



**Regional HIV/AIDS Prevention and Care Strategy
2011-2016**

Regional Health Office Vision Statement

“USAID/West Africa Regional Health Office (RHO) is a recognized leader in improving the health status of the vulnerable population, especially that of women and children, in West Africa, by promoting and building partnerships to scale up evidence based interventions”

HIV/AIDS Vision Statement

“USAID assistance mitigates the population-level impact of HIV/AIDS in the West and Central Africa regions through strategic partnerships wise investments”

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Executive summary

USAID West Africa's Regional Health Office (RHO) supports health programming across twenty-two countries in the West and Central Africa sub-region. The RHO's HIV/AIDS budget for these countries is on average US\$3 million per year and while some countries in the region have large President's Emergency Plan for AIDS Relief (PEPFAR) bilateral funding for HIV/AIDS, those that do not have little access to USG funding. At the national level, many countries in the region are demonstrating ownership and increased commitment to the HIV response by directly funding HIV programs and instituting boards, AIDS commissions and policies to guide program administration and improve coordination. The Economic Community of West African States (ECOWAS) strategy, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) priorities and other donor assessments, including the World Bank's West Africa HIV/AIDS Epidemiology and Response Synthesis (2008) and USAID's Action for West Africa Region project (AWARE) II assessments all seem to be in agreement about the major challenges and areas in need of more robust programming. Most notably, two main regional priorities in need of increased focus are prevention with most at risk populations (MARP) and promoting strategies to combat stigma and discrimination at all levels. The Global Fund is also very active in the region and has USD\$ 3.6 billion in proposals dedicated. ECOWAS recently completed its five year HIV strategic plan (2012 – 2016) to help guide future investments for HIV response in the sub-region.

The RHO's HIV/AIDS strategy was developed with input from the above sources and is meant to guide USG investments and align them with regional priorities. The RHO will utilize its comparative advantage to focus on four strategic objectives to fill identified gaps:

- 1) Enhance country capacity to build the evidence base for effective policy and programming
- 2) Support countries to establish and sustain an enabling environment for an optimized HIV response
- 3) Improve prevention, care and support services, especially for MARPs
- 4) Establish a Research/Evaluation agenda.

The RHO will achieve these objectives by working with and through strong and strategic partnerships with global, regional and national institutions such as National governments, Ministries of Health, National AIDS Commissions, UN Agencies, the Global Fund, regional networks of civil society organizations, researchers and other Non-Government Organizations (NGOs) to mitigate the population-level impact of HIV/AIDS in West and Central Africa.

I. Background

Sub-Saharan Africa is the most affected region by HIV/AIDS. In West and Central Africa, heterogeneous HIV epidemics exist both within and between countries in the region. Sexual transmission accounts for the largest portion of HIV transmission. While national HIV prevalence ranges from less than one percent to five percent, prevalence among MARP, including sex workers (SW) and men who have sex with men (MSM) is significantly higher. For instance, HIV prevalence among SW and MSM is 30 and 19 times than the general population prevalence in Niger and Senegal, respectively. Few data are available on other at-risk populations, including size or prevalence estimates for people who inject drugs [PWID].

Despite low HIV prevalence among the general population, relative to other regions of sub-Saharan Africa, West and Central Africa contribute a significant number of new infections to the global burden due to its large population. Adolescent and adult populations in West and Central Africa have some of the lowest levels of correct knowledge about HIV. It is estimated that less than 50 percent of the population aged 15-49 years have comprehensive correct knowledge about HIV/AIDS¹. Systematic non-use of condoms, multiple partners and trans-generational sexual partnerships are common in West Africa and can influence the current speed transmission of the epidemic. HIV prevalence is two to three times higher in urban than rural areas; and two to three times higher among young women compared to young men.

Despite some improvements, stigma and discrimination remain serious concerns for people living with HIV, especially for women. Qualitative reports have indicated that women living with HIV and AIDS are considered vectors of HIV and therefore should not get pregnant. Sometimes community members and health workers think that these women cannot (or should not) raise children². In Annaba State, Nigeria, a recent survey found that two-thirds of health workers have disclosed the confidential HIV-status of individuals to others and 13% believed that people living with HIV should be segregated³. Stigma and discrimination continue to be issues faced by MARPS, and in the context of HIV, the influence of both is multiplied. A recent survey in Ghana found that 75% of people did not favor decriminalizing sex work or homosexuality and 69% would not welcome MSM into their homes⁴.

In 2000, a report commissioned by ECOWAS found that HIV has resulted in reduction of agricultural production, productivity losses in enterprises due to absenteeism of sick staff members, considerable expenditures on health and funerals and difficulties in replacing qualified staff who die from AIDS. Education and defense sectors face similar impact with the loss of qualified staff. In the health sector, in addition to the loss of qualified health workers, HIV increases the burden on staff, reduces the offer of services, and increases health expenditures. Life expectancy has declined by ten years in Cote d'Ivoire and Burkina Faso as a result of HIV. Millions of children have been orphaned (2.5 million in Nigeria, 440,000 children in Côte d'Ivoire and 330,000 children in Cameroon); and because of loss of the primary income earner,

¹West Africa HIV profile, 2011- USAID West Africa

²High level consultation on the sexual and reproductive rights of women and girls living with HIV, 2011-02-24, New York

³Ibekwe, Igwe et al. 2008, cited by AWARE II MARP assessment policy report.

⁴Nzambi, Bevalot et al. 2010 cited by AWARE II MARP assessment policy report

there is an increased dependency on the affected extended families (2.8% in Togo, 4% in Liberia)⁵.

II. Overview of the Regional Response to HIV/AIDS

Key Countries Responses' Highlights and Success in the Region

International commitment for the HIV/AIDS response funding support is evident. Countries in the region have begun demonstrating ownership and increased commitment to the HIV response by directly funding HIV programs and instituting boards and policies to guide program administration. A majority of countries have established National AIDS Commissions (NAC) and have developed National Strategic Plans (NSP) for improved coordination. Several NAC in the region are Principal Recipients for awards from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Several countries in the region, including Burkina Faso, Benin, Senegal, and Mali are progressing towards universal access to treatment, having achieved approximately 70% treatment coverage. Strong political commitment is evident in several countries. For example in Ghana, the government provides financial resources to increase access to HIV services and combat stigma for high risk populations. The majority of the countries in the West and Central Africa sub-region have adopted HIV laws to protect the rights of people living with HIV. Most of these countries have aligned with the UNAIDS three-one principle.

Regional Organizations' Response-ECOWAS/West Africa Health Organization (WAHO)

ECOWAS is a regional group of fifteen countries, which promotes economic integration in all fields of economic activity including those impacted by HIV/AIDS. In May 2011, ECOWAS convened a high-level consultation meeting to discuss and validate its five year HIV strategic plan (2012-2016). The strategy focuses on regional action to better address common issues including: strengthening of the on-going public-private partnership initiative for the sustainable production of quality and affordable HIV drugs and commodities; bulk purchasing of medicines and use of TRIPS flexibility; creating regional movement to eliminate mother to child transmission; improving coverage of HIV/AIDS services for MARP; enabling legal environments; increasing ownership and sustainable financing; and coordinating capacity building efforts. It is expected that WAHO, the health arm of ECOWAS with a mandate to provide leadership in responding to the health needs of citizens in ECOWAS member countries, will be a major player in implementing this strategic plan. USAID/West Africa Regional Health Office's approach is to support regional organizations/institutions and coordinate efforts for complementary interventions. With this approach in mind, RHO will collaborate with ECOWAS to the implement its HIV strategy.

Global Fund for AIDS, Tuberculosis, and Malaria in West Africa

In West and Central Africa, the GFATM is the major funder of HIV/AIDS prevention, care and treatment services. In total, the GFATM has approved USD\$ 3.6 billion in proposals for the sub-region, representing 16% of GFATM resources which is second only after the East Africa region. Despite these significant investments, allocation of resources to address MARPs has been low. In

⁵ECOWAS HIV strategy 2011-2015

Round 8, only nine percent of total HIV proposals approved globally had MARPs focused interventions. In Round 10, the GFATM established an incentive mechanism to promote the prioritization of interventions addressing MARPs where epidemiologically appropriate. This effort will be continued in Round 11.

USAID and PEPFAR Program in West Africa

The USAID West Africa Regional Health Office covers twenty-two countries⁶ in the West and Central Africa sub-region, eight of which are USAID presence countries. The RHO portfolio includes the following program elements: family planning and reproductive health (FP/RH)-71%, HIV/AIDS-23%, maternal and child health (MCH)-6% with an average annual budget of US\$14 million. This figure shows the challenges that the RHO is facing to support the needs and budget activities especially for the USAID non presence countries.

While PEPFAR is the second largest donor in the region, the resources are disproportionately allocated to several priority countries through bilateral agreements. These countries in the region receive from USD\$ 1-450 million: Benin, Cote d'Ivoire, Guinea, Ghana, Liberia, Mali, Nigeria, Cameroon, Senegal and Sierra Leone. The other countries remain under the auspices of the USAID/RHO and do not receive any PEPFAR funds through bilateral agreements, including: Burkina Faso, Cape Verde, Chad, Equatorial Guinea, Gabon, The Gambia, Guinea Bissau, Mauritania, Niger, Sao Tome and Principe and Togo. Currently, PEPFAR programs in the region are implemented through the following US government agencies: USAID, Centers for Disease Control and Prevention (CDC), Peace Corps, Department of Defense and Department of State.

In July 2003, USAID/West Africa entered into a cooperative agreement with FHI to develop a five-year USD\$ 34.7 million project named AWARE-HIV/AIDS. The critical tasks of this flagship program included dissemination and replication of best practices, advocacy for policy change, capacity building, cross-border interventions and support for the West Africa Ambassadors' AIDS Fund (WAAF) implementation. The project positioned USAID as a key player and funder of regional prevention, care and support interventions. The follow-on program, USAID AWARE II, implemented through Management Sciences for Health and partners Engender Health and Futures Group, builds on the successes of its predecessor and aims to "create a positive operating environment enabling countries to plan and implement selected high quality health service programs for people of the region." The contract includes both family planning (FP) and some HIV/AIDS specific activities. This project began in July 2009 and is scheduled to end in July 2012.

Because of the importance of GFATM resources in the sub-region, USAID provides technical assistance to Country Coordination Mechanisms (CCM) and to Principal Recipients (PRs) and Sub-Recipients for successful GFATM implementation, targeting key priority areas (grant negotiation, governance, CCM restructuring, transition Phase I-II, Monitoring and Evaluation, etc.).

⁶ The program serves the nations of Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Central African Republic, Cote d'Ivoire, Equatorial Guinea, Gabon, The Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, and Togo.

III. HIV Strategy Description

Process

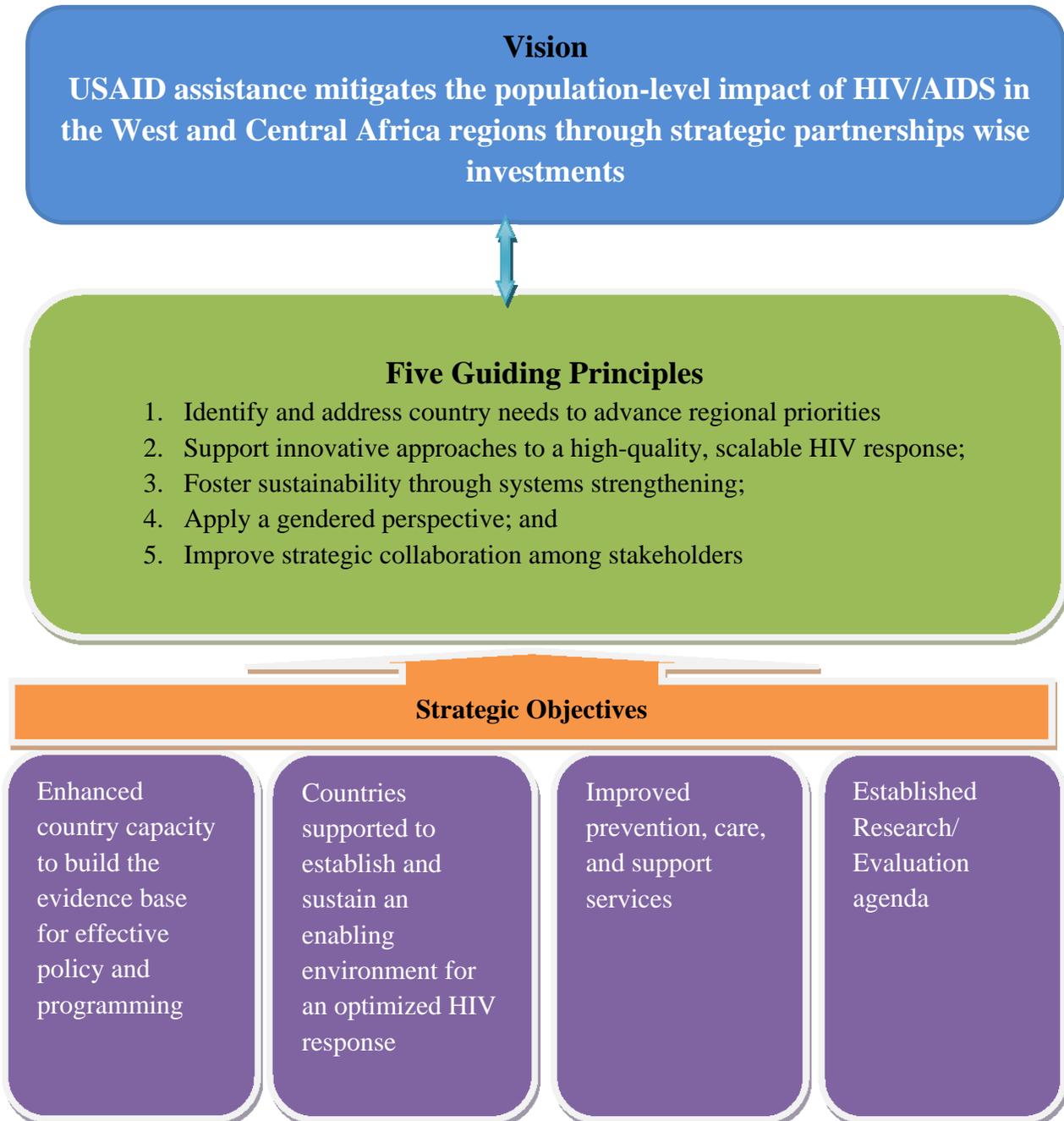
In December 2010, the RHO began internal discussions to validate its mission and mandate on HIV in order to respond to the changing needs of key stakeholders, including USAID bilateral missions and regional counterparts. In February 2011, RHO identified the need to develop an HIV/AIDS strategy and commissioned a strategic needs assessment as part of the process.

USAID AWARE II Project conducted a review of the HIV/AIDS literature (both peer reviewed and gray) focusing on the current epidemiology, policy and programmatic state for countries in the region. The review built on the World Bank's West Africa HIV/AIDS Epidemiology and Response Synthesis (2008) to provide up-to-date epidemiological and programming data. Some of the key findings and conclusions from the documents include:

- The most important core and bridging populations in the HIV epidemics in West Africa are female sex workers (FSWs) and their male clients;
- Research indicates that high percentages of men with high mobility occupations buy sex;
- The importance of MSM in the HIV epidemic is being increasingly recognized; and
- Much more prevention focus is needed on the specific risk groups in which the epidemic and its transmission are primarily concentrated.

This document reflects consultations and recommendations from key stakeholders and partners, including regional staff from multi-lateral organizations, NACs from various countries, USAID/Washington, bilateral USAID missions, and implementing partners. The strategy identifies a set of guiding principles, priorities and strategic action steps. Its successful implementation will require inclusive leadership and collaboration with stakeholders such as civil society organizations, ECOWAS, regional partners/organizations as well as continued donor commitments. An implementation plan will be developed separately.

Regional HIV Strategy representation



Guiding Principles

The overall vision to mitigate the impact of HIV/AIDS in the West and Central Africa region is underpinned by five guiding principles, which are in line with the Global Health Initiative's key principles and PEPFAR's strategic priorities. These principles provide a lens through which implementation of the strategic objectives should be viewed.

(1) Addressing country needs to advance regional priorities. Limited resources and vast needs are compelling reasons for the USAID West Africa Regional Health Office to work with its stakeholders (i.e. USG-country teams) to find solutions to issues that have implications beyond individual country borders. The RHO should be identified as a regional platform foremost and secondly as a multi-country platform.

(2) Supporting innovative approaches to a scalable HIV response. Similarly, limited resources preclude the regional office from taking programs to scale in specific country settings. However, in collaboration with other regional and national stakeholders, the RHO will identify novel approaches to improve program efficiencies, demonstrate how to implement program more efficiently, show how efficiencies gained improve cost-effectiveness, rate and coverage of services taken to scale.

(3) Fostering sustainability through systems strengthening. Sustainability of the HIV/AIDS response throughout West/Central Africa will in part be achieved through strengthening the systems of regional platforms. Institutional and systems strengthening will allow for a more efficient response, promote the appropriate use of limited resources, and provide an effective advocacy platform. In particular, the RHO recognizes the important role of ECOWAS and WAHO in providing regional leadership to address HIV/AIDS and meet governments' commitments, while recognizing their limited institutional capacity to address the needs of all populations, particularly MARPs. Sustainability will also be achieved by working with regional partners to align priorities with those identified by the individual countries and dictated by the current HIV epidemic.

(4) Applying a gendered perspective. Gender-related inequalities and disparities disproportionately compromise the health of women and girls globally. At the same time, male norms surrounding masculinity can contribute to stigma and discrimination faced by MSM and SW. Recognizing that gender inequalities are important contextual factors for the HIV epidemic globally, the RHO will apply a gendered perspective, ensuring culturally sensitive approaches that acknowledge the significance of traditions, address harmful gender norms, and reaffirm positive and protective norms where these exist.

(5) Improving strategic collaboration among stakeholders. The RHO is one of many key stakeholders in the West Africa sub-region, and recognizes that improving health outcomes throughout the region is a shared responsibility. To that end, it aims to improve strategic collaboration among governments, multilateral donors, implementing partners, and other key institutions, including the largest funding platform in the region, the GFATM. Building off of existing regional strategic approaches, the RHO is aligned with the principles of the ECOWAS Regional Strategic Plan for HIV/AIDS Control and will continue to build the capacity of the WAHO to be a regional leader in the HIV/AIDS response. Finally RHO will

continue to develop its relationships with regional civil society networks supporting HIV/AIDS care and prevention programs in the region.

Focal Areas

The broad scope of HIV/AIDS needs in the sub-region necessitates focusing efforts in areas suited to RHO's comparative advantage. Two such areas have been identified by both the RHO as well as by ECOWAS as regional priorities: prevention with most-at-risk populations and stigma and discrimination.

MARPs, particularly sex workers and men who have sex with men contribute a disproportionate number of new infections to the various epidemics in the region. However, the needs of these populations have not been strategically and sufficiently addressed by other donors and stakeholders. The RHO will demonstrate leadership and maximize USAID technical expertise in this area, as well as call attention to the prevention and care issues faced by MARPs. Relatedly, stigma and discrimination related both to HIV/AIDS as well as to MARPs has been identified as the major barrier to the delivery and uptake of HIV prevention, care, and treatment services and programs. Without adequate attention to this barrier, the ability to achieve universal access to prevention, care, and treatment services will be severely hindered.

Strategic Objectives

The RHO will focus on four strategic objectives.

1. Enhanced country capacity to build the evidence base for effective policy and programming

There is a paucity of data in the region for strategic programming, "exporting" successful programs to new settings, and scaling up "what works" efficiently. Data for program planning at various levels - regional, national and sub-national- are scant, and where data are available, they often are not up-to-date to inform programs, particularly for MARPs programming.

RHO wants to focus more on quality data that helps evidence based programming and implementation of best practices through a shared research agenda with regional counterparts, regional institutions as well as other USG bilateral programs, and draw a dissemination plan for best practices and research findings sharing.

Building an evidence base in the region will require strengthening country-level capacity for both qualitative and quantitative research, as well as monitoring and evaluation. The RHO is well poised to:

- Provide technical assistance (including facilitating south-to-south assistance) to build country capacity to begin or continue sentinel surveillance, conduct population based survey work, and conduct systematic bio-behavioral surveys where these activities have not been done, but are necessary for strategic programming.
- Work across countries to better identify and map MARPS and other vulnerable populations in cross-border regions as well as other contexts of heightened HIV risk where migrant or migratory individuals may converge.

- Coordinate with other stakeholders including multilateral partners, other donors and national governments to leverage resources for research activities with implications across the region.

2. *Countries supported to establish and sustain an enabling environment for an optimized HIV response*

USAID believes in strong partnerships with regional institutions such as Joint United Nations Program on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), West Africa Health Organization (WAHO) and ECOWAS, regional network of civil society organizations, universities, researchers and key regional champions to stabilize the epidemic and reduce the number of new infections in the sub-region.

Across the West/Central Africa region, political commitment, institutional leadership, and legal/policy frameworks to address drivers of the epidemic, which are illegal or stigmatized (i.e. sex work, male-male sex) are insufficient to allow a robust programmatic response that will have population-level impact. Additionally, cultural and social intolerance of such behaviors contribute to stigma and discrimination against marginalized populations, resulting in decreased availability of and access to appropriately targeted HIV prevention, care, and treatment services. As a regional platform, the RHO will engage with countries and regional partners, to improve the political, legal, and social environment to optimize the HIV response. Establishing and sustaining an enabling environment involves not only addressing policy/political barriers, but also resource gaps that prohibit adequate scale, quality, and intensity of programs. Broadly, key activities for this objective can include:

- Harmonizing principles of HIV/AIDS policies across countries to reflect epidemiological context and international standards;
- Building political and institutional leadership to facilitate a comprehensive and appropriate HIV response;
- Providing technical assistance to GFATM Country Coordinating Mechanisms (CCMs), as requested, to improve resource mobilization and successful grant implementation with a strong focus on HIV prevention funded activities;
- Support regional stakeholders to facilitate donor coordination and resource mobilization; and
- Advocating for supportive legal frameworks and political commitment via existing regional platforms (e.g. ECOWAS).

3. *Improved prevention, care, and support services.*

Throughout the region, prevention, care and support services are being implemented by organizations, with various target populations, scope, coverage, and quality. While evidence-based models exist to address needs of MARPs in West Africa and globally, many interventions in the region have been implemented as “pilots,” ill-prepared for scaling to achieve coverage sufficient to reduce HIV at the population level. While limited resources do not make it possible for the RHO to implement services at scale throughout the region, the RHO can improve the level of services provided through several different mechanisms. First, the RHO can engage in “program seeding”– developing/adapting, testing and disseminating Promising Practices Models,

and tools to bring quality-assured evidence-based programs to scale efficiently, under the assumption that successful programs can be brought to scale utilizing or harnessing resources from other development partners. Secondly, the RHO can assist with improving the implementation of country-level GFATM activities through targeted support from mechanisms such as Grant Management Solutions, a USAID centrally funded partner).

4. Established Research/Evaluation agenda.

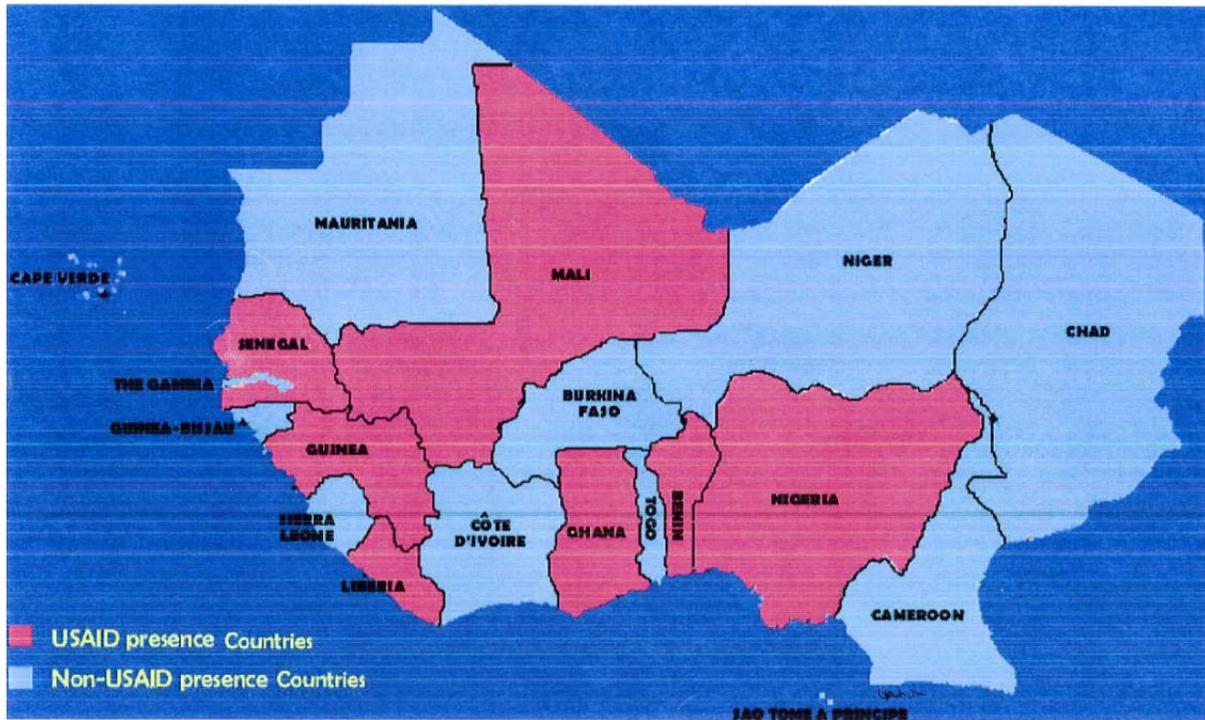
In order to have evidence-based programming addressing MARPS, stigma and discrimination, strategic information on the basic epidemiology of HIV vulnerability is needed that is representative of the region where there is a paucity of data to inform resource allocation and prioritization. Basic epidemiologic studies are needed to define, enumerate the size, geographic location and distribution of MARPS and other vulnerable populations. Sentinel survey data, population based survey (where data are absent or older than five years), and systematic biologic and behavioral surveys of MARPS are needed to track trends in specific populations. For instance, integrated bio-behavioral surveys of female sex workers, their clients and men who have sex with men, as well as Demographic and Health Surveys with HIV testing or even antenatal clinic (ANC) surveillance, could be triangulated to inform priority risk groups and specific demographics in country settings where both are done. Using the regional perspective to help identify similar local epidemic dynamics where targeted interventions can be seeded or scaled up for impact. In addition to these quantitative studies, qualitative studies are needed to better understand the barriers to effectively delivering HIV prevention, care and support, and treatment services to those in need, particularly MARPS who are engaging in stigmatized HIV risk behaviors. The RHO may provide technical assistance and collaborate with other stakeholders in implementing activities to obtain these types of data for programming.

IV. Conclusion

HIV in West and Central Africa is complex because of its heterogeneity within and between countries in the sub-region. Sexual transmission accounts for the largest portion of HIV transmission with most at risk populations bearing a disproportionate burden of the HIV epidemic in the region. This is why there is a need for appropriate strategy to focus existing and future efforts to deliver better services to these populations. However, USAID/West Africa Regional Health Office will take opportunities to make the case for new investments and funding to maintain current global successes, such as the reduction in new HIV infections and in the mortality due to HIV/AIDS a reality in this region. Per the guiding principles, this strategy sets a clear focal area that is complementary to regional initiatives and provides unique opportunity to USAID to increase its leadership in the support of HIV programs in the region. Included in the strategy's four Pillars is an ambitious research agenda that will help boost West Africa's effort to fight HIV/AIDS and ensure USAID's efforts produce a more coordinated and collective response to HIV/AIDS. With regional partnerships, multi-sectorial response and a strong partnership with civil society, including people living with HIV and affected communities, USAID West Africa can help mitigate the population-level impact of HIV/AIDS in West Africa.

VI. Annexes

Annex 1: Map of USAID West Africa Supported Countries



Annex2: HIV prevalence among the General Population and MARPs

Countries	HIV Prevalence (%)			
	General population (DHS)	General population (UNAIDS)	SW	MSM
Cote d'Ivoire	-	3.4	35.5	19.0
Burkina Faso	1.8	1.2	16.0	-
Niger	0.7	0.8	35.6	-
Mauritania	-	0.7	7.6	20.0
Togo	-	3.2	44.5	-
Guinea-Bissau	-	2.5	39.6	-
Guinea	1.5	1.3	32.7	-
Sierra Leone	1.5	1.6	8.5	-
Gambia	-	2.0	39.0	-
Cape Verde	0.8	-	-	-
Benin	1.2	1.2	24.7	25.3
Ghana	2.0	1.8	25.0	13.5
Nigeria	-	3.6	37.4	21.8
Senegal	0.7	0.9	19.8	-
Liberia	1.5	1.5	-	-
Mali	1.3	1.0	35.3	35.0
Cameroon	5.5	5.3	36.0	-
Chad	-	3.4	20.0	-
Gabon	-	5.2	23.2	-
Equatorial Guinea	-	5.0	-	-
SaoTome et Principe	1.6	-	-	-