. We also reviewed current program implementation across the 24 policy inputs. Below, we summarize, focusing on FSWs, clients, and MSM. There were few data on IDUs, and we report the relevant details on all of these groups in Chapter 4.

FSWs. Systematic reviews suggest that risk-reduction counseling, male condom promotion, and testing and counseling for HIV should be considered the minimum package of interventions for FSWs, to which we can add screening and treatment for sexually transmitted infections (STIs) and HIV treatment based on eligibility.

- There is evidence that these interventions are occurring, but it is unclear if they occur at scale.

- A review of programs suggests multiple interventions in the region involving peer education on condom use. Yet levels of consistent condom use at last commercial sex, as reported by clients, remain low. Interventions with clients are necessary, but one gap may be the ability of nongovernmental organizations (NGOs) to take interventions to scale. Also, structural interventions to improve condom negotiation may be needed.
- A number of documents have raised the issue of the lack of consistent condom use with non-paying partners of FSWs. Interventions that provide risk-reduction counseling to FSWs should include this concern. However, based on our limited review, this does not appear to be a focus in current programs.
- Post-exposure prophylaxis following sexual exposure for FSWs seems a missed opportunity.
- Community-level interventions that intend to increase the ability of FSWs to negotiate condom use have not been explored at scale in the region. The criminalization of sex work, with the exception of Senegal, makes it difficult for FSWs to organize formally. However, peer-led networks exist, including horizontal associations started by an external group, e.g., the “Sister-to-Sister” project of Population Services International (PSI) in Togo. Such organizations should be started in more countries of the AWARE II region.

Clients. Evidence from non-experimental studies in the region suggests that risk-reduction counseling for clients can result in increased rates of consistent condom use. Clients in the region often are targeted in a site- and group-specific manner, e.g., at truck stops. This suggests that, with limited prevention resources, site- and occupation-specific targeting could maximize reduction in HIV incidence. However, not all countries have such targeted programs. Some have non-targeted condom and risk-reduction strategies.

MSM. Risk-reduction counseling and condom plus water-based lubricant (WBL) promotion can reduce self-reported unprotected anal intercourse. Small group and community interventions (e.g., group counseling) are also effective. Our review suggests that, while consistent condom use rates among MSM in the AWARE II region are low, related interventions have not reached scale. In some countries, small-scale programs utilize locational targeting and knowledge of networks to reach MSM, with innovative use of media. In Mali and Sierra Leone, special teams plan to reach MSM at clustering locations. Fixed sites exist in Côte d’Ivoire and Senegal, which enable access to messaging, counseling, and condoms/WBL. In general, the use of peer or special team educators is more likely to succeed than fixed-site-based models to reach the key MSM populations, especially in an atmosphere in which criminalization and related stigma and discrimination drive individuals underground.

Findings and recommendations. HIV prevention programming for MARPs in the region currently is not appropriate or adequate at either an individual or structural level. However, targeted programs are becoming common, utilizing knowledge of local epidemiology, location of key demographic groups from within MARP categories, and MARP behaviors. These are more likely to be effective in an era of constrained resources. Such targeted programs have not been adopted across the region, as they should be. Even targeted programs require scale-up, and it appears that United States government (USG) leadership in countries focused on by the President’s Emergency Program for AIDS Relief (PEPFAR) can be used as an example for strategies funded by other donors.

The following are some specific recommendations in the context of HIV prevention:

1. Clients are too large a group to approach with disjointed prevention strategies, in addition to being instrumental in HIV transmission. More countries should conduct a review of sex work locations, clients’ characteristics and risk behaviors, and other mapping according to geography or occupation.

2. More should be shared on what is working, not normatively, but in the context of individual countries and epidemic contexts. Effective approaches that remain small scale seem unlikely to be replicated outside of their country or even locale. Stakeholders should consider an “HIV prevention with MARP” conference, bringing together implementers and policymakers across the region.
3. Prevention strategies will not succeed in a climate of stigma and discrimination. Criminalization or punitive regulation of certain behaviors related to MARPs makes it harder to reach them with prevention programming. Policymakers should be approached with evidence-based advocacy highlighting the prevention benefits of an accommodating and enabling environment for MARPs.
4. Our analysis focused on the “most at-risk” populations: FSWs, clients, MSM, and IDUs. However, there are other groups whose behaviors leave them at higher than average risk of HIV infection, for example, prisoners. We suggest a review of HIV policy toward these groups as well.

2. Within the region, are HIV services for treatment, care, and mitigation responsive to the needs of MARPs?

The numbers of MARPs in any of the AWARE II countries are significant. In this context, HIV treatment, care, and mitigation services for MARPs will add significantly to the total averted morbidity and mortality. Such services would be responsive if they reach a substantial portion of a country’s MARPs and are cognizant of the socioeconomic position, behaviors, and legal status of these populations. HIV services must be especially cognizant of the impact of stigma and discrimination for MARPs.

Two Approaches to Combating Stigma and Discrimination

1. **Verticalization:** the use of mobile sites, stand-alone sites, or specific times for MARPs at other sites.
2. **Horizontalization:** MARPs are encouraged to use existing services aimed at all PLHIV.

Making existing HIV services “MARP-friendly” can help in the context of stigma and discrimination. We distinguish two approaches in this context. The first is **verticalization**, which refers to the use of mobile or stand-alone sites (e.g., drop-in centers) or specific times for MARPs at other sites. The second is **horizontalization**; in this scenario, MARPs are encouraged to use existing services aimed at all PLHIV. In the AWARE II region, the verticalization mode approaches exist. Senegal used a horizontalization approach, utilizing mediators to help MSM access health services.

Even with verticalization, we do not find enough instances of programs or evidence of scale to suggest that HIV treatment and care services are responsive to MARPs’ needs. The most commonly offered verticalized, non-prevention intervention is STI screening and treatment. There is no general availability of targeted antiretroviral treatment (ART) services for one or more MARP groups except at the small urban scale.

Among the MARP groups, there is a higher likelihood of verticalized programs for FSWs than MSM. This may reflect that FSWs comprise the largest group after clients. However, this finding also partially reflects the fact that, in all the countries, there is a contradictory approach toward MSM.

3. Is there general recognition within governments in the region of the importance of MARPs in HIV programming?

The response is mixed. Certain institutions for which government is a prominent partner—namely the Country Coordinating Mechanisms (CCMs)—are keenly aware of the importance of MARPs, especially for prevention. Government strategies often mention MARPs and a need for a MARP focus in prevention. Also, the governments in Mali, Ghana, Burkina Faso, and a few other countries (e.g., Cameroon, Liberia) have reached FSWs with targeted prevention interventions.

However, beyond this boundary of institutions and Formal Policies, MARPs, especially MSM and IDUs, are not recognized in government policy. Such policy rarely involves constructive engagement of MARP group members in the definition and execution of HIV programs. The lack of effective networks of these individuals is a factor, as is the lack of capacity to nominate MARP members for institutions.

Government documents from the region generally do not speak of targeted curative and palliative services for any MARP (including FSWs and clients) beyond STI screening and treatment. In the context of policy inputs that are laws and regulations, the official stance in the region is profoundly contradictory. The policy seems not to recognize the effects of existing criminalization or punitive laws on worsening stigma and discrimination. While national documents and strategies often recognize the importance of a prevention focus for MARPs, they do not comment on the fact that some existing laws and regulations worsen stigma and discrimination and hence diminish chances of prevention success.

The laws related to criminalization and punitive regulation are old; the modern HIV-specific laws, including those based on N’djamenan model legislation, set a more enabling environment for PLHIV. The N’djamenan laws evolved following a meeting for West and Central African countries held in N’djamenan, Chad in 2004. These laws are major contributions to the process of introducing an explicit human rights focus to the legal treatment of PLHIV. The model laws do not have specific provisions for MARPs, but these populations nevertheless are governed by them in theory. In the civil law systems of Francophone West and Central Africa, the courts lack authority to act where there is no legislation/statute, and judicial precedent has less weight than enacted legislation. Therefore, court actions will not change the situation without top-down legislation.

In countries that have adopted them, we recommend certain amendments to the N’djamenan model HIV laws to tackle sections that can be improved as to language and intent. We discuss these specific areas later in the report. The AWARE II project is assisting several countries in the region with this need.

4. Are best practices in HIV services for MARPs being adopted in the region?

Systematic reviews as well as recently published guidelines suggest some highly effective prevention interventions for MSM, IDUs, and potentially for FSWs. These acknowledge the need to adapt to a context of widespread and doubled stigma and discrimination. Recent PEPFAR guidance on HIV prevention with IDUs and MSM (released separately) suggest that for USG-supported programs, there is an increasing likelihood that country operating plans (COPs) in the region will feature best practice for MARPs.

The situation for government-led programming, especially when it uses a government’s own resources or Global Fund grants, generally is less clear. For FSWs, we feel optimistic that the “minimum effective package” increasingly is recognized as needed. However, implementation takes many forms and requires a more careful review against the latest guidance.

However, as previously discussed, there appears to be a gap in the region’s government programming for HIV prevention services for MSM and IDUs, even in countries where these groups are known to exist. Small-scale

programs exist as implemented by NGOs. Therefore, it may be premature to speak of best practice in terms of the adoption of combined prevention for MSM or the consensus of nine interventions for IDUs.

Best practices in HIV prevention currently emphasize a “continuum of response” that involves an optimal mix of prevention, care, and treatment policies, all of which contribute to a reduction in incidence. Since care and treatment for MARPs from this continuum are inadequate in the region, we are more certain that best practice in HIV services for MARPs is lacking, at least outside of the USG-funded sector.

Next Steps

Our report has taken a regional perspective rather than conduct a country-by-country analysis. There are several reasons for this. A detailed country-level analysis needs to be done, but remaining at the regional level in this report allowed us more time to validate our approach, seek stakeholder comments and viewpoints, and work through potential modifications to the framework before beginning the arduous task of applying the framework to a selection of the 21 AWARE II countries.

The following are next steps for this report and the technical team:

- Seek comments from USAID, country-level experts, MARP groups, and advocacy experts on the report and facilitate a discussion around the recommendations for HIV prevention with MARPs.
- Create dissemination products with the report, including technical briefs, country briefs, and a PowerPoint presentation.
- Expand the analysis to a country-by-country investigation, using the framework developed in this report. The priority will be countries with large MARPs with high HIV prevalence.

Abbreviations

ANC	antenatal clinic	NGO	nongovernmental organization
ART	antiretroviral therapy	NSP	needle and syringe program
ARV	antiretroviral	OI	opportunistic infection
AWARE	Action for West Africa Region	OST	opioid substitution therapy
BCC	behavior change communication	OVC	orphans and vulnerable children
CBO	community-based organization	PAF	population attributable fraction
CCM	country coordinating mechanism	PAMAC	Programme d'Appui au Monde Associatif et Communautaire
COP	country operating plan	PEP	post-exposure prophylaxis
CSO	civil society organization	PEPSE	post-exposure prophylaxis following sexual exposure
DHS	Demographic and Health Survey	PEPFAR	President's Emergency Program for AIDS Relief
DOD	Department of Defense (U.S.)	PICT	provider-initiated counseling and testing
ECOWAS	Economic Community of West African States	PLHIV	people living with HIV
FC	female condom	PMTCT	prevention of mother-to-child transmission
FP/RH	family planning/reproductive health	PREP	pre-exposure prophylaxis
FSW	female sex worker	PSI	Population Services International
GBV	gender-based violence	STI	sexually transmitted infection
GHAIN	Global HIV/AIDS Initiative – Nigeria	TBD	to be developed
HCT	HIV counseling and testing	UAI	unprotected anal intercourse
IBSS	Integrated Bio-Behavioral Surveillance Survey	UNAIDS	United Nations Joint Program for HIV/AIDS
IDU	injecting drug user	UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
IGA	Income-generation activity	USG	United States Government
MARP	most-at-risk population	WBL	water-based lubricant
MNCH	maternal, newborn, and child health		
MSM	men who have sex with men		
MSW	men who have sex with women		
NASA	National AIDS Spending Assessment		

1. Overview of the Report

1.1 Background of the AWARE II Project

The Action for West Africa Region II (AWARE II) is USAID West Africa’s flagship project to provide an innovative, comprehensive approach to scale up integrated best practices in family planning and reproductive health (FP/RH); maternal, newborn, and child health (MNCH); and HIV/AIDS in 21 countries of West Africa. AWARE II is implemented by Management Sciences for Health (MSH) in collaboration with Futures Group International and EngenderHealth.

The strategic objective of AWARE II is to create an enabling environment for countries in the region to plan and implement selected high-quality health service delivery programs. The five key results are as follows:

- Result 1: Regional common strategic vision and priorities for improving the health status of West Africans;
- Result 2: Policies developed and implemented to foster effective regional and national health programs;
- Result 3: Replicating Best Practices: Selected high-impact best practices adopted and replicated;
- Result 4: Using Strengthened African Capacity: A selected number of West African (WA) institutions and networks strengthened; and
- Result 5: Leveraging Funding: New funds mobilized for health programs; existing donor and national resources used effectively.

Result 1 was achieved during the first year of the project. Result 5 was pursued at a modest level during Year 1. Year 2 efforts for the project center on achievements under Results 2, 3, and 4: Policy, Best Practices, and Capacity.

Under Result Areas 2–4, the following are Year 2 priorities:

1. Pursue an integrated and mutually reinforcing package of policy, best practices, and capacity building interventions in FP/MNCH and HIV/AIDS with local NGOs/community-based organizations (CBOs) in four focus countries.

2. Provide monitoring and advocacy to improve contraceptive commodity logistics for all 14 USAID non-presence countries (four focus countries + 10 others).
3. Identify, involve, and respond to needs of most-at-risk populations (MARPs) for HIV/AIDS in 21 countries where evidence shows there is a need—conduct a situation assessment of MARPs in West Africa.

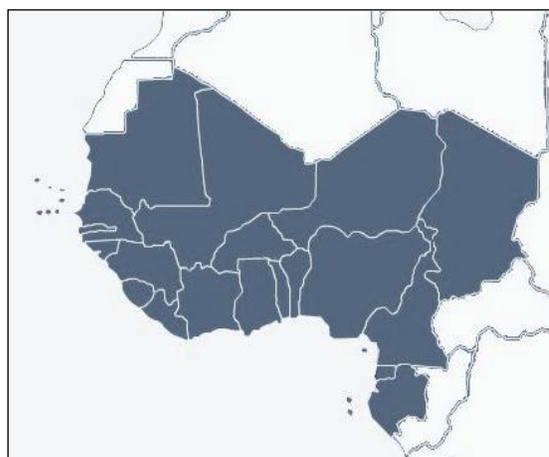
This report derives from the MARP priority area above. It is the **second volume** in an overall situation assessment of MARPs for the AWARE II region, which includes countries from the Economic Community of West African States (ECOWAS), i.e., Benin, Burkina Faso, Cape Verde, Côte d’Ivoire, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, and Togo. In addition, the AWARE II region includes the non-ECOWAS countries of Cameroon, Chad, Gabon, Equatorial Guinea, Mauritania, and São Tomé and Príncipe.

The **first volume**, on which this report draws at various levels, focuses on a desk review of the epidemiology of MARPs in the AWARE II countries and the related strategic or planning orientation (Kellerman, Holtz et al. 2011). This first volume updates the state of knowledge on MARP epidemiology in the region from a report commissioned by the World Bank (Lowndes, Alary et al. 2008). The World Bank report focused only on the ECOWAS countries, so there is the additional value in the current situation assessment of adding Mauritania and the Central African states.

This report, the **second volume**, focuses on the subject of policy, which involves, among other elements, laws, regulations, and programs (sets of interventions). Broadening the definition of “policy” beyond these familiar elements in the context of MARPs is another focus. Overall, the report has two objectives. The primary objective involves creating a framework for policy related to MARPs and using this framework to assess the situation in the AWARE II region, learning from evidence gathered across the 21 countries. The assessment involves creating an inventory of existing laws, regulations, and programs in the region. The secondary objective is to interpret the inventory and data to identify barriers to effective prevention and treatment/care programming for MARPs in the region.

The analysis presented here draws heavily on the data and conclusions from the 2008 World Bank report and a review of subsequently published journal, conference, and gray literature. Among the important sources for information on the policy situation were data collected in each country by consultants. We describe the data collection and analysis process later in the report.

Figure 1. Action for West Africa II (AWARE II) Region—21 ECOWAS and non-ECOWAS countries



1.2 What Is Included under “Policy”?

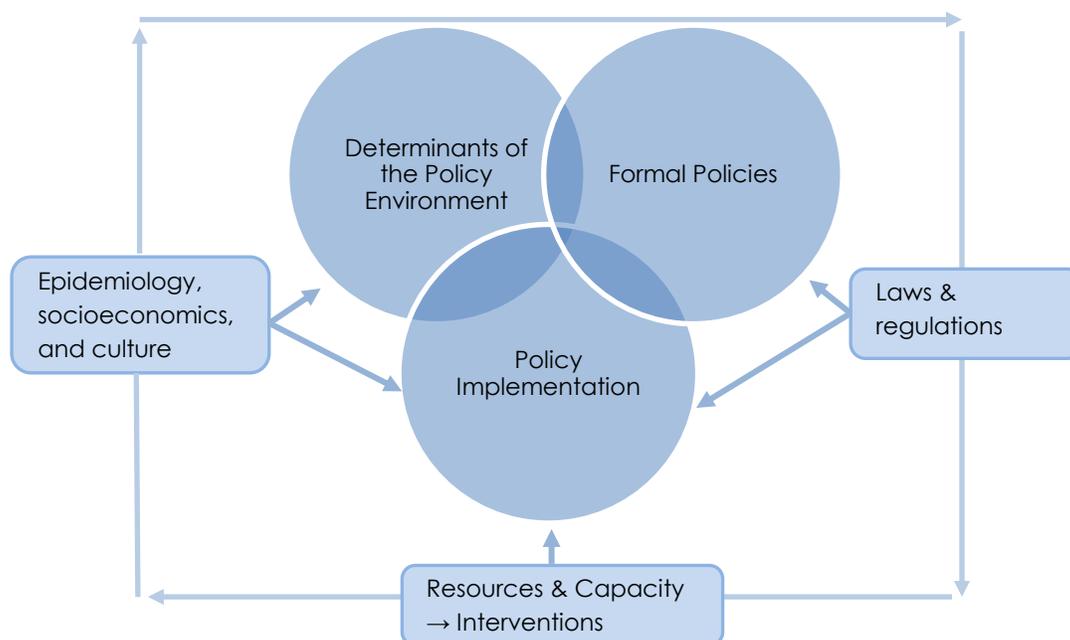
There has been considerable thinking and research around the issue of health policy and how it can be conceptualized to improve service delivery and hence health outcomes. The health policy space can be seen as a sum of documents (formal policies), ideas, and agreements embodied in the stance of key stakeholders, as well as programs and related resources that implement agreed-upon formal policies and ideas. The policy space is constantly evolving as these individual elements change over time due to various inputs, for example, changes in disease dynamics, resources, and society and its laws. Formal policies are themselves “living documents” that change with the input of leadership, monitoring data, and new research (Bhuyan, Jorgensen et al. 2010).

In Figure 2, we reframe the idea of a policy space for HIV/AIDS, building on a prior model (Health Policy Initiative 2009). We consider three areas within the space: the **Determinants of the Policy Environment**—that is, ideas and agreements among stakeholders; the **Formal Policies**; and **Policy Implementation**—that is, the programmatic response. We highlight several sets of policy “inputs” (smaller rectangular boxes in Figure 2) that affect one or more of the conceptual areas (circles). These inputs can be considered “building blocks” for the policy areas. The lists within the boxes in Figure 2 are not exhaustive. There are other key inputs we omitted from the diagram but discuss elsewhere.

The first set of key inputs includes epidemiology, socioeconomics, and culture—all of which can affect ideas and agreements among stakeholders, as well as the design of Policy Implementation. The resources and capacity that lead to interventions are inputs into the definition of a programmatic response and hence, overall Policy Implementation. Laws and regulations are key inputs into Formal Policies.

We see “strategies” (e.g., “national strategies for HIV/AIDS”) as part of the overlapped area between Formal Policies and Policy Implementation. We see some of the Formal Policies acting as areas of agreement and ideation among stakeholders—for example, formal laws on criminalizing sex work reflect the ideas of some but not all legislators and opinion-makers about the norms of social behavior. Such areas of overlap are indicated in Figure 2. There is also interconnection between inputs—resources and capacity have some effect on the socioeconomics of the disease (e.g., modifying the burden on society); and socioeconomics affect laws and regulations regarding disease, which in turn affects resources.

Figure 2. Conceptual framework of the policy space related to HIV/AIDS. Adapted from (Health Policy Initiative 2009)



We accept that the conceptual framework outlined in Figure 2 may be drawn in several ways and the arrows may point in other directions, reflecting the complexity of the policy process and the dynamics inherent in the multisectoral aspect of the HIV/AIDS response. The conceptualization in Figure 2 fits very well with the task undertaken by this report, however. While issues of culture and socioeconomics—inputs into the policy space shown in Figure 2—are worthy of extensive discussion in the context of HIV/AIDS, we have largely omitted these in the present report, in the interest of conciseness and available resources. We draw on some of these issues when we discuss certain determinants of the policy environment for MARP, such as stigma and discrimination around PLHIV, which draws from cultural stereotypes and imposed norms. Similarly, we have omitted a lengthy discussion of capacity, though we discuss the programmatic response and hence bring out aspects of missing capacity in the shape of missing programs that are essential. In the same spirit, we discuss resources in the context of MARPs and so primarily discuss resources for prevention, though we also touch on the need for other HIV services. We discuss these emphases in the next section.

1.3 Organization of the Report

When applying the policy framework in this report, we have also consistently applied the lens of MARPs. While the policy spaces for MARPs and other vulnerable groups (as well as PLHIV) overlap and are closely related, the ranking of policy issues is not the same. Later, we will discuss the nuances in framing “who are the MARPs” vs. “who are the vulnerable” in the context of HIV infection as well

as HIV-related morbidity and mortality. Given constraints of length, and to draw attention to what is relevant for strategy and advocacy, we have focused on those issues important for MARPs.

With the MARPs lens, in Chapter 2, we closely examine the key policy inputs for the AWARE II region in the overall area of Determinants of Policy. Table 1 outlines the inputs we had the data and resources to consider and in what chapter we discuss them most thoroughly. In Chapter 2, we also consider resources for prevention, which relates to Policy Implementation.

In Chapter 3, we develop a sub-framework to further explore the areas of Formal Policies and Policy Implementation, specifically stressing the barriers to access and to the effectiveness of HIV prevention, treatment, care, and mitigation policies. This sub-framework clarifies the level at which interventions are effective, whether at the structural or individual level, and the functional aspects therein. A set of 24 policy inputs or aspects of policy are developed specifically from the perspective of MARPs. These key policy inputs relate to laws, regulations, and programs (sets of interventions).

Chapter 4 discusses the results of our data collection using the 24 inputs developed as part of sub-framework. This data collection was done in 19 of the 21 AWARE II countries, using primary and secondary sources in-country and available databases for the literature. Chapter 5 analyzes the results from Chapter 3, putting them in the context of the discussion from Chapters 1 and 2, as well as providing our overall policy conclusions and discusses areas for further research.

Table 1. Policy areas and key policy inputs in this report—what is included and where

Chapter	Determinants of Policy	Policy Implementation	Formal Policies
Chapter 2 (Results and Analysis)	Epidemiology, Effectiveness Research, Stigma and Discrimination		-
	-	Resources	
Chapter 3 (Framework)	-	Laws, Regulations, and Programs: 24 Key Inputs	
Chapter 4 (Results)	-	Laws, Regulations, and Programs: 24 Key Inputs	
Chapter 5 (Analysis)	Analysis of Chapter 4 results, overall conclusions		

2. | MARPs Matter and What Matters for MARPs in the AWARE II Region

In this chapter, we examine certain inputs into the Determinants of the Policy Space for HIV/AIDS that are related to MARPs. Generally, we examine inputs into policy that guide a focus toward extending or intensifying—as necessary—prevention, treatment, care, and mitigation efforts to certain at-risk population groups in the AWARE II countries of West and Central Africa. For example, we consider inputs such as epidemiology, resources, effectiveness research, and culture/social norms related to stigma and discrimination toward MARPs. The data and reasoning introduced here also are relevant to Formal Policies and Policy Implementation, which we examine in subsequent chapters. Such interconnection among the conceptual areas of policy is inherent in the framework we posited in Chapter 1, Section 1.2.

Here we consider epidemiological and resource allocation information updated since 2008, adding to the knowledge base from the World Bank’s epidemiological synthesis report of HIV/AIDS in West Africa (Lowndes, Alary et al. 2008). Additionally, we consider those non-ECOWAS countries not included in that report but which are part of the AWARE II group. The epidemiological data are summarized to highlight the high probability of HIV transmission from certain high-risk population groups to the general (low-risk) population, and the relatively high HIV prevalence within these most at-risk groups. The former fact is important for prevention targeting, especially in the context of breaking the process of transmission, and is crucial, given constrained resources. The latter fact is developed as a case for MARP-related consideration in treatment, care, and mitigation. A focus on MARPs in these areas can lead to greater effectiveness, i.e., preventing more mortality, morbidity, and economic deprivation per resource unit; such a focus also is a human rights and equity imperative.

Discussion of MARPs in West and Central Africa can involve a varying cast of population groups wherein issues of risk and vulnerability are dealt with imprecisely. To give weight to the policy discussion, within the general category of MARPs, we focus on female sex workers (FSWs), men who have sex with men (MSM), sex work clients (clients) and, where they occur, injecting drug users (IDUs). With this as a backdrop, we consider issues of risk and vulnerability and defend our selection of these groups as central to setting MARP-related policy. In Section 2.1, we attempt to refine the classification of epidemics in the AWARE II region, given data limitations. This can help to relate a MARPs focus on prevention to established principles. Later, we consider the enhanced vulnerabilities the four groups can suffer due to stigma and discrimination. In this chapter, we also briefly summarize the current understanding of the heterogeneity in these four groups across the AWARE II countries. Before concluding, we discuss effective prevention as well as treatment, care, and mitigation policies for MARPs, especially given the size of the groups in the AWARE II region.

2.1 Epidemiological Determinants of Policy

As a part of the distinction between concentrated and generalized HIV epidemics, it is accepted that the greater prevention focus should be on concentrated epidemics within a few groups, where the substantial portion of new HIV infections will emerge (Wilson and Halperin 2008; Wilson and Challa 2009). These groups would be the main focus of biological and behavioral surveillance. In many countries, the groups most commonly included in this category are FSWs, MSM, and IDUs. The terminology used to refer to these few groups is varied, and the differences may signify emphases deriving from prevention, or more broadly from human rights. Therefore, these groups have been characterized as “vulnerable,” “most at-risk,” “core,” or “target” groups. In an emerging distinction, “vulnerable” can be separated from “most at-risk.” We discuss this in Section 2.2. In this report, we generally use the “most at-risk” construction, in which the risk is that of becoming infected with HIV, and discuss any aspects of socioeconomic vulnerability and programmatic targeting explicitly. We also mean “most at-risk groups or populations” when using the common acronym “MARPs.” Unless otherwise indicated, “general population” means adults 15–49, and related HIV prevalence can be interpreted in this way.

As a byproduct of the greater risk of infected faced by individual MARPs, the HIV prevalence in these groups is much higher than the general population, i.e., all low-risk groups. In the first volume, we provided a summary table of HIV prevalence in three MARP groups—FSWs, MSM, and IDUs. Illustratively, based on 2008 data from the World Bank report, the average HIV prevalence among FSW in Benin (25.5%) was 17 times that of a low-risk female, and in Burkina Faso (16%) it was 8.9 times. Surveillance during 2010 in Cameroon suggests the prevalence among FSW was 36 percent (CCM Cameroon 2010). In Ghana, the average HIV prevalence among MSM in 2008 (25.3%) was 16.9 times that among all men (Lowndes, Alary et al. 2008). A systematic review of the global HIV epidemic among MSM suggests that they have significant odds ratios of HIV infection in low-prevalence or very low-prevalence countries, 14.4 and 58.4, respectively (Baral, Sifakis et al. 2007).

Given high HIV prevalence and the absence of effective prevention, MARPs can be important in the transmission of HIV at two levels. The primary level is risky sexual contact between certain core MARPs and related “bridging” groups (terms to be fully defined in Section 2.2). This is a channel through which there can be wider transmission of HIV infection into the lower-risk general population. Briefly, risky sexual interaction of uninfected bridging individuals with infected MARPs can lead to “first wave” infections, which can grow into a local generalized epidemic based on how productive these infections are, i.e., how many further infections they cause, and whether a chain of transmission is then sustained over time. A secondary level is HIV transmission within the MARP groups, for example, MSM and IDUs. For FSWs and IDUs, all sexual partners are a bridging population. For FSW, the key bridge is clients, though non-paying casual sex partners are also often included in this category. Clients have relatively high average HIV prevalence from first-wave infection and produce subsequent infections among uninfected spouses and lower-risk sexual partners. Therefore, they are a MARP for our purposes.

How much sex work contributes to new infections in the general population can be related to specific factors. In epidemiological modeling of sex work, three factors are noted: the relative risk, or the ratio

of prevalence in FSWs vs. the low-risk adult population; the etiological factor, or the proportion of new HIV infections among clients attributable to sex with the FSWs; and the population attributable fraction (PAF), or the proportion of new infections among adult males attributable to sex with FSW (Table 2).

Table 2. Estimated contribution of sex work to new infections in the general male population

Location	PAF	Year of data	Source
Accra, Ghana (“best estimate”)	84%	2004	(Côté, Sobela et al. 2004)
Cotonou, Benin	76%	1998	(Alary and Lowndes 2004)
Rufisque and Tambacounda, Senegal	81%	2005	(Wilson and Fraser 2011)
Lomé, Togo	32%	2005	(Sobéla, Pépin et al. 2009)

Portions of this table adapted from (Wilson and Fraser 2011)

A more general framework to discuss the importance of sex work in HIV transmission also would include the proportion of all men who participate in procuring sex, the average number of low-risk sexual partners for such clients, and the consistency of condom use during transactional sex acts, all of which determine whether infections in the bridging population and their lower-risk contacts continue a chain of infections. This “sustained” transmission within a lower-risk sexual network and related groups, enabled by other factors such as the lack of male circumcision or a high population-level frequency of multiple sexual partnerships, can lead over time to generalized HIV epidemics.

The HIV epidemics in West Africa have been difficult to categorize at a regional level, unlike the categorization of southern or eastern Africa as regions featuring (mostly) generalized epidemics. It should be emphasized that West Africa is the most populous region in Africa, totaling 340 million people (Table 3), and prior reports stated that it does have a serious HIV epidemic (Lowndes, Alary et al. 2008).

To discuss the importance of MARPs for surveillance and programming and frame the policy issues introduced in this report, it is helpful to consider the overall epidemiological situation. The World Bank report on ECOWAS countries used three groupings: mixed, concentrated, and some “countries in the middle” (Lowndes, Alary et al. 2008). Based on new data since 2008, we revisit these groupings. We began this discussion in the first volume (Kellerman, Holtz et al. 2011). For the present discussion, we consider the AWARE II countries in **three sets**, based on their HIV epidemiology.

The **first set** contains certain AWARE II countries where epidemiological analysis suggests that transmission between MARPs and their bridging populations contributes a significant proportion of new infections, at least in parts of the country. Additionally, there is some sustained level of HIV transmission within low-risk heterosexual groups, at least in parts of the country (e.g., Nigeria, Côte d’Ivoire, and Ghana). This subset of countries can most appropriately be said to have *mixed* epidemics. The relative intensity of these two forms of transmission and their spread can help in epidemic classification and policy setting. Modes-of-transmission studies can provide more evidence for the presence of a mixed epidemic. Countries with such mixed dynamics include a subset with geographically diverse epidemics, where certain regions display the characteristics of a generalized

epidemic and others, concentrated. Mixed epidemics also include those in which “temporal mixing” is occurring, i.e., where there is a *potential* for epidemics to expand from a high-risk group to the general population (Wilson and Fraser 2011). While below we discuss epidemiological data since 2008 related to MARPs, we do not yet have enough data to clearly distinguish between geographically mixed vs. temporally mixed epidemics.

Mixed epidemics merit the judicious behavioral and biological surveillance of the antenatal/general population where appropriate, and more intensive surveillance and prevention programming among MARPs (Wilson and Halperin 2008). The balance is dictated by local transmission dynamics. The rationale for balance is that even if transmission among and from the MARPs is stopped with effective prevention programs, the transmission among low-risk groups could sustain a part of the epidemic.

This first set includes some countries that the World Bank report considered “in the middle” between concentrated and mixed: Benin, the Gambia, Guinea, Guinea-Bissau, Mali, Liberia, and Sierra Leone. The World Bank report discusses how the “in the middle” countries have transmission dynamics that are unclear to inform prevention policy. It is uncertain whether their epidemics could be maintained by transmission in the low-risk population alone without productive waves from MARPs.

In the case of Côte d’Ivoire, the World Bank report states that there was until recently “substantial transmission” between certain MARPs and the general population via the bridging groups (Lowndes, Alary et al. 2008). A modes-of-transmission study was conducted in 2009 (Ahimou 2011) but has yet to be released. This study could allow a better classification. However, recent discussions have suggested that the country should be classified as having a mixed epidemic (Wilson and Fraser 2011).

The mixed epidemic countries also include Cameroon, Ghana, Nigeria, and Togo. A recent modes-of-transmission study for Ghana suggests that 41 percent of all new infections in a year can be traced to infections among FSWs, MSM, IDUs, and clients, plus the first generation of “produced” infections among their partners (Bosu, Yeboah et al. 2010). Sex in the general low-risk population accounts for 59 percent of new infections. This distribution of new infections suggests that Ghana too has a mixed epidemic. Similarly, the Nigerian modes-of-transmission study suggests a mixed epidemic in which the key MARPs (FSWs, MSM, and IDUs) contribute 23 percent of all new infections in the country by themselves, and when bridging populations are included the total, account for 40 percent of all new infections (NACA 2008). Nigeria is one of the few countries in the region with data on prevalence among IDUs—the Integrated Bio-Behavioral Surveillance Survey (IBBSS) in 2007 indicated a level of 5.6 percent, compared to antenatal clinic (ANC) prevalence data, which showed 4.6 percent.

A study conducted in 2005 in Togo found HIV prevalence of 45 percent among sex workers in Lomé and 18 percent outside it—13 and 5 times the general population level, respectively (Sobéla, Pépin et al. 2009). The related levels for clients were 8.3 percent in Lomé and 3.9 percent outside of Lomé, levels close to those of the general population. Authors of the study estimate that in Lomé, one-third of prevalent cases of HIV among men were acquired from transactional sex.

Table 3. Basic facts on AWARE-II countries in West and Central Africa

AWARE-II country	2010 Pop., "000s ¹	2008	2009
		Adult 15–49 HIV prevalence, % ²	
Benin	9,212	1.2	1.2
Burkina Faso	16,287	1.6	1.2
Cameroon	19,959	5.1	5.3
Cape Verde	513	N/A	N/A
Chad	11,506	3.5	3.4
Côte d'Ivoire	21,571	3.9	3.4
Equatorial Guinea	693	3.4	5
Gabon	1,501	5.9	5.2
The Gambia	1,751	0.9	2
Ghana	24,333	1.9	1.8
Guinea	10,324	1.6	1.3
Guinea-Bissau	1,647	1.8	2.5
Liberia	4,102	1.7	1.5
Mali	13,323	1.5	1
Mauritania	3,366	0.8	0.7
Niger	15,891	0.8	0.8
Nigeria	158,259	3.1	3.6
Sao Tome & Principe	165	N/A	N/A
Senegal	12,861	1	0.9
Sierra Leone	5,836	1.7	1.6
Togo	6,780	3.3	3.2

Sources: ¹ (United Nations Population Department 2010) ² (UNAIDS 2011)

A recent PEPFAR consultation on mixed epidemics included presentations from Cameroon, Côte d'Ivoire, Ghana, and Nigeria (AIDSTAR-One 2011). Here it was suggested that based on their transmission dynamics, Togo and Cameroon also could have mixed epidemics. We note that Togo was considered “in the middle” in the earlier World Bank report and “generalized” in its Global Fund Round 8 proposal. In the absence of a modes-of-transmission stud, such discrepancies are hard to reconcile.

In Burkina Faso, there are marked differences in HIV prevalence between regions. The South West region, at 3.7 percent, has the highest level after the capital region (Wilson and Fraser 2011), potentially driven by migrants repatriating from Côte d'Ivoire, gold-washers, and travelers going to and from Ghana (Lowndes, Alary et al. 2008; Larmarange, Vallo et al. 2010). Migrants were identified

as a high-risk group in the World Bank report. Such dynamics often are not picked up in routine ANC surveillance for the country (Larmarange, Vallo et al. 2010). Migrants can become clients of sex workers or may engage in transactional sex themselves in the Burkina Faso context (Khan, Patnaik et al. 2008). Separately, a study in Bobo-Dioulasso—a city in a region adjacent to the South West—found an HIV positivity rate of 34.5 percent among female sex workers, 20 times the prevalence in the general population (Traore, Meda et al. 2008). If transmission is being fueled by migrants and FSWs in one part of the country, whereas others, including rural areas, have stable low prevalence, Burkina Faso may have a temporally mixed epidemic or one expanding from concentrated to mixed/generalized.

Among the countries labeled “in the middle” (Benin, The Gambia, Guinea, Guinea-Bissau, Liberia, Mali, Sierra Leone), many have recent population-based prevalence between 1 percent and 2 percent (Table 3). The historical approach of using a threshold for the national HIV prevalence would have considered these concentrated epidemics and automatically suggested a focus on certain high-risk groups. However, a classification based on transmission dynamics is better able to inform prevention and lead discussion of the importance of MARPs in HIV policy. This requires modes-of-transmission studies to appropriately suggest if there is a trend toward a mixed epidemic.

We are not aware of published modes-of-transmission studies for this subset of countries at this time. A draft for a Benin study from 2008 has not been published. Seroprevalence and behavioral surveillance data since 2008 are scarce in these countries, for the general population or MARPs, with the exception of Benin.

In Benin, a study in several major cities, such as Cotonou, Parakou, and others, found very high HIV prevalence among self-declared FSWs, at levels 14 to 40 times that in the general population, depending on the city and the characteristics of the sub-sample of FSWs (Ahoyo, Alary et al. 2009). A long-term study of male clients of FSWs in Cotonou found the HIV prevalence rates in this group to be consistently 5.3 times higher than the general population (Lowndes, Alary et al. 2007). A modes-of-transmission study for Benin currently is not available, but a small sample qualitative study conducted in a border community between Nigeria and Benin suggested that 90 percent of HIV infections could stem from sexual transmission, and 7 percent from injecting drug use (Fasinu 2010).

The other six countries from this subset are relatively neglected in the HIV literature, especially as to epidemiology for MARPs. For example, to our knowledge, the most recent seroprevalence data among FSWs in Mali is from the 2006 Integrated STI/HIV Behavioral Survey, which reported a prevalence of 35 percent (USAID 2010). In Guinea-Bissau, small sample sentinel surveillance among FSW in 2009 showed an overall prevalence of 39.6 percent across HIV-1 and HIV-2, nearly 16 times the general population level (SNLCS 2010). There was extensive geographical variation in the prevalence among FSWs. Qualitative work on MARPs has occurred in a few countries, including The Gambia; what work has been done (Mah and Dibba 2008) suggests that local epidemics may be fueled by sex work.

In countries with mixed epidemics—Burkina Faso, Cameroon, Côte d’Ivoire, Ghana, Nigeria, and Togo—there is clear benefit in focusing on surveillance and prevention programming in the focal MARP groups, as well as the key bridging population, i.e., sex work clients. This should be supplemented with judicious surveillance and programming for other vulnerable groups and portions

of the low-risk population, designed as to fit local transmission dynamics. A related consideration is that given the high prevalence among the MARPs in mixed epidemics, treatment, care, and mitigation efforts that recognize their needs will convey benefits via reduced overall HIV-related mortality and morbidity.

We have discovered little new information to change the finding of the World Bank 2008 report that Benin, the Gambia, Guinea, Guinea-Bissau, Liberia, Mali, and Sierra Leone are “in the middle.” These may qualify for the definition of expanding or temporally mixed epidemics where there is the potential for concentrated transmission to expand into a mixed/generalized dynamic in the absence of effective policies. Regardless of the imprecision in the typology for these countries, it is relatively certain that an HIV prevention focus on MARPs is necessary in their programs.

The **second set** of AWARE II countries includes those with a relatively high UNAIDS reference group adult HIV prevalence (Table 3) but with insufficient data on their epidemics or transmission dynamics to make any significant conclusions on categorization. This set comprises Chad, Equatorial Guinea, and Gabon. These non-ECOWAS countries were not included in the World Bank 2008 report. In Gabon, recent sentinel surveillance data from only 18 sites was used to estimate a national HIV prevalence of 5.2 percent for 2009 (Ministère de la Santé 2010). In Chad, the situation of armed conflict and internal displacement has made a population-level seroprevalence study difficult—the most recent data available at this level are from 2005. The 2009 national HIV prevalence is estimated at 3.4 percent. A study among pregnant women in one location showed a near-doubling of HIV prevalence from 5 percent to 9.5 percent from 2002 to 2009. Risk of sexually transmitted diseases among internally displaced people and the fishing communities around Lake Chad is considered high. An investigative report from 2009 (CNLS Chad 2010) puts the prevalence among female sex workers at rising above 20 percent.

Equatorial Guinea reported a generalized epidemic, with substantial and sustained transmission in the general population and consistently high and increasing ANC surveillance values for HIV prevalence (PNLS 2010). There is some urban-rural and inter-regional variation in levels. Surveillance during 2004 had estimated an ANC prevalence level of 3.4 percent, which increased to 7.3 percent in 2008. Table 3 also suggests an increasing trend in the estimated adult HIV prevalence. There are few data on prevalence in MARPs such as FSWs, a situation described as resulting from inattention to the issue (PNLS 2010). The ongoing 2011 DHS will help to explore the dynamics of HIV in Equatorial Guinea.

Despite the lack of detailed epidemiological information, the relatively high HIV prevalence in these countries, compared with the relative lack of resources for prevention (at least in Chad and Equatorial Guinea; see Figure 3), suggests that a targeted prevention effort is necessary. In Gabon, the Round 8 Global Fund grant establishes a priority of promoting safe sex behaviors among FSWs, characterizing them as one of the populations with high HIV risk. In Chad, though recognizing that condom use among FSWs was low—only 29 percent reported using a condom during their last sexual encounter (CNLS Chad 2010)—there was no prevention targeting for such MARPs.

In Chad, only 29 percent of FSWs reported using a condom during their last sexual encounter.

The **third set** concerns those that the World Bank report labeled as “concentrated epidemics”: Cape Verde, Niger, and Senegal. There is some new MARP-related information for these countries since 2008. In Senegal, a study found high HIV prevalence (22.9%) among FSWs over 30 years of age—a level 23 times the general population prevalence (Kane, Diawara et al. 2009). Among MSM, the prevalence in 2007 was 22 times that in the general population (Wade, Larmarange et al. 2010). Although precise data from recent years are not available, past studies have drawn attention to the heterosexual partnerships of MSM in Senegal, which if discordant, are a site for secondary infections (termed “first wave” in the World Bank report), especially since condom use was not consistent—23 percent of anal intercourse acts with men and 38 percent of vaginal intercourse acts were unprotected (Larmarange, Wade et al. 2010). These heterosexual partners can act as a bridging population. The productive nature of these secondary infections—that is, whether they lead a next wave—depends on their partners’ behavior.

For the small country of Cape Verde, recent general population prevalence estimates are missing. A prevalence estimate of 0.8 percent dates from the country’s 2005 DHS. This indicates the relatively poor sero-surveillance system in the country.

In Niger, the prevalence based on sentinel surveillance during 2009 was 21 percent among FSWs (CSLS 2010). Mauritania was not included in the World Bank report from 2008, as it is a non-ECOWAS country. Its low general population HIV prevalence suggests it does not belong in the special consideration “second set” discussed above. The country does not show dramatic internal variation in its low levels of HIV prevalence (CNLS Mauritania 2010). A survey among sex workers in 2007 suggested an HIV prevalence of 7.6 percent, 11 times the general population level. High levels of male circumcision may have dampened transmission outward in the low-risk population, just as in the case of Niger (WHO 2007). This suggests a typical concentrated epidemic.

The data on general population and MARPs HIV prevalence and transmission dynamics since 2008 do not change our interpretation for this third set of countries as concentrated epidemics.

Table 4. Summary of epidemiological update since 2008 for AWARE II countries

Three Country Sets	Type of Epidemic
1a. Cameroon, Côte d'Ivoire, Ghana, Nigeria, and Togo 1b. Benin, Burkina Faso, The Gambia, Guinea, Guinea-Bissau, Mali, Liberia, Sierra Leone	1a. Likely mixed 1b. “In the middle”
2a. Chad, Gabon 2b. Equatorial Guinea	2a. Unclear, likely mixed. 2b. Likely generalized
3. Cape Verde, Mauritania, Niger, Senegal	3. Likely concentrated

2.2 HIV Risk and Vulnerability among Population Groups

An emerging distinction between “most at-risk” and “vulnerable” challenges the frequent semantic mixing of the two terms. This mixing has belied important differences in policy response. Briefly, while all of the most at-risk groups, or MARPs, are “vulnerable,” not all vulnerable groups are “most

at-risk.” We accept that the “risk” in most at-risk is that of HIV infection. This stems from their high-risk behaviors, such as unprotected anal or vaginal sex or injecting drug use with shared needles. As a corollary, these groups have relatively high HIV prevalence levels (discussed in detail in the previous section), and levels of morbidity and mortality via the progression of HIV and opportunistic infection higher than comparably aged cohorts in the population. The latter fact can suggest a definition of “vulnerability” focusing on relative social and economic stressors that increase the likelihood that HIV disease will have a negative impact on a particular group (Onwuliri and Jolayemi 2005; Fatusi 2007). In Section 2.5, we explore how vulnerability in this sense may be higher among HIV-positive MARPs than other PLHIV because of structural problems that prevent access to or utilization of necessary treatment, care, and mitigation services for MARPs. Thus, analysis of policy issues linked to these problems is necessary.

From a prevention perspective, vulnerable groups are the overall category of individuals with a higher risk of HIV infection than the general population, due to their behavior (Djomand 2011), and these *include* MARPs. The differentiation with other definitions of vulnerability (socioeconomic or cultural) is important to avoid blurring of boundaries between distinct groups (Lowndes, Alary et al. 2008). While there are no international guidelines as to the threshold at which “*most*” at-risk becomes an applicable label, it is suggested that a group may be vulnerable (higher risk) without being the most at-risk. This understanding exists among in-country stakeholders, as demonstrated by a recent study in Ghana (Jeffers, Dohlie et al. 2010). Examples of vulnerable groups beyond FSWs, MSM, and IDUs in the West African literature include migrants, prisoners, transport workers, men in uniform, itinerant or indigent persons (e.g., peddlers, street youth), and occasionally, out-of-school young people (Table 5). There *is* evidence for the higher risk status of some of these, especially as clients. Migrants can be opportunistic sex workers as well as clients, as shown in a study from Burkina Faso (Khan, Patnaik et al. 2008). They are likely to engage in unprotected casual sex behavior away from regular partners. Behavior based in promiscuity and being clients of FSWs is associated with men in uniform in West Africa (Biague, Månsson et al. 2010).

These vulnerable groups often are mentioned in the same context as FSWs and MSM in Global Fund proposals (Table 5; not shown but similar: Chad, Guinea-Bissau). In the current National Strategic Plan for Nigeria, MARPs include FSWs, IDUs, MSM, long-distance drivers, young people, and men in uniform (NACA 2010). We expect that some of these groups are included as clients and hence *are* included in our definition for this report. These groups together have been termed “priority populations,” e.g., in the terminology of the Resource Needs Model (Futures Institute 2010). Prisoners, young people, and out-of-school youth also have been included in the same terminologies. These three groups are not obvious clients of sex work. A cursory analysis of the language suggests that when risk is used explicitly as a construct, it is more likely that groups traditionally considered most at-risk will be referenced. Constructs such as “most affected” and “difficult to reach” also have been used for MARPs (Table 5), which suggest issues related to service delivery that will be essential in our policy framework.

Table 5. Included groups and semantics around “most at-risk” populations in Global Fund proposals

Country	Grant Proposal/Focus	Terminology	Groups Referred and Included*
Benin	HIV Round 9/Prevention	“key high-risk”	Sex workers and their clients, MSM, incarcerated populations
		“key high-risk and vulnerable groups”	All above, plus “young people”
Côte d’Ivoire	HIV Round 9/Prevention	“key populations at high risk of HIV infection”	Sex workers, prison population, MSM
Gabon	HIV Round 8/Comprehensive	“most affected populations”	Pregnant women, infants born to HIV+ mothers, “PLHIV,” OVC, sex workers, out-of-school 10–24 yr. olds
Nigeria	HIV Round 9/Comprehensive	“most-at-risk populations”	FSWs, MSM, IDUs
		“difficult to reach populations”	FSWs, MSM, IDUs
		“other most-at-risk population groups”	Young people, sex workers, MSMs, military, out-of-school young people

* Naming of groups as per the original text.

For this report, as suggested earlier, we focus on the following as the MARPs, as echoed in most West African policy and epidemiological documents: FSWs, MSM, clients, and IDUs. We recognize the importance of the other vulnerable groups and include certain policy issues in our framework—to be discussed further below—that address prevention among them. However, we reiterate that our focus on these four MARPs is driven by their high susceptibility to HIV infection, which over time drives a relatively high group-specific prevalence. Given this, a policy focus follows for MARPs from their importance in prevention. Data presented in Section 2.1 from modes-of-transmission studies in certain AWARE II countries strongly indicate the large number of new infections that can be attributed to these MARPs. Current epidemic classifications suggest that widely agreed global strategies concentrating surveillance and targeted interventions on MARPs are appropriate for most AWARE II countries. From a treatment and care viewpoint, MARPs can be more vulnerable to adverse health and non-health outcomes related to HIV. The latter, conflated with structural factors, is an important issue to consider for treatment, care, and mitigation programming and policies.

This definition of MARPs for prevention can be improved by paying attention to the nuance of “core” and “bridging” groups introduced earlier. The four groups included in our definition of MARPs differ on these labels. The use of “core” emerges from the World Bank and other epidemiological synthesis reports, and seems synonymous with the highest levels of HIV risk and its sustained levels over time in a particular group. In the case of the AWARE II countries, as in much of sub-Saharan Africa, the pre-eminent core group is FSWs. The core groups of FSWs and clients are linked; clients can infect FSWs as well as be infected by them. Here HIV-positive clients act as a “bridge” to the lower-risk general population through their other sexual partnerships, including spouses and long-term partners

(Lowndes, Alary et al. 2008). The use of the “bridging” group terminology is becoming more common in West Africa and is being applied to sub-categories within the client group, such as transport workers (Adeyemi, Azeez et al. 2010).

Prior analysis has suggested that MSM in West Africa are core (highest risk) and also bridging, where the latter role is through lower-risk partners, including the heterosexual (Larmarange, Wade et al. 2010).

While information on IDUs in West Africa is still evolving, there is cause to place IDUs among the core groups, based on modeling in Nigeria, where the modes-of-transmission study estimated 9–10 percent of annual new infections came from IDUs and MSM (NACA 2008). A recent global review identified that 16 out of the 47 sub-Saharan African countries have injecting drug use (Mathers, Degenhardt et al. 2010). Another factor that suggests IDUs as a core group is that risky injecting behavior may coexist with risky sexual behavior, based on studies from non-African contexts (Pisani, Sucharya et al. 2003).

2.3 Heterogeneity within the Core MARPs

We briefly consider the heterogeneity within the AWARE II region in the cases of FSWs and MSM, the two core groups on which we will devote considerable attention when developing our policy framework.

Female sex workers. Other studies have discussed the heterogeneous nature of sex work in West and Central Africa (Lowndes, Alary et al. 2008; WHO 2011). We find heterogeneity expressed along three lines: *location* of sex work, *nature and frequency* of the transaction, and other *characteristics of the sex worker* (e.g., age, local vs. foreign, etc.). Each of these sources of heterogeneity has significance for policy. These lines of difference can be interconnected: for example, foreign women practicing sex work in a country may be more overt and commercialized, with sex work forming the sole source of income.

Issues of location of sex work can be expressed in the form of distinctions between those sex workers who choose to work from an established location, i.e., “seaters” working from a brothel or home, and those who prefer to work from the street, bars, or no fixed location, i.e., “floaters” or “roamers” (Fatusi 2007; Lowndes, Alary et al. 2007). It appears that those practicing from a fixed location would be easier to enumerate and target with behavioral change communication and other interventions. This also may be correlated with the epidemiological need. Seaters in the region have shown higher levels of HIV prevalence than roamers (Nagot, Ouangre et al. 2002; Villalba-Diebold, Saidu et al. 2008).

There also may be differences in the client profile of seaters vs. roamers in ways associated with sexual risk and a possible role of clients as “bridge.” Clients of seaters in Accra were more likely to be HIV positive and know how to demand unprotected sex (Côté, Sobela et al. 2004). Because fixed locations may signify more overt or “professional” sex work, they differ from floaters and roamers, who by definition are harder to pin down. The latter may include a subset of those who choose to roam due to a desire to practice clandestinely. Clandestine sex workers might be more difficult to approach with interventions because the individuals may not want to be identified as selling sex. For example, in

Burkina Faso, street peddlers also exchange sex for money with truck or bus drivers (Nagot, Ouangre et al. 2002; Côté, Sobela et al. 2004). On the other hand, registered sex workers exist in Senegal. Condom use rates were higher among registered than unregistered FSWs in Dakar, who mostly identified clients in bars and hotels (Lowndes, Alary et al. 2007).

Distinctions based on the nature of sex work and its frequency, established between opportunistic, commercial, and survival sex work, are now well-known, and may apply to the West and Central African context. Overarching frameworks also have been proposed to create a more descriptive typology. These can distinguish between six types in Burkina Faso (Nagot, Ouangre et al. 2002) to as many as 25 types of sex work globally (Harcourt and Donovan 2005). While “transactional” sex work is a broad category, its practitioners include those who occasionally and opportunistically engage in sex work in exchange for gifts, money, and other considerations. Commercial sex workers, often overt or professional, can have more clients and can depend on sex work for larger proportions of their overall income. Commercial sex work also can be associated with brothel-based sex work, as well as coercion in some contexts by traffickers, pimps, and “madams.” The level of agency in sex work is variable.

Opportunistic sex work:

practitioners occasionally and opportunistically engage in sex work in exchange for gifts, money, and other considerations.

Commercial sex work:

practitioners, often professional, depend on sex work for larger proportions of their overall income.

Survival sex work:

sex work practiced in situations of dire necessity, either for the person or their dependents.

Survival sex work is defined as transactional sex work practiced in situations of dire necessity, either for the person or their dependents, and often occurs in situations of forced migration and economic or food deprivation. Poverty, migration, and sex work have been linked in the AWARE II region, most recently in the context of the Niger delta (Oyefara 2007; Udoh, Mantell et al. 2010). Understanding the nature of sex work in the program area may help in better designing interventions.

Finally, age and nationality are important characteristics of sex workers in the West and Central African context. Age, as a proxy for cumulative exposure, is positively correlated with HIV prevalence among sex workers in West Africa in multiple studies (Côté, Sobela et al. 2004; Sobéla, Pépin et al. 2009; Trop 2009). Movement between countries for sex work, whether voluntary or involuntary (trafficking), is very common in the region. Studies in Togo, Burkina Faso, and elsewhere have suggested that foreigners practice overt sex, especially as seaters, whereas local women offer sex for

exchange more clandestinely and may represent a larger proportion of roamers (Nagot, Ouangre et al. 2002; Sobéla, Pépin et al. 2007; Sobéla, Pépin et al. 2009). Other sampling studies of sex workers have reported widely on the diverse nationalities in any one location (Trop 2009). Coerced movement for sex work also occurs, and though often reported in the local media, it has not been studied systematically. Coerced movement can occur within the AWARE II region (Omorodion 2009) as well as out of it (Carling 2005).

Men who have sex with men. The use of the term “men who have sex with men” may obscure considerable sexual diversity in behavior within the AWARE II region. We already have discussed the research suggesting the heterosexual partnerships of MSM in the region (Larmarange, Wade et al. 2010). In Senegal, 94 percent of sampled MSM reported sex with a woman in 2004, dropping to 73 percent in 2007 (Larmarange 2010; Larmarange, Wade et al. 2010). The IBBSS in Nigeria suggested 50 percent of MSM also had sex with women. A similar level, 60 percent, was seen in Burkina Faso (CCM Burkina Faso 2010). Anecdotally, using heterosexual marriage among MSM as a social cover is common in the region (World Bank/NACA 2008).

The MSM-related terminology, used since the 1990s as a way to describe behaviors other than social or cultural identities, has been critiqued recently as conflating very distinct groups based on sexual orientation, gender identity, and other issues related to social class and culture (Cáceres, Aggleton et al. 2008). More research is required to understand if such distinctions are applicable to the West and Central African context, for example, whether there are communities of the transgendered or other sexual minorities present, and to understand their significance in terms of HIV transmission and vulnerability.

Men who sell sex to other men (and to women) are present in the region—the IBBSS in Nigeria estimated that one-third of MSM had sold sex to other men (World Bank/NACA 2008). The Gambia has a community of male sex workers known as “bumsters” who sell sex to local and foreign clients (Mah and Dibba 2008). Small sample studies have also documented the presence of male sex workers in Nigeria who seek male clients (Karlyn, Adebajo et al. 2010; Busari, Busari et al. 2011). Transactional sex among MSM also is known (Drah, Clement et al. 2010).

2.4 HIV Prevention Policy and MARPs

The discussion above highlights the high risk of HIV infection for MARPs compared to the general population, the complex composition of MARP groups in the AWARE II region, and their overall importance for prevention in concentrated and mixed epidemics. There is evidence that suggests certain prevention approaches work to contain epidemics started and sustained by HIV transmission related to core MARPs. In this section, we explore the evidence for prevention in the context of sex work, MSM, and IDUs, using studies from the AWARE II region wherever possible. Thereafter, we discuss the policy implications in the context of current prevention spending in the region.

Prevention in the context of sex work. In Asia, experiences in Thailand and Cambodia (Wilson and Halperin 2008) as well as southern India (Moses, Ramesh et al. 2008) suggest that, in concentrated epidemics driven by sex work, targeted interventions can work to contain transmission. Such interventions focused on sex workers include behavior change communication and counseling, condom promotion, improved sexual health (i.e., related to STIs), and structural changes allowing brothel-based FSWs to negotiate condom use and improve health and work conditions. A systematic review of published data on evaluations of HIV and STI prevention interventions among FSWs, in terms of effectiveness in reducing HIV incidence, reached the following conclusions (Shahmanesh, Patel et al. 2008):

- Based on observational data, there was evidence for the effectiveness of risk-reduction counseling along with male condom promotion, and for male condom promotion by itself. There was insufficient evidence for the effectiveness of female condoms in reducing HIV incidence. A separate meta-analytic review found a small effect from peer education (trained FSWs provide information and assistance to other FSWs) in increasing condom use that would be connected to incidence, although the results were for regular partners only (Medley, Kennedy et al. 2009).
- The effectiveness of STI treatment among FSWs as a means of reducing HIV acquisition had limited support in the evaluation literature. The effects of presumptive treatment for STIs were at best short lived, but “innovative outreach services” (e.g., at truck stops) could improve the coverage “of dispersed and clandestine” FSWs. A study from South Africa posited insufficient coverage and low uptake of STI interventions as reasons for a lack of HIV prevention effect (Vickerman, Terris-Prestholt et al. 2006).
- There is some evidence from observational studies (Sonagachi, India) as well as a randomized control trial (Dominican Republic) for structural interventions that are comprehensive in nature and target brothels with improvement in solidarity for FSWs, condom promotion, and STI screening and care. In Chapter 3, we will explore other interpretations of “structural” issues in the context of MARPs. The systematic review notes that when the “model brothel” was implemented through policy in the Dominican Republic—i.e., making condom use mandatory and a responsibility of brothel owners, enforced through support and sanctions—it had greater effect (Shahmanesh, Patel et al. 2008).

The systematic review stresses that the evaluation of prevention has centered on brothel or red-light area-based FSWs, and not on roaming/mobile FSWs. Some have suggested that, as formal sex workers or seaters come to be associated with HIV risk, clients favor roamers or “non-professionals” (Nagot, Ouangre et al. 2002; Wilson and Fraser 2011), although this assumes knowledge of prevailing risk. The latter type of sex worker is common in the AWARE II region. A quantitative analysis of sex work in Accra, Ghana suggested that the ratio of roamers to seaters may be nine to one (Côté, Sobela et al. 2004). Despite their numerical preponderance, roamers had fewer clients than seaters per night, based on the same study; also, their client profile was less risky in terms of existing average HIV prevalence. Countering this effect, roamers or non-red-light area-based FSWs were also less likely to have encountered prevention messaging and hence engaged in higher-risk sexual activity (Shahmanesh, Wayal et al. 2009). The study in Ghana also suggests that solidarity among FSWs at certain seater venues maintained higher levels of consistent condom use, with the corollary that men who wanted to avoid condoms were pushed to other venues.

While the systematic review could not find unequivocal evidence for any of the prevention interventions among FSWs in the context of HIV incidence, there is encouragement for risk-reduction counseling, male condom promotion, and structural interventions for an enabling environment (especially those imposed by policy). Observational data collected for local interventions in Abidjan and Cotonou suggest that programs had achieved good coverage among FSWs—until interrupted by

local political conflict—and there was potential for behavioral change leading to reductions in HIV prevalence (WHO 2008).

Analysis conducted of a developed country sex work setting found that local regulations such as policing or zoning restrictions—an aspect of policy in this context—can have unforeseen consequences (Shannon, Strathdee et al. 2009). These include pushing sex work into areas where FSWs were less able to negotiate condom use, e.g., servicing clients in cars or public spaces. We are cautious in extrapolating these findings to West Africa because of the difference in context. At the very least, however, they suggest that policy and its manifestation in laws and regulation can have several levels of effects in terms of enabling or disabling an environment for safer sex work.

In the concentrated and mixed epidemics that dominate the AWARE II region, prevention programs that focus on sex work must include clients (Lowndes, Alary et al. 2007). Mathematical modeling of sex work-driven epidemics suggests that in settings where prevalence among sex workers is not higher than 50 percent—as is the case for many AWARE II countries, based on epidemiological data presented in Section 2.1—regular clients may act as a “sustaining population,” increasing infection and undermining interventions focused on sex workers alone (Watts, Zimmerman et al. 2010). Since clients are a heterogeneous group across age, socioeconomic, and occupational categories, the messages for risk reduction and condom use need to be tailored to the local context. Analysis of DHS and other data for sub-Saharan Africa showed a relative peak in demand for sex work in the 20–24 age group (Carael, Slaymaker et al. 2006), suggesting an age-based focus of prevention messaging when resources are constrained.

Prevention in the context of men who have sex with men. While structural issues have been emphasized in the prevention of HIV infection among MSM in sub-Saharan Africa, including those from a rights-based approach (WHO 2008; Wilson and Halperin 2008; Smith, Tapsoba et al. 2009), there have been no systematic studies of the effectiveness of HIV prevention interventions in this context. Again, in the next chapter we will explore in depth what is included in these structural issues, and their significance.

A systematic Cochrane review investigated the effectiveness of interventions in reducing risky sexual behaviors among MSM (Johnson, Diaz et al. 2008). The conclusions were the following:

- Behavioral interventions—individual counseling and social and behavioral support (e.g., peer education)—can reduce the quantum of self-reported unprotected anal intercourse (UAI) by 27 percent and the proportion of men reporting UAI by 23 percent. This is based on both randomized trials and other studies.
- Small group and community interventions (e.g., group counseling, workshops, and training community leaders) also can lead to significant risk reduction among MSM.

Much of the literature surveyed in the systematic review concerns ethnically homogenous MSM populations in the United States and Europe. While interventions and programs targeting HIV incidence among MSM exist in West and Central Africa, as we will show in the results of our situation assessment in Chapter 4, they have not been evaluated systematically. Our desk review of the interventions suggests that interventions are localized and have difficulty in reaching scale such that

they can have an impact on transmission among the MSM population. More research is needed on the effectiveness of HIV prevention interventions for MSM in Africa, including the AWARE II region.

While evidence is being generated, program design has been informed by knowledge of what is relevant in the context of risky behavior among MSM. In West Africa, levels of UAI were found to be high in distinct studies from Cameroon and Senegal (Henry, Marcellin et al. 2010; Larmarange, Wade et al. 2010). In Senegal, a non-experimental evaluation suggested that the institution of a combined prevention program among MSM since 2005—STI and HIV treatment, raising awareness on sexual risks, and advocacy for MSM—was associated with an increase in consistent condom use of 35 percent during the previous month’s anal sex (between 2004–2007) (Wade, Larmarange et al. 2010). A study with the same population in 2007 suggested that non-participation in an MSM prevention program increased the odds of UAI (adjusted odds ratio of 3.47).

Such combined prevention approaches may be increasingly effective as they combine reduction of individual-level risk—rate of UAI per individual, riskiness of UAI episodes, and number of partners for UAI—with group-level risk (STI and antiretroviral treatment, safe sex communication to reduce overall prevalence of UAI). Condoms and lubricants are both relevant in the reduction of individual risk of transmission during UAI. Also, a comprehensive review of the published literature on the risks per UAI act (insertive and receptive) suggests that risks of HIV infection are 99 percent lower with successful ART than without (Baggaley, White et al. 2010). In addition to these interventions, combined prevention also may address the structural factors for an enabling environment for prevention and treatment among MSM.

Prevention in the context of people who inject drugs. There is now consensus on a minimum package of nine interventions for IDUs (WHO, UNODC et al. 2009), following several studies in recent years on the effectiveness of interventions in reducing HIV incidence. Of these nine, which are all relevant for prevention and treatment, we highlight below the six that are the most important in reducing HIV incidence—effectiveness data are from recent documents (IOM 2009; WHO, UNODC et al. 2009):

- Needle and syringe programs (NSPs)—marked decrease in HIV transmission, of up to 33–42 percent. Effective NSP programs can offer a range of “wrap-around” services, including condoms, bleach, risk-reduction information, and other care and treatment modalities (PEPFAR 2010).
- Opioid substitution therapy (OST) and other drug dependence treatment—highly effective in reducing injecting behaviors that put IDUs at risk for HIV; also improve access and adherence to ART and reduce mortality. While the greatest community-level effects in reducing incidence are seen where there are large numbers of IDUs and a severe HIV epidemic among them (for example, Eastern Europe and South-East Asia), these findings are broadly relevant to IDU communities within the AWARE II region as well.
- HIV testing and counseling—helping IDUs know their status and providing behavior change counseling (including safer sex) has an important role in prevention in this population.

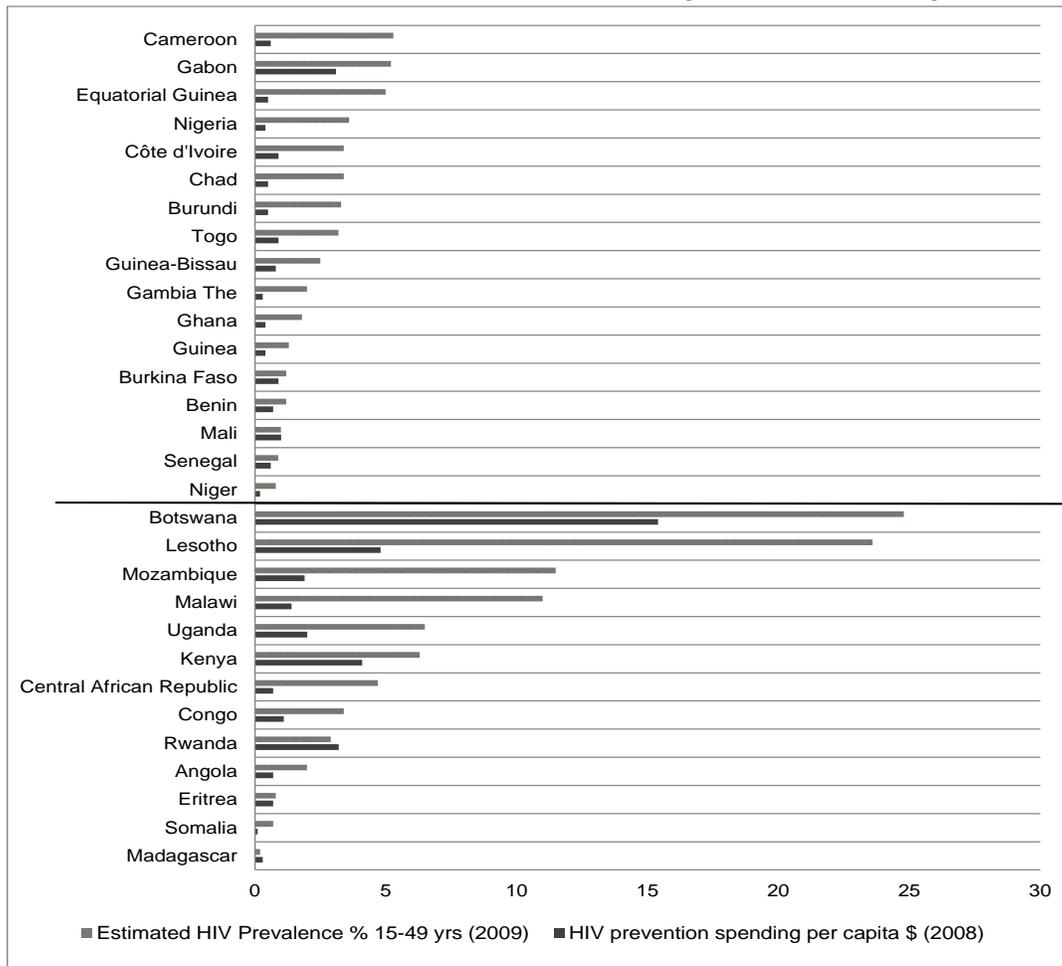
- Antiretroviral therapy (ART)—efficacy of ART among IDUs is “comparable to other populations” (IOM 2009), and evidence indicates that IDUs can successfully undergo treatment and reap benefits.
- Prevention and treatment of STIs plus condom programs for IDUs and their sexual partners—STI treatment, especially among female injectors, and specifically those who engage in sex work, is considered important in HIV prevention (WHO, UNODC et al. 2009). However, the overall evidence is for a more modest impact on HIV prevention from STI treatment and condom provision among IDUs.
- Targeted information, education, and communication for IDUs and their sexual partners—can be important in increasing the impact of the interventions described above. However, the independent impact on prevention among IDUs and their sexual partners is considered weak (WHO, UNODC et al. 2009).

A separate meta-analytic review of peer education interventions suggests that they produce significant reductions in equipment sharing, leading to important prevention benefits (Medley, Kennedy et al. 2009).

Interventions drawing from the list above are scarce in those sub-Saharan African countries that have reported IDU populations. Out of 16 such countries, 14 had no reported NSPs, and only three had OST (Mathers, Degenhardt et al. 2010). One of the latter three was Senegal from the AWARE II region. In Nigeria, a study reviewed the size estimates and behavioral surveillance of IDUs at various locations in the country during the previous decade and found a high level of consistent risky practices, such as sharing of needles and rinse water (Adelekan and Lawal 2006). The lack of strong programs for IDUs in Nigeria suggests that prevention in this population may not be getting the importance it deserves. We will review the response in this context in Chapter 4.

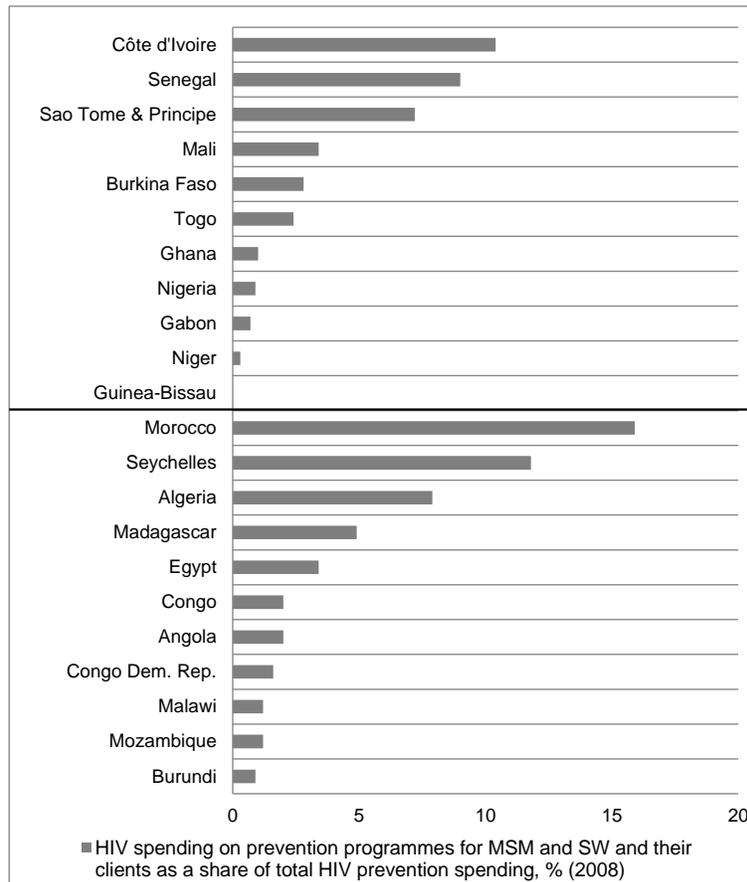
Spending on prevention and MARPs in the AWARE II region. Prevention spending per capita is low in the AWARE II region (except for Gabon) compared to other regions of sub-Saharan Africa. In general, the region has lower prevalence than southern or eastern Africa, although when compared with countries of comparable prevalence (Rwanda), Cameroon, Nigeria, and Côte d’Ivoire still spend much less (Figure 3). One hypothesis is that prevention spending in the AWARE II region is much better targeted and hence lower spending per capita is prudent—given scarce resources—and effective. As we have discussed throughout this chapter, such a focus on MARPs has an epidemiological rationale in these countries, except Equatorial Guinea, which also should place emphasis on reducing transmission in low-risk groups.

Figure 2. Adult HIV prevalence and HIV prevention spending per capita: Comparing AWARE II countries to the rest of sub-Saharan Africa (Data: UNAIDS 2011)



We test the hypothesis with 2008 data collected by UNAIDS from national HIV/AIDS strategies and from National AIDS Spending Assessments (NASA). Figure 4 summarizes the information. We accept data limitations and possible improper characterization of spending as having a MARPs component (see discussion in Section 2.2). The results suggest that the hypothesis may be true for Côte d’Ivoire and Senegal, but not for the other countries in the AWARE II region. We find that generally, HIV prevention spending in the region is not sound from an epidemiological basis. In fact, the issue of misaligned HIV prevention spending has been emphasized both globally (GHPWG 2010) and for the region (Lowndes, Alary et al. 2008). The NASA in Ghana from 2007 suggested that 9 percent of HIV prevention spending was spent on MSM, IDUs, sex workers, and clients, despite these groups accounting for 41 percent of new HIV infections when first-wave transmissions were included (Bosu, Yeboah et al. 2010). Similar findings were reported in the 2008 World Bank report—in Mali, the proportion of the prevention budget allocated to FSWs was 0.9 percent (Lowndes, Alary et al. 2008).

Figure 3. Percentage of HIV prevention spending focused on MSM, FSWs, and clients in the AWARE II region compared to other parts of Africa in 2008 (Data: UNAIDS 2011)



The non-targeted HIV-related prevention services (i.e., at a general population level) do imply some protection for MARPs. Therefore, the percentages above may be understated, as suggested by the higher value in the NASA in Ghana. However, the emphasis of this section is that spending focused on MARPs is smarter spending in the context of these epidemics and is too low in the AWARE II region. Also, for treatment and care, specific structural issues can make services provided at the general population level ineffective for the needs for MARPs. We introduce this topic in the next section.

2.5 Some HIV Service Delivery Considerations among MARPs

This section considers the reasons why a focus on MARPs is important in the context of HIV services other than those considered in Section 2.4. Such services include ART, HIV testing and counseling (HCT), prevention of mother-to-child transmission (PMTCT), and care and mitigation services. We primarily look at the two aspects below. First, we examine the issues of stigma and discrimination, which increase the vulnerability of HIV-positive MARPs. Vulnerability is understood in the context of HIV services as signifying HIV-related outcomes worse on average than those of non-MARP PLHIV. The second issue concerns HIV-positive MARPs, which are important to this set of HIV services in AWARE-II countries because of the proportion of all PLHIV they represent. Their large

representation within the PLHIV group emphasizes the benefits of a MARPs focus in terms of effectiveness in reducing overall morbidity and mortality in the region.

Stigma and discrimination in the context of HIV services. Stigma and discrimination are distinct but related concepts that should be better defined to understand the impact on services for MARPs. A single, explicit definition of stigma in the HIV context is hard to find. However, the concept of stigma is widely discussed in the field. Stigma generally has been defined as an attribute imposed or adopted at the individual level that establishes a socially visible difference or “deviance”(Parker and Aggleton 2003). In the context of HIV, stigma is often an attribute that emerges from fear of infection, especially with a disease considered incurable or fatal (Gilmore and Somerville 1994). Emerging structural understanding of such a stigmatizing attribute suggests that it is not only cognitive, but determined by ongoing social processes, such as inequality and power dynamics (Mahajan, Sayles et al. 2008).

As a concept, discrimination moves from the stigmatized individual to the “producers” of stigma. Discrimination is a consequence of stigma. In this context it involves “unfair and unjust” behavior toward an individual based on his or her real or perceived HIV status. Such behavior may be directed toward the real or perceived PLHIV by an individual (e.g., a health worker refusing to treat someone) or it can be structural and institutional (e.g., loss of job, travel restriction). A survey in the state of Anambra, Nigeria found that two-thirds of health workers would breach the HIV status confidentiality of individuals, and 13 percent believed that PLHIV should be segregated (Ibekwe, Igwe et al. 2008). As an expression of stigma, discrimination in the HIV context can be physical (e.g., confinement), social (e.g., reduced visits by neighbors), linguistic or verbal (e.g., mocking and insults), and institutional (e.g., excessive or unnecessary precautions in healthcare settings) (Ogden and Nyblade 2005). Such behavior can lead to stigmatized PLHIV facing systematic disadvantage in occupational choice, education, housing, and access to health services (Mahajan, Sayles et al. 2008). In the specific case of health services, “self-imposed discrimination” can be a barrier to utilization as a result of the fears of discriminatory behavior (Kinsler, Wong et al. 2007).

An overlay of HIV-related stigma interacts with and exacerbates pre-existing sources of stigma based on class, culture, and occupation. This is extremely important in the context of MARPs—MSM, FSWs, IDUs, and clients—who also are subject to pre-existing stigma. Such stigma easily can lead to a “shaming” processes, as reported anecdotally for PLHIV in Ghana (PEPFAR 2010b). This leads to a vicious circle or doubling of stigma and discrimination. For example, PLHIV are stigmatized because they are assumed to be from a marginalized group, such as MSM, in a context of homophobia. The marginalized groups face more stigma because they are assumed to be PLHIV (Parker and Aggleton 2003). The levels of pre-existing stigma can change over time as society changes culturally, economically, and politically.

Levels of stigmatizing attitudes related to MARPs among the general population can be high in West African countries. A recent survey of 4,689 respondents in Ghana found that 75 percent did not favor decriminalizing sex work or homosexuality, and 69 percent would not welcome MSM into their homes (Nzambi, Bevalot et al. 2010). Individual MARPs themselves had discriminatory attitudes in

Discriminatory policies include the criminalization of sex work, homosexual behavior, and injecting drug use. Legal and regulatory approaches to MARPs can be a result of prevailing stigma internalized by the policy structure or a cause of such stigma in itself.

the survey—25 percent of FSWs (N=606) would “ostracize” a fellow FSW and 63.4 percent would do so for an HIV-positive FSW.

We also draw attention to the effects of official policies on stigma. Discriminatory policies include the criminalization of sex work, homosexual behavior, and injecting drug use. Legal and regulatory approaches to MARPs can be a result of prevailing stigma internalized by the policy structure or a cause of such stigma in itself. In the next chapter, we will discuss such legal and regulatory aspects as a part of the overall structural framework of policy on MARPs. A number of authors have drawn attention to such structural

reforms as one of the ways to reduce HIV-related stigma and discrimination, potentially supplemented by efforts at individual and community levels (Parker and Aggleton 2003; Mahajan, Sayles et al. 2008).

Qualitatively, the association of stigma and discrimination with HIV services has been well studied. Self-discrimination among FSWs in Nigeria has been seen as a barrier to prevention and treatment-seeking behavior (Akpan, Ofobrukmeta et al. 2002). Perceptions of discrimination among Nigerian FSWs have reduced their belief in HIV test results received from health centers (Dutse, Abubakar et al. 2008). Stigma may also make certain MARPs more clandestine, rendering them “hidden” and reducing the ability of HIV services to target and reach them. Knowledge of the effects of stigma and discrimination on HIV services is crucial for designing a response that effectively focuses on the supply and demand of HIV services.

However, specific effects of discrimination have been difficult to quantify, due to a lack of rigorous evaluations and, potentially, because discriminatory behaviors—unlike cognitive measures—are harder to observe because of their negative valence, even via surveys that can capture beliefs (Obermeyer and Osborn 2007). Also, it is essential, but difficult, to understand the extent to which self-imposed discrimination contributes to lower utilization of critical interventions such as HIV testing and counseling. The direction of effect can be clouded, especially when wider availability of HIV intervention reduces HIV-related stigma, such as in the case of the scaling up of testing during the early 2000s in Botswana (Mahajan, Sayles et al. 2008) or ART in Tanzania (Roura, Urassa et al. 2009). In Botswana the examined mechanism of effect led from more individuals knowing their status to a reduction in stigma, which stimulates further testing for others (Weiser, Heisler et al. 2006). Ongoing attempts to create a generalizable stigma index may help to generate studies that can better estimate the correlation or causation of stigma and discrimination with the effectiveness HIV services and outcomes.

The effect of reduced stigma and discrimination on health services uptake is also conditional on the health system functioning properly. In a forthcoming model-based analysis of the relationship between stigma and PMTCT, Watts and others estimate that in a high-functioning health system (where functioning is an attribute of the health system) with an ANC HIV prevalence of 15 percent,

eliminating stigma would reduce mother-to-child transmission of HIV by 53 percent. In a low-functioning health system, the effect of eliminating stigma would be 26 percent (Watts, Zimmerman et al. 2011).

Service delivery and the size of MARPs. In a recent Global Fund proposal, the Nigerian government estimated that the number of individuals from MARPs numbered nearly 1 million in 2010 (CCM Nigeria 2009). This number is considered a conservative estimate and is based on the IBBSS from 2007 as well as the modes-of-transmission study conducted by the World Bank and NACA. The proposal estimates that only 3.8 percent of these MARPs—drawing from MSM, FSWs, and IDUs—were being reached by HIV services in 2010.

While it is difficult to verify figures for Nigeria from the Global Fund Proposal, it is an indication that MARPs are important demographics for targets, and ensuring access to and utilization of HIV services among these groups will be necessary to achieve significant declines in HIV/AIDS-related morbidity and mortality. Several countries, such as Ghana and Nigeria (see *Notes*) will or are conducting mapping studies for MARPs. An implication of these studies is that a focus on MARPs requires additional resources (Sarkar, Menser et al. 2009). In Côte d’Ivoire, official estimates indicate 34,400 HIV-positive FSWs (CCM Côte d’Ivoire 2009).

Later in this assessment, we attempt to provide some estimates of the size of MARPs in the AWARE II region to provide some quantitative support to the assertions above. This also serves as a point of reference to discussions in subsequent chapters and anchors the overall emphasis here.

Table 6. Estimated urban female sex workers in select countries of the AWARE II region, 2009

Country	Females 15–49 (2009)	Prevalence of FSWs		Estimated Urban FSWs, 2009			Total FSWs, 2010
		Capital city	Other Urban	Capital city	Other urban	Total	Quoted in reports and proposals
Benin	2,118,000	1.20%	0.40%	2,585	2,697	5,281	12,400
Burkina Faso	3,752,000	4.30%	-	14,695	-	> 14,695	31,000
Cameroon	4,817,000	2.20%	-	10,814	-	> 10,814	49,300
Côte d’Ivoire	5,056,000	0.70%	0.60%	8,965	7,787	16,752	78,200
Ghana	6,058,000	1.10%	0.70%	10,381	15,021	25,402	49,300
Niger	3,425,000	2.60%	-	4,593	-	> 4,593	28,000

Source: review and analysis. Data: (Vandepitte, Lyerla et al. 2006; UN Population Division 2010; WHO 2011)

In Table 6, we provide an estimate of the number of urban FSWs in certain AWARE II countries in which we could locate the key data for the analysis. We used the estimated “FSW prevalence” (i.e., the proportion of FSWs among all adult women—those ages 15–49—expressed as a percentage) from a previous study (Vandepitte, Lyerla et al. 2006). In the source documents for these prevalence estimates, definitions of sex work varied, but in general, definitions included both open/formal and hidden/ clandestine sex work. We assume that the FSW prevalence reported remains constant—a fairly

limiting assumption forced by lack of data—and can be applied to updated population figures. The calculations use the estimated shares of the overall adult female population in capital cities and other urban areas. The results indicate significant population concentrations of FSWs—from five to six FSWs per 1,000 adult men in Benin or Burkina Faso to 36 FSWs per 1,000 men in Côte d’Ivoire.

These estimates are in the range established by previous studies. An estimate for Lomé from 2005 suggested a ratio of 13 FSWs per 1,000 adult males (Sobéla, Pépin et al. 2009). A study for Accra gave a ratio of 7.2 in 2004 (Côté, Sobela et al. 2004). From our estimate, this ratio is 7.9 for 2009. Our numbers suggest a doubling in the number of FSWs since 2004, and given a near-constant ratio of FSWs per 1,000 men, this tracks the doubling of Accra’s population over the period 2004–2009. Estimates of *total* FSWs are quoted by others (Table 6), but without corroborating methodology or data (also see **Notes**, at end).

We use DHS and the latest population data to estimate the number of sex work clients in each country. There is social desirability bias in the responses of men on the DHS question related to “sex with a sex worker in the past year” (Glick and Sahn 2008), leading to under-reporting of such transactions. Hence, in relying on DHS estimates, we run the risk of underestimating the true population figure for clients. For example, the study in Togo estimated that 32.2 percent of adult men (ages 15–59) in Lomé had paid for sex (Sobéla, Pépin et al. 2009)—well above the range from the DHS studies for urban areas in the region (Table 7). The DHS values used for the calculations behind Table 5 better match the levels outside Lomé from the same study. As West African countries rapidly urbanize (levels of urbanization of populations range from 17 percent to 51 percent for the countries in Table 7), the likelihood of increasing access to sex workers and changes in behavior may raise the proportion of all men having sex with FSWs. Therefore, the figures in Table 7 should be understood in light of the caveat that the data are conservative for the present and indicative of future levels. We used both urban and rural shares of the total adult male population in the calculation (not shown).

Table 7. Estimated sex work clients (male) in select countries of the AWARE II region, 2009

Country (Year of DHS)	Males 15–49 (2009)	% Men reporting sex with a sex worker		Urban Clients	Rural Clients	Estimated Total Clients
		Urban	Rural			
Benin (2006)	2,218,000	1.5%	1.7%	13,973	21,869	35,843
Ghana (2008)	6,240,000	2.1%	1.4%	66,830	42,806	109,637
Guinea (2005)	2,457,000	0.4%	0.3%	3,440	4,791	8,231
Liberia (2007)	965,000	3.0%	2.2%	13,896	11,040	24,936
Mali (2006)	3,121,000	2.7%	1.3%	30,336	25,967	56,303
Niger (2006)	3,238,000	2.4%	1.1%	13,211	29,563	42,774
Nigeria (2008)	37,756,000	1.6%	1.2%	302,048	226,536	528,584
Senegal (2005)	3,065,000	1.5%	1.0%	19,310	17,777	37,087
Sierra Leone (2008)	1,349,000	1.7%	2.0%	8,715	16,728	25,442

Source: analysis by authors. Data: (UN Population Division 2010; MeasureDHS 2011).

The results suggest that the numbers of clients are significant. We previously reported that clients have high HIV prevalence (varying by characteristics, e.g., clients of roamers vs. seaters). The estimate for Nigeria from Table 7 partially validates the count of 1 million (quoted above) for all MARPs in 2010.

As an extension of the results from Tables 6 and 7, we posit that clients and FSWs are a significant proportion of the overall number of PLHIV and hence the overall number of recipients of HIV-related services from the treatment, care, and mitigation domain. This is before we consider the structural factors that can render such MARPs more vulnerable, such as stigma and discrimination.

There are no systematic estimates of the number of MSM or IDUs in the countries of the AWARE II region. Several recent global reviews report HIV prevalence among MSM in these countries, but not population sizes (Baral, Sifakis et al. 2007; Smith, Tapsoba et al. 2009). Enumeration is difficult in a group that is often hidden, but several countries have estimated numbers in the context of Global Fund proposals (see **Notes**). Surveys in the region have regularly recruited several hundred MSM in various urban areas, such as surveys conducted by the ELIHoS project in Senegal (Larmarange, Wade et al. 2010). In general, MSM and IDUs concentrate in areas where they feel more secure, and even so, many do not openly state their status. This prevents us from extrapolating counts from small-sample “capture-recapture” or snowball surveys to proportions applicable to the broader population.

2.6 Conclusions

Do MARPs matter? The review of the Determinants of Policy in the context of MARPs suggests that these groups matter for prevention success, especially given the epidemiology of HIV/AIDS in the region. Our analysis suggests that many of the countries in the AWARE II region of West and Central Africa have mixed or concentrated epidemics. The established guidance, following two decades of experience with the epidemic in sub-Saharan Africa, suggests that, in such contexts, a MARPs prevention focus is essential to halting transmission and reversing annual levels of incidence. There are proven prevention interventions for each of the four MARP groups, and while more research is needed into their effectiveness in the West and Central African context, our primary hypothesis is that these proven interventions are applicable. However, the AWARE II region is neither spending enough on prevention nor directing it appropriately toward MARPs. Given a resource constraint for HIV/AIDS strategies, such a focus would produce smarter investments, allowing more prevention with fixed resources.

As stated earlier, we consider four groups “most at risk” on the basis of risk of infection from HIV—FSWs, MSM, clients, and IDUs. We consider the set of population groups with heightened risk of infection to be “vulnerable groups.” Not all who are vulnerable belong to our definition of “most at risk,” however. Of the non-MARP but vulnerable groups mentioned in the literature, we will consider some in certain policy contexts in the next chapters. One example is prisoners. For the four key MARP groups, there is evidence from the AWARE II region for relatively high levels of HIV prevalence, and modes-of-transmission studies indicate that these groups contribute high numbers to overall incidence.

These four groups also matter because they constitute a significant target group for the delivery of key HIV/AIDS services, such as treatment, care, and mitigation. Our analysis of DHS and epidemiological

data shows significant numbers of FSWs and clients in countries of the region—furthering the credibility of a MARPs focus and adding to the finding that targeting them for HIV services other than prevention can have significant overall health benefits for a country.

What matters for MARPs? Stigma and discrimination matter for MARPs and may pose a barrier, preventing access and utilization for such services. Within an overall context of stigma and discrimination for PLHIV, MARPs are more affected due to the doubling with other sources of stigmatization for the four marginalized groups. The presence of stigma and discrimination can prevent MARPs from adequately accessing treatment, care, and mitigation services, rendering such groups “hidden” or hard to reach in the context of prevention services. Such a climate of stigma and discrimination can severely hamper the success of an overall HIV strategy for the countries of the region, and a lack of appreciation for stigma and discrimination faced by MARPs, within an overall lack of a MARP focus, could lead to avoidable morbidity and mortality in these countries. There are effective ways to counter stigma and discrimination, however. From both human rights and program effectiveness points of view, a MARPs focus is important. Focusing prevention on MARPs in mixed and concentrated epidemics also is efficient.

This chapter investigated some of the key inputs in the context of the overall conceptual framework for HIV policy outlined in Section 1.2. We applied the filter of MARPs, and the policy inputs we examined in this context for the AWARE II region include, but are not limited to the following, which flow into the Determinants of Policies and Policy Implementation areas:

- Epidemiology as a basis for policy, and the evidence for effective prevention interventions;
- Resources for prevention, especially given a MARPs focus; and
- Stigma and discrimination, which draws from culture, socioeconomics of power, and other factors.

In the next chapter, we propose a subordinate framework to examine other inputs into the policy space, especially those flowing into the areas of Formal Policies and Policy Implementation.

3. | A Framework for Formal Policies and Policy Implementation Related to MARPs

In this chapter, we focus on the Formal Policies and Policy Implementation areas of the overarching framework introduced in Chapter 1. We propose a sub-framework that relates to these areas.

We use this sub-framework to better specify a set of key inputs into the MARPs policy space—using the terminology of Figure 2, Section 1.2—that are building blocks for the Formal Policies and Policy Implementation areas. Parsimoniously, for each input, we focus specifically on the related laws, regulations, and programs (sets of interventions). We do not explicitly include strategies, guidelines, and protocols. While HIV strategies are an expression of national vision and priorities, they have been reviewed elsewhere and lose some formal policy force when under- or inappropriately financed. They are also comprehensively tracked globally through mechanisms such as the National Composite Policy Index process developed by UNAIDS. Since programs are the articulations (in most cases) of the strategies, we implicitly consider the latter in our review. We refer to guidelines and protocols in some discussions of the regulations under specific policy inputs (Chapter 4) but largely assume that they are relevant if the program they guide exists and irrelevant if it does not. We do review programs and hence have subsumed these under the discussion of guidelines and protocols for services.

The desired policy inputs are mutually exclusive and the list is close to exhaustive. The design and use of the sub-framework also drives a process for data collection in the AWARE II region. This data collection, discussed at the end of this chapter, leads to the results presented in the next chapter and our conclusions pertaining to the Formal Policies and Policy Implementation areas.

The sub-framework for Formal Policies and Policy Implementation draws on important categorizations of HIV-related interventions. These categorizations extend the taxonomy to factors that enable a positive environment for the success of HIV prevention, treatment, care, and mitigation. These factors are closely related to laws, regulations, and programs. We introduce an important categorization below prior to explaining the sub-framework. We end the chapter with a discussion of the 24 key inputs and discuss our data collection strategy for them.

3.1 The Structural and Individual Levels of Interventions for HIV/AIDS

The separation of some interventions as structural has been broadly proposed for all health programming. One study refers to structural interventions as those that “alter the structural context within which health is produced and reproduced” (Friedman, Dworkin et al. 2006). The structural level for HIV interventions has been introduced repeatedly over time and stressed in several different ways. A formal beginning was in a special issue of the journal *AIDS* in 2000 that discussed the structural level in the context of *HIV prevention* as those physical, social, cultural, organizational,

community, economic, legal, or policy aspects of the environment that impede or facilitate efforts to avoid HIV infection (Sumartojo, Doll et al. 2000). Given the breadth of this definition, we present some other, more distinct formulations from the literature.

The specific distinctions that highlight a structural level have been discussed in several studies. Some authors have separated behavioral, biomedical, and structural HIV prevention interventions as three distinct categories (Rotheram-Borus, Swendeman et al. 2009). The individual vs. structural distinction, especially for HIV prevention, is commonly used and is expressed in various ways:

- Based on the *locus of the prevention intervention*: the “individual level” is viewed as being around or between individuals, while the “structural level” is outside of the area of control of a single individual (Cohen and Scribner 2000). Individual-level prevention interventions are those based on a biomedical paradigm in which risk is explained by biology, individual education, or psychology. Male circumcision (biological), testing (biological), behavioral counseling (psychological), and knowledge sharing (educational) are potential individual-level interventions.

An important aspect of Cohen and Scribner’s taxonomy is that there is an operational dimension in terms of the intervention levers pulled—that is, physical vs. social structures—and a *functional* dimension in terms of whether the intervention has an individual- or population-level preventive effect. “Operationally structural” interventions can have an individual-level “functional effect” (e.g., a wall can produce infection control in a facility), just as “operationally individual” interventions can have a population-level effect (e.g., male circumcision).

- Based on *distance from an effect on risk of infection*: Structural factors are those with a longer path to an effect compared to “proximate” factors. Of these, macro-environmental factors (e.g., the economy, governance) are the most distant, and those micro-environmental factors (migration, urbanization) that shape local context are less distant, and thus have a more direct effect on risk (Barnett and Whiteside 2002).
- Based on the *level of operation*: “superstructural” factors affect national or cultural norms, structural factors affect a portion of the population (laws and policies), “environmental” factors affect the conditions and resources of individuals, and “individual” factors affect how individuals adapt to and experience environmental factors (Sweat and Denison 1995).

A variety of authors also have applied the adjective “structural” to HIV prevention interventions they evaluated, ranging from condom provision (Ko, Lee et al. 2009; Shannon, Strathdee et al. 2009) to interventions for IDUs (Des Jarlais 2000). According to a review, the defining characteristic of structural-level interventions in the context of HIV prevention is that they aim to “change the social, economic, political, or environmental factors that determine HIV risk and vulnerability in specified

Box 1

Defining the “structural” level—IDUs

“structural-level interventions modify the environment in which psychoactive drug use and HIV-risk behaviors occur. The environment to be modified may be the social, legal, policy or cultural environment” (Des Jarlais 2000).

contexts” (Gupta, Parkhurst et al. 2008). This is a generalized form of Box 1 and implies some continuity in definitions from studies in the early 2000s.

These definitions of “structural” are largely theoretical. In a policy or applied context, the terminology is used in advocacy, which stresses the existence of barriers to successful policy implementation. Such advocacy has been carried out widely in the context of HIV/AIDS prevention and MARPs. In Chapter 2, we discussed prevention intervention effectiveness for FSWs, MSM, and IDUs—the core MARP groups—and briefly mentioned that regulation, laws, and other aspects of Formal Policies can have an enabling (positive) effect as well as unforeseen negative consequences. We develop this concept more carefully below.

Before we turn to the framework, it is important to mention that the structural lens has been applied to HIV treatment in addition to prevention. ART is primarily an individual-level intervention in its locus of effect on morbidity, mortality, and level of operation, although it also provides preventive benefits, and hence population-level effects. The structural lens applies to ART when considering barriers. For example, a study looking at the South African experience highlights economic, institutional, political, and cultural barriers that prevented higher ART adherence and therefore effectiveness (Kagee, Remien et al. 2010).

While introducing our sub-framework for Formal Policies and Policy Implementation below, we discuss how stigma and discrimination comprise one aspect of the structural “environment.” For this reason, policy inputs drawing from laws, regulations, and programs that have a bearing on stigma and discrimination can be structurally helpful in removing barriers to access for HIV services, as well as increasing their effectiveness.

3.2 A Framework for Key Inputs into the MARPs Policy Space

The definition of the structural level adopted above generally emphasizes laws, regulations, and programs as aspects of the “structural environment” in which HIV risk and vulnerability—both to infection and the subsequent progression of disease—are determined. More specifically, we discussed the HIV/AIDS literature, in which an emphasis on certain laws and regulations derives from the overall separation of the structural and individual (or “proximate”) levels. Specifically for laws and regulations—which are inputs into Formal Policies—we discussed how their structural nature emphasizes a role in the context of barriers to access and program effectiveness. In this understanding, a “structural improvement” would aim to reduce the barriers stemming from factors such as the social, legal, and economic contexts, and it would use changes to laws and regulations as levers.

The emphasis on laws, regulations, and programs also has a non-structural aspect. Earlier we discussed the non-structural in the context of the individual level, especially for prevention, although it clearly also applies to treatment and care. Based on Cohen and Scribner (2000) and Barnett and Whiteside (2002), we also highlighted that the distinctions between the individual and the structural draw on the locus of interventions (where they occur) as well as characteristics of effect (e.g., closer/distal to risk of infection).

With the MARPs lens, we apply the distinction of levels, using both the locus and effect ideas, so that we can build the right set of policy inputs for study. Many interventions for MARPs have primarily been designed with prevention in mind, which follows from the construct of “most at risk.” A prevention focus for MARPs also helps us define the following framework (Figure 5 below), which incorporates treatment and care issues.

Figure 4. A framework for key inputs into Formal Policies and Policy Implementation for MARPs

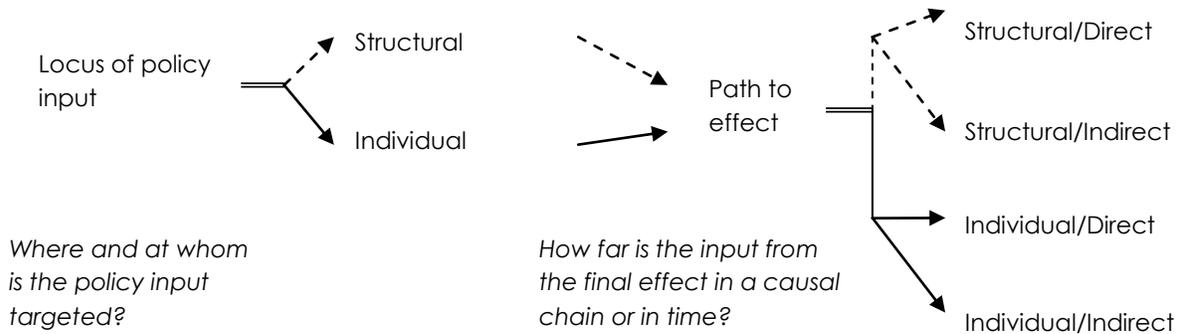


Figure 5 illustrates the evolution of the four categories of policy inputs that we will use: Individual/Direct, Individual/Indirect, Structural/Direct, and Structural/Indirect. By applying the factor of length of time before or distance in a causal chain from the effect of interest (reduced risk of HIV infection and associated vulnerabilities), we have built on the literature’s emphasis on functionality and impact. Below, we describe these four categories in the context of MARPs:

1. **Individual/Direct.** These are laws and regulations (part of Formal Policies) or programs (Policy Implementation) that reduce risky behavior and/or the intensity of the risk among core MARPs and bridging groups. These are targeted at the individual from a MARP group, with interventions that can have discernible individual-level and population-level effects. Therefore, they operate at the “individual” level, with a “direct” effect on the MARPs policy variable of interest: risk of infection. For example, laws that prohibit sale of condoms to minors impinge on the ability of under-age FSWs or clients to protect themselves and hence increase the likelihood of risky behavior (unprotected vaginal intercourse) for these individuals. In another example, programs that provide free lubricants to MSM reduce the intensity of risk during risky behavior (unprotected anal intercourse).
2. **Individual/Indirect.** These are laws, regulations, and programs that can have an indirect effect on the risk of HIV infection (depending on the law and other factors) and generally have a direct effect on the potential morbidity, mortality, and deprivation caused by the progression of the disease in an HIV-positive individual from a MARP group. For example, programs such as OST, aimed at harm reduction among IDUs, can reduce the need to inject and hence the likelihood of unsafe injecting practices while also reducing the vulnerability to opioid-induced health effects, including overdose. In another example, laws or regulations that prohibit

discrimination in health services can be extended to include MARPs such as FSWs, leading to an increase in the number of FSWs, especially those who are HIV positive, who access services and are treated fairly, producing related health benefits.

3. **Structural/Direct.** There are structural factors that determine the environment in which certain groups face HIV-related risk, such as by being in occupations with an increased likelihood of risky behavior, e.g., commercial sex work. Some of these factors, especially those related to economic deprivation (survival sex work) or drug trafficking (likelihood of local IDUs) cannot be affected by HIV-related policy, or at least not solely by it. We focus on inputs that are primarily in the HIV policy space. Laws and regulations here directly affect the quantum of increase in risk of HIV infection for a group and/or the ability of the group to cope with this risk. Targeting at the group level is a key distinction from *Individual/Direct*. For example, laws or regulations that prohibit brothels from employing a minor as an FSW (structural/direct) protect some vulnerable youth from risk of HIV. However, programs targeting stigma and discrimination among FSWs or MSM (individual/direct) improve the agency and self-esteem of most individuals in these groups. In the case of the former, such programs may improve the FSW's ability to negotiate condom use.
4. **Structural/Indirect.** These structural factors are primarily from the Formal Policies area (laws and regulations) and affect social and individual perceptions of the acceptability and legality of the behaviors that define a MARP group, for example same-sex intercourse and relationships. This area is closely connected to the stigma and discrimination issues considered in Chapter 1 via the context of Determinants of Policy. However, the focus here is on laws and regulations, as well as certain programs that affect a MARP group's status in society and the likelihood of it continuing its defining behaviors. These policy inputs determine a group's overt or clandestine nature, and hence affect the ability to reach the group with prevention and treatment/care services. Therefore, indirectly, these laws and regulations affect the levels of risky behavior as well as morbidity and mortality.

Table 8 groups under these four categories the 24 policy inputs we will be considering related to Formal Policies and Policy Implementation. We summarize the relative importance of the group in HIV prevention vs. treatment and care, including the preventive benefits of HIV treatment.

We will describe each of the individual policy inputs (#1–24) in Table 8 more fully, along with the results of our data collection, especially in terms of the effects on the domains of prevention, treatment, and care. While the discussion of programs associated with these policy inputs is relatively straightforward, the selection of the policy inputs that draw more from the Formal Policies arena will benefit from further background, especially those involving laws and regulations. This background also will illuminate why certain policy inputs were included above in Table 8. Therefore, before concluding this chapter with an overview of the data collection process in the AWARE II countries, we review laws and regulations in the context of MARPs. Below we cover the few West African countries that were studied in this context.

Table 8. Key inputs into Formal Policies & Policy Implementation for MARPs—applying the framework

Policy Input	Prevention	Treatment and Care	Possible Types of Input
Individual/Direct			
1. Control of the distribution or sale of condoms to minors	●		Reg., Prog.
2. Consistent condom use by clients of FSWs	●		Reg., Prog.
3. Availability of post-exposure prophylaxis for MARPs	●		Reg., Prog.
4. Availability of HIV treatment & care for MARPs	●	●	Reg., Prog.
5. Site-specific condom provision around sex work	●		Prog.
6. Needle & syringe programs for people who inject drugs	●		Reg., Prog.
7. Condoms and lubricants for MSM, incl. MSW	●		Prog.
Individual/Indirect			
8. Medically assisted therapy in people who inject drugs	●	○	Reg., Prog.
9. Physical safety of sex workers	○	○	All
10. Discrimination in access to health services for MARPs	○	●	All
11. HIV testing for MARPs – VCT, PICT, and mobile CT	●	○	Reg., Prog.
12. Confidentiality of information related to HIV status	○		Laws, Reg.
13. Targeted non-health services for MARPs	○	○	Prog.
Structural/Direct			
14. Factors affecting minors participating in sex work	○		All
15. Factors affecting the legality of sex work	○	○	Laws, Reg.
16. Control of human trafficking	○		Laws, Prog.
17. Issues of the criminality of HIV transmission	○		Laws
18. Discrimination against MARPs (general)	○	○	Laws, Prog.
19. Factors affecting rights of transient settlement near major industrial or resource extraction sites	○		Reg., Prog.
20. Factors surrounding injecting drug use behavior	○	○	Laws, Reg.

Policy Input	Prevention	Treatment and Care	Possible Types of Input
Structural/Indirect			
21. Laws concerning legality of same-sex behavior	○	○	Laws
22. Factors concerning the status of same-sex union	○	○	Laws
23. Laws on age of consent, same-sex and heterosexual	○	○	Laws
24. Factors affecting the unrestricted association of MARPs	○		Laws

● Signifies strong or primary effect; ○ signifies weaker or secondary effect.
 Reg. = regulations; Prog. = programs

3.3 Laws and Regulations in the Context of MARPs

Both laws and regulations are the building blocks of our Formal Policies area. As an important structural input into the policy environment, the legal issues surrounding HIV/AIDS have seen renewed interest in recent years. Fourteen of the 24 policy inputs in Table 8 involve laws, and 14 deal with regulations (including those that involve “All” inputs). There are some legal aspects to HIV/AIDS that are beyond our purview, especially because they do not affect or involve MARPs.

It is necessary to distinguish laws from regulations at the outset. Laws are formal rules that govern the behavior of the members of a society and are generally produced via legislation. Laws can make mandatory, prohibit, criminalize, or decriminalize certain actions, and empower the organs of the state to apply sanctions against those who contravene the law. A law criminalizing an activity will usually mention the type of sanction (imprisonment, fine, other). A law prohibiting an activity may not mention the sanctions associated with breaking the law. Laws of special interest in the context of the HIV/AIDS pandemic are the civil code, criminal laws (the penal code), and special “HIV/AIDS laws” or “model laws” adopted to govern specific behaviors. We will discuss these in more detail below. Because of their instrumental nature in defining societal rights from wrongs, certain types of laws are important. Any assessment of the legal environment must be sensitive to their presence and absence.

Regulations are also standards of behavior for individuals or organizations but do not have the authority of law. Often regulations are an expression of a governing law, and as such are adopted by a government agency or department to control its own or others' behavior. For example, a specific law may mandate HIV testing for all members of the armed forces. A particular uniformed service may then issue a regulation on when, where, and how such testing should be conducted. Given that they derive mainly from very specific contexts and overarching legislation, we consider regulations more briefly than laws.

Laws. Issues of legality in the context of HIV/AIDS have been around since the beginning of the epidemics in the developed world and have more recently been emphasized and acted upon in the developing world, where most of the PLHIV and vulnerable groups exist. There are many ways of

categorizing the legal issues to enable a summary. We draw on several major reviews (UNAIDS 1999; Gable, Gamharter et al. 2007; Gable, Gostin et al. 2009) in the categorization below:

Laws that govern spending on HIV/AIDS and use of related resources. Laws such as these direct a certain level of spending toward the HIV epidemic in a country as a part of a government's responsibility for public health and/or empower certain institutions within the government to coordinate and apply these resources. At the country level, certain laws and provisions in developing countries allow for the mandatory licensing of HIV-related drugs that are on patent in that country or in a country from which they could be imported legally. Such a license would allow the government or a third party to produce a generic version of the patented drug.

Laws that provide certain institutions with powers to require or prohibit HIV-related interventions. In this general phrasing we include several controversial issues. Laws in this category derive from the public health role of government and can arrogate the ability to mandate testing (though this is rare) or release names of the HIV positive in regular reporting. For specific groups, the authorities may make treatment or harm reduction mandatory—for example, for incarcerated populations who are HIV positive and/or IDUs.

Laws that criminalize or prohibit certain behaviors. In the context of MARPs, this category includes laws criminalizing certain sexual acts, sex work, procuring or pimping, injecting drug use, and HIV transmission itself in various contexts. The law may extend to those deemed as “abetting” these behaviors, which can implicate individuals attempting to reduce harm. For example, a criminal statute in Bangladesh considers providing clean needles to IDUs as abetment of illicit drug use (GMHC 2009).

Laws that protect rights and prohibit discrimination. Just as some laws may criminalize behaviors, others may protect vulnerable groups or those considered widely discriminated against regarding access to services or in certain occupations. Simultaneous presence in a society of laws that criminalize certain HIV-related behaviors and laws that protect the related groups from discrimination would be contradictory but is not uncommon, as we will see in the next chapter for the AWARE II region. Such protective laws are significant to MARPs because of “doubled” stigma and discrimination (Section 2.5).

Several countries in the AWARE II region have adopted special or “model” HIV/AIDS laws (Table 9) as a result of the regional partnerships that evolved following a meeting for West and Central African countries held in N'djamena, Chad in 2004. This was facilitated by the first AWARE project. Hence *some* of these legislations have been referred to as “N'djamena model laws.” These laws are major contributions to introducing an explicit human rights focus to the legal treatment of PLHIV.

Table 9. Specific or “model” laws for HIV/AIDS – status in the AWARE II region

Country	Date of legislation
Benin*	2006
Burkina Faso*	2008
Cameroon	2002 (draft)
Cape Verde*	2007
Chad*	2007
Côte d'Ivoire	2010 (draft)
Equatorial Guinea	2006
The Gambia	(draft)
Guinea*	2005
Guinea-Bissau*	2007

Liberia	2008
Mali*	2006
Mauritania	2007
Niger*	2007
Nigeria Enugu state	2005
Nigeria Lagos state	2007
Senegal*	2010
Sierra Leone*	2007
Togo*	2005

* Known to be N'djamena-type model law.
Sources: (GNP+ 2010), UNGASS reports

Over the last few years, HIV-specific laws have been adopted in 15 AWARE II countries and are in draft stages in three others (the Cameroon law has been a draft for a longer time). In fact the AWARE II region dominates the list of African countries with such laws adopted—15 of the 28 such countries belong to the region. These laws have been extensively reviewed, appreciated, and critiqued, and we will discuss certain aspects of them as they pertain to the policy inputs in Table 8.

A human rights approach to MARPs may consider action on all four of the types of laws discussed above (UNAIDS 1999). This was explicitly the basis of the N'djamena model laws as adopted by many countries. These laws were consensus documents, crafted in a participatory manner.

Our framework considers the latter three issues for laws in the development of the 24 policy inputs introduced in Table 8. Programs in this context—hence bringing in Policy Implementation—may involve the provision of legal aid to MARPs who are subject to laws criminalizing their behavior. This is a critical input when we consider that many MARPs cannot or will not access legal representation, given that they may be clandestine, affected by stigma, and lacking resources.

Regulations. In some countries sex work is not criminalized, and may be regulated. In Senegal, “official” sex workers are registered in the STI health center under the “sanitary control file” (Lo 2006). There may be at least 1,500 thus registered in Dakar (Wang, Hawes et al. 2007). However, as previously discussed, registered counts miss the many clandestine, roaming FSWs. Licensing—and thereafter registering sex workers and brothel owners—is a possible approach for public health authorities to take. The authority for this derives from a *lack* of criminalization of sex work in the country, or at least the lack of explicit decriminalization, though contradictory approaches (regulation alongside criminalization) are possible.

In addition to, and sometimes in spite of, the regulations on sex work, public safety and public health authorities may use other legal or quasi-legal provisions to control, harass, or otherwise interfere with

sex workers and clients (Gable, Gamharter et al. 2007). Regulations on loitering in public places or “breach of public order” can be interpreted by police to interfere with sex work. Similarly, regulations on settlement near resource extraction or industrial sites can be selectively interpreted to prevent sex workers from the right to live near mines, road-building sites, and factories. Imprecisely worded laws or regulations therefore obscure the actual legal status of sex work and are prone to variable interpretations. The effect on the domains of HIV prevention, treatment, and care is generally poor. When these vague regulations and laws produce harassment of sex workers, they may be driven underground, rendering them less accessible to HIV-related programs. Table 8 has policy inputs related to these issues (inputs #15, #19, and #24).

In addition to the regulation of behavior, there are regulations on who may access certain drugs and commodities, and when. For example, regulations on the availability of methadone, important for OST, can affect harm-reduction programs for IDUs (Reshevska, Foreit et al. 2010). Regulations deriving from fundamental laws on rights to privacy (or to information) also control HIV-status related data. Generally, regulations can attach to many of the policy inputs we considered in Table 8 that have a legal aspect.

3.4 Data Collection Process

This study has included two types of secondary data collection processes. First, we utilized literature review and desk analysis to understand the current perspectives on MARPs, and more specifically, the current state of knowledge on various inputs into the Determinants of Policy and Formal Policies regarding MARPs in West and Central Africa. The results of this literature review have already been discussed at some length in sections above, and we will summarize the background process below. Second, we utilized field- and headquarters-based consultants with knowledge of specific countries in the AWARE II region, who liaised with their contacts in the HIV/AIDS field in each country and summarized data on the 24 policy inputs from Table 8 above. This process is described below as well.

Literature review. We searched PubMed and Google Scholar for a large number of keywords and key search phrases related to the epidemiology of HIV/AIDS in the West and Central African region, stigma and discrimination, and resource spending, often searching for specific country information. These search engines cover most of the journals and reports we could consider. In addition, we included a systematic search of the published abstracts from the Vienna (2010) and Mexico (2008) International AIDS Conferences, searching for key MARPs-related terms.

We repeated similar searches for the issues covered in this chapter related to structural interventions, and then for laws and regulations. We included grey (project) literature by visiting the webpages of known HIV-specific projects, as well as other projects with presence in the region, such as AIDSTAR, Health Policy Initiative, etc. We also searched the webpages of the Global Fund for AIDS, Tuberculosis, and Malaria (for grant proposals) and the UNGASS reports database maintained by UNAIDS for specific country information. In addition, we searched the Cochrane database of systematic reviews of the evaluations of prevention interventions for the core MARPs (discussed in Chapter 2).

Field-level secondary data collection. Given the need to supplement the data and attention to West African MARPs in the literature, the AWARE II team called upon a wide network of headquarters (in Accra and the United States) and field consultants to complete detailed data templates for the 24 policy issues listed in Table 8. Individual country consultants drew from the literature where possible, but relied extensively on direct interviews and grey literature in many of the respective countries, including the following groups: MARP groups, where such exist; ministries of health and national AIDS commissions/councils; UNAIDS and other UN offices; rights-based and other activist NGOs; and other USAID projects. The consultants submitted completed templates to the study team in Accra and Washington, DC for initial review, with translation as necessary. The study team analyzed the data and drafted the conclusions.

3.5 Conclusions

In this chapter, we focused on the Formal Policies and Policy Implementation areas of the MARPs policy space. This follows the language from the overarching framework introduced in Chapter 1. This chapter also introduced the methodology we used to guide data collection. We stated that our focus would be on laws, regulations, and programs. In the context of this methodology, we reviewed existing categorizations of issues and interventions in the HIV literature.

A common typology uses the distinction of structural vs. other factors. Structural factors shape the environment in which groups, including MARPs, face the risk of HIV infection and develop vulnerability to the progress of HIV disease when infected. Such structural factors operate at a level that can be at a remove from targeting a particular individual but are still extremely important in terms of defining the legal, social, political, and sometimes the physical environment in which individuals behave in ways related to their exposure to HIV risk. In contrast, there are individual-level factors that primarily affect the intensity of transmission risk in an individual's risky behavior, such as unprotected anal intercourse, and the frequency of such behavior. Both structural and individual-level factors have associated interventions that aim to correct or modify the HIV-related aspects, and these can have a specific MARPs focus or an outcome of interest to MARP groups.

In terms of outcomes, structural-level interventions can have effects on individuals but are usually at a distance causally from the final outcome (e.g., risk of infection, morbidity). Generally, they modify the conditions for entire groups, for example, by increasing the ability of FSWs to negotiate for condoms or facilitating FSWs' receiving health services without discrimination. Individual-level interventions have effects closer to the ultimate outcome, which can have population-level results by shifting the prevalence curve. For example, needle programs reduce incidence among IDUs and, as a result, among their sexual partners.

We used the distinction of structural vs. individual in developing a framework for categorizing key policy inputs into the areas of Formal Policies and Policy Implementation. The framework divides policy inputs across Individual/Direct, Individual/Indirect, Structural/Direct, and Structural/Indirect categories, which merges the distinctions in terms of level of intervention (where the interventions occur and whom they target), as well as the causal and temporal distance to the effects of interest, whether risk or morbidity and mortality.

Using the four categories as a basis for seeking mutually exclusive and exhaustive inputs, we identified 24 policy inputs that are key individual and structural-level factors in the policy space for MARPs. These are listed in Table 8. They cover mostly laws, regulations, and programs, which are our focus.

There are several types of laws relevant both to the HIV sphere and MARPs. These include laws defining the public health responsibilities of government, which can require funding or access to drugs. There are laws authorizing government agencies to prohibit or require certain HIV-related interventions. Other laws criminalize or prohibit certain HIV-related behaviors, including HIV transmission itself under different contexts. Such laws have a particular significance for MARPs, who tend to be associated in a stigmatizing way with such behaviors. However, laws can also be protective in the context of MARPs and similar stigma, especially when they intend to prohibit discrimination. A review of recent literature suggests that these different legal aspects have been adopted in several AWARE II countries of West and Central Africa through “model” or specific HIV/AIDS legislation that followed from a process beginning with a meeting of policymakers and legislators in Chad in 2004.

Our framework for Formal Policies and Policy Implementation, which includes 24 policy inputs, has broad coverage across these aspects of law, as well as the regulations flowing from the laws. The framework was used to guide secondary data collection using literature review and field-level interviews and document review. The results of this data collection are presented in the next chapter, along with further detail on each of the policy inputs, using specific country examples.

4. | Assessment of Formal Policies and Policy Implementation for MARPs in the AWARE II Region

This chapter presents the results of the data collection around the 24 policy inputs. We present results in a tabular manner where possible and also analyze them qualitatively with additional detail from the literature review, as appropriate. For each policy input, we provide an overview of the issue at stake, applying the MARPs focus. This focus means that, while some of the inputs are generally applicable to many population groups in which individuals bear a risk of HIV infection, we focus on aspects that concern HIV infection and transmission in MARP groups, and the access to and availability to HIV services for MARPs. Where relevant, we provide a brief background of recent developments on the input from the AWARE II region of West and Central Africa. We present data from the literature review, secondary data collection, and in-country structured interviews in summary format, followed by a focused analysis.

4.1 Individual/Direct Policy Inputs

1. Control of the distribution or sale of condoms to minors

Issue. The focus of this policy input is the availability of condoms (male or female) to adolescents (minors). Sale or distribution of condoms for minors can be a policy matter, especially given social norms about sexual debut or more generally about sexual activity among adolescents. The related distribution among non-minor youth is less controversial and therefore not included here. Availability of information for the appropriate and consistent use of condoms may be controlled. Currently, PEPFAR regulations do not allow funded organizations to distribute condoms or condom-related information to youth ages 14 and under (Han and Bennish 2009). National governments also may have specific rules. For example, in many Anglophone Caribbean countries, sale of condoms to minors is punishable, regardless of the presence of STI, pregnancy, etc. (PANCAP 2008).

Minors are present among the groups involved in our definition of MARPs, as are their sexual partners. Therefore, this policy input is relevant to MARPs. This policy input can involve all three elements. Formal laws or regulations can control such sale and distribution. Relevant programs could advocate for or against such sales, and/or sales or distribution of condoms specifically to these groups. Programs could also help to reduce inhibitions among youth in acquiring condoms due to fears born from stigma.

Background related to the AWARE II region. Social marketing of condoms, with subsidized pricing, has been a mainstay of condom programs in West Africa, supported by a multiplicity of donors. These programs use a variety of delivery agents, including the private sector. Often these programs originate in the FP/RH sector. A report on the region indicated that clients may have a preference for receiving condoms from private outlets, rather than getting free condoms from a government facility (Dowling 2005). This suggests that when substantial condom provision still occurs through the private sector, explicit laws and regulations are meaningful, both in permitting sale as well as requiring it if the vendor refuses. In the context of age, laws can explicitly restrict condoms for minors, limit or deter condoms for adolescents by requiring parental consent, or prohibit a vendor from withholding condoms from adolescents.

A report on the AWARE II region indicated that clients may have a preference for receiving condoms from private outlets, rather than getting free condoms from a government facility (Dowling 2005).

While explicit laws on the sale or distribution of condoms to minors or even youth are not common, there may be an indication of legal action from rules that govern programs, e.g., school-based HIV prevention. The 2005 Children’s Act in South Africa prohibits any person from refusing to sell or distribute (if free) condoms to adolescents 12 years and older (Han and Bennish 2009). Building on this law, the South African Department of Education allowed schools to determine whether to make condoms available.

Data. There are no specific legal provisions like in the South African law on selling condoms to minors in the AWARE II region. However, the countries that adopted N’djamena-type model laws have an article allowing HIV/AIDS education in schools, and in the case of minors, usually only with the explicit consent of parents on the content and materials. This extends to information on condom use. This is *Article 2* of the model N’djamena-type law, which was adopted by Benin, Burkina Faso, Cape Verde, Chad, Guinea-Bissau, Guinea, Niger, Senegal, Sierra Leone (with revision in 2010), and Togo. We expect school-based programs to have only limited relevance in the context of minors who are FSWs, since they are likely not in school (though students can practice transactional sex). We discuss condoms for FSWs and clients later. Also, school-going adolescent boys may be clients of FSWs. In Cameroon, data from 2001 suggested that 4 percent of adolescents ages 15–19 had paid for sex at some time (Carael, Slaymaker et al. 2006).

Investigation in the region revealed many programs with a condom provision activity targeted at youth; however, it is not clear if this extends to youth below the age of consent or any other definition of minor. Countries with programs for distribution of condoms to “youth” include Benin, Burkina Faso, Cameroon, Chad, Côte d’Ivoire, The Gambia, Ghana, Guinea-Bissau, and Senegal. In Togo, we found a clear record of a PSI program (funding: USAID) targeting youth ages 15–24 years, which also included a condom provision (*Projet Agbelen’ko*). In Burkina Faso, the Global Fund Round 10 grant suggests that a UNICEF/UNFPA and DANIDA program will target adolescents ages 10–24 with HIV prevention messaging, though it is unclear if condoms will be distributed. PSI is launching the “Kool” brand of condoms targeted at youth ages 15–24 in Benin. The Global Fund Round 8 proposal for Mali suggested condoms would be distributed to “pupils” in the formal and informal educational

sector. A similar program, operated by the Ministry of Education, is planned in Côte d'Ivoire at public and private schools, utilizing PEPFAR funding (PEPFAR 2010a).

Since 2006, the “Alert School Model” program in Ghana has included a comprehensive HIV and AIDS education platform for adolescents 12 and above. A program in The Gambia targets HIV prevention messages at children ages 10–14 (“Window of Hope”). However, to our knowledge, condom availability is not part of these programs. An HIV & AIDS Prevention and Education project targeting out-of-school youth (age range unknown) was also reported from Ghana (GAC 2010).

Conclusions. The AWARE II region lacks formal legislation or regulation that allows the sale of condoms to minors, or requires such sale in the case of vendor refusal. Programs that provide free condoms to “youth” exist through donor support in many countries, but their inclusion of minors in this category is unclear except in a few cases (Benin, Côte d'Ivoire, and Togo). Availability of condom-related information is more widespread. As the dominant source of condom provision remains the private sector, whether social-marketed or not, the presence of formal rules for sales to minors would clarify the conditions for HIV prevention. This is especially so given evidence that minors do form a proportion of clients of sex workers, and hence are a proportion of that MARP group.

2. Consistent male condom use by clients of FSWs

Issue. The focus of this policy issue is the consistent use of male condoms by clients of FSWs. Female condoms, which can improve the power dynamic, are excluded here but are included in #5. Female condoms have low utilization among FSWs in the region (see **Notes**, at end). Non-paying regular partners are also an at-risk group for HIV infection and play the role of bridge to the general population. Several studies in West Africa have found FSWs reporting low rates of condom use with such non-paying regular partners (Wang, Hawes et al. 2007), who can have HIV prevalence higher than the average client (Lowndes, Alary et al. 2007). They are a smaller than clients, however. The non-paying partner aspect is not included in this policy input.

As per several systematic reviews of the literature, increase in consistent use of male condoms by clients can be done via client education (whether peer or other), condom “enforcement,” or through empowering FSWs to negotiate consistent condom use (Foss, Hossain et al. 2007; Shahmanesh, Patel et al. 2008). A case of the enforcement approach was seen in the Dominican Republic, where a local government policy mandated 100 percent condom use by clients and charged brothel owners with enforcing the policy (Kerrigan, Moreno et al. 2006). This was moderately successful.

This policy input can involve all three elements. Laws or regulations can enforce consistent condom use and make commercial sex operators responsible for compliance. Programs involved with this issue may use behavior change communication (BCC) and IEC to influence consistency of condom use among clients and FSWs, and/or methods to empower FSWs.

Background related to the AWARE II region. Client refusal is a key reason for the lack of consistent condom use in sex work. In a study from Ghana, women cited client refusal (73%), receiving a higher payment (33%), and client brutality (43%) as reasons for not using condoms (Adu-

Opping, Grimes et al. 2007). DHS data also show inconsistent condom use by clients as a problem for the AWARE II region, indicating that the proportion of men surveyed who used a condom during last commercial sex (self-reported) is mostly lower than a majority (Table 10). However, non-DHS surveys of clients shown in Table 10 reported much higher levels of condom use. A long-term study from Cotonou, Benin suggests that basic STI testing and risk-reduction counseling for clients was associated with significant increases in consistent condom use, from 39 percent (1998) to 86.2 percent (2005) (Lowndes, Alary et al. 2007). While self-reported condom use figures from FSWs and clients refer to the same type of event, experts hold that the data from clients are less subject to social desirability bias (Côté, Sobela et al. 2004).

The variability in clients' condom use reports also pertains to FSWs, where both optimistic and pessimistic findings abound. Among the former, in a study from Dakar, FSWs reported condom use rates higher than 90 percent (Wang, Hawes et al. 2007). However, this survey was mainly carried out among registered FSWs who had access to prevention messaging and free condoms. Data suggest that condom use among unregistered FSWs in the same city was lower. From 1991 to 1997, an increase in FSWs' reported condom use with last client was seen in Abidjan, Côte d'Ivoire at an STD/HIV clinic offering peer education and condoms, though that study overlapped with major changes in the demographics of the sex worker population (Ghys, Diallo et al. 2002). In Ghana, the 2009 BSS among FSWs suggested that only 4.1 percent believed they did not need to use condoms with their clients (GAC 2010). The proportion that used condoms consistently was not reported. On the other hand, a small sample study in the state of Ekiti, Nigeria found that 92 percent of the 120 FSWs surveyed did not regularly use a condom during sex work (Seyi 2010).

Table 10. Condom use at last commercial sex reported by clients, various estimates, AWARE II region

Country (Year of DHS)	DHS estimate*	Location	Other estimates	Source (estimate)
Benin (2006)	41.5%	Lomé, Togo	93% (2005)	(Sobéla, Pépin et al. 2009)
Ghana (2008)	54.1%	Other, Togo	88% (2005)	
Liberia (2007)	47.6%	Cotonou, Benin**	68.1% (2002)	(Lowndes, Alary et al. 2007)
Mali (2006)	51.8%		94.6% (2005)	
Niger (2006)	49.3%			
Nigeria (2008)	61.3%			
Senegal (2005)	31.2%			
Sierra Leone (2008)	28%			

* Condom use at last commercial sex, self-reported

** Note that the sample size declined across years.

Chad's UNGASS report found that 29 percent of FSWs used condoms during their most recent sexual encounter (CNLS Chad 2010). Benin's Global Fund Round 9 grant indicators report a baseline value of 55.3 percent in 2008 for the proportion of FSWs who reported using a condom during their most recent sex work. This number deviates from the 79.7 percent reported via the Second Generation STI/AIDS Surveillance Survey of 2008 (World Bank 2011). In Cameroon, a survey of 385 FSWs showed that 48.8 percent did not use a condom consistently with non-spousal partners (Talnan, Moukam et al. 2010). This study also found that FSWs who were pressured by a partner were significantly more likely to use condoms inconsistently.

A recent WHO review of sex work in Africa stresses the importance of the environments in which sex work takes place because these locations reflect client typologies and FSWs' negotiation power (WHO 2011). Data collected from countries as diverse as the Dominican Republic and Canada also demonstrate the impact of location on the negotiating advantages of FSWs. For this policy input, as well as input #5 below, site-based regulations and interventions are weighted. These inputs use context-specific methods at locations where low condom use is reported.

Data and conclusions. Our review could not find any laws or regulations that stress local enforcement of a condom use policy. The cultural context for imposing such policies may not be present. Our review found many programs that target condom use among FSWs and specific clients, including corridor projects, such as the World Bank's Abidjan-Lagos Corridor Organization project. Of note, the USG program in Ghana has adopted a MARPs-centered approach that includes condom programming to clients and partners using peer-led networks, as well as community and PLHIV organizations (PEPFAR 2010b). The GHAIN project in Nigeria promotes consistent condom use for clients. A new USG MARPs-centric project is expected there; other interventions will target FSWs at non-brothel sites for condom negotiation skills. Table 11 lists current major programs with condom interventions and explicit client aspects.

Table 11. Programs promoting consistent condom use by clients in the AWARE II region (see Abbreviations)

Country	Program; Type and Targets	Implementer
Benin	Global Fund Round 9; Peer education for FSWs on condom use, condom distribution	PSI
	World Bank/Government of Benin 2 nd Multisectoral HIV/AIDS Project; Condom distribution	PSI & others
Burkina Faso	Global Fund Round 10, also bilateral; Condom promotion, truckers, gold washers—as clients, FSWs	PSI/PROMACO (Global Fund), PAMAC (WHO/DANIDA)
Cameroon	Global Fund Round 10; Condom promotion, truckers, FSWs	Various, esp. CAMNAFAW
	CIDA “main roads” project; Condom promotion, truckers, FSWs	CARE Canada
Ghana	PEPFAR implementers; Peer-group condom programs among CSW, non-paying partners, and clients, also men in uniform	AED/SHARP follow-on; also CBOs for PLHIV/MARP
	Global Fund Round 8; FSWs and miners, men in uniform, transport workers—as clients	MOH/Ghana Health Services, GAC, PPAG
Liberia	Global Fund Round 8; FSWs, IDU, youth, men in uniform, etc.	NGOs in urban areas
Mali	MAP (World Bank); CSW and partners, miners, truck drivers, household workers—as clients	MOH
	Global Fund Round 8; Condoms USAID donated, targets are FSWs and clients, transport workers, seasonal workers, miners	Group Pivot/Santé Population, SOUTOURA for FSWs
Mauritania	MAP2 (World Bank); CSW and clients, truck drivers, army	MOH and affiliated NGO
Nigeria	PEPFAR; Condom negotiation—brothel and non-brothel, condom provision to FSWs, transport workers, migrants	GHAIN, and unclear (some TBD)
Senegal	Global Fund Round 9; CSW and clients (specific regions)—condoms will be donated by USAID/UNFPA/KFW	National AIDS Alliance, NAC
Togo	Global Fund Round 8; Condoms for CSW, migrants, truckers	PSI (using Round 4 condoms)

3. Availability of post-exposure prophylaxis for MARPs

Issue. The focus of this policy input is the availability of post-exposure prophylaxis following sexual exposure (PEPSE) for FSWs, their clients, and MSM. When injecting behavior is included, the overall category can be defined as non-occupational post-exposure prophylaxis, or PEP. Recently, there has been discussion about the efficacy of pre-exposure prophylaxis (PREP) using antiretrovirals (ARVs). However, the efficacy of PREP is not included in the current policy input, which also excludes

PMTCT and prophylaxis for opportunistic infection. Large-scale availability of PREP for certain MARPs may require stockpiles of ARVs for the purpose of official sanction. This potential requirement is driven by the mixed results of PREP in terms of adverse effects, efficacy profile, and cost-effectiveness when the HIV-status of the source is unknown (Lunding, Katzenstein et al. 2010). In the case of PREP, regulations and specific guidelines can define the circumstances—such as the level of risk, time from exposure—under which defined populations can access PEPSE. Guidelines for these exist in many developed countries. Programs relevant here would work to improve access to PEPSE for these MARP groups.

Background related to the AWARE II region. PEPSE interventions often involve some counseling and a PEPSE “pack” with instructions and a starter dose of ARVs (CDC 2005). Small-scale use of PEPSE has been documented in West Africa (in Abidjan, Côte d’Ivoire, for example) for those potentially exposed to the HIV virus through rape, unprotected sex, and condom failure (Ehui, Tanon et al. 2010).

Table 12. Countries with post-exposure prophylaxis guidelines (non-occupational), AWARE II region

Country	Guideline;* target populations	Sources
Benin	Yes; unknown	Global Fund Round 9 Proposal
Burkina Faso	Unknown; context of prisons	Global Fund Round 10 Proposal
Côte d’Ivoire	Unknown; sexual assault victims	Global Fund Round 9 Proposal
Ghana	Unknown; sexual assault victims	UNGASS (GAC 2010); (PEPFAR 2010b)
Liberia	Yes (TBD); sexual assault victims	Global Fund Round 8 Proposal

* TBD: To be developed.

Data. In addition to the details in Table 12, we also surveyed country-wide strategies. In Ghana, the recent UNGASS report states that gaps remain in availability of PEPSE for sexual assault victims. The Nigerian government claims in its Round 9 proposal that it includes PEPSE in its strategy, but no details of implementation are provided, including the context of provision. Mali has PEP guidelines for occupational exposure only and has a program to train health workers in this type of PEP. Of the most comprehensive plans in the PEPSE context, Liberia has plans to scale up the availability of prophylaxis for sexual assault victims to 100 percent of health centers and hospitals, according to its Round 8 Global Fund Proposal (2009–13).

Conclusions. The AWARE II region lacks a comprehensive view on PEPSE. Many countries see it as only for sexual assault victims and even then, it is being used in a limited number of countries. An occupation-based view on HIV exposure and related PEP is also worryingly absent except for a few countries. A comprehensive view on PEPSE targeted toward high-risk exposures would include FSWs, clients, and MSM, and could avert a large number of infections if intervention is scaled up.

4. Availability of HIV treatment and care for MARPs

Issue. The focus of this policy issue is the availability of HIV treatment and care to PLHIV among the MARPs. In this context, we include first- and second-line ART, as well as cotrimoxazole prophylaxis and curative treatments for opportunistic infections (OI), including STI. We also can include palliative care when it is part of these treatment and care regimens.

As we have discussed previously, both self-imposed and other forms of discrimination stemming from stigma can be barriers to initiating and sustaining treatment in the case of MARPs in sub-Saharan Africa. The potential preventive benefits of ART for reducing the risk of transmission in patients who are responding to therapy are well-known. Given the modes-of-transmission studies and the information on HIV prevalence among MARPs in the AWARE II region, such prevention benefits cannot be ignored. Further, the potential excess morbidity and mortality being suffered by MARPs because of their inadequate utilization of treatment implies that special considerations for access to HIV treatment and care should be evaluated. Even in the absence of stigma and discrimination, FSWs face barriers in accessing HIV services due to the nature of their work and the location and timing of health services. Laws and regulations could reduce barriers for FSWs to access HIV treatment and care. Formal Policies regarding discrimination in health services are considered under policy input #10 below. This input is limited to HIV treatment and care. Programs here could focus on providing free or low-cost treatment to MARPs or work to reduce stigma and discrimination in HIV treatment and care.

Background related to the AWARE II region. In Senegal, where sex workers can be legally registered, there is a program for them to receive targeted HIV services at specific clinics, including HIV treatment and care related to OIs. NGOs such as ENDA Health are financed through the Global Fund to provide such care and treatment, though specific details on coverage are not currently available. However, availability of targeted services does not obviate the concerns raised before. In a long-term study conducted in Senegal, losses to follow-up rates on ART were very high (>50%) among FSWs (Sow, Traoré et al. 2011). Such targeted, confidential service delivery also exists in Côte d'Ivoire. While targeted HIV service delivery is a response to stigma and discrimination, it may not do enough to reduce stigma and discrimination toward MARPs.

Data and conclusions. We found little evidence for a legal-regulatory approach related to the availability of HIV treatment and care for MARPs in the AWARE II region. Laws on discrimination in general health services exist and will be dealt with later in this report. Table 13 reports the results of a review of strategies to identify targeted treatment and care programs. There was an emphasis on targeted services for STI treatment and *not* on ART. Also, there were insufficient data about whether STIs were dealt with as an OI among the HIV positive, or as a risk factor among HIV-negative MARPs. When a focus was provided, it was usually on FSWs, and less frequently for MSM. There was no evidence of an IDU focus.

We found several instances of a specific MARPs focus in treatment and care, especially in Ghana and Côte d'Ivoire, but little evidence for Liberia, Mauritania, or Niger. There were insufficient data for conclusions related to Cape Verde, Equatorial Guinea, Guinea, Guinea-Bissau, or Sierra Leone.

There was evidence that the USG, through PEPFAR, is leading the MARPs focus in treatment and care for the countries in which it operates in the region. Notably, a new USG-funded project in Côte d’Ivoire will focus on increasing coverage of care services for FSWs as well as for clients and MSM (PEPFAR 2010a). In Ghana, the USG is pushing for the increased “MARPs friendliness” of existing treatment delivery sites (including PMTCT), which can be construed as avoiding vertical programming for MARPs, and can reduce overall stigma and discrimination (PEPFAR 2010b). In this context, the Ghana Global Fund Round 8 proposal asks for the integration of specialized patient management services for STI among FSWs in three “at-risk” zones (Bougouni, Sanso, and Zégoua), even though 15 specialized sites for STI prevention, diagnosis, and treatment also would be set up (CCM Ghana 2008).

Table 13. Countries with targeted HIV treatment and care services for MARPs, AWARE II region

Country	Target; Type of Intervention	Sources
Benin	FSWs; STI treatment	Global Fund Round 9 Proposal
Burkina Faso	MSM, FSWs; Increase MARPs-friendly service sites from 22 to 39, training of health workers	Global Fund Round 10 Proposal
Chad	FSWs and male sex workers; STI care	Global Fund Round 8 Proposal
Côte d’Ivoire	FSWs, men in uniform (as clients); Community care (unclear)	Global Fund Round 9 Proposal, (PEPFAR 2010a)
Côte d’Ivoire	Male and female sex workers, MSM; STI treatment and ART since 2006	Clinique de Confiance, Abidjan (FHI) (Vuylsteke, Sika et al. 2009)
Ghana	MARPs; Training for STI clinics to make them MARPs friendly, linkages for ART	(PEPFAR 2010b)
	FSWs; Clinical outreach for STI in Accra and Kumasi	
	FSWs and MSM; STI services through drop-in centers and specialized sites (15 for FSWs)	Global Fund Round 8 Proposal
Nigeria	MSM, FSWs, and clients; STI treatment	(PEPFAR 2010c)
Senegal	MSM and FSWs; STI treatment in the context of HIV	Global Fund Round 9 Proposal
Sierra Leone	MSM, FSWs, “beach boys”; STI treatment	Global Fund Round 9 Proposal

In addition to the major programs in Table 13, there are others in other Francophone countries, such as those identified in Senegal and Côte d’Ivoire. In Gabon, the French Red Cross has set up an ambulatory HIV care and treatment facility that also caters to MARPs around Libreville (Ndong, Adam et al. 2008). Anecdotal information suggests that in Mauritania, private sites provide MARPs-friendly treatment services (Aliou 2011). In Mali, despite a focus on MARPs on the prevention side, we could find little evidence for a similar treatment focus in the World Bank-supported Multisectoral HIV/AIDS Project. An important consideration in viewing the achievements of the PEPFAR programs in Ghana and Nigeria is that they are not present in all of the geographical areas of those countries, given the intra-country focus adopted by the World Bank and the division of responsibilities with other donor-supported programs.

5. Site-specific condom provision around sex work

Issue. This policy input is closely tied with #2 above but is more narrowly concerned with whether regulations require and programs facilitate the availability and use of condoms at specific sites of sex work. This policy input recognizes the locational aspect of the interaction between sex workers and clients, which can be exploited for greater effectiveness of condom programming, as well as cost savings. Both male and female sex workers can be included, and both male and female condoms can be provided. In addition, water-based lubricant gel is considered in this policy input, especially in the context of FSWs and clients. We expect this policy input to involve regulations and programs only.

Background related to the AWARE II region. We have already discussed in detail the inconsistent condom use in the region among clients during commercial sex (see #2 above). Programmatic response has incorporated the importance of location in targeting clients with both condoms and messages related to safer sex behaviors (including consistent condom use) at sites such as brothels, bars, and truck stops. Table 13 above should be read in conjunction with this section, because such thinking is inherent in targeting transport workers with interventions promoting consistent condom use. Reaching truck drivers has been a component of projects like the Abidjan-Lagos Corridor Organization (ALCO).

Although not related to a MARP, the Burkina Faso, Côte d'Ivoire, and Ghana initiatives to provide condoms in prisons are noteworthy, given that previous regulations did not allow condoms for prisoners, a vulnerable group (sources: Global Fund proposals, PEPFAR Country Operating Plans)(CCM Côte d'Ivoire 2009; CCM Burkina Faso 2010; PEPFAR 2010a). This involves engagement with stakeholders such as the Ministry of Justice. This is a good example of a site-specific orientation, based on need, driving a change in Formal Policies. A need to serve rural sites with condoms (Benin, Cameroon, and Côte d'Ivoire), “universal access” for condoms (Chad), and condoms in educational workplaces (Côte d'Ivoire) are instances that require more detail in terms of support from epidemiology.

Many of the projects below, especially those aiming for Rounds 9 or 10 Global Fund support, also aimed to procure or receive donated water-based lubricant gel packs to distribute at these sites for FSWs and clients. The focus on lubricants is a change from previous rounds in which they were not as commonly mentioned. Lubricants are now recognized in their role in reducing the risk of transmission during sex.

Table 14. Location-specific targets for male condom provision around sex work in the AWARE II region

Country	Locations or occupations	Sources/Project
Benin	Rural areas, brothels, truck stops, camps for men in uniform, job training areas	Global Fund Round 9 Proposal (through Plan Benin, PSI)
Burkina Faso	PECM sites (workers)	Global Fund Round 10 Proposal
Cameroon	Rural areas, truck drivers, "riversides"	Global Fund Round 10 Proposal
Côte d'Ivoire	Rural areas, transport workers	PEPFAR program
	Brothels, hotels, bars, "busy streets"	Global Fund Round 9 Proposal
Guinea	Bars	<i>Projet Frontières et Vulnérabilités au VIH</i>
Gabon	"Work sites of FSWs" (to be identified)	Global Fund Round 8 Proposal
Ghana	MARP group meetings; bars, esp. those in cocoa-growing areas; Ghana Armed Forces	PEPFAR program (along with DOD)
	"Hot spots," bars, hotels, night clubs	Global Fund Round 8 Proposal
Liberia	Transport workers, IDUs, armed forces	Global Fund Round 8 Proposal
Mali	Transport, mining, & seasonal job workers, "family aid helpers"	Global Fund Round 8 Proposal
Nigeria	"Hot spots," transport workers, migrants, military sites`	PEPFAR program (along with DOD)
Sierra Leone	13 sites selected, including brothels	Global Fund Round 9 Proposal

Data: Table 14 reviews the data on specific locations where a certain geographic targeting logic is in play. It does not include all other general health service delivery sites (e.g., PMTCT sites, ART clinics, testing and counseling sites) that also will generally make condoms available. Where an occupational category is mentioned, we preserved the language of the original document. This should be read as indicating the locations where this occupation is centered, e.g., mining sites for miners.

Female condoms (FC) were mentioned in all of the Global Fund proposals that mentioned male condoms. Procurement or donated supply was incorporated in planning, but there was less specificity about site selection for distribution of FCs, which was aimed mostly through outreach or existing facilities. Given low levels of use, Benin and Côte d'Ivoire planned for more subsidy for the FCs in terms of volume or amount of subsidy (CCM Benin 2009; CCM Côte d'Ivoire 2009). The Burkina Faso Global Fund Round 10 proposal identified community centers as a proposed site to stock donated FCs (CCM Burkina Faso 2010).

Conclusions. While location-based targeting in male condom distribution related to sex work has spread, promoted by country-specific and corridor projects, it is still missing in a few countries such as Chad, Niger, and Guinea-Bissau. This finding is based on official documents, though some bilateral USAID and other donor projects may exist for which we presently do not have data. In terms of such

site-specific targeting, we find PEPFAR- and Global Fund-supported programs equally active. The location-based targeting used for male condoms should also be used for the female condom, especially to drive the uptake of this higher-priced yet effective intervention.

6. Needle and syringe programs for people who inject drugs

Issue. The focus of this policy issue is the provision of unused clean needles and syringes, which reduce the risk of HIV transmission due to needle-sharing among IDUs. The availability of needles is not merely a programmatic matter. Regulation can affect the availability of unused needles by controlling the sales of needles and syringes and restricting their use. Alternatively, regulations may require that needles are available in appropriate locations, at acceptable prices. In 13 sub-Saharan countries—none in the AWARE II region—IDUs may purchase sterile injecting equipment at pharmacies (GMHC 2009). Programs relevant here could focus on creating opportunities for needle and syringe interventions.

Background related to the AWARE II region. A previous global review identified a lack of NSP in sub-Saharan Africa overall, and did not find IDUs accessing such services at all anywhere in the AWARE II region (Mathers, Degenhardt et al. 2010). Studies suggest that IDUs exist in the region, especially in Nigeria (Adelekan and Lawal 2006) and Sierra Leone, but potentially many other countries as well (IHRN 2011). The latest HIV prevalence data among IDUs in the region are from Nigeria, which reported a level of 5.5 percent in 2008 (Mathers, Degenhardt et al. 2008), though earlier studies showed higher levels. Also, several sources have noted that IDUs and other MARPs may mix, for example, there is injecting drug use among FSWs.

Data. During our in-country interviews, anecdotal accounts suggested that NSP existed in Cameroon, Nigeria, Côte d’Ivoire, and Sierra Leone. We investigated the strategic documents, including UNGASS reports from these countries, to try and confirm this.

We found no evidence of NSP in Cameroon and Côte d’Ivoire in official documents. This may indicate that the interventions are missing, small scale, or historical. While we found evidence for a general prevention intervention with IDUs in Nigeria, funded by PEPFAR and implemented by the Men’s Health Network Nigeria, we could not confirm the presence of any NSP. In Sierra Leone, the Round 9 Global Fund proposal planned for NSP across nine sites chosen in conjunction with the National Dangerous Drugs Control Board (CCM Sierra Leone 2009). However, subsequent Global Fund grant-related documentation does not indicate that this intervention was approved or is being carried out.

Conclusions. Our data show that NSP is a missed opportunity in the AWARE II region, given the high probability of IDU presence in the region. Several MARPs mapping and enumeration studies that include IDUs will help to form an advocacy basis for these interventions, including the Formal Policies that will enable needle and syringe programs.

7. Condoms and lubricants for MSM, including men who have sex with women (MSW)

Issue. The focus of this policy issue is the reduction of the risk of transmission through UAI among MSM. Use of condoms reduces risk in such contact, while water-based lubricants (WBL) would enhance this reduction, and in the case of latex “vaginal” condoms and anal intercourse, should be considered necessary to reduce failure rates (Golombok, Harding et al. 2001). WBL used without condoms still confer some protective value in UAI. We mostly expected to encounter programs for this policy input. Programs here would focus on targeted condom and lubricant provision to MSM, peer education about correct condom and lubricant use, and/or cost reduction for purchase of these commodities. Studies have shown that consistent condom use among MSM is associated with lower condom failure rates, and hence such programming would have additional value (Stone, Heagerty et al. 1999).

Background related to the AWARE II region. Consistent condom use rates among MSM in the AWARE II region have been documented to be low. This should be viewed against the high HIV prevalence in the community and the higher risk of transmission of HIV per UAI vs. an act of unprotected vaginal sexual intercourse. In a small sample study in Togo, consistent condom use rate among MSM was only 21 percent (Koumagnanou, Montcho et al. 2010).

Data and conclusions. Recent Global Fund HIV grant proposals (Rounds 9 and 10) from the region generally mention MSM, but we sought specific details on condom and WBL programming for the group. The mention of condoms plus WBL for MSM was noted in the Burkina Faso and Cameroon Round 10 proposals, Mali Round 8, and the Sierra Leone and Senegal Round 9 HIV proposals. Condoms (only) for MSM were mentioned in the Côte d’Ivoire Round 9 proposal.

The PEPFAR-funded Clinic de Confiance site in Abidjan served more than 400 MSM in 2009. The PEPFAR programs in Ghana and Côte d’Ivoire plan to continue to promote condom and WBL gel use together, targeting both FSWs and MSM (PEPFAR 2010a; PEPFAR 2010b).

Most of the Global Fund-financed services were planned to be implemented through specific NGOs or civil society organizations. In Burkina Faso, four health service delivery sites would be refurbished and staffed with MSM-friendly health workers. Condoms and lubricants will be made “freely” available by civil society organizations and the Programme d’Appui au Monde Associatif et Communautaire (PAMAC). In Mali, special “night teams” comprising peer educators will identify MSM clustering locations and provide condoms and WBL. A similar design, minus the “night teams,” was identified by Sierra Leone. This is a valuable use of the location-based targeting approach discussed in the context of FSWs and clients for policy input #5. In Côte d’Ivoire, peer educators and community agents would provide BCC and distribute condoms. Senegal, which has had the longest history of MSM-specific interventions, would utilize ENDA Health’s services to distribute condoms and WBL for MSM (and FSWs).

As previously mentioned in the context of STI (#4), the PEPFAR program in Ghana, through the implementer EXP Momentum, will employ peer educators within MARPs support groups to provide services. This will include condom and WBL distribution. As a new product, PEPFAR will introduce single-use WBL packets in Ghana, using JSI/DELIVER to strengthen the related condom/WBL supply

chains (PEPFAR 2010b). The Ghana PEPFAR program is notably comprehensive: it also includes help lines with trained telephone counselors who will provide assistance on appropriate condom and WBL use. In Nigeria, the PEPFAR program intends to expand condom and WBL availability for MSM, with implementers such as the Population Council. The implementer will work from six sites across Nigeria: Abuja FCT, Lagos, Ibadan, Calabar, Kano, and Kaduna.

We found no condom or WBL-related programming targeted at MSM in the Global Fund proposals for Chad, Gabon, Guinea, Guinea-Bissau, Liberia, Mauritania, or Niger (which intends to study MSM first).

4.2 Individual/Indirect Policy Inputs

8. Medically assisted therapy among people who inject drugs

Issue. The focus of this policy issue is the provision of medically assisted therapy, especially OST for IDUs. This forms one of the nine priority interventions for IDUs and has the potential to be an HIV-prevention effect by reducing the frequency of injecting drug use, and hence potential episodes of needle sharing. Also, by reducing the illicit nature of the behavior and combining the OST with counseling, programs can reduce the effect on IDUs of being clandestine and distant from HIV-prevention interventions. Regulations can affect the price and distribution of methadone or buprenorphine, the key drugs in OST, and the ability of IDUs to access such services. Programs relevant here could focus on OST provision, related peer education, and other related interventions (counseling).

Background related to the AWARE II region. A global review suggested that Senegal was the only country in the region to offer OST, utilizing mainly buprenorphine in its intervention (Mathers, Degenhardt et al. 2010). Again, similar to #6 above, our anecdotal data from in-country interviews suggested that Cameroon may also provide OST that utilizes methadone; its National Strategic Plan from 2006–2010 had regulations allowing its sale in pharmacies. We tried but could not confirm these accounts by searching the official record in UNGASS reports and recent Global Fund proposals.

Data. While Cameroon’s new National Strategic Plan 2011–2015 does include a budget line item for IDU programs, there was no detail and it is not clear if OST is provided. Further investigation in Cameroon is required. We could not find any language related to OST in Cameroon’s Global Fund proposals. In Senegal, we could not find data to corroborate the item in the study by Mathers et al. (2010).

Conclusions. While OST is generally not available in the region, we need to investigate the potential for its existence in Senegal and Cameroon, including in small-scale interventions.

9. Physical safety of sex workers

Issue. The focus of this policy issue is the protection of sex workers, male and female, from all forms of gender- and identity-based violence. Gender and sexual identity can be a basis for violence perpetrated against sex workers, by clients and non-paying sexual partners. Gender-based violence (GBV) has been cited in observational studies as a determinant of a woman’s risk of HIV infection (Dunkle, Jewkes et al. 2004). When such violence is penetrative, it can add to a male sex worker’s HIV risks. Even when the violence is not penetrative, it increases a climate of self-discrimination among sex workers, potentially leading to difficulties in reaching them with prevention and other services. Note that we are not extending this policy input to the issue of “willful” transmission or exposure to HIV risk, which is considered separately under #17 below. Laws can provide legal recourse to sex workers who are victims, and sanctions for perpetrators. Programs relevant here would focus on peer education, capacity building for victims, likely perpetrators, and law enforcement, as well as advocacy to support the status of victims.

Background related to the AWARE II region. Levels of GBV in the region can be high—in data from Côte d’Ivoire, 12 percent of women ages 15–49 reported having been victims of GBV (PEPFAR 2010a). We looked for laws that could have relevance to legal aid for sex workers, especially if the laws criminalized sexual violence—including rape, and specifically mentioned the context of sex work. We did not expect any laws disaggregating sex workers by gender but investigated if programs existed in this context.

Table 15. Laws protecting FSWs from gender-based/intimate partner violence

Country, Year	Law or regulation
Benin (2003)	Law No. 2003-04—Sexual and Reproductive Health—prohibits violence and sexual abuse
Burkina Faso (1996)	Criminal code (Art. 2,3 of Constitution)—general protection against violence and battery
Cameroon (1997)	1. Law to protect against assault on bodily integrity; 2. Regulation against violence to pregnant women and infants
Côte d’Ivoire (1981/2000)	Criminal code (Title 2—“crimes and offences against individuals”), and Article 3 of the constitution—protects women from violence
Ghana (2007)	Domestic Violence Act
Mali (2001)	Criminal code (Sections 179, 1980, 1981—punish indecent assault)

Data: Table 15 summarizes our findings on laws related to legal aid for FSWs.

Outside PEPFAR-supported programs, we found few interventions working with FSWs to provide aid in the context of violence. In the Gambia, a group of female lawyers working in association with the police was assisting MARPs, especially females. Police Domestic Violence Victim Support Units exist in Ghana to handle abuse against women and children, as well as men (Jeffers, Dohlie et al. 2010). These units will receive PEPFAR-funded training related to HIV and AIDS stigma (PEPFAR 2010b). In Cameroon, the “National Program for Fighting Violence against Women and Children” was set up, which may be called upon to assist FSWs in the case of intimate partner violence.

Conclusions. PEPFAR programs in Côte d'Ivoire, Ghana, and Nigeria continue to push strongly against GBV through many individual PEPFAR-funded interventions and using different approaches. There may also be bilateral USAID programs in other AWARE II countries that we did not review. An intervention as a part of the PEPFAR program in Ghana aims at reducing violence among FSWs and MSM. Service providers in MARPs-friendly clinics would be trained to recognize signs of violence and act appropriately. The implementer is an NGO called CDD. In a link with #3 above, PEPFAR is supporting PEPSE for victims of GBV in Nigeria, though the FSW aspect is unknown.

While the legal apparatus to provide due process for FSWs and MSW affected by violence exists at a broad level in many of the countries, it is not specific to sex workers, and we could not investigate whether these means are used in practice. Male sex workers are generally absent from the policy space in this context. Further advocacy with government, especially in the context of criminalization of sex work (to be discussed below) may be necessary. A separate review of existing donor-funded GBV programs is warranted, especially with a view toward their coverage of these MARPs.

10. Discrimination in access to health services for MARPs

Issue. The focus of this policy input is discrimination in access to general health services for MARPs. Issues of targeted HIV services for MARPs, which is a response to such discrimination, were discussed under #4 above. In Chapter 2, we discussed how externally imposed discrimination and self-discrimination are barriers to MARPs utilizing health services. There are human rights imperatives to correct such low utilization in an already marginalized set of groups. Low utilization has obvious mortality and morbidity effects and encompasses the HIV prevention aspect if, as a result of this process, MARPs also are less exposed to safer sex messages and condoms available at health facilities/outlets. Laws and regulations can reduce or eliminate such discrimination. Programs relevant here would focus on preventing stigma and discrimination in healthcare or providing targeted outreach to MARP groups suffering such discrimination.

Related laws in the AWARE II region. The *International Guidelines on HIV/AIDS and Human Rights* (UNAIDS/OHCHR 2006) suggest that public health authorities prohibit discrimination on the basis of actual or perceived HIV status, including in healthcare settings. We have discussed how many MARPs are HIV positive or may be stigmatized doubly on the basis of their MARP identity in addition to their actual or perceived HIV status. Such anti-discrimination guidelines specific to PLHIV were accepted by the 10 countries in the AWARE II region that adopted N'djamena-type model HIV laws (see Section 3.3). Other countries with similar HIV-specific laws have also adopted anti-discrimination statutes. In addition, several countries have broader laws and legislation, including articles from their constitution that prohibit such acts of discrimination in public services (e.g., Chad, Côte d'Ivoire, Guinea, and Togo). In addition, there are international conventions to which many AWARE II countries are signatories that prohibit discrimination.

However, in practice, as we will see below in the context of Formal Policies related to criminalization of certain behaviors, there is a gulf between such anti-discrimination laws and their import at the individual health facility level, especially in the context of self-discrimination. These effects have been confirmed in small sample studies from the region, for example with MSM in Ekiti, Nigeria (Akoro

and Ipadeola 2010). In this context, few countries offer MARPs-friendly HIV services, as listed in Table 13. Additionally, while public sector facilities may be governed by anti-discrimination laws, the private sector can continue to refuse to treat. In those situations, it is important to identify if refusal is based on PLHIV status, MARP status, or ability to pay (Gable, Gamharter et al. 2007).

Programs. We looked for programs that offered general health services to MARPs or worked at eliminating discrimination. Beyond STI and HIV services, we found very few instances of interventions targeting MARPs’ usage of general health services. Targeting STI and HIV treatment, HCT, PMTCT, and HIV care services using MARPs-friendly facilities is a “verticalization” approach to the problem of discrimination. Alternatively, mediators have been used on a small scale in Senegal to reach MSM and accompany them on their visits to a public health facility, ensuring that they can access certain services. There is qualitative evidence that MSM appreciated such mediation (Konare, Diaw et al. 2010).

A review of PEPFAR country operating plans (COPs) from the region, filed for Côte d’Ivoire, Ghana, and Nigeria, revealed interventions targeting stigma and discrimination at the point of access of HIV-related services—generally for PLHIV, and specifically for MARPs. Beyond HIV services, we found less evidence of such activities, though in Ghana, the National MARP Working Group is taking leadership with USG support on reduction of stigma and discrimination among public sector staff, including health workers (PEPFAR 2010b). Initiatives targeting gender inequality in access and utilization of health services are common, funded through both HIV and general health sector funds of the USG and other donors. However, while a more detailed review of such gender programming is necessary, in the COP, we did not find any intersection of gender-sensitive health interventions related to advocacy or service delivery and MARP groups such as FSWs. This may neglect the significant non-HIV health risks faced by FSWs due to their occupation, GBV, and socioeconomic deprivation (Choi 2010). Non-health services targeted at FSWs exist; we discuss these under policy input #13 below.

MARPs are not always PLHIV, and are often missed in anti-discrimination interventions aimed at ensuring access to both HIV and general health services.

Conclusions. Our review suggests that MARPs are being missed in anti-discrimination interventions aimed at ensuring access to both HIV and general health services. While there are programs in most West African countries to ensure access to healthcare for PLHIV, drawing on both specific HIV-related “model” laws as well as broader constitutional provisions against discrimination, we note that MARPs are not necessarily PLHIV. An HIV-specific focus for services and related discrimination is common for MARPs, neglecting their broader health needs and their potential for self-discrimination. Innovative approaches such as mediation or MARPs-friendly general healthcare sites need to be scaled up.

11. HIV testing for MARPs—VCT, PICT, and mobile CT

Issue: The focus of this policy input is the provision of all types of HCT for MARPs (VCT, provider-initiated counseling and testing [PICT], and counseling and testing [CT]) and the presence of any

“mandatory” testing provisions that impinge on the human rights of MARPs. Law and regulation can mandate for the testing of MARPs, which enforces stigma associated with these groups and can lead to MARPs avoiding healthcare, including the offer of HIV prevention services. Programs relevant here could focus on making HCT available to MARPs without mandatory aspects; another option is working to remove mandatory aspects. Guidelines and protocols for HCT are assumed to exist in all countries implementing the intervention and are not considered in this policy input.

Related laws in the AWARE II region. The *International Guidelines* suggest the prohibition of mandatory HIV testing of any target group, including those at risk (UNAIDS/OHCHR 2006). This has been adopted in all of the N’djamena-type model laws and hence is present in at least 11 AWARE II countries (Table 9). The N’djamena-type legislation broadly prohibits mandatory testing, with some exceptions, such as the following:

1. When a person is indicted for HIV infection or attempts to infect another person with HIV;
2. When a person is indicted for rape;
3. When determination of HIV status is necessary to solve a matrimonial conflict;
4. In cases of organ, cell, or blood donation; and
5. When a pregnant woman undergoes a medical checkup (in English version of the model law).

In Togo, the N’djamena-type model legislation included Article 50, which requires mandatory periodic testing of sex workers for HIV and STI (Pearshouse 2007). This may need to be examined for compliance with the *International Guidelines*, which discourages mandatory testing related to sex work; mandatory testing may contribute to stigma for FSWs. There is a requirement in Guinea for mandatory testing before marriage. This may be relevant to any individuals from MARPs who desire to marry. Such provisions need to be monitored in practice, as they can be misused by those who would discriminate against MARPs.

Of the seven other AWARE II countries with draft or adopted HIV-specific legislation, a legal review of provisions against mandatory testing needs to be conducted. Ghana does not have an HIV-specific law and hence mandatory HIV testing does not pertain (Jeffers, Dohlie et al. 2010). We have less information on laws related to testing in the other two countries (Gabon and São Tomé & Príncipe).

Programs. Provision of HIV counseling and testing services for MARP groups is a basic intervention in the region wherever such groups are considered for HIV prevention and treatment/care (see Tables 11, 12 and 14, and input #7). Some of the Global Fund proposals reviewed for recent rounds planned major scale-up of access to HCT for MARP groups across the region. The Burkina Faso Round 10 HIV proposal specifically remarks on the lack of HCT services for FSWs, MSM, and prisoners. The Senegal Round 9 proposal also showed a strong commitment to HCT among MARPs, and the World Bank Multisectoral project in Mali had a MARPs target for HCT. Other recent proposals (Round 8 or later) reviewed suggested that Benin, Mali, and Chad did not have a discernible MARPs focus in their Global Fund-based testing strategies. In fact, the Chad proposal adopts a more universal testing approach.

The preferred HCT modes in the region were the voluntary and mobile/ambulatory, though provider-initiated HCT was being added in many countries with recent grants (e.g., Nigeria). A detailed review of these multiple programs and their linkage to treatment and care could not be completed for this report.

Data provided for Ghana suggest that utilization of HCT among FSWs, MSM, and “partners of PLHIV” increased 180 percent from 2,500 to 7,000 between 2008 and 2009 at public facilities. The MARPs-friendly sites (FSWs and MSM) previously mentioned for Ghana (see Table 13 and input #7) would also increase HCT uptake and would promote acceptance and receipt of test results. In addition, the Ghanaian military was voluntarily testing 1,000 individuals annually but also performed mandatory testing for 5,000 military personnel during new recruitment and pre-deployment (PEPFAR 2010b). Testing was not mandatory for blood transfusion or tissue and organ transplants.

Nigeria has used “stand-alone” HCT sites to drive testing of MARPs by utilizing strategic location and demand creation (PEPFAR 2010c).

In 2010, Côte d’Ivoire health facilities were adopting “opt-out” testing as the HCT principle (finger prick algorithm), and this could raise concerns in the context of MARPs if facility staff do not adequately convey information on the right to refuse (opt out). We recognize that the opt-out modality might increase testing rates compared to an “opt-in” approach (Jürgens 2007). The passage of the draft Côte d’Ivoire HIV-specific bill may assuage concerns about informed consent. Routinized opt-out or opt-in testing, offered to everyone, helps to reduce stigma by not isolating or making mandatory the testing of certain groups.

Conclusions. The prevalence of mandatory provisions related to HIV testing and counseling in the AWARE II region is low, though pockets of mandatory testing exist, even in countries with N’djamena-type model laws. Also, the exceptional cases in which testing is mandatory under model laws should be noted.

A MARPs focus in HCT programs was also increasing and was included as a part of the HIV prevention strategy in countries with new Global Fund grants or a strong donor-funded program. Some countries did not have a MARPs focus for HCT, suggesting that this is not a universal imperative in the region. We recognize a shift in testing modalities and recommend further review of HCT in the region, especially to understand the effect of increasing provider-initiated and opt-out policies on MARPs and related stigma and self-discrimination issues.

12. Confidentiality of information related to HIV status

Issue. This policy input relates to the confidentiality of information on an individuals’ known HIV status. The presence of mandatory disclosure policies or a process of designating those tested and their results by name may reduce uptake of HCT. This may be due to a fear of stigma and discrimination subsequent to involuntary disclosure, effect on occupation or personal relations, or any other desires for privacy. Laws and regulations can authorize or require a level of confidentiality, and/or define circumstances under which an individual must disclose his or her status or when a health worker should or should not disclose HIV status to the client’s sexual or other partner (“duty to warn”).

Related laws in the AWARE II region. Confidentiality of test results is taken as one of three Cs of HIV testing, along with counseling and (informed) consent (WHO 2007). The *International Guidelines* (UNAIDS/OHCHR 2006) suggest only voluntary disclosure. Only “simplified pretest information” should be collected, as per the WHO and UNAIDS guidance. The guidance also suggests that clients be informed that local laws could mandate the “disclosure of HIV status to sexual and/or drug injecting partners” (see Table 16) and thereafter informed consent should be obtained. The WHO guidance on testing mentions that in the case of MARPs, additional measures to *ensure* informed consent may be appropriate.

Table 16. Laws on disclosure of patient information related to HIV testing in 7 AWARE II countries

Country, Year	Law	Patient	Provider
Benin (2006)	Law No. 2005-31 “On prevention, care, and control of HIV/AIDS”	Obligated to disclose (Art. 4)	Prohibited (Art. 4), exceptions (Art. 6) ¹
Guinea (2005)	Law No. 2005-25 “On prevention, care and control of HIV/AIDS”	N/A	Art. 23—inform partner; Art. 25 allows breach ²
Guinea-Bissau (2007)	Framework law relating to the prevention, treatment, and control of HIV/AIDS	Obligated to disclose (Art. 26)	N/A, possibly prohibited
Mali (2006)	Law No. 06-28 “establishing rules relating to prevention, care and control of HIV/AIDS”	Obligated to disclose (Art. 27)	Art. 27 allows breach ³
Niger (2007)	Law No. 2007-08 “relating to the prevention, care and control of HIV”	Obligated to disclose (Art. 15)	Art. 17 allows breach ⁴
Sierra Leone (2007)	“Prevention and Control of HIV and AIDS Act (2007)”	Inform in advance of risk, Art. 21 (1)	Art. 21 allows breach ⁵
Togo (2005)	Law No. 2005-012 “on the protection of people with respect to HIV/AIDS”	Obligated to disclose (Art. 9)	Art. 10 allows breach ⁶

¹ Benin: Article 4 forbids a healthcare professional from disclosing the client’s HIV status, but Article 6 allows certain exceptions where the provider—and anyone else with the information—can disclose when they feel a “duty to warn” due to a felt risk of transmission, inability of the HIV-positive person to consent, and in the case of minors without legal capacity.

² Breach of confidentiality allowed in the case of the similar exceptions, as in the Benin law Art. 6.

³ Article 27 (part 3) is similar to Benin and Guinea, but requires permission of the PLHIV and counseling.

⁴ Article 17 is similar to Benin and Guinea, but requires that the “6-week grace period” first pass before breach.

⁵ Article 21(7) allows breach by the physician if he or she can determine that the client had not taken “reasonable precautions” to prevent transmission and informed the partner, if the client is pregnant and at risk of vertical transmission, or if the PLHIV did not request the physician to notify first (which is an overbroad exception).

⁶ Does not specify conditions under which the confidentiality can be breached, and therefore may be overbroad.

N’djamena-type model laws generally impose an obligation for disclosure to partners. As previously stated, there is such legislation in 11 of the 18 countries with draft or adopted HIV laws in the region. The N’djamena model law template includes Article 26 that requires the person with diagnosed HIV infection to disclose as soon as possible and by six weeks at the most. No penalty is specified for non-

compliance (Pearshouse 2007). In the context of the specific local laws, Table 16 reviews the information for seven of the 11 countries with model laws. Data are drawn from a recent review of the N'djamena laws (AWARE II 2011) and Pearshouse's study (2007).

Conclusions. Our review suggests that, while many of the AWARE II region countries have acted to limit potential loss of confidentiality in test results, which is beneficial to MARPs and their related concerns of stigma, there are still a few gaps. Their adoption of the WHO guidelines on testing enshrines many of the related rules, but the rules also allow disclosure to respect local laws. In such cases where local law is relevant, informed consent is necessary to proceed with the test. This is crucial in the context of MARPs. The local laws allowing patient confidentiality to be broken by the healthcare provider vary but mainly are drawn from the provisions in N'djamena-style model legislation. Of the 18 countries with HIV-specific laws that potentially protect confidentiality, 11 have such N'djamena-type laws, and reviews by legal experts suggest the wording on when confidentiality could be amended. Some of the countries are revising certain portions of their laws, with assistance from AWARE II.

13. Targeted non-health services for MARPs

Issue. The focus here is on the provision of non-health services for MARPs. These services primarily involve mitigation for the effects of their occupation in the case of FSWs and, for all MARPs, mitigation for their HIV status if HIV-positive. For FSWs, having no other source of income was positively associated with higher HIV prevalence in a statistical study in Benin (Ahoyo, Alary et al. 2009). Programs can include income generation activities, vocational training, counseling on violence and legal recourse, and other interventions related to MARPs' socioeconomic status (including nutritional support). We mostly expect programs for this input, though Formal Policies could require the availability of such services.

Data. Income generation activities (IGA) generally did not have a MARPs focus, except in the cases noted below. Generally, IGA for PLHIV, women, and female orphans and vulnerable children (OVC) were found in different forms within the PEPFAR programs in Côte d'Ivoire, Ghana, and Nigeria. In Global Fund programming, OVC were the only specific group receiving IGA other than a general PLHIV target (Burkina Faso, Mali). Mali planned "300" IGA projects under its Round 8 funding. Ghana has the Ambassador's Self-Help Program for vulnerable women and female OVC. There were IGA for youth in Côte d'Ivoire, and planned nutritional support, vocational training, and IGA for PLHIV/OVC families (PEPFAR 2010a). We mention these as it is possible that clients and FSWs, two of our MARPs, could be included.

In Ghana, there is a specific program funded through a variety of sources, which links FSWs with civil society organizations (CSO), especially those that are faith based, for income generating programs. The evaluation offered by PEPFAR stated that these have had mixed effects—few FSWs are leaving sex work, though their overwhelming dependence on sex work has been reduced (PEPFAR 2010b). A similar PSI-Togo project, "Sisters-to-Sisters," also included a vocational training and social reintegration approach targeted at FSWs. A new USG-funded project focused on MARPs in Côte d'Ivoire (yet to start) would include more comprehensive IGA for all of the key MARPs, including

MSM and regular partners of FSWs. In Nigeria, the 2010 PEPFAR program introduces vocational skills training and counseling on savings to reduce dependence on sex work (PEPFAR 2010c).

Non-health interventions among MSM were not frequent outside of the programs in planning noted above. Small-scale programs combining microfinance and IGA were found in Senegal, run by ENDA Santé, based on a qualitative review (Ndoye 2010). Senegal's Round 9 proposal also planned "social reinsertion" into IGA for 200 MSM and 700 FSWs. An interesting finding in the qualitative review from Senegal was that receipt of loans may have raised the vulnerability of the MSM to risky behavior (paid sex work) because of difficulties in repayment. Therefore, targeting microfinance at a group rather than individuals, and respecting the existing qualifications for IGA would help better serve the original intentions.

Conclusions. Non-health services drawing from a menu of IGA, vocational training, nutritional support, and psychosocial aid were not commonly targeted at MARPs in the region or provided at sufficient scale. Forthcoming orientation in PEPFAR programs in Côte d'Ivoire and Ghana may change this. Small-scale interventions with FSWs and MSM were found, but the qualitative and anecdotal information suggests that the experience has been mixed, and unanticipated effects need to be evaluated.

4.3 Structural/Direct Policy Inputs

14. Factors affecting minors participating in sex work

Issue. The focus of this policy input encompasses the structural factors related to the procuring, trafficking, and/or brothel sex work of minors. Minor sex workers are less able to negotiate condom use with clients, may be less aware of their HIV status, and less able to access prevention services. Hence, avoiding the participation of minors in sex work is a matter for policy. This input can include all three elements. Laws and regulations may prohibit minors in sex work or processes leading to it (e.g., trafficking). Programs can sensitize minors against sex work and/or can assist minors already working in the field in their exit.

Data. In addition to laws on age of consent (reviewed under input #23), which can provide sanctions for sex with minors when this is considered statutory rape or sexual assault, there may be specific laws on minors in the context of sex work. We expect mostly laws in the context of females. We note that a consultation was held for West African countries in Libreville in 2000 on child trafficking. A cooperation agreement between the governments of Mali and Côte d'Ivoire was signed in 2000 to reduce trans-border trafficking in children and to re-integrate trafficked children to their original communities. Not all child trafficking occurs in the context of sex work—many are intended for unpaid domestic work. In the past Benin has had village committees organized to combat child trafficking (UNICEF 2005).

Table 17. Laws related to minors in sex work settings and/or sexual exploitation of minors

Country, Year	Prohibition or Criminalization
Ghana , 1960	Criminal code, Ch.6 prohibits—defines a minor sex worker as under 16 years.
Nigeria, 1990	Criminal code, Ch. 21, 29—criminalizes “prostituting girls under 16.”
Togo, 1980, 2005, 2007	Children's code, Art. 353-356—criminalizes violence against children less than 15 years. Criminal code Art. 78-79—criminal penalty of 5–10 years for all forms of violence where the minor is under 12 years. Law No. 2005-009—on child trafficking—protects children against all forms of exploitation, including trafficking.

We found many projects that historically oriented themselves against child trafficking, especially with UNICEF support—the countries in this context include Benin, Gabon, Mali, Nigeria, and Togo. These have been reviewed previously (UNICEF 2005). The response was managed through several different institutional stakeholders and had high-level strategies. A more recent update on these projects is needed, and a related review should be done.

We found few instances of current programs targeting minor-age sex workers specifically. The PSI-Togo project “small Sister to Sister” (Global Fund/UNICEF) provides rehabilitation services for minor FSWs, including vocational training, STI/HIV testing, and social reintegration. A project in the Gambia (ECPAT Netherlands) worked until 2010 on issues related to minor-age sex workers who may have been trafficked.

Conclusions. Outside of Togo, where there has been legal and program-related reaction, the policy issue of minor sex workers is relatively under-emphasized in the AWARE II region. However, there is considerable awareness of the issue of child trafficking, and policy responses to that issue exist.

15. Factors affecting the legality of sex work

Issue. The focus of this policy issue is the legality of sex work as it is variously defined based on frequency, place of occurrence, drivers, and degree of agency (voluntary or forced). In Chapter 2, we focused on the heterogeneity in sex work within the AWARE II region. A legal view on this may or may not recognize the distinctions as expressed here, or may recognize other distinctions. The view on the effect of legal provisions is mixed—while legal sanctions against an individual being forced into sex work are generally considered positive, the view on criminalization of other, voluntary sex work is that it adds to stigma and discrimination, including self-discrimination. Criminalization may prevent sex workers from reporting abuse or seeking legal recourse after rape or GBV. It may dissuade them from accessing health services and prevention messaging, rendering them more clandestine and hard to reach for proactive prevention and health interventions. In the climate of criminalization, harassment of sex workers by security personnel may be more common—and is documented—which reduces trust in public institutions and further removes them from positive influences. While we primarily focus on laws here, it is possible that interventions exist that reach out to sex workers, male and female, with legal aid.

Related laws in the AWARE II region. The 1993 United Nations Declaration on the Elimination of Violence against Women made the first general reference to a distinction between “forced” and “voluntary” sex work (Mgbako and Smith 2009). This distinction is relevant in terms of who is prosecuted under laws related to sex work: those who operate establishments of commercial sex work (as an example), solicit sex in exchange for payment, or the individual sex workers themselves working in different contexts. While brothel-managers or owners may not necessarily force sex workers into the occupation, they can be liable for prosecution under laws related to procuring (see Table 18).

Table 18. Laws related to sex work in the AWARE II region

Country, Year	Law*, Article/chapter	Procuring	Soliciting	Other**	Legal regime
Burkina Faso (1804)	N/A	Illegal	Illegal	-	Abolition
Cameroon (1997)	Art. 343	Unknown	Illegal	Illegal	Prohibition
Côte d'Ivoire (1981)	Art. 334-341	Illegal	Illegal	Illegal	Prohibition
The Gambia	-	Unknown	Illegal	-	Prohibition
Ghana (1960)	Ch. 6 “sexual offences”	Illegal	Illegal	-	Unclear
Liberia (1976)	-	Illegal	-	-	Abolition
Mali (2001)	Law 01-017	Illegal	-	-	Abolition
Mauritania	-	-	Illegal	-	Unclear
Nigeria (1990)	Ch. 24	Illegal	Illegal	-	Prohibition
Togo (1980)	Sec. 3, Art. 90-91	Unknown	Illegal	-	Abolition

* If not specifically mentioned, this refers to the criminal code.

**This involves private acts of sex for exchange.

Following Mgbako and Smith (2009), we distinguish four possible legal states in the context of sex work: prohibition, abolition, legalization, and decriminalization. These are not found in the exact definitions we will provide but serve as archetypes for the laws and understanding their valence. *Prohibition* is the criminalization of all aspects of sex work and all parties involved—the sex worker, the procurer, and the clients. *Abolitionist* legal regimes may target procuring and soliciting only, hoping to reduce the activity or remove it entirely. *Legalization* often subjects sex work to state control and regulation. Regulation can involve zones where sex work can be practiced as well as expectations of sex workers to register and behave in certain ways. *Decriminalization* is the removal of all laws relating to sex work.

Conclusions. Our review suggests that sex workers in themselves may not be subject to criminal prosecution in all cases, but the laws are not always clear, and practices may be different in either direction. In most countries, sex workers are not regularly prosecuted, although they may be harassed routinely by law enforcement personnel. In more cases, those who organize sex work face prosecution. It was not clear with such prosecutions if there needed to be a demonstration of force inflicted on the

individual, forcing them to enter sex work or if the fact of being a brothel-owner/manager or procurer was sufficient. Clients or sex workers soliciting paid acts faced prohibition or criminalization in a number of countries with a prohibitionist regime.

We are aware of current debates in some of the West African countries. In Ghana, while brothels, procuring, and soliciting are illegal, sex workers are generally tolerated, which is why we classified the regime as abolitionist. They can be subject to police harassment, however (Jeffers, Dohlie et al. 2010). Proponents of legalization point to the ability to regulate the profession and derive taxes. The opponents fear increase migration for sex work and even sex tourism. This debate and relevant references are covered in detail in a recent review (Mgbako and Smith 2009).

A case study is Senegal, where sex work has been legalized—not decriminalized—since 1969 and is embedded in a regulatory framework with obligations for registered sex workers to attend health check-ups with their *carnet sanitaire*. As we have frequently mentioned in this report, this approach does miss the clandestine sex workers, many of whom may be roamers. The requirement to be 21 years old to register also misses those FSWs who are younger. Deregistration after leaving the sex work profession is also slow, which may dissuade some from registering (Open Society Institute 2006). Clearly, legalization policies can be improved further.

A dominant amount of sex work in West Africa does not involve intermediaries such as brothel-owners or pimps, but is through directly identifying clients at bars, hotels, night clubs, and the street, and receiving money (WHO 2011). Because sex workers have agency in these transactions, they can control the location and conditions of sex work (e.g., number of clients). Legalization in these contexts may be more relevant to sex workers if it reduces stigma and encourages them to visit healthcare settings.

16. Control of human trafficking

Issue. The focus of this policy input is on the intra-country or cross-border trafficking of individuals generally or for the purpose of sex work. Trafficked women and girls are more likely to enter sex work forcibly and less able to exert any power on their role or in negotiating condom use. They are more likely to have no access to prevention messaging and even condoms. We see trafficking under this policy input as concerning girls and women, which in turn is concerned with laws and programs. Programs here could work with trafficked women (minors were considered under #14), or advocate against trafficking.

Background for the AWARE II region. The movement of FSWs across the region has been well-documented with surveys of the population in cities regularly enquiring about nation of origin. While most of this movement is likely a voluntary response to political strife or economic conditions in the home country and better opportunities in the target country, there are also instances of human trafficking within the region (Olujuwon 2008; Omorodion 2009) and out of it (Carling 2005). For intra-regional human trafficking, well-known pathways were identified by Olujuwon (2008). Human trafficking directly related to forced sex work has been more recently documented in Côte d’Ivoire and Nigeria (Human Rights Watch 2010). The AWARE II region generally contains “source” countries for

trafficking, but also some that are destinations, and is considered a particular problem area for this practice (UNICEF 2005).

Laws related to the policy input in the AWARE II region. There has been considerable awareness of this policy issue in the region. The ECOWAS countries jointly issued a Declaration and Plan of Action against Trafficking in Persons in 2001. This declaration established national taskforces as well as a secretariat at the ECOWAS level to coordinate the plan of action. Countries in the region have also ratified or signed the UN-sponsored “Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children” of 2000. Table 19 shows the specific country laws in this context.

Table 19. Laws applicable to prosecution related to trafficking of persons, including sex trafficking

Country, Year	Law, Content of Law
Burkina Faso, 2008	Law No.029-2008/AN, criminalizes human trafficking and related practices
Cameroon, 1997	Criminal code, prohibits procurement of women and “violation of freedom”
Côte d’Ivoire, 1981	Criminal code, Art. 372, infringement on individual freedom & peace
The Gambia, 2007	Trafficking in Persons Act—criminalizes human trafficking
Ghana, 2005	Law 694—“Human trafficking act” renders the practice illegal
Liberia, 2005	Anti-Human Trafficking Law criminalizes the practice
Mali, 2002	Law 02-020 ratifies the UN protocol (see above)
Nigeria, 1990, 2003	Criminal code makes transporting girls under 18 for “sex” illegal Prohibitions Laws Enforcements & Administration Act 2003—trafficking is illegal
Togo, 2005	Law 2005-009 on child trafficking; but women are not specifically protected

Programs. Many countries established national taskforces against trafficking as a result of the ECOWAS agreement. Their current status is unclear. The taskforce is active in Burkina Faso. A national program in Côte d’Ivoire supports the UN protocol on sex trafficking. A program in Ghana was set up to monitor high-risk areas (fishing populations around Yeiji, Brong Ahafo, and Volta Lake) for trafficked persons. We could not complete a review by country of the status of smaller, CSO-led interventions against trafficking or with trafficked women and girls.

Conclusions. There are robust inputs related to Formal Policies on the control of trafficking in women and girls in the region, yet countries still continue to suffer very high rates of intra-regional and externally oriented human trafficking. A detailed analysis of the programmatic response in this context is necessary.

17. Issues of the criminality of HIV transmission

Issue. The focus here is on the Formal Policy inputs related to negligent or willful exposure or transmission of HIV disease. Laws that criminalize negligent or willful exposure “seek to deter

individuals whose actions lead to exposure of others to HIV and potential transmission” (Gable, Gamharter et al. 2007). In this context, intent and actual occurrence of transmission may be relevant legally, though difficult to prove. A WHO guidance on this matter determined that criminalization of HIV transmission should be a “last resort,” seen as a failure of prevention efforts, and only undertaken in a manner consistent with human rights (WHO 2006). The guidance also raised the issue of such criminalization being potentially linked to greater stigma and discrimination for PLHIV.

A related UNAIDS paper suggested that general criminal law, rather than HIV-specific provisions, might be better suited to deal with cases of willful transmission (UNAIDS 2002). We consider this relevant for MARPs who may avoid HIV testing or public health settings if such prosecutions are likely in the context of unsafe sex or injecting drug use. We consider laws in this context below, though certain regulations governing the behavior of healthcare workers in determining such transmission cases might be relevant.

Related laws in the AWARE II region. Article 36 of the N’djamena-type model law refers to willful transmission, defined as “transmission of HIV through any means by a person with full knowledge of his/her HIV/AIDS status to another person” (Pearshouse 2007). This would include cases in which condoms were being used but failed, when a shared needle was first disinfected through approved means, and most controversially, vertical transmission from mother to child. We omit the discussion of criminal liability in the case of willfully negligent healthcare workers here, since it not relevant when using the MARPs lens. In Table 20, using data from AWARE II’s recent review (AWARE II 2011) and Pearshouse (2007), we consider laws related to the N’djamena-type model laws. The specific titles of the laws can be read from Table 16.

Conclusions. Our review suggests that many of the AWARE II region countries that adopted N’djamena-type model laws have acted to criminalize transmission of HIV but may not have appropriately defined the conditions under which this is considered willful or negligent. In Sierra Leone, the original law, drafted and adopted in 2007, potentially criminalized vertical transmission between mother and infant. This law was repealed in 2010 and will be rewritten, potentially with AWARE II assistance.

Generally, the criminalization of willful transmission is prevalent in the eleven countries that have adopted the model laws. The status in the other 7 that have similar laws in draft or in adoption needs to be researched. These laws are problematic in the context of FSWs, who may not have sufficient agency to negotiate safe sex, even if they are aware of their HIV status and wish to do so. As per the WHO and UNAIDS recommendations, it would be better to handle such cases through the general criminal system, where there is demonstrated willful exposure by an individual who knows his/her status, toward an HIV-negative partner via unprotected sexual intercourse or used needle sharing for injecting drug use, and where the person has demonstrable choice in the possible use of safer behaviors. In 2011, some of the countries are revising certain portions of their laws, with assistance from AWARE II.

Table 20. Laws related to the criminalization of willful transmission of HIV in 7 AWARE II countries

Country, Year	Article of law – criminalization related to a person who knows his/her status
Benin (2006)	Art. 27—"unprotected sexual relations" without disclosure, transmission is not required ¹ Art. 30—unprotected sexual relations with coercion, transmission is not required
Guinea (2005)	Art. 35—transmission through sex or blood is an offense ² Art. 36—"unprotected sex with the proven intent to infect," transmission not required Art. 37—unprotected sexual relations with coercion, transmission is not required
Guinea-Bissau (2007)	Art. 37—Same as Art. 36 of the model law ³
Mali (2006)	Art. 37—willful HIV transmission ⁴
Niger (2007)	Art. 39—"willingly expose to another person the risk of infection" ⁵ Art. 40—unprotected sexual relations with coercion, transmission is not required
Sierra Leone (2007)	See text below (this law was revised)
Togo (2005)	Art. 14—obligation on all persons to use male or female condoms in risky sex ⁶ Art. 13—prohibits PLHIV from "unprotected sex" ⁷

¹ Benin: Unclear if unprotected sexual relations include lower-risk sexual practices (e.g., oral sex). In the case of FSWs, it is unclear how the law will be used if the FSW lacks the power to engage in protected sex due to inability to negotiate use of a condom. This comment also applies for Guinea Article 36.

² Unclear if this includes the need for the person exposing to know their HIV status, and if it excludes MTCT.

³ See issues related to safe sex failure, failure of needle disinfection, and MTCT (vertical transmission).

^{4,5} This comment includes those issues raised above related to Benin Article 27 and Guinea Article 37.

⁶ This makes any vaginal or anal sex without a condom an illegal act. See FSW comment under Benin Article 27.

⁷ See comment related to FSWs above, and one can also add MSW. The law does not define unprotected sex.

18. Discrimination against MARPs (general)

Issue. The focus of here is on Formal Policy related to laws and regulations that affect the structural environment related to discrimination faced by MARP groups and their dependents in accessing social services, including those involving health and education. Generally, this is relevant for HIV prevention in the context of contributing to stigma and discrimination, which has effects we discussed earlier. We have also discussed discrimination in the context of health services, and reviewed the programs and legal inputs into the existence of targeted non-health services. The services considered here are non-targeted social services. Laws here would specifically address the issue of discrimination in services. Programs in this category can address the discrimination in such non-targeted social services.

Data and conclusions. General provisions of the constitutions of the AWARE II countries guarantee freedom from discrimination in access to social services provided by the state, for example, Article 17(3) of the Ghanaian constitution. In addition, most of the constitutions for the countries we

reviewed do include provisions against discrimination in occupational settings. However, there are no specific provisions in the constitutional articles for discrimination that stems from HIV-related stigma (either due to actual or perceived HIV status, and/or being an at-risk group).

The N’ djamena laws adopted by at least 11 of 18 countries with HIV-specific laws have several human rights-based provisions that do address such discrimination. For example, Article 33 relates to access to credit and insurance services (AWARE II 2011). The article states that no one may be denied access to credits, loans, health insurance, etc., based on actual or perceived HIV status. The only requirement is that the person should not have concealed their status to the provider. This is a robust provision in including the private sector, which can provide a substantial portion of services in these countries.

19. Factors affecting rights of transient settlement near major industrial or resource extraction sites

Issue and conclusions. The focus of this policy input is the settlement around certain locations in a country, specifically near industrial activity or resource extraction. The main import of this for MARPs policy is that it may control the rights of FSWs in terms of their area of domicile and potentially force them to live in clandestine ways that can make it difficult to reach them with prevention interventions. This input has special value in West Africa, given its extensive activities in oil drilling, pipelines, and oil refining. Other types of mining sites are also important. The focus here is on regulations, though we include the possibility of targeted interventions that help resettle FSWs from such sites.

We found limited data related to this issue from the AWARE II region, though the region has many resource extraction projects that are growing in size and intensity. In similar contexts, the issue of sex work around the sites was mentioned in southern Africa. In the few cases we found, the items regulated were housing, especially via zoning near industrial sites. Cameroon and Ghana have limited interventions to resettle FSWs from such sites. This input needs further research to establish concrete conclusions.

Table 21. Regulations on right to settle near mining or industrial sites

Country	Item Regulated	Program Recipients	Program Focus
Cameroon	Housing and zoning near industrial sites	Vulnerable groups (incl. MARPs)	Resettlement housing
Gabon	-	Specific (military)	Testing & prevention of mobile military (considered transient)
Ghana	-	FSWs	Settlement, West. Region (oil extraction)

20. Factors surrounding injecting drug use behavior

Issue. The focus of this policy input is the criminalization of injecting drug behavior, and the regulation of the drugs related to injecting drug use, usually opioids, such as heroin. This policy input covers laws and regulation on the sale, general distribution, possession, and illicit use of such drugs. Criminalizing possession has the effect of rendering IDUs clandestine, making them very difficult to reach with prevention programming and harm reduction interventions. Regulation of related injecting drug use paraphernalia (though not for medically assisted therapy) at pharmacists or health facilities is included. Programs here would mostly concern demand or legal aid for IDUs.

Data. Very little information specifically related to regulation was found on the availability and sale of injecting drug use paraphernalia. Therefore, this is excluded from further discussion. Many countries in the region have laws that criminalize possession and illicit use of drugs that can be injected. Burkina Faso, Cameroon, Chad, Ghana, and Togo criminalized possession of drugs under their schedule of controlled substances (these differ across countries but definitely include heroin, the most commonly injected opioid). Countries that criminalized possession routinely also criminalized sale and trafficking.

In Cameroon, there is regulation of opioids, such as morphine, which is allowed to be sold in regulated pharmacies and allowed in the possession of regulated, registered health workers. In Côte d'Ivoire while trafficking was criminalized on the supply side, on the demand side, only "illicit use" was criminalized, which requires us to further investigate the conditions under which use is illicit. We may assume with some confidence that this implies conditions away from healthcare settings. It was not clear if possession also was criminalized or was taken as tantamount to illicit use. Also, more details are needed on the amount of drug possession considered illegal.

Conclusions. While the policy area related to IDUs as MARPs in the region is underdeveloped, we find that criminalization exists, which will make future harm-reduction strategies related to NSP and OST difficult to plan and execute, as IDUs may remain hidden. Further research into the current criminalization laws is needed to understand the nuance related to possession and illicit use.

4.4 Structural/Indirect Policy Inputs

21. Laws concerning legality of same-sex behavior

Issue. The focus of this policy input is the legal status of same-sex behavior, male-male or female-female (considered in Table 21 below as "type" of sex act). As we discussed before in Chapter 2 (Stigma and Discrimination) and then in Chapter 3 (Laws), such legal sanctions have a profound effect on MSM, who may become hidden and hence less accessible for prevention, treatment, and care interventions in their area. A recent review suggested that HIV prevalence among MSM is higher in settings with criminalization of same-sex behavior than those where it is legal (MSMGF 2010). Also, the very existence of some of these laws is considered suspect from a human rights standpoint.

In our review, we also include the legal status of homosexuality that is rooted in religious law, which is a strong factor in the region. Informal normative "rules" are important, as they may pertain in

certain tribal and regional settings, but are not reviewed here. This input specifically focuses on the sexual practice, rather than the status of same-sex unions (considered separately under #22 below). However, it is possible that if prohibition is placed on same-sex union, and there is no explicit mention of the behavior in law, then the behavior itself is considered prohibited.

Data. Table 22 presents the countries for which we could complete the review. We did not adopt a classification system for criminalization as we did for sex work (see #15 above). A classification system for legal regimes using “repressive,” “highly repressive,” “moderately repressive,” “neutral,” and “protective” has been proposed to understand the issues we discuss here (Cáceres, Aggleton et al. 2008). The distinction is based on criminalization of certain male-male sex acts and the penalties imposed (or not).

Table 22. Laws related to criminalization of certain sex acts in the AWARE II region

Country	Value, Type of Sex Act	Law – Source
Cameroon	Criminalizes (type unclear)	Criminal code, Art. 347b
Côte d'Ivoire	Criminalizes (type unclear)	Criminal code, Art. 355-359, Section 2
Ghana	Criminalizes (male-male)	Criminal code, Ch. 6 Art. 105
Liberia	Criminalizes (type unclear)	Criminal code
Nigeria	Criminalizes (male-male)	Criminal code Ch. 21, Shariat law (9 states)
Togo	Criminalizes (type unclear)	Criminal code, Art. 88
Senegal	Criminalized (all)	Criminal code Art. 319:3

The penalties can be significant. In Cameroon, the violation of Article 347b carries a prison term from six months to five years, and a fine of 20,000 to 2000,000 CFA francs. In Senegal, the violation of Article 319:3 of the criminal code carries penalties ranging from imprisonment for one to five years, and a fine of 100,00 to 1.5 million CFA francs.

Based on data from the region, we find that the legal regimes of most countries are repressive, though the extent or classification is not possible without further research on the type of sex acts covered, the likelihood of prosecution, and the usual penalties imposed.

Conclusions. We find the same inconsistency as in other studies in the treatment by the West African region of same-sex behavior (Legrand, Elliott et al. 2010). While recent Global Fund proposals and National Strategies have acknowledged the presence of MSM and recognize the need to target this community with human rights-sensitive prevention interventions, a criminalizing environment remains based on official laws. This acts in the way of building an enabling environment for better prevention. We recognize that the involvement of civil society in the Global Fund grants and CCMs, and the rise in awareness of MSM as a vulnerable population, can potentially lead to positive changes.

22. Factors concerning the status of same-sex unions

Issue. The focus of this policy input is the legal status of same-sex unions, including marriage, in law and in society. Both male-male and female-female unions are considered. The importance of this for stigma and discrimination, and hence HIV services, is similar to that already discussed for #21 above.

Related laws from the AWARE II region. Same-sex marriages are prohibited under the constitution in Cameroon, Cape Verde, and Guinea-Bissau. This prohibition is in the form of disallowing any union but that between a heterosexual man and woman. In Cape Verde, the criminal code explicitly “allows” only the union of monogamous heterosexuals, which can be read to mean that homosexual union is disallowed. In Ghana, Liberia, Mauritania, and Togo, the relevant injunction stems from the criminal code, which prohibits the practice. In Benin and Côte d’Ivoire, the family law (civil code) prohibits same-sex unions. For some of these laws, we have interpreted the prohibition by virtue that only a certain type of union is deemed lawful. The conclusions we draw from this are similar to those for #21 above.

23. Laws on age of consent, same-sex and heterosexual

Issue. This policy input focuses on laws on the age of consent for heterosexual and same-sex acts. This influences sexual conduct among MARPs who are minors, as well as sexual onset. This has a bearing on policy input #14 above. Prohibition in this context refers to the legality of sexual contact with someone below the age of consent. Often the legal minimum “age of marriage” is set by law, which we have understood to signify age of consent by extension. This is noted as “context” in Table 23. Generally, no age of consent was set for same-sex acts.

Table 23. Laws related to age of consent

Country	Value (context)	Source
Benin	Prohibits (heterosexual marriage)	Civil code. Age of marriage = 18 (male/female)
Cameroon	Prohibits (heterosexual)	Criminal code. Age of consent = 18
Cape Verde	Prohibits (heterosexual marriage)	Civil code. Age of marriage = 18
Côte d’Ivoire	Prohibits (heterosexual)	Criminal code. Age of consent = 15
Ghana	Criminalizes (heterosexual)	Criminal code. Age of consent = 16
Guinea-Bissau	Prohibits (sex with minor <18)	Criminal Code
Liberia	Prohibits (heterosexual)	Other law. Age of consent = 18 (female)
Nigeria	Criminalizes (heterosexual)	Criminal code, Ch. 21. Age of consent = 14 (male), 16 (female). Shariat states interpret differently (lower)
Togo	Prohibits (heterosexual)	Other law. Age of consent = 14

24. Factors affecting the unrestricted association of MARPs

Issue. This policy input concerns the members of the MARP groups and their ability to meet, associate, and if desired, form an association or network. This is an important structural factor in whether MARP networks are able to legally register or even come into existence. We have noted how MARP networks are being targeted in terms of their role in delivery of key HIV services (see policy input #7). The ability of FSWs to form a union or network may assist in their ability to advocate and petition policymakers, given instances of harassment, GBV, and discrimination.

The association may be formal or informal, as desired. Programs relevant here could advocate for/against or directly institute such an association or network. As discussed earlier, specific to MSM, explicit criminalization of same-sex behavior, can, by extension, render their networks illegal, though practical application of such a finding by courts and authorities is key. This input covers the related laws of free association, but we first begin by reviewing if such associations are known to exist.

Data. We found anecdotal and informal evidence in the form of newspaper and other resources that remark on the presence of local FSW collectives and support groups in several AWARE II countries. As previously discussed, the PEPFAR program in Ghana will engage with peer groups of FSWs to promote consistent condom use. The Mali Global Fund grant intends to use MSM networks to target condoms and lubricants. Therefore, such groups, even if not organized as formal associations; must exist in the region for these programs to succeed, even in the context of criminalization.

We surveyed Burkina Faso, Nigeria and Côte d'Ivoire. For Burkina Faso and Côte d'Ivoire, we found that laws allowing free association exist, though in the latter country case, the law stipulates that the association should not “offend public morality” (Law 60-315 (1960) on associations). In Nigeria, the criminal code disallows “criminal assemblies”—however, it is unclear if the rendering of FSW and MSM behavior as illegal also disallows their association (Criminal Code, Chapter 10).

Conclusions. Programs in the region intend to use networks or associations of MARPs as a location-specific targeting mechanism for HIV prevention and a way of reaching hidden populations. However, the possibility for such associations to exist formally is not provided for in most laws, unless the general provisions on freedom of association are also extended to MARPs, despite a context of criminalization.

5. | Discussion and Recommendations

In this chapter, we review some of the main conclusions from the previous chapters across the three policy areas of Determinants of the Policy Environment, Formal Policies, and Policy Implementation, as related to MARPs in the AWARE-II region. In favor of brevity, not all of the findings can be discussed here. We suggest reading previous chapters in their entirety for the policy-related conclusions, especially on individual policy inputs from the total of 24. For the latter two policy areas, we conduct our discussion below around the framework from Chapter 3 and the results of the analysis in Chapter 4 of 24 policy inputs across four categories (Individual/Direct, Individual/Indirect, Structural/Direct, and Structural/Indirect). We present the following discussion in terms of some overarching questions on MARPs in the region, and any recommendations we can provide are related to the answer we reached, or failed to conclusively reach on a particular question.

5.1 Key Questions

5.1.1 Is HIV prevention policy in the region appropriately responsive to the importance of MARPs?

The importance of MARPs in prevention of HIV in countries of region was established in Chapter 2, where we reviewed the epidemiological evidence from the World Bank’s 2008 report (Lowndes, Alary et al. 2008), as well as data since 2008. In the mixed and concentrated epidemics commonly seen in the region, a prevention focus on MARPs is requisite and cost-effective (Sarkar, Menser et al. 2009), and this involves enhanced behavioral- and sero-surveillance, as well as targeted prevention programs among MARPs. In the same way for the group of countries considered “in the middle” between concentrated and mixed, high levels of HIV prevalence and risky behavior among MARP groups suggest that outward transmission emanating from these groups must be stopped or reduced. These are essential from the “know your epidemic—know your response” perspective, as well as for “smart investments.”

We review current HIV prevention spending, current prevention programming, and discuss the related trend for MARPs and HIV prevention. We focus on FSWs, clients, and MSM. For IDUs, where data were more limited, we suggest reviewing the results for policy inputs #6 and #8 from Chapter 4.

Current Spending. While there is no threshold for the appropriateness of the proportion of HIV spending focused on MARPs, there is strong evidence that such spending is cost-effective, given the higher rates of transmission among core and bridging groups, and hence, all other things being equal, a high number of infections can be prevented per unit of spending on effective interventions among MARPs. For more general rules on spending, we suggest countries keep in mind as a benchmark, the weighted proportion of total HIV incidence in a year attributed to infections among MARPs and first-

wave transmission among the bridging groups. Given that we include clients, first-wave infections encompass those female partners of clients. Use of weights with HIV prevalence levels for evaluating spending was suggested in the past for MARPs (WHO/UNAIDS 2010). Our approach improves on this by considering incidence.

The weight can be the proportion that MARPs represent of all adults 15–49 years old at risk of HIV infection. Estimates of the size of MARP groups can help to define the numerator for this weight. This ratio will be small in a generalized epidemic, as we would expect the denominator to be very large. However, in concentrated and mixed epidemics, the denominator to calculate the weight should not include all adults. Instead, it should include, besides MARPs, adults in localities with sustained transmission among low-risk groups, plus the total estimate of sexual partners of bridging populations. Even with the denominator set at 10 percent of all adults, a vast proportion, we find that Nigeria could benchmark 3 percent of its prevention budget for MARPs, while Ghana could benchmark 6 percent. We suggest conducting this calculation with actual data based on MARPs mapping and other surveys.

Table 24. HIV spending on prevention programs for MSM, FSWs, and clients as a share of total HIV prevention spending, % (2008)¹; updated epidemic classification; and MARPs proportion of incidence

Country	MARPs % spending	Likely epidemic type	MARPs proportion of all incidence (unweighted)
Niger	0.3%	Concentrated	N/A
Gabon	0.5%*	Mixed	N/A
Sao Tome & Principe	0.8%*	Concentrated	N/A
Nigeria	0.9%	Mixed	23% (FSWs, MSM, IDUs, plus 1 st wave)
Ghana	1%	Mixed	41% (all MARP plus 1 st wave)
Togo	2.4%	Mixed	33% in men, Lomé (FSWs, 1 st wave only)
Burkina Faso	2.8%	Mixed	N/A
Mali	3.4%	In the middle	N/A
Senegal	9%	Concentrated	N/A
Côte d'Ivoire	10.4%	Mixed	N/A
Guinea-Bissau	17.6%*	In the middle	N/A

* Value from 2009.

¹ Source: (UNAIDS 2011).

Table 24 summarizes the analysis from prior chapters. Values for the proportion of HIV prevention spending focused on MARPs were available for several countries from the AWARE II region for 2008. We also use the values from 2009 available for three countries. A caveat on these spending figures was noted in Chapter 2; that is, that some non-targeted spending does benefit MARPs. However, our analysis also finds that the spending proportions are highly variable and there is either no reliable definition of what spending on prevention is related to MSM, FSWs, and clients, or

priorities vary annually. For example, Guinea Bissau's proportion of HIV prevention spending on MSM, FSWs, and clients was 0 percent in 2008, increasing to 17.6 percent in 2009. Ghana's value was 9.1 percent in 2007, declining to 1 percent by 2008. Spending on MARPs from PEPFAR sources may not be included. Much better tracking of sector-wide spending on MARPs across donors and government is needed to understand the sufficiency of the focus.

Based on the data reported to UNAIDS and the epidemic classification, it appears that, for many countries in the AWARE II region, prevention spending on MARPs is too low.

Current prevention programming. In Chapter 2, we established that the number of MARPs in each AWARE II country can be significant. For example, the estimate by Nigeria in its Global Fund grant proposal of nearly 1 million MARPs in the country for 2010 appears credible if we consider our estimate that there may be more than 528,000 clients. In this context, current prevention programming would be appropriate if it reached a substantial portion of MARPs and was targeted to the MARPs with specific interventions proven to be effective for FSWs, clients, MSM, and IDUs, respectively. We covered these interventions in Chapter 2. Current programming would also be more appropriate if it considered the impact of stigma and discrimination on the success of the prevention programs.

FSWs. Systematic reviews suggest that risk-reduction counseling for FSWs with male condom promotion can be effective in reducing incidence. Testing and counseling for HIV is necessary so that individuals know their status and adjust their behavior and seek treatment. These three parts can be considered the minimum package of interventions, to which we can add STI screening and treatment, and HIV treatment on eligibility. The following are *high-level* findings for this minimum package of interventions. (The summary below cannot replace the close reading of findings on individual inputs in Chapter 4.)

- There is evidence from many of the AWARE II countries that these interventions are occurring, but it is unclear whether they are occurring at sufficient scale. Since we also found that prevention funding specific to MARPs is lower than optimal, the default assumption should be that scale generally is not achieved. Countries that have achieved scale tend to have an active USG program with a focus on MARPs. As an example, Ghana reached large numbers of FSWs with prevention interventions (PEPFAR 2010b).
- A review of recent Global Fund grant proposals submitted by AWARE II countries, as well USG- and World Bank-funded programs, suggests multiple interventions in the region to target FSWs with peer education on condom use. Many programs are operated by NGOs, funded as Global Fund grant sub-recipients or as PEPFAR grantees (see Ch. 4, input #2). Yet levels of consistent condom use at last commercial sex reported by clients remain low in DHS data. Interventions with clients are necessary (discussed next), but, a gap may be the ability of NGO implementers to take interventions targeting FSWs to scale. More analysis of the resources is required to enable such scale-up. Also, structural interventions to improve condom negotiation power may be necessary (discussed below).
- The issue of a lack of consistent condom use with non-paying partners of FSWs has been raised in documents. Interventions that provide risk-reduction counseling to FSWs should

include this aspect. However, based on our limited review, this does not appear to be a focus in current programs.

- PEPSE for FSWs seems a missed opportunity in the AWARE II region. While a limited number of countries have written proposals in which PEPSE is mentioned in the context of sexual assault for women more generally, these are missing a view toward its provision for FSWs, even though FSWs often are victims of gender-based violence and regularly exposed to risk of infection due to inability to consistently negotiate condom use.

Community-level interventions that intend to increase the ability of FSWs to negotiate condom use have not been explored at scale in the region. The criminalization of sex work, with the exception of Senegal, makes it difficult for FSWs to organize formally and share knowledge on ways to avoid infection and abuse. However, peer-led networks are still seen in a few countries, including horizontal associations seeded by the work of an external organization, e.g., PSI's "Sister-to-Sister" project in Togo. Such organizations should be started in more countries of the AWARE II region, especially as the involvement of an external partner may provide official cover as well as capacity building. USG emphasis on such peer-led programming for FSWs, put in place through country operating plans, is laudable.

Clients. Evidence from non-experimental studies in the region suggests that risk-reduction counseling for clients can lead to significant increases in rates of consistent condom use. At present, clients in the region are commonly targeted in a site- and group-specific manner; for example, occupational groups at high risk are targeted at their locations for procuring sex work, such as truck stops (see Ch. 4, input #5). This suggests that with limited prevention resources, site- and occupation-specific targeting occurs in the region, which can maximize utility in reducing HIV incidence. However, not all countries have such targeted programs. Some still have non-targeted, diffuse condom promotion and risk-reduction strategies, as discussed in the text. Site- and occupation-specific risk-reduction and condom promotion projects need to increase even in countries that already have them, especially given that some corridor projects targeting a single client type, such as truckers, are ending. In areas for which DHS, behavioral, and epidemiological surveillance indicate a high HIV prevalence among clients, counseling, IEC, and condom provision may need to be broader than specific groups.

MSM. Risk-reduction counseling and promotion of condoms plus WBL can reduce the quantum of self-reported unprotected anal intercourse, based on our review of the literature. Small group and community interventions (horizontal networks, group counseling) are also effective in reducing risky behavior. Our review suggests that, while consistent condom use rates among MSM in the AWARE II region are documented as being low, related interventions have not reached scale.

In some countries, small-scale programs are increasing potential effectiveness by using location and knowledge of networks to reach MSM, with innovative use of media and other ideas similar to targeted strategies used with clients. In Mali and Sierra Leone, special teams would reach MSM at clustering locations and provide condoms and WBL. Small-scale fixed sites are used in Côte d'Ivoire and Senegal, which enable access to prevention messaging, counseling, and condoms/WBL, supplemented by targeted outreach. In general, the use of peer- or special team-educators is more likely to succeed in reaching key MSM populations than fixed-site-based models, especially in an

atmosphere in which criminalization and related stigma and discrimination drive individuals underground.

Finding and recommendations. HIV prevention programming for MARPs in the region is currently *not appropriate* at either an individual or structural level, given the epidemiological imperatives. The proportion of HIV prevention spending on FSWs, clients, and MSM seems inadequate, whether viewed in terms of reported percentages of funding or through the achieved scale of related interventions. However, there is cause for optimism. Targeted programs that utilize knowledge of local epidemiology, location of key demographic groups from within MARP categories, and their behaviors, are most likely to be effective in an era of constrained resources. Such targeted programs have not been adopted across the region, as they should be. Even targeted programs require scale up, moreover, and it appears that USG leadership in PEPFAR focus countries can be used as an example for strategies funded by other donors. More recent Global Fund grants reflect the targeted approach, as seen in Mali and Sierra Leone with the example of MSM. However, where the epidemiology and local behavior requires this, we suggest the addition of community-level and more diffuse (i.e., not specific to certain locations or occupations) interventions as well. For FSWs, building the strength of peer-led networks will be an important component in a climate of stigma and discrimination to improve their ability to share knowledge and avoid harm.

The following are some specific *recommendations* in the context of HIV prevention:

1. Clients as a group are too large and instrumental in HIV transmission to approach with disjointed prevention strategies. A country-specific review of the locations of sex work, the characteristics and risk behaviors of clients, and other mapping by geography (“hot-spot”) and occupation should be conducted to suggest the best prevention targeting for the demographic groups that comprise the category of clients. This has occurred in a few countries, conducted by PEPFAR implementers (e.g., Côte d’Ivoire). Many countries in the region miss this information, however. Second generation behavior and epidemiology surveillance surveys, with some modification, offer an opportunity. However, very few countries in the AWARE II region plan to conduct such surveys in the near term. We also note the possibility of MARPs mapping studies in a few countries (see **Notes**).
2. This report is an attempt at gleaning and sharing knowledge across the region on what should be done normatively as opposed to what is being done currently. However, more information needs to be gathered and knowledge shared on what is working, not normatively, but in the context of individual countries and epidemic contexts. Effective approaches that remain small scale seem unlikely to be replicated outside their country or even their locale. Such knowledge sharing needs to be fostered so that promising interventions can be taken to scale and re-seeded. Therefore, a “HIV prevention with MARPs” conference should be considered, bringing together implementers and policymakers across the region.
3. Prevention strategies will not succeed in a climate of stigma and discrimination. We have raised numerous policy inputs related to prevention (see Table 8) that affect and are affected by stigma and discrimination. Criminalization or punitive regulation of certain behaviors related to MARPs will make it harder to reach them with prevention programming.

Policymakers should be approached with evidence-based advocacy that highlights the prevention benefits, and hence downstream savings in terms of averted healthcare costs, of an accommodating and enabling environment for MARPs.

4. Our analysis was focused on the “most-at-risk” populations: FSWs, clients (category includes a variety of groups sometimes quoted on their own), MSM, and IDUs. However, there are other groups with discrete behaviors that also leave them at higher than average risk of HIV infection, for example, prisoners. We suggest a review of HIV policy toward these vulnerable, but not MARPs, groups.

5.1.2 Are HIV services in the region for treatment, care, and mitigation responsive to the needs of MARPs?

The number of MARPs in an AWARE II country can be significant. In this context, HIV treatment, care, and mitigation services for MARPs will add significantly to the total averted morbidity and mortality and reduce other negative effects of the disease on society. Such services would be responsive to their needs if they reached a substantial portion of the MARPs and if they were targeted, given the context in which specific MARP groups exist in terms of their socioeconomic position, behaviors, and legal status. Specifically for the latter, HIV services must be cognizant of the impact of stigma and discrimination.

Below, we review our findings on current programs featuring non-prevention HIV services for MARPs. We focus on FSWs, clients, and MSM. For IDUs, for which data were more limited, we suggest reviewing the results for policy inputs #6 and #8 from Chapter 4.

Current HIV services for MARPs. We acknowledge that without tackling the stigma and discrimination faced by key MARPs—FSWs and MSM—major progress in increasing utilization of HIV treatment and care in these groups will not occur. However, making existing HIV services “MARPs friendly” can help. We distinguish two approaches in this context. The first is *verticalization*, which refers to mobile or stand-alone sites (e.g., drop-in centers), or specific times at other sites, offering HIV and sometimes other health services to MARPs, especially FSWs and MSM. The second is *horizontalization*; in this scenario, MARPs are encouraged to use existing services aimed at all PLHIV, and the existing health service delivery sites are made “MARPs friendly” via other means, such as training and sensitizing health workers or using health mediators, who can accompany individuals to ensure they receive care and increase their confidence in the system.

In the AWARE II region, where an attempt is made to increase the “MARPs friendliness” of HIV treatment and care services, as well as broader health services, it has been through the verticalization mode (see policy inputs #4 and #10). This may be a necessary choice when resources are not available or the time is not right for training on stigma and discrimination alleviation among health workers. However, we worry that verticalization does not engage with existing stigma and discrimination; nor does it ensure that the key MARPs are integrating into society and its services, just as other PLHIV, or more broadly as other citizens. We also are concerned about the scalability of the verticalization

approach. Will such approaches be amenable to scaling, given that the numbers of FSWs and MSM in these countries are large?

A horizontalization approach, as seen in Senegal, with the use of mediators to help MSM access health services, albeit at a small scale (Konare, Diaw et al. 2010), should be evaluated, judging its applicability to other West and Central African contexts.

Even with the verticalization approach, we do not find enough instances of programs or evidence of such approaches existing at scale to suggest that HIV treatment and care services are responsive to the needs of MARPs. The most commonly offered verticalized, non-prevention intervention is STI screening and treatment. There is no availability of targeted antiretroviral treatment services for one or more MARP groups except at the small urban scale (e.g., Clinique de Confiance in Abidjan). Therefore, our response to the question above is negative. This should be seen against the need established in the disproportionate burden of HIV prevalence among MARPs. They are also disadvantaged through other pathways, such as socioeconomic status and stigma, which enhance their vulnerability. If stigma and discrimination did not exist, we would expect that MARPs would be served through the existing HIV and general health system, and we would investigate whether the system had sufficient capacity and resources to accommodate the total need. However, stigma and discrimination do exist, and there is evidence for their effect in modifying access and utilization for HIV treatment and care services for MARPs in the region.

Within MARP groups, there is a higher likelihood of targeted verticalized programs for FSWs than for MSM. This may reflect the fact that, within our MARP groups, FSWs are the most numerous after clients. However, this finding also partially reflects that in all the countries, there is a contradictory approach towards MSM. While they are mentioned in HIV strategies written in Global Fund grants, and an occasional targeted prevention effort is launched, the Formal Policies for extending care and treatment services to this group are missing or deleterious. Services when offered—whether verticalized or horizontal—are offered by NGOs, and in only a few countries such as Senegal and Ghana.

5.1.3 Is there general recognition of the importance of MARPs in HIV programming within government for countries in the region?

There is a contradiction in the official approach to MARPs, which yields a mixed answer. Certain institutions in which government is a prominent partner—namely the Country Coordinating Mechanism (CCM) for the Global Fund grant process—are very aware of the importance of MARPs, especially for prevention. This is evidenced by the frequent reference to MARPs and the presence of MARPs-related interventions in recent Global Fund grants. The translation of proposed interventions into funded and executed interventions should be analyzed in this context. Government strategies, which we did not review

There is a contradiction in the official approach to MARPs. Certain institutions are very aware of the importance of MARPs, especially for prevention. However, MARPs, especially MSM and IDUs, are not recognized in government policy.

comprehensively, mention MARPs and a need for a MARPs focus in prevention in many cases. Similarly, MARPs, especially FSWs, are reached with targeted prevention interventions by government agencies in a few countries (Mali, Ghana, Burkina Faso, and others).

However, beyond this boundary of institutions and Formal Policies, MARPs, especially MSM and IDUs, are not recognized in government policy. Constructive engagement of MARP group members in the definition and execution of HIV programs is rare. Beyond including PLHIV, broadening representation to include MARPs does not appear to be a feature of the region's CCM, though Cameroon's CCM seems to address this by engaging with MARPs (GFATM 2010). The lack of effective networks of these individuals is a factor; even if such network existed, they are unlikely to have the capacity to nominate members who could participate in the CCM.

Government documents from the region generally do use language referencing targeted curative and palliative services for any MARPs (including FSWs and clients) beyond STI screening and treatment. The latter can be viewed as an HIV prevention intervention since certain STIs increase susceptibility to HIV infection. In the context of policy inputs related to laws and regulations, the official stance in the region is profoundly contradictory and seemingly does not recognize the effect existing criminalization or punitive laws have on stigma and discrimination, and hence the success of the supported prevention focus on MARPs.

The laws related to criminalization and punitive regulation are of a certain vintage; the modern HIV-specific laws, including those based on N'djamena model legislation, set a more enabling environment for PLHIV. The model laws do not have specific provisions for MARPs, but MARPs are governed by them in theory. The distance between theory and practice for both the HIV-specific laws and the laws related to criminalization is key. In the civil law systems of Francophone West and Central Africa, the courts lack authority to act where there is no legislation/statute, and judicial precedent has less weight than enacted legislation. Therefore, court actions—positive or negative with a viewpoint of MARPs—will not change the situation without top-down legislation.

5.1.4 Are best practices in HIV services for MARPs being adopted in the region?

The answer requires us to establish first that best practices exist and are known globally. As we noted above, systematic reviews and recently published guidelines suggest some highly effective prevention interventions for MSM, IDUs, and potentially for FSWs. These acknowledge the need to adapt to a context of widespread and doubled stigma and discrimination. We reviewed some of these in Chapter 2. We also know that HIV treatment and care services are effective and applicable to the MARPs context.

Recent PEPFAR guidance on HIV prevention with IDUs and MSM (released separately) suggest that for USG-supported programs, there is an increasing likelihood that COPs in the region will feature best practice for MARPs. Current USG programs in the region have very little IDU content, which may change as a result of a round of PEPFAR regional “IDU meetings” that will inform planning for

2012. However, the related meeting in Africa (June 2011) may not have participation from West and Central Africa, which would be a missed opportunity.

Many of the USG programs have conducted national trainings for implementers on minimum standards for FSWs and MSM interventions (e.g., peer education). In our review of COPs from Côte d'Ivoire, Ghana, and Nigeria, we found evidence that many suggested interventions for FSWs, clients, and MSM are being funded through implementers, though not necessarily as combined packages. Our report is not intended to be a review of the effectiveness of interventions. In Nigeria, a USG MARPs-specific project may assist in institutionalizing and scaling up best practice. All of the PEPFAR programs contribute to the national program, and hence can facilitate the spread of best practice, or at least a minimum effective package.

In general, the situation for government-led programming, especially through own resources or using Global Fund grants, is less clear. For FSWs, we feel optimistic that the “minimum effective package” for HIV prevention, i.e., risk-reduction counseling (whether peer led or otherwise), male condom programming, and HIV counseling and testing, is increasingly recognized as needed by CCM and Ministries of Health. However, implementation takes many forms and requires a more careful review against latest guidance. In addition, many countries have STI treatment and care services for FSWs.

As previously discussed, there appears to be a gap in the region for HIV prevention services for MSM and IDUs in government programming, even for countries where these groups are known to exist. Small-scale programs exist as implemented by NGOs. Therefore, it may be premature to speak of best practice in terms of the adoption of combined prevention for MSM, or the consensus of nine interventions for IDUs. It may also be premature to think of any assessments for accessibility, targeting, and acceptability (in a context of stigma and discrimination), until the interventions reach some threshold of scale. A minimum number of effective interventions with a government role should at least be established and reach scale. Such an implementation gap is even more profound for treatment and care, as already discussed.

Best practices in HIV prevention currently emphasize a “continuum of response” involving an optimal mix of prevention, care, and treatment policies, all of which contribute to a reduction in incidence. Since care and treatment for MARPs from this continuum are inadequate in the region, we are more certain that best practice in HIV services for MARPs is lacking, at least outside of the USG-funded sector.

5.2 Next Steps

Our report has taken a regional perspective rather than conduct country-by-country analysis. There are several reasons for this. First, we have proposed a new framework for the analysis of HIV-related policy for MARPs, which has broad applicability and needs to be applied across countries. This framework builds on existing knowledge and theory, but also responds to the programmatic and epidemiological reality faced in developing countries with high HIV burdens. Second, a regional analysis gives us the opportunity to use country-level data while also learning across countries at a regional level. Comparing and contrasting across countries may assist in future advocacy on the need

to enhance MARPs-related programming. Also, this analysis is intended to inform the strategy of the USAID West Africa regional office. Third, while a detailed country-level analysis is required, remaining at the regional level in this report allowed us more time to validate the approach, seek stakeholder comments and viewpoints (discussed below), and work through potential modifications to the framework before we begin the arduous task of applying the framework to a set from the 21 AWARE II countries.

The following are next steps for this report and the technical team:

- Seek comments from USAID, country-level experts, MARP groups, and advocacy experts on the report and facilitate a discussion around the recommendations for HIV prevention with MARPs.
- Create dissemination products with the report, including technical briefs, country briefs, and a PowerPoint presentation.
- Expand the analysis to a country-by-country investigation, using the framework developed in this report. The priority will be countries with large MARPs populations with high HIV prevalence.

Notes

1. **Female Condoms.** A review of the availability of female condoms (FC) in the region was conducted by AWARE II staff as a part of an inventory of HIV/AIDS interventions. This review found that the FC has been widely distributed, including specifically to FSWs, and is nearly always mentioned in the context of condoms in Global Fund proposals. However, there is also somewhat frequent mention of a lack of utilization. In general, even with availability, utilization rates remain low. Possible reasons for low utilization of the FC have been explored for Asia and sub-Saharan Africa. These include the high price of the first generation FC—nearly 10 times the unit cost of the male condom, even with UNAIDS-negotiated pricing. Other reasons include clients' lack of awareness of the FC or skill in its insertion, negative perceptions, and discomfort during sex for both partners. Cultural issues that prevent community backing have also played a role, despite successful acceptability pilot tests using first generation FCs (Tambashe, Talnan et al. 2002; PATH 2005; FHI 2007; Aliou 2011).
2. **Sources of HIV funding in the AWARE II countries.** AWARE II staff reviewed the current status of funding for HIV/AIDS in the region, across the main donors (Aliou 2011). Table 24 presents these results, updated till the 9th Round of the Global Fund (GF below).
3. **Overall estimates of FSW numbers, per country.** The source documents are noted below, which vary from Global Fund proposals and National Strategies. The methodology and further detail on sources are not available.
4. **MARPs mapping exercises.** We reported in the text that a few countries are planning MARPs mapping exercises to better understand the numbers of FSWs, MSM, and IDUs. The best information on a planned study comes from Ghana, where a USG-funded exercise involving the University of California, San Francisco will work with the Ghana AIDS Commission to understand current data and use the IBSS to estimate the size of MARP groups. Further detail is available in the last PEPFAR Country Operating Plan (PEPFAR 2010b). In Nigeria, the second wave of IBSS will include a wide range of MARPs and vulnerable groups and a larger sample frame covering more of the country. It will specifically target the “bridging” groups and will include transport workers, men in uniform, and adult males (PEPFAR 2010c). Benin is also considering a “situational analysis study” among FSWs, IDUs, and MSM, along with developing a second generation surveillance survey (CCM Benin 2009). Niger planned a qualitative study on MSM specifically as part of its Global Fund Round 7 grant proposal. The Gambia also planned a baseline study on MARPs and developed a study protocol in response to a proposal review question (Global Fund Round 8). It is unclear whether this study is now complete.

Several different studies plan to investigate the issue of IDUs, on which so little is known in the region. This includes the studies above, plus a USAID-funded Project SEARCH activity to understand epidemic drivers in Ghana, including IDUs; as well as an expected UNAIDS effort in the country.

Table 25. Funding status of countries in region

Country	Timeframe of Funding Available							Funding Source
	2010	2011	2012	2013	2014	2015	2016	
Benin	X	X	X					GF Round 9 , World Bank
Burkina Faso	X	X	X	X	X	X	X	GF Round 6 & 10, PAMAC
Cameroun	X	X	X	X	X	X	X	GF, CIDA, PEPFAR
Chad	X	X						GF Round 8
Cape Verde	X	X						Red Cross Luxembourg
Côte d'Ivoire	X	X						GF Round 9, PEPFAR
Ghana	X	X	X	X				PEPFAR, GF Round8
Gabon	X	X						GF Round 8
The Gambia	X	X						GF Round 8
Senegal	X	X	X					GF Round 9, USAID
Liberia	X	X	X	X	X	X		USAID, GF Round 8
Mali	X	X						World Bank, USAID
Mauritania	X	X						World Vision, USAID
Niger	X	X	X	X	X	X		World Bank
Nigeria	X	X						PEPFAR
Sao Tome	X	X						GF Round 5
Sierra Leone	X	X	X					GF Round 9
Togo	X	X						GF Round 8

Table 26. Estimates of FSWs, by country

Country	Total FSW	Sources, Year
Benin	12,402	UNAIDS 2008 (Modes of Transmission, unpublished)
Burkina Faso	31,000	National Strategic Framework, 2011–15
Cameroon	49,300	NAC: Profile Estimate Reports, 2010–2020
Côte d'Ivoire	78,191*	Estimate by the NSI, data from Vandepitte et al., 2008
Gabon	10,000	Global Fund Round 8 Proposal, 2008
Ghana	49,300	NAC Profile Estimate Report 2010; PEPFAR estimate: 34,000
Guinea-Bissau	3,000	Resource Needs Model (NSP, 2006)
Mali	15,591	GOALS Assessment Model – Operational Plan, 2006
Niger	28,000	Global Fund Round 10 Proposal, 2010
Senegal	12,815	Global Fund Round 9 Proposal, 2009 (incl. "clandestine")
Sierra Leone	6,000	Global Fund Round 9 Proposal, 2009

* The Global Fund Round 10 proposal for Côte d'Ivoire expects to target 96,778 sex workers by 2014, presumable both male and female (see Note 4 below). There was no explanation for this figure.

Table 27. Estimates of MSM, by country

Country	Total MSM	Sources, Year
Benin	13,591	UNAIDS 2008 (Modes of Transmission, unpublished)
Burkina Faso	3,174	Global Fund Round 10 Proposal, 2010
Cameroon	17,763	NAC: Profile Estimate Reports, 2010–2020
Côte d'Ivoire	11,892	NSI/Clinique de Confiance/Ruban Rouge; 2008
Côte d'Ivoire	>7,825	Male Sex Workers. Global Fund Round 10 Proposal, 2010
Ghana	17,763	NAC Profile Estimate Report, 2010
Mali	2,172	GOALS Assessment Model – Operational Plan, 2006
Niger	11,304	Global Fund Proposal Round 10, 2010
Senegal	2,650	Global Fund Round 9 Proposal, 2009
Sierra Leone	12,000	Global Fund Round 9 Proposal, 2009
Togo	>4,900	(Koumagnanou, Kassegne et al. 2010)

Estimates of the number of MSM, per country: These estimates were reported in various documents, such as Global Fund proposals. The methodology and further detail on sources is not available

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