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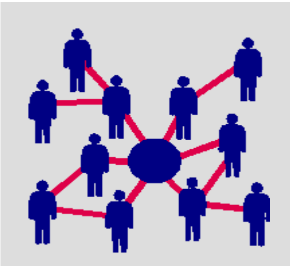

# Building Alliances for Regional Solutions for the HIV Response in West and Central Africa: Governments, Donors and Civil Society Partnering for Results

## Stakeholders Technical Workshop for Key Populations in West and Central Africa

**Accra, Ghana | May 27th – 29th 2014**

## WORKSHOP REPORT

HEALTH POLICY PROJECT

PACTE-VIH
Pour une réponse innovante au VIH en Afrique de l'Ouest

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

# Table of Contents

Table of Contents ..... 2

Acknowledgements ..... 6

Acronyms ..... 7

Executive Summary ..... 9

Section 1: Introduction  Overview ..... 12

Meeting Objective ..... 12

Welcome Remarks ..... 12

Section 2: Setting the Stage: Reality and Challenges of KP Programming ..... 14

KP Epidemiology and Context of WCA ..... 14

Setting the Stage: Characterizing the Context of KP Programs and Research in WCA: Multi-Sectorial Challenges ..... 15

Vincent Pitché, National AIDS Control Council, Togo ..... 15

Jaegan Loum, Worldview, The Gambia ..... 15

Marguerite Thiam, Ministry of Health, Cote d'Ivoire ..... 15

Trudy Nunoo, ProLink, Ghana ..... 15

Daouda Diouf, Enda Santé, Senegal ..... 16

Franz Mananga, Alternatives-Cameroon, Cameroon ..... 16

Discussion ..... 16

Section 3: KP: Country Initiatives and Regional Strategies ..... 17

Emerging Data and Corresponding National Strategies: Togo, Cameroon, Burkina Faso | Regional Perspective: WAHO ..... 18

Togo: Programs, Research, and National Strategy, Vincent Pitché, NACC-Togo ..... 18

Cameroon: Second Phase Research and Programs, Jean-Bosco Elat, NACC-Cameroon ..... 19

Burkina Faso: Programs, Research and National Strategy, Dr. Sylvestre Tiendrébéogo, MOH-BF ..... 19

Discussion regarding emerging data and programming: Liberia, Benin, Burkina Faso, Cameroon, Togo, WAHO ..... 20

Long-term surveillance and programming among KP: Ghana, Cote d'Ivoire and Senegal | Regional Perspective: UNAIDS, UNICEF ..... 20

Analysis of the Epidemiological Situation and the Response to the HIV Epidemic Targeting KP, Moise Tuho, UNAIDS ..... 20

Ghana: Long-term surveillance of KP and its influence on national strategic planning and service delivery, Kyeremeh Atuahene, GAC-Ghana ..... 21

Cote d'Ivoire: national coordination; country-level research; PEPFAR-GF Synergies, Dr. Marguerite Thiam, MOH-CI ..... 21

Senegal: long-term surveillance of KP, Data to inform programming; national coordination, Abdou Khoudia Diop, MOH-Senegal ..... 22

Discussion: Long-term surveillance, programming and national coordination for KP in the WCA region: UNAIDS, Ghana, Senegal, Cote d'Ivoire ..... 22

KP – Civil Society: Roundtable Discussion ..... 23

Section 4: KP – Donor and Stakeholder Synergies with Regional Strategies in WCA ..... 26

Towards an AIDS-free generation: PEPFAR KP updates, funding and collaboration, R. Cameron Wolf, Laurent Kapesa, USAID ..... 26

Strategic vision for KP in WCA- opportunities under the new funding model (NFM), Sonia Florisse, Global Fund. ..... 28

Strategic Vision: World Bank, by Elizabeth Mziray, World Bank ..... 28

Discussion: ..... 29

Section 5: Day 2: Challenges, Innovative Solutions and Priority Setting for KP in WCA ..... 30

Financing for HIV Interventions among KP: International trends and future direction in the financing of HIV programs in Africa; Coordinated finance response in the WCA region ..... 30

Discussion ..... 30

Section 6: KP Research Models: Innovations to address challenges of KP service delivery ..... 36

Strategic Information: Epidemiological approaches to strategic information and storage, Stefan Baral, JHU ..... 36

Population Size Estimates: Challenges and Innovations and Population Level Research ..... 38

Case study from Ghana: Sam Wambugu, FHI 360 ..... 38

Multiple Method Approach for Estimating the Population Size of MSM, Silas Quaye ..... 38

Population Size Estimates, Erin Papworth ..... 38

Discussion One: Strategic Information, Population Size Estimate Methods, Surveillance Methods: . 39

Community and Research: Data needs, usage and effects of KP, Steve Nemande, AMSHeR ..... 41

Research and Data for KP Programming: Data Usage in the Field, Daouda Diouf, Enda Santé ..... 41

Data needs and initiatives for KP under the Global Fund's New Funding Model (Financing and KP Epidemiology), Joshua Galjour, GF ..... 41

Discussion Two: Community-driven data needs and usage, evidence-based programming, data for funding mechanisms ........ 41

Discussion ........ 42

KP research models general discussion points: ........ 43

Section 7: Models for KP Programming ........ 43

Models and package of service: community-driven approaches by Jean Paul Tchupo, FHI 360, and Raymond Sodji, ONG FAMME ........ 43

Discussion ........ 43

New Approaches to Reach KP in WCA, By Kimberly Green, FHI 360 and Joshua Akuamoah, Community Liaison Officer ........ 44

The continuum of prevention, care and treatment for KP in West Africa: A case study (Clinique de Confiance and CHAMP), by Ehouman Sylvain, Espace Confiance-CI, Esso Yedmel, Heartland Alliance-CI ........ 45

Continuum of Prevention, Care and Treatment by Cameroon, by Youssouf Ouattara, Care Cameroon ........ 45

Discussion ........ 46

Section 8: Enabling Environments: Policy and Legal Context WCA ........ 48

Structural factors and the enabling environment in WCA | Tools for advocacy and community engagement by Sandra Duvall and Darrin Adams, Futures Group ........ 48

Roundtable discussion regarding Regional approaches for MSM engagement and advocacy, by Cyriaque Ako, AMSHeR and Grace Kamau, ASWA ........ 50

Section 9: People who inject drugs: Regional Context: context, review of existing data, research and projects in Ghana, Burkina Faso, Senegal (WCA region) ........ 52

Dr. Rose Adjei, Knust-Ghana ........ 52

Dr. Sidibé Ndoye, NACC-Senegal ........ 53

Dr. Ashley Grosso, JHU ........ 53

Discussion: PWID in the region, data gaps and existing programs ........ 53

Section 10: Day 3: Regional Coordination, Conclusions, Recommendations ........ 54

Coordination at the regional level: JURTA KP TWG Priorities and Updates. Effective coordination practices; Adolescents in KP, by Abdelkader Bacha, UNICEF ........ 55

Coordination at the regional level: OCAL, by Edy Anthony and Serge Guidigbi ........ 55

Discussion ........ 55

Section 11: Working Group Recommendations ........ 56

Overview of recommendations from the Workshop: ........ 56

Specific Working Group Recommendations: ... 57
Violence and persecution: ... 57
Stigma and discrimination: ... 57
Care and treatment ... 57
M-Health: ... 58
Stakeholder Engagement ... 58
Advocacy and Leadership Training ... 58
Innovative ways to improve mobile counseling among KP ... 58
Enabling Environment ... 59
Access to Services ... 59
Final Comments ... 59

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***NOTE: The authors' views expressed and the views of participants quoted in this report do not necessarily reflect the views of the United States Agency for International Development or the United States Government.***

# Acronyms

amfAR – The Foundation for AIDS Research
AMSHeR – African Men for Sexual Health and Rights
ARV – anti-retroviral therapy
ASWA – African Sex Worker Alliance
BCC – behavior change communication
C/L (indicator)
CBO – community-based organizations
CCM – Country Coordinating Mechanism
CDC – The United States Center for Prevention and Disease Control
CEDEAO: West African Economic Community
CI/CDI – Cote d'Ivoire
CN – Concept Note (for Global Fund Grant submission)
CNLS – (NAC) National AIDS Control Committee
CoPTC – continuum of prevention to care
CSO – Civil society organizations
DANIDA – Danish International Development Agency
DFID – Department for International Development (UK)
DIC – Drop-in Center
ECOWAS – Economic Community Of West African States
FSW – female sex workers
GBV – gender-based violence
GF – Global Fund
HCT – HIV counseling and testing
HCW – Health Care Worker
IBBS – Integrated Biological and Behavioral Surveillance Studies
ICASA – International Conference on AIDS and Sexually Transmitted Infections
IMF – International Monetary Fund
JHU – Johns Hopkins University
JURTA – Joint UN Team on AIDS
KP – Key Populations
KPLHIV – key populations living with HIV
LGBT – lesbian, gay, bisexual, and transgender
M&E – monitoring and evaluation
MDG – Millennium Development Goals
MOH – Ministry of Health
MSH – Management Sciences for Health
MSM – men who have sex with men
NAC – National AIDS Commission
NACC – National AIDS Control Committees
NFM – New Funding Model (Global Fund)

NGO – non-governmental organization
NSUM – network scale up method (population size estimate)
OCAL – The Abidjan-Lagos Corridor Organization
OHA – Office of HIV/AIDS at USAID
PEPFAR – President's Emergency Plan for AIDS Relief
PLHIV – people living with HIV
PWID – people who inject drugs
PWUD – people who use drugs
RDS – respondent-driven sampling
S&D –stigma and discrimination
SIAPS – System for Improved Access to Pharmaceuticals and Services
STI – sexually transmitted infections
SW – sex workers
TA- technical assistance
TG – transgender people
TWG – technical working group
UCSF – University of California San Francisco
UNAIDS – Joint United Nations Programme on HIV/AIDS
UNESCO – United Nations Educational, Scientific, and Cultural Organization
UNFPA – United Nations Population Fund
UNICEF – United Nations Children's Fund
USAID – United States Agency for International Development
USG – United States Government
WA – West Africa
WAHO – West Africa Health Organization
WB – World Bank
WCA – West and Central Africa
WHO – World Health Organization

# Executive Summary

**Introduction:**
This meeting was held to bring together key stakeholders working with key populations (KP) in multiple countries in the West and Central Africa (WCA) region to share and discuss the latest experience in programming and policy making, especially for men who have sex with men (MSM) and transgender people (TG), female sex workers (FSW), and people who use drugs (PWUD). This meeting allowed for sharing research methodologies and promising practices with regional and country partners in order to identify and develop strategies and innovative next steps to advance HIV prevention, treatment, and control of HIV in the WCA region.

A review of the epidemiology of HIV in WCA shows that HIV epidemics in the region are more concentrated in KP than in other regions of Africa. The burden of HIV among FSW and MSM found in WCA Africa elucidates the need to develop comprehensive and integrated HIV prevention, care and treatment programs in the region. Heightened HIV prevalence and associated risk factors among this population implies regular HIV testing for this population in order to obtain early diagnosis and integration into the continuum of care and treatment programs is essential. High levels of sexual and physical violence in both populations must be addressed programmatically and politically. Regional distribution of HIV also implies cross-border migration, and sexual and social networks can be capitalized to better disseminate prevention messages as well as ensure retention in care facilities.

Key challenges in the region for KP programming and research center primarily on the high levels of stigma and discrimination these populations face.  Negative views of and actions perpetrated toward these populations drive populations underground and make access to service provision and research studies limited. The legislative context in many countries proves a challenge, as many countries criminalize the behaviors of these populations, including sex work, drug use, and same-sex behavior. This furthers stigma and discrimination, but also hinders the abilities of health care providers to provide services and of researchers to study these populations. Careful management of the political climate is key to ensure the safety of the community as well as health service providers. This meeting was designed to facilitate dialogue, discussion and coordination among key stakeholders in key population programming from the government, civil society, program implementers and donors in the WCA region.

**Conference Objectives**:
The objectives of this meeting were to:

- Share and discuss the latest multi-country experiences in KP programs, specifically related to MSM, FSW, and PWUD.
- Research methodologies and practices with key regional and country stakeholders.
- Develop/identify regional strategies and innovate next steps to advance HIV prevention, treatment, and control in the WCA region.

**Key Themes that Emerged:**
Key themes that emerged from the meeting included the complex working environment in which KP programmers, governments and donors function in the region. Programs address multiple facets of society as well as approaches such as advocacy, police training, the utilization of technology to reach hidden groups, and crisis management for community-based organizations' security systems. The meeting produced important discussions and shared experiences of stakeholders regionally. Inclusion of communities in the development of programs and strategies at the country and regional level was emphasized in all conversations. While mitigation of stigma and discrimination at the individual and structural level is imperative, communities have developed their own coping mechanisms that are important to integrate into comprehensive programming.

Research among KP is nascent, and establishing best practices and data to better inform programs is occurring, but will take time. Testing of the use of multiple population size estimation methods are providing better estimates than before. Testing models of program implementation, such as standalone clinics, integrated clinics and hybrid clinics are occurring and all methods must continue to be developed in order to inform scalable interventions.

Donors and funding for HIV in the region will continue to focus on KP, so ensuring strategic investment at the donor and country level is imperative. This means integrating research methods into programming, coordinating at the country level what investment funds what activity and establishing standards for best practices are important next steps for governments, donors and implementers alike.

**Key Recommendations**:

- There has been increasingly a constant and productive dialogue between health professional including Ministries of Health (MoH), CNLS, donors, and civil society organizations (CSOs) that have improved KP access to services. However, the structural environment remains similar in many countries and less conducive to HIV programming enough for positive outcome in terms reduction of incidence of HIV among KP. Regional entities including the West African Health Organization (WAHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) provide advocacy platforms at the ministerial and national level. The KP meeting recommends that WAHO uses its platform to bring this dialogue outside of the traditional Health stakeholders to include official and technical in the sectors of law making, justice, security, and finance to further the support for programming.
- Service delivery is at different stages of provision. Minimum packages of services to KP vary in terms of quality, costs, standardization and effectiveness. Harmonized basic packages of services including standardizing care, different options for service delivery (stand-alone, integrated), and best practices is needed. An assessment is recommended to evaluate best practices in order to inform the development of a regional standardized minimum package of services and tools with associated unit costs.
- The communities know their needs, know how to access the desired beneficiaries and know how to deliver safe, protective and empowering programs. When they are integrated into the program development and when dialogue is facilitated between the community and police, legal professionals,

media and health providers, the human rights of KP and service access advance. Assistance for capacity building of CSOs in management, data collection, evaluations, and programming is needed with direct access to donors' funding.

- Countries are at different stages in terms of data gathering and usage. Data exist in countries, but collection methods not standardized and might be expensive if not done routinely. Using the outcome of the Global Fund to Fight AIDS, Tuberculosis and Malaria supported mapping of research, it is recommended that a regional approach to research which includes the harmonization of protocols and tools and cost analysis and allows domestic resources mobilization is developed.
- The regional meeting has set the stage for regional consultations on KP and has provided a unique platform for regional experience exchange and dialogue with donors, key government officials, CSOs, KP and implementing partners. It is recommended that this forum is established annually but discusses specific programmatic areas or specific KP groups at the next meeting with sufficient time for discussions
- As countries are at different stages data gathering and use, service delivery and coordination of interventions. It is recommended to establish possibilities of learning exchanges between countries including regional meetings, study tours and coaching between teams.
- Donors, the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund and the World Bank (WB) are focused on high impact and strategic investment based on the epidemiology of HIV globally and in the region. Donor-level coordination by country is highly recommended to standardize policy and ensure implementation at the community level is harmonized.
- Country-level implementation is also dependent on the national-level leadership and governments to coordinate donors, implementers and civil society members in order to increase comprehensive and to-scale country programming. It is recommended that stakeholders and governments facilitate and support country leadership for coordination of various investments and activity in the country in order to increase better coverage of services by KP. Recommendations included country leadership for coordination and development of best practices.

**Conclusion:**

This workshop was the first of its kind in the region of WCA and allowed stakeholders from all levels of KP programming to interact, discuss, debate and learn from the experiences of others. Donors were able to hear the realities of government constraints and civil society perspectives, while implementers and civil society were able to present best practices and initiatives ongoing in the region.

The issues facing KP are complex, however stakeholder dialogue and the exchange of various approaches to KP programming produced actionable recommendations that can be used in developing a framework for KP programming in the sub-region of WCA.

# Section 1: Introduction

## Overview

The issues facing KP are complex. Research data on KP, including data on human rights, and community- and structural-level data, on KP is needed to advance HIV prevention. This data is difficult to gather for many of the reasons mentioned earlier. Research is also needed to estimate the population size and geographic variation. Over time, countries should work to routinely collect most of these data, minimizing the need for targeted research.
Maintaining a high priority of the AIDS response on the political agenda is also necessary when faced with limited funding, but national strategies must improve interventions targeting KP and address the widespread stigma, discrimination, and violence they face. Donors such as the Global Fund, PEPFAR, USAID, and the World Bank are focused on high impact and strategic investment based on the epidemiology of HIV globally and in the region. There is a focus on service delivery, creating an enabling environment, and including civil society.

Building network alliances that involve community members to create the enabling environment to address these issues from the bottom up, public health practitioners should be clear, convincing, and understandable when articulating messages about KP to actors in other sectors in order to stimulate change. Addressing violence against KP is one such area in need of immediate response that will require this action from other sectors.

## Meeting Objective

To share and discuss the latest multi-country experiences in KP programs, specifically relating to men who have sex with men (MSM), female sex workers (FSW) and people who use drugs (PWUD); research methodologies and promising practices with key regional and country stakeholders; and identify and develop regional strategies and innovative next steps to advance HIV prevention, treatment, and control in the WCA region. *The agenda of the meeting is attached to the appendix of this report.*

## Welcome Remarks

Dr. Didier Mbayi Kangudie was the moderator for the morning. He stated that partnerships, innovation and results are the objectives of this meeting against HIV.

Daniele Nyirandutiye, the West Africa Regional Health Office Director for the United States Agency for International Development (USAID), gave the first welcome address. She thanked the Government of Ghana for hosting the conference as well as the participants for their attendance, adding that USAID partnership with West Africa is part of the United States Government's (USG) strategic plan to advance social and economic well-being in West Africa by West Africans. Sub-Saharan Africa is one of the

region's most severely affected by HIV and AIDS. Here, governments and civil society organizations (CSO) have increased efforts to fight against HIV. However, critical challenges remain in the fight, including limited funding and laws that prohibit access to HIV services. Recent investments in HIV prevention, care, treatment, and support are paying dividends in other sectors of society as people living with HIV (PLHIV) are living longer and healthier lives, allowing them to contribute more to national economies.

There is a need to extend and operationalize these services in WCA, and leadership must come from communities and governments. Preventing new HIV infections in KP and providing care and support to some of the most vulnerable in West and Central African societies is the joint goal. The platform is being set for building alliances for regional solutions to HIV in WCA. She thanked their implementing USAID partners.

Dr. Xavier Crespin, the Regional Director of the West Africa Health Organization (WAHO), gave the second welcome address. He thanked the USAID West Africa office for the opportunity to attend this workshop. He observed that thirty years after the outbreak of the HIV pandemic, access to treatment has increased in the region due to the efforts of national stakeholders and the international community. Many challenges remain, undermining heads of states' commitment to the Millennium Development Goals (MDG). These include:

- How to keep HIV as a major health issue in the development agenda.
- How to target intervention for KP despite sociological and political context.
- How to prevent the increase of mother-to-child transmission and tuberculosis.
- How to combat the widespread HIV-related stigma, discrimination, and violence.
- How to ensure availability and use of data across countries in the region.

Regional strategies put in place are in line with the Economic Community of West African States (ECOWAS) Goals for 2020. That is, an ECOWAS of people instead of an ECOWAS of state. He was convinced that this workshop would contribute to the ECOWAS regional strategy on AIDS.

Dr. Crespin Xavier, Director General WAHO; Daniele Nyirandutiye, Deputy Regional Health Director for USAID/WA; Dr Laurent Kapesa, Senior Regional HIV Advisor, USAID/WA

# Section 2: Setting the Stage: Reality and Challenges of KP Programming

Sonia Florisse from the Global Fund (GF) moderated the next session to discuss the complexity and realities of HIV programming for KP in the region, with brief presentations from several participants.

## KP Epidemiology and Context of WCA

Stefan Baral from Johns Hopkins University (JHU) discussed the HIV epidemics in WCA, which are far more concentrated among KP than in other regions of Africa. The definition of KP groups was discussed, followed by a summary of epidemiologic data and programmatic gaps across regions for each group. In West Africa, the epidemic pattern is similar to Asian and Latin American patterns.
KP include:

- Female, male, and transgender sex workers and their clients
    - Evidence suggests that sex workers have 14 times higher risk of infection than non-sex workers and that HIV incidence has been sustained among FSW. However, 50 of 150 countries reviewed have no HIV prevalence data for FSW in the past 10 years.
- Gay men, other MSM, and transgender people
    - There is more consistency about HIV prevalence among MSM across the region than there are differences. There has never been a decline in the rate of new HIV infections among MSM and the highest incidence rates are among young MSM.
- People who use drugs.
    - The drug trade in West Africa is increasing. When this has occurred in other regions, HIV prevalence has experienced explosive growth. However, there is limited data available concerning PWUD in the region. Approximately 0.2% of people in Africa as a whole inject drugs, which is about 1 million people. Approximately 120,000 people who inject drugs are living with HIV on the continent.

The following take home messages were provided:

- KP in West Africa are showing sustained burdens of HIV.
- The West Africa region has been leading data collection on KP, with the majority of studies focusing more on FSW than MSM.
- Assessing social networks, communities, public policy, and barriers to treatment are better investments than simply assessing individual factors such as condom use.
- There is a need to strengthen the continuum of care in order to optimize treatment outcomes and to invest in assessing the treatment cascade.

## Setting the Stage:

## Characterizing the Context of KP Programs and Research in WCA: Multi-Sectorial Challenges

This session was a panel discussion with representatives from different stakeholder groups, including government, civil society, and program implementers narrating the experiences they have in their countries. Specific challenges faced concerning KP surveillance and programing were discussed.

**Vincent Pitché, National AIDS Control Council, Togo**

Challenges concerning the implementation of interventions for KP in Togo include the need to know who the KP are, where they can be found, and what packages of services that can be offered them. The existence of laws that criminalize the behaviors of KP makes it difficult to offer services. These laws also make it difficult to collect data on hidden populations such as KP.

**Jaegan Loum, Worldview, The Gambia**

The issue of HIV among KP began in 1994 and there are now two main CSOs working with KP. There are three levels of challenges:

- Religious and Cultural Context: Negative views of sex workers because of the religious and cultural context leads to high levels of stigma toward this population.
- Legislative Context: A sex worker found with condoms will be charged with a crime but a non-sex worker would not. There are also legal challenges for MSM.
- Community- and Institutional-Level Challenges: People refuse to assist in burying known KP when they die.

Criminalization of sex work and same-sex behavior is a challenge in the Gambia. The constitution does not mention anything about sex workers and the political climate is unfavorable toward them, meaning work with sex workers and MSM must be done discreetly.

**Marguerite Thiam, Ministry of Health, Cote d'Ivoire**

Work is needed to improve the environment for KP in Cote d'Ivoire, especially concerning stigma and discrimination. Fifty-four percent of MSM hide health concerns because of fear. Recent experience and studies have shown that KP also face abuse and violence. For example, the headquarters of a pro-MSM non-governmental organization (NGO) was destroyed. Another example includes a group of sex workers from Adjamé being chased from the places in which they lived, in addition to recurrent violence from police and clients.

There are also concerns about the sustainability of programs and uncertainty about what will happen in 2016 when PEPFAR funding runs out. The third challenge presented was quality of data. The mobility of KP presents a challenge, as does double counting, though unique identifying system can help address this.

**Trudy Nunoo, ProLink, Ghana**

Four key challenges were identified:

- Both direct and indirect KP exist in Ghana. Direct KP are those who have come out to do exclusive sex work. Indirect KP are those hiding, like students, bargirls, etc. The challenge is how to identify those who are indirect?
- Young FSW should be given education and support services with regards to health and education. Can we learn and scale up?
- KP face financial challenges. They should be provided sustainable income to access health services.
- Gender-based violence (GBV) facing KP and GBV screening tools are an issue. Where do you refer a KP to after screening? What shelter is there for them? Do you send them back to a community to suffer more violence? In Ghana the Commission on Human Rights and Administrative Justice has instituted a reporting system. This is supported by the programs mFriends and mWatchers that assist with referrals for KP and GBV.

**Daouda Diouf, Enda Santé, Senegal**

The same challenges already discussed exist in Senegal as well. There is a need for precise and up-to-date data to better understand the climate and effects among KP in order to act in an efficient way. The various stakeholders are doing extraordinary work and KP are being discussed easily among health actors. However, the discussions should be brought outside of the health actors and some say it's too complicated to discuss. Visibility of KP is creating tension. These issues fill up newspapers but politicians who have visibility avoid issues around homosexuality.

The political, religious, and social contexts are key. The question of human rights is appearing with force, and visibly creating tension on a social level. The human rights organizations working with KP have more pressure. We are actors of human health not of human rights. Carefully managing the political climate is key for programming to ensure the safety of the community as well as the health service providers.

**Franz Mananga, Alternatives-Cameroon, Cameroon**

Communities of KP are hidden due to stigmatization. Self-stigma is a problem, but there is also stigma from health professionals – especially paramedics and nurses – which discourages KP from accessing services. By talking about KP with the general population, they begin to understand, so there is a need to link, sensitize, and work with religious leaders, legal experts, the police, and others.

Programs for KP should be integrated into national AIDS control programs and routine surveys should be conducted to show the scope of the problems facing KP. There is a challenge with limited lubrication distribution in rural areas and holistic programming is necessary.

**Discussion**

Sonia Florisse summarized the challenges the speakers raised and opened the floor for questions and discussions.

1. *During the 2nd phase of planning of the Global Fund, we were asked to look at KP who were sex workers, MSM, etc. I think what we have here is too extended. Are we talking about the vulnerable or the populations at risk?*

The important part of the definition of someone as part of a KP is not their identity, but their behavior that puts them at higher risk than others. This is easier for epidemiology than it is for programming. The

World Health Organization (WHO) definition of a KP is in 2 categories: vulnerable populations and KP. This is an issue to be defined by technical working groups at the country level.

2. *Who do we define as a female sex worker, the overt or the hidden?*

This should be defined by technical working groups at the country level as well. The term KP goes back three years and there is no globally accepted definition of a sex worker. People have different perspectives. There are more women who have exchanged sex for money than there are those who are exclusively sex workers. The actual risk factors in the acquisition and transmission of HIV are what is being looked at.

3. *There are also male sex workers who are organized as well as transgender people who were not mentioned in the KP in the studies.*

The dimension of gender is very important to consider in sex work. The phenomenon of sex workers in Cameroon is generalized at the level of MSM and these are young people who have been rejected and have to sell themselves without condoms for survival. They are subjected to violence once it is realized they are men on the streets.

4. *If we don't have data, how do we know that MSM are at high risk?*

We do have enough data to show there is a problem. Every result shows the same issues with KP and HIV. For example, we know there are more infections in urban areas than in rural areas. However, we must continue to collect more data and there are now classical methods that can be used.

5. *What can be done to increase the contribution of parliamentarians and magistrates in the elaboration of local projects and policies?*

Start with sensitization and advocacy. It will be a process of progressive inclusion.

*Other Comments*

- An integrated biological and behavioral surveillance (IBBS) survey is underway in Cote d'Ivoire. Preliminary data show high levels of abortion and unwanted pregnancies among FSW. There is great need to take sexual and reproductive health and family planning into account.
- The minimum package is focused on services but is not comprehensive. It needs to be reoriented with a national document that is comprehensive and must address specific needs of FSW and MSM.

# Section 3: KP: Country Initiatives and Regional Strategies

National AIDS Control Committees (NACC) and civil society representatives from the region discussed their experience with surveillance and data use for KP HIV programing to set the stage for the complex

and sensitive context in which governments and civil society groups are attempting to provide services to KP in the region.

## Emerging Data and Corresponding National Strategies: Togo, Cameroon, Burkina Faso | Regional Perspective: WAHO

This session was moderated by Laurent Kapesa, USAID/WA, and Claver Touré, Alternatives-CI
Regional Approach to Policy Change and Political Support by the West African Health Organization.
Dr. Carlos Brito of the West Africa Health Organization (WAHO) provided a brief description of WAHO, his mandate, the HIV strategy plan and some key achievements. WAHO was formed in 1987 as a specialized agency of ECOWAS with the mission of promoting regional integration. Management structures of WAHO include heads of state and government, a council of ministers and an assembly of health ministers. The organization has various divisions, including primary health care and human resources development, among others. The harmonization of medical training curricula, the dissemination of best practices, and the training of young professionals are some of the interventions of the organization.

Dr. Brito spoke about the ECOWAS HIV and AIDS regional strategic plan, particularly the need to maintain the AIDS response on the political agenda. He also spoke of strategies to improve interventions targeting KP and the need to address widespread HIV stigma, discrimination and violence against PLHIV.

WAHO 2014 commitments include financial assistance for the implementation of the PLHIV Stigma Index Study. A document was released with criteria for a minimum legal framework to fight stigma and discrimination, on the right to education on HIV AIDS, consent for HIV testing, criminal provisions. The ECOWAS multi-sectorial committee on AIDS was also organized.

**Questions:**

1. *Can you tell us a little more about the minimum legal framework?*

The basic document was created and given to the ECOWAS council. But the situation has changed in our countries. We are still discussing the need for legal frameworks for PLHIV and KP. We have to go slowly and deliberately to develop a 2016 strategic plan, and that is why we decided to work on a legal framework against stigmatization. That includes ministers and parliamentarians who will be invited for a regional consultation we are planning in September 2014. We know that we can count on our partners for support. At the same time, we encourage individual countries to go further in ensuring legal frameworks for KP.

**Togo: Programs, Research, and National Strategy, Vincent Pitché, NACC-Togo**

Togo's National HIV strategic plan has 3 axes:

- Reinforce prevention
- Increase HIV treatment and care
- Research, including among KP

In addition, Togo has a national plan for research and national surveillance for 2012-2017, consisting of epidemiological study. The country has data on sex workers since 2003 as well as behavioral studies for MSM and transgender people.

Several good practices were presented, such as creating a political document of prevention, setting up technical thematic groups, and sensitization activities for security forces and community leaders. However, challenges remain. Integration of services, especially HIV and reproductive health services, is a problem as they are managed by different departments. Stakeholders, including UNFPA, provide support to improve collaboration between the two MOH divisions. Other challenges include the legal environment, which is not always favorable, and human rights violations. Access to KP remains a problem, as does stigma since the community does not always accept KP. Finally, the age of consent can be a challenge when working with KP. Research is often piecemeal and data is needed on issues in addition to HIV prevalence. KP in Togo are SW, MSM, PWUD, and prisoners.

**Cameroon: Second Phase Research and Programs, Jean-Bosco Elat, NACC-Cameroon**
KP are defined as SW, MSM, and truck drivers. Routine data on these KP are not readily available at the national level, but some data is available from M&E and some can be used as baseline data. This includes the 2011 IBBS in Yaoundé and Douala, other behavioral studies on MSM (2012), and size estimates. These studies have been used as a baseline for future activities, and a technical working group synthesizes information annually for the following year.
Among challenges, there is a poor understanding of the cost of the studies because most of these studies were done by partners without the true cost incurred always being shared. Additionally, this funding for KP is unbalanced. 85% of the allocation to KP goes to MSM with very little focus placed on truck drivers.
Best practices given include that TWG designed and implemented the IBBS, the harmonization of packages, and a document on best practices being finalized.

**Burkina Faso: Programs, Research and National Strategy, Dr. Sylvestre Tiendrébéogo, MOH-BF**
The national HIV response of Burkina Faso began in 1987. The various strategies implemented include updating factual bases on KP, fighting stigma and discrimination, monitoring and evaluation of interventions, and a national framework to better coordination. There are many organizations working together to provide essential services to all KP groups, including MSM, SW, PWID, and PLHIV. Interventions mostly focus on SW, but there are some for the other KP groups and prisoners will also be the subject of study. However, the minimum package is not harmonized. Other best practices include collaboration between researchers, universities, and other actors.
KP are a priority in Burkina Faso. The commitment of the Government and the development partner’s community will be needed to bring interventions to them. Initiatives should be undertaken to build the capacity of health workers. Advocacy and sensitization are needed to gradually involve stakeholders, and these should be done at a higher level.

**Discussion regarding emerging data and programming: Liberia, Benin, Burkina Faso, Cameroon, Togo, WAHO**

1. *In Cote d'Ivoire, we see high rates of reproductive health needs among FSW. Does anyone have experience with this?*

The most important thing is to integrate services and harmonize who does what. Partners must collaborate.

2. *There is a problem of profiling and integration of services.*

Integration is very important and we have to evolve towards that. A minimum package of services has to be provided to sex workers and in so doing, information can be gathered on them.

3. *We need to define KP.*

We must truly understand profiles within KP communities in our own countries to develop effective programs. This includes understanding the different kinds of SW and the different kinds of MSM.

*Other Comments and best practices shared-*

- During the IBBS among MSM in Cameroon, the National AIDS Commission played a big role in writing the proposal, developing the protocol, and obtaining ethics approval. The NAC is extending this work and will harmonize the packages offered to KP in Cameroon thru the cost extension USAID has granted to CARE Cameron. A best practices document is currently being finalized, and a new project is building on this achievement. So, the government takes KP issues seriously.
- The legal context must be taken into consideration. Advocate, but introduce new topics progressively and carefully. The research is great and all of the work is excellent and important. But if we are working within adverse legal frameworks we will always be limited.

## Long-term surveillance and programming among KP: Ghana, Cote d'Ivoire and Senegal | Regional Perspective: UNAIDS, UNICEF

Moderated by Peter Wondergem, USAID

**Analysis of the Epidemiological Situation and the Response to the HIV Epidemic Targeting KP, Moise Tuho, UNAIDS**

Keeping the AIDS response high on the political agenda in the context of many competing priorities is difficult, especially when considering that more than half of countries have no protective laws for KP. Data show that current funding for KP ranks from 0.5% to 5% of the entire HIV funding available to countries, making KP a low priority. Scaling up combination HIV prevention services, including test and treat, with these scarce resources is a challenge. The availability of strategic information was also discussed. Indicators are available for MSM, SW, and PWID, but not for prisoners.

**Ghana: Long-term surveillance of KP and its influence on national strategic planning and service delivery, Kyeremeh Atuahene, GAC-Ghana**

Reaching KP with HIV services is a public health priority in Ghana. The country has one of the most progressive HIV policies in Africa, incorporating human rights and discussing how to treat KP. Ghana also has a long history of KP surveillance. A national KP surveillance system was established in 2010 and in 2011 a large study of MSM in 6 cities in Ghana was conducted with CDC and University of California San Francisco (UCSF). Existing KP data sources include program data, surveys and surveillance, and evaluation and research projects. Surveillance is used to monitor epidemiological trends and track program outcomes among KP.

Main elements of the KP program include:

- Implementing comprehensive prevention, care and treatment
- Addressing structural barriers to access of services
- Addressing gender-based and sexual violence
- Providing discordant couples counseling
- Using technology to increase KP's access to services, including social media to reach MSM and SMS/cell phone reminders for ARVs.
- Improving psychosocial support

There is a great deal of coordination and many partnerships for improved service delivery. The Ghana AIDS Commission provides leadership for the multi-sectoral coordination of stakeholders. Capacity building and stigma reduction has been done in the health sector, CSOs have been actively involved, workshops have been conducted with parliamentarians, and there are continued efforts to work with police and pre-service police personnel, judges, and lawyers.

Several challenges remain, but there are promising solutions:

- Stigma and discrimination in the health sector; inclusion of clinical services in DIC'S activities.
- Arrests and rapes are still occurring, especially for SW, even by police who have been trained. This is why advocacy and training are key priorities and should continue to receive more attention.
- Data quality overstating the number of KP reached: targeted research and the development and validation of best practices for research and implementation science programs among KP is key.

**Cote d'Ivoire: national coordination; country-level research; PEPFAR-GF Synergies, Dr. Marguerite Thiam, MOH-CI**

In CI, progress has been made on data collection and consensus on targets which include MSM, SW, clients of SW, and PWUD.

Coordination and harmonization of documents and policies is improved. A KP technical working group exists and meets regularly, an annual workshop allows partners to share their progress in KP programs, and platforms for KP to discuss with partners exist.  These are mainly coordinated at the national level and we play an important role in bring all stakeholders to the table.

Donor Synergy is being built and requires more efforts. Coordination exists between the GF and PEPFAR, but more is needed, as they split the national territory for better program coverage. The challenge is to ensure the basic package of services is standardized across donors.
Gaps in the data include national size estimates, information on transgender persons, and PWUD, and data on cervical cancer.

**Senegal: long-term surveillance of KP, Data to inform programming; national coordination, Abdou Khoudia Diop, MOH-Senegal**

KP groups are more exposed to the pandemic than the rest of the population and stigmatization against these people is frequent and often violent. People working in mines and truck drivers are vulnerable and the Casamance is a hotspot for HIV.
The Senegal National HIV strategy has included the needs of KP, including by:

- Ensuring participation of KP in decision-making and coordination of activities
- Increasing MSM leadership with 11 MSM associations getting support nationwide to participate in the HIV response
- Advocating toward health professionals, religious groups and security forces
- Promoting voluntary HIV screening
- Distributing syringes and condoms
- Follow-up and research
- Building capacity of leadership
- Integrating services
- Installing a network of MSM-friendly doctors nationally. Doctors were trained to provide services to MSM, but also religious leaders. A future goal is to have all medical and non-medical staff trained.
- Implementing methadone programs

Many good practices were identified, including advocacy with various sectors such as security corps, religious leaders, and medical and non-medical healthcare facility staff. Both medical and non-medical healthcare facility staff received training and sensitization concerning KP. An integrated approach to service delivery was discussed, as were sub-regional strategies involving border countries. Another good practice was the development of livelihoods activities for KP.

**Discussion: Long-term surveillance, programming and national coordination for KP in the WCA region: UNAIDS, Ghana, Senegal, Cote d'Ivoire**

1. *Concerning budgets and the cost of addressing KP, how can we mobilize resources? Sustainability is difficult.*

Some approaches might include taking available budget and funds and redistributing them so that KP programming is a larger percent of the total budget. Cote d'Ivoire for example has established a national HIV fund to mobilize domestic resources for local NGOs to do their work.

2. *I did not quite see the role of the community in the HIV program in Ghana. I have concerns with the level of the epidemic, which is more to the south. Could it be explained by sociocultural factors?*

From the primary level, we recruit and train peer educators who in turn do the same, working in their communities. We have been able to support the establishment of SW CBOs as well. MSM and SW communities are involved in most services.

3. *IBBS are very expensive. In Nigeria, it was US$4 million, 20% of the national budget for KP. If partners should pull back, who will pay for it? How can we produce data for KP in a cost effective and sustainable way?*

IBBS are quite costly. We need to work on that. The government of Ghana contributes to the studies, usually from its own funds. We are able to leverage funding from our development partners like DANIDA, UNICEF, and others apart from mainstream funding. The Ivorian government's contribution takes the form of subsidies given to NGOs annually, but it is still weak because it is mainly geared towards prevention.

**KP – Civil Society: Roundtable Discussion**

*Moderators: Daouda Diouf, Enda Santé, Senegal; Erin Papworth, JHU*
*Participants: Cyriaque Ako, AMSHeR, Senegal; Mac-Darling, CEPHERG, Ghana; Josiane Tety, Blety, Cote d'Ivoire; Grace Kamau, ASWA, Kenya;*

1. *Do you have a resolution to strengthen what has been noted as key challenges to KP programming said this morning?*

Daouda, Enda Santé: this morning we have spoken of the challenges we face. How do we ensure the participation of these KP? These organizations should have the sufficient capacity and staff. There are 100 of such organizations in these 13 countries out of 21 but resources are low. I believe these are aspects we have to work on. For Cyriaque, there is need to ensure meaningful participation and credible partners. Organizations need TA and resources. They have the unique position to reach populations.

2. *Do you think that this is something to be obtained right now or it's a process?*

The process has already started. We have to have it now. Providing technical support and resources to CSOs should be a priority in the next programming cycle. In addition, there is a need for a regional program/initiative that can address at same time the combination of preventions and the human rights aspects across countries.

3. *Do you have the same concerns as a sex workers' organization, Grace?*

Yes, I do. If you use the KP itself, you'll be able to get the KP. We need to listen to them and work directly with them. Need to strengthen existing KP organizations. The government that is protecting and giving condoms is the same government that is arresting and not offering services. There is a paradox that must be addressed and can only be seen at the community level.

1. *Have you seen good interventions across sub-Saharan Africa in condom distribution and police violence?*

Not so good. Sex workers are able to communicate with one another to avoid police traps and dragnets but nothing legal – Kenya.

Mac-Darling: Ghana has done a lot but there is a gap between the community and high levels. The challenge when it comes to police harassment is issues of blackmail and extortion, the quality of the condoms and lubricants – including condoms breaking, lubricant causing rashes and unavailability- not carrying condoms around. We have had a police officer that has been very helpful but recently he's not being so helpful and we think it's a question of motivation.
I think all of that is interesting. Now that more and more epidemiological data on KP are available, KP should be more involved. The question is to know: what is the direction to be followed in programs for vulnerable groups?

Cyriaque: We conducted community dialogue in 8 countries under UTETEZI where the communities themselves have identified intervention priorities. We should not only be focused on hospital interventions but we have to make it personal. We have to combine public health and human rights issues since it seems violence and arrests are more pressing than long-term issue of HIV as people say they have not died after 10 years living with HIV. There is the need to put in place consultation frameworks. Governments, community leaders, religious leaders, police with KP at the table. Such platforms prevent violation of human rights.
Josiane: Today, the priority of KP is to be allowed to speak because they are no longer invisible. It is true that they are hidden because of stigma and violence but there is a visible part of the iceberg and it needs a

voice. I am satisfied because the situation is being improved. We are given the opportunity to express ourselves in various countries, but what we want is to be listened to, not just heard. They speak in our place without knowing what we want or need. There must be a structural and organizational capacity strengthening so we can carry out a lot of projects. Train us to carry out community activities and human rights because the KP are real victims of violence. Sex workers suffered a wave of violence recently in a village in Cote d'Ivoire. I believe we need capacity building in all these areas.

2. *How do you think the programs could be strengthened through the involvement of the KP?*

Mac-Darling: I think most KP need different things but most programs come with fixed packages and a fixed set of indicators so you are forced to fit in (e.g. PEPFAR uses C/L indicator rather than capacity strengthening and things that make us human). The community doesn't feel like they own the process, and programs are not meeting the needs of the communities. Most of these programs do not look at skill development. The impact of most of the programs is a bit questionable in terms of the people we need to reach. We need a program that will involve the people more instead of having "champions" doing their own thing. We should be able to involve the community. For example, programs selling C/L to SW may not work with young MSM who do not have money to buy them. These are the challenges we have sometimes.

3. *Grace, do you have some positive examples in case studies because of community engagement?*

Grace: Yes. There was a project to estimate size. The researchers were from the government but the research assistants were from the KP. We did what we were told to do and the results were very great. There was also a small research study on violence. 100 SW per year are killed so SW asked to do mapping. After a series of meetings, a tool was developed to collect data on violence with a hotline number to police for SW. Sex workers were successfully able to do a mapping in their area to curb killing in their areas. (Kenya)

4. *Based on your experiences, how do you provide support to CSOs that give support to MSM (criminalized by government)? The President of Nigeria has just signed a bill criminalizing support for sex workers.*

In Kenya, we use the ministry of health because they understand why we use the KP – address the issue from the health perspective.

MSM have no access to services and face high levels of stigmatization, even from within their own community. Those living with HIV also lack community acceptance; thus, it is not surprising that legal support is difficult to attain. Even when legal support is in reach, police serve as foes and friends. They may work with and warn SW one day but bribe them for money the next.

We want to create a platform that allows MSM to express their needs to provide services accordingly. However, there are hurdles that must be overcome before gaining answers. For instance, in Gambia, the IBBS implicated MSM to conduct interviews. The SW were illiterate and could not conduct them which prevented proper assessment. Instances such as these call into question whether some organizations are working for the KP or are simply in it for the money.

5. *Dr. Henry from UNAIDS: There are different levels of stigma. How to deal with young MSM living with HIV and S&D, including self-stigma that may lead to depression and suicide?*

Cyriaque: MSM living with HIV is a serious issue. AMSHeR's approach is to take into account the expressed needs of the population. MSM living with HIV and TG living with HIV do not have access to services because the services do not meet their needs. For example, psychological services are not adapted. MSM living with HIV are not accepted among PLHIV or among MSM. A group of MSM living with HIV was created within AMSHeR. They are developing a program, and the document will be shared.

6. *How to mobilize allies in a difficult structural environment?*

Grace: It is challenging but you can use the MOH because they understand the public health side. You can come from a health perspective and be strategic in terms of which allies can be targeted in the government.
Josiane: Everyone should work to change. In the Ivory Coast, we began a process of change around violence that implicated law enforcement. Law enforcement and SW were invited to a conference to exchange information about laws. SW learned that soliciting is illegal, and law enforcement learned that GBV against SW is not acceptable. Law enforcement recommended giving a badge to SW and information about hot spots. Since then, violence has decreased, and law enforcement has encouraged SW to report GBV.

# Section 4: KP – Donor and Stakeholder Synergies with Regional Strategies in WCA

*Moderated by Stefan Baral, JHU and Sheila Mensah, USAID*

**Towards an AIDS-free generation: PEPFAR KP updates, funding and collaboration, R. Cameron Wolf, Laurent Kapesa, USAID**

Cameron Wolf of the office of HIV/AIDS (OHA) in Washington described KP as a key plank of the PEPFAR blueprint developed in 2012. One of the key principles of the PEPFAR blueprint is ending stigmatization for people living with HIV/AIDS and KP (PEPFAR blueprint). The blueprint calls for smart investments going where the virus is by targeting evidence-based interventions for populations at greatest risk. At the beginning of PEPFAR, we focused on generalized epidemics. KP is a relatively new focus but PEPFAR has made great progress in KP programming:

- Now we have the PEPFAR technical guidance on combination HIV prevention among KP
- The WHO consolidated guidance for KP released during the 2014 AIDS conference
- Focus on transgender people as different from MSM is also relatively new
- The State Department is also focusing on LGBT rights

We are showing a focus on service delivery, an enabling environment, and civil society strengthening through several new and ongoing initiatives within PEPFAR platforms:

- The KP Challenge Fund of US$20 million announced by the US Secretary of State in 2012 during the WDC AIDS conference.
- US$15 million for KP Implementation Science. The implementation science focuses on characterizing the current status of and utilization of services for a discrete stage or at each stage of the prevention, care and treatment continuum that includes community facilities.
- Health and human rights discussion in places where there is a law and it's not enforced or the law goes into counseling and support.
- Understanding the risk environment is imperative: Risk assessments, safety and security contingency planning with services and programs while thinking about public health system, community system, or private providers where protective measures are required. Collecting any data in this hostile environment is extremely difficult. All funding is tied to data and being able to show results. Strategies differ with gender diversification or KP together. For example Alternatives Cameroon is broadening their services to others in the communities (geographical).
- Commitment to invest $2 million to bolster the efforts of civil society groups to reach KP through the Robert Carr Civil Society Network Fund.
- Even in own PEPFAR staff, HPP will be launching the PEPFAR LGBT and gender training
- Collaborating with UNAIDS on monitoring and evaluation guidance for KP
- Collaborated with amfAR on key priorities for implementation science for people who inject drugs

**USAID/ WA Regional HIV/AIDS Strategy was presented by Dr. Laurent Kapesa**
USAID/WA Mandate: as defined by the US Department of State, there are 21 countries, 7 of which have bilateral missions. The regional health office focuses its efforts on 14 non-presence countries but regional interventions impact bilateral mission countries. Its HIV strategy aims to mitigate the population-level impact of HIV/AIDS in the WCA regions through strategic partnerships wise investments. In fact, USAID/West Africa regional office wants to leverage partnerships to improve health and advance HIV response in the region. One of the key principles of the HIV regional strategy is to identify and address country needs to advance regional priorities. The HIV strategy is implemented through the following pillars:

- Service Delivery managed by FHI360
- Research managed by JHU
- Advocacy managed by HPP
- Capacity building and system strengthening including technical assistance to improve supply chain management under MSH/SIAPS and TA to GF as cross-cutting areas.

The following milestones were set as a way forward:

- USAID/WA will operationalize regional dashboard for the early warning system for HIV commodities (June 2014);
- Develop quality improvement and accreditation of NGOs and Service outlets providing services to KP;
- Disseminate a special issue to be published in an open journal for KP programs WA (October 2014).

**Strategic vision for KP in WCA- opportunities under the new funding model (NFM), Sonia Florisse, Global Fund.**

- Global Fund strategy 2012-2016.
    - Strategic investments- focus on the highest-impact countries, interventions and populations.
    - Promote and protect human rights in all programs.
        - Integrate human rights considerations throughout the grant cycle.
        - Show the Global Fund does not support programs that infringe human rights.
        - Address barriers.
    - Sexual orientation and gender identities strategy (2009) was approved by the board in May 2009. Outlines concrete actions that the GF can take to address sexual vulnerabilities. Now seeking to operationalize.
- Definition of KP is congruent with WHO definitions.
- Principles of new funding model: Bigger impact, predictable funding, ambitious vision, flexible timing, more streamlined.
    - More ability to fund KP programs.
    - The KP' action plan will soon be shared.
- Questions remaining:
    - Definition of KP, when we can define a group as KP – incidence, size?
    - Understand investment of impact, when can we say we have enough, representative data?
    - When we can say we have enough evidence to inform the response? What works? Legal, implementation, etc. Do we have any research studies to say what works in this region? Implementation science, design, package. We cannot just use global guidance, must be adapted to local context.
    - Who are the right groups to have tailored interventions? What did not work?
    - Sustainability of IBBS? Best way to obtain evidence in the region? Is sentinel surveillance possible?

KP in West Africa:

- Strengthen evidence base
- Country dialogue with KP community engagement
- High-impact programs – national service packages
- Enabling environment

**Strategic Vision: World Bank, by Elizabeth Mziray, World Bank**

The World Bank's goals are to end extreme poverty (<$1.25/day) within a generation and to boost prosperity and promote income equality for the bottom 40%. People with lower socioeconomic status have less access to services, including health services. The purpose of the UNAIDS, USAID, WB partnership is the provision of technical support to improve the scale, efficiency, rollout, targeting, coverage, quality and measurement of the impact of HIV services for SWs. Key aspects of the joint program are assessment; integrated, long-term TA (2014-2015); training; sharing (including South-South collaborations); mobilization.

- Globally, 90% of HIV occurs in low and middle income countries.

- WB focuses on generating and disseminating evidence of what works and how to deliver it.
- The WB emphasizes the how-to of implementation including understanding the problem, designing interventions (allocation efficiency), designing the lowest cost interventions without reducing quality, delivering interventions, and sustainability.
- Two entry points to governments: financing or technical support and coordination.
- WB lending for stand-alone HIV programs is becoming rare.

**Rapid assessments from the World Bank** to inform the technical assistance to the country on FSW; informs the training on the packages. Identify different training needs they have. Leverage existing resources. 2014-2015 for technical support, plan implement and evaluate sex worker programs; efforts in national SW programs. 5 focus countries: Niger, Sierra Leone, Cameroon, Cote d'Ivoire, and Nigeria.

**Discussion:**

1. *Question to Global Fund: The new funding model has the questions of rights, but it is different with MSM in Africa. We need to give ourselves time to allow public health to drive the perspective so that we do not lose resources and support. Even in a difficult context, it is possible to ensure access to health services as a right rather than talking about other human rights.*

We have worked this way in Gambia, and the question is always "should we push for a human rights perspective, or a public health perspective?"
The Global Fund is not a human rights organization, but human rights are part of the enabling environment.

2. *Cameroon: Health and human rights challenge. What is the best way to support human rights where there is a law that applies to support services?*

Safety and security plans are important, as are treatment contingency plans. "If clinic X is targeted, have option X." Consider including private providers, who may be less subject to scrutiny. Also, expand services to include other types of people so clients are not identified as KP by attending specific services. You may also rely on community systems or others as collecting data is a challenge. Security assessments should be ongoing. We are all learning together how to work in these environments.

3. *[Question to World Bank] And who is going to do it? How will it be delivered? Is two years enough?*

The idea of a rapid assessment was to ensure that training is focused on the relevant issues, to articulate the training curriculum. The intention is to do a regional training program rather than in individual countries because funding is limited.

4. *At what level are you going to be providing the support?*

Elizabeth: We want to support the national program. We want to provide the impetus to expand the scale. The goal is to be able to support the national program so they can have an impact. The entry point is the needs or the situation of the country in question.
There is a law on health and human rights but it's not enforced. It's such a challenging area. We need to understand the risk environment, do a risk assessment, and have contingency plans.

5. *Question: Is PEPFAR support possible for needle exchange and methadone programs?*

PEPFAR can fund all of these programs but that's not all we do. We call them wrap-around activities. The World Bank, IMF, and PEPFAR have the same interests. The problem is how we coordinate our efforts at the country level. We need to strengthen this coordination. Our only priority is to have strategic investment. PEPFAR is launching regional LGBT/gender trainings for all PEPFAR country teams. PEPFAR can fund a program overall and get DFID or other funding to pay for needles, etc. Need synergies between donors so that some fund gap areas that others are not funding.

6. *Question: What is the best way to obtain data/evidence – sustainability of IBBS?*

Sentinel surveillance in Asia and Eastern Europe is low cost. We can do analysis of existing data instead of special studies.

*Other comments*

- Governments have so many priorities. If governments are allowed to choose where funding goes, they will build roads and other more visible things rather than focus on health. We need to tell them why investment in health is crucial.
- The Global Fund doesn't have a funding problem. The money is there, we just have to use it – governments must say exactly what will happen with the money.
- The Global Fund is decreasing funding to lower prevalence countries. There is a need to push countries to take responsibility because achievements will be lost otherwise.
- There is money that is not in use. There is a need for absorption capacity on good interventions.

# Section 5: Day 2: Challenges, Innovative Solutions and Priority Setting for KP in WCA

Wrap up of Day 1: We heard about KP programs being implemented in different countries across the region. We continued to discuss how to work in constrained legal environments. But we especially focused on the importance of community participation and genuine engagement at all levels and moments of programming targeting towards them, and how to achieve this.
Dr. Mbayi was the moderator for the morning.

## Financing for HIV Interventions among KP: International trends and future direction in the financing of HIV programs in Africa; Coordinated finance response in the WCA region

*Daniele Nyirandutiye, USAID/WA; Elizabeth Mziray, World Bank; Sonia Florisse, GF; Joshua Galjour, GF; Henri Nagai, UNAIDS; Daouda Diouf, Enda Santé; Singo Assétina, NACP-Togo; Holger Till, GIZ; Xavier Crespin, WAHO*

**Discussion**

1. *From your perspective, what are the responsibilities of governments in ensuring a sustained and evidence-based response from KP in W/C Africa?*

**Global Fund**: From the GF perspective, sustainability is key for KP programs but also for HIV. GF wants to find increases in government contribution to financing three diseases. Governments must take responsibility too. Within the new fund model, GF insists that the questionable 15% of the fund can only be released if governments show commitment to using their own funds to address the three diseases. Governments have been moving out of funding health, so it's important that they come back into it. GF sponsors programs in health. GF plays a key role in ensuring the participation of KP in dialogues. It has a great responsibility to finance studies that help to understand which activities are high-impact activities. It is difficult to ask governments to program for KP and ask them to increase their overall contribution to health. The mandate remains the same for the financing arm of the international community. Our responsibility is to fund high level programs for KP with clear outcomes and high impact. GF also has a large responsibility to finance studies, reports, and operational research that help us understand which activities will have the highest impact. We must ensure the role of KP in the country dialogue. Participation should be transparent and collaborative (criteria for eligibility). In 10 years in WCA, government has been moving out of funding health. It is important to institutionalize issues. For example, Cote d'Ivoire has a strong KP program within the national strategy for HIV/AIDS with a director in charge of KP in MOH who can ask for accountability in the government.
**WAHO**: I thank the IMF and WB for their support. Stating their investment is very important. We continue to seek ways and means to achieve sustainability. I believe the real sense of responsibility is down to the fact that we were unable to sustain the program. We have to admit to ourselves that there is a paradigm shift. The environment in our region is quite difficult politically and with the perception of the population. We have to go beyond the political level and try to be prudent. We should try to facilitate dialogue between various stakeholders: ministry, legal, health, and justice, in order to improve the legal environment so the discussion can take place at the public health level.
WAHO – CEDEAO appreciates international support to fight the three diseases. Two considerations:

- GF investments are heavy and important. We think that since more than 10 years ago we looked for capacity to guarantee program continuation. We can't do that yet, and that is our true shared responsibility – to ensure sustainability of programs.
- Re: OS interventions – our country context is very difficult – politically and re population's perspectives. This is bigger than a political problem.
- We suggest that dialogue be facilitated between the police, judges, and ministers of justice, but also the ministry of health. Look at the question of stigma. Who discriminates, when and how? And also look at modes of transmission models.

**Dr. Singo, Togo**: Several years ago, we had nearly no data on KP, but now we have put a few things in place. We have a technical working group that includes SW and MSM and have data and a platform. We have also met with journalists but it's very difficult to speak openly. We signed a charter for health rights for the whole population. We must be prudent. Financing for KP is too premature. We should include them gradually by, for example, strengthening the community generally so we can talk about it in a few years. We need to include and reinforce community organizations.
**Ghana, UNAIDS:** Smart investment, package of services, sustainability- these were the three key themes since yesterday.

UNAIDS has a very ambitious plan to end AIDS by 2030. What will be the price tag? We need to know the unit cost and total cost to advocate. There has to be active involvement of various sectors including the ministries. We need to have something we can see and say yes if we are asking for this money, it's worth it. UNAIDS currently has a plan to end AIDS by processes set in place. They are meeting in South Africa to look at all of the interventions, coverage distributions, and populations involved to estimate a cost for this goal.
**Elizabeth Mziray, World Bank:** The political will to keep funding and implementing is crucial. We need to move beyond advocacy to sustained financing. We need sustained packaging of services that is defined and effective. Government also has a very important role bringing partners together and should be held accountable for engaging the community at all levels, including planning, implementation, and evaluation.
We have sufficient data to start planning programs in spite of the problem of lack of data. We need to articulate well with the ministries of finance with supporting data. Use what we have for programming, and start implementing them. Assess the impact of national programs and move toward domestic financing. What are the repercussions for not investing in KP?
Urgent need for impact evaluation of national programs, important when moving from donor financing to government financing.

*2. How can we help develop political will?*
Data is critical to convince governments to move from one policy to another. We need to think about the health system in general and not just KP. We need to strengthen the system to allow more access to KP.

**USAID**: Different countries are in different stages. Country context is important and should be worked within. Encourage countries that are on the path to doing new exciting things.
We must be able to convince government to change policy. Countries must be convinced that something is a problem in order to enact change. When we look at country context in general, we need to look at the medical system. WA is still a very medicalized context. Can we open up the system, such as through task shifting or task sharing, to allow for more expanded services for KP?

**Daouda Diouf, Enda Santé**: We shouldn't wait for the government. We don't wait for political will. When actors are mobilized, they work with the government and show them the way. Perhaps this will pave the road for government collaboration. We need to show them data that prove that KP programs can improve population health. Smart investment must be able to address the needs of the population. We are not fully satisfied but will continue to work with the governments to achieve results. There is no significant increase in health sector investment in our country. We have moved towards universal health coverage, which is good, but will this leave out KP? Our African governments want this post-2015 and its good, but we must make sure that KP remain a priority. Go to the government and have them pay for the three diseases in general. Finance that is available, smart investments must be able to address the needs of the population. We are not fully satisfied; we will continue to work with the government.

If two or three governments in the region enact effective programs, other countries will follow their lead because civil society will insist this happens. The idea isn't to tell governments to pay more for KP. It's to

get results. We need to make sure that investments are going for the good of the population and the needs of the population.
Pitch investment as something that will be seen favorably in elections. WAHO and ECOWAS could showcase countries with good results and use them as examples. This will show countries that they can't make excuses because some countries have been able to pay for addressing the diseases in general. Sustainability is a big concern for civil society.

**Sonia Florisse, Global Fund**: There is the need for sustainability and institutionalization of these issues. In Cote d'Ivoire, we have a strong KP program within the national strategy for HIV, and there is a director for KP programming. If you have everything on paper, you can demand accountability from government. We should advocate more for this government accountability in the region

3. *Community involvement at all levels is a key theme. This is a challenge. What will this look like in the future, especially in places with increasingly difficult legal frameworks?*

We must change our approach in engaging governments in the countries where these problems exist. Citizens and those who understand KP should start within their countries to talk about these issues. When this push comes from outside, the problem becomes more complicated. We need to work from within.

**World Bank**: We have to make sure KP are insured. Improve access to condoms for sex workers, for example. It is important to understand local context and work around it. Look at what brings people to the table. Is it a public health approach?

**Joshua Galjour, Global Fund**: We need a more global approach regarding KP program integration, because there is a lot of overlap in populations and needs. On investment, we need to reinforce the system. Finance activities to reduce stigma. How this will work out in each country depends on the context and environment of that particular country. There are some countries where we can talk openly about human rights, and others where this will not be accepted. Our role as donors is to think of the approach that will work in each context.

**Daniele Nyirandutiye, USAID**: We should look at how we engage other sectors in human rights. We should go to our colleagues working in peace, democracy, and governance to find points of entry in legal frameworks. If we frame the issue of health as a human rights issue, then we can get the communities to help. We should look at it in a broader way. Those of us in public health are not the experts in human rights.

**Daouda Diouf, Enda Santé, Senegal**: It is very important to have a country dialogue. We shouldn't force things but rather discuss these issues with all the sectors of society, including the religious leaders. The dialogue is not to push but to understand. You have to have data to show them that if there is a good program, this will work. It is not just one or two meetings, but a continual process.
In 2008 after ICASA, there was backlash in the community in Senegal, but we had a dialogue where we talked about data and programs. Ministers of justice, imams, etc. were present and through dialogue were better able to understand the programming efforts.

Dialogue isn't just to prepare a concept note. It's an ongoing process and its preventative. We don't have any crisis-prevention methods but we need to incorporate this into what we do.

**WAHO**: As much as I agree with the dialogue suggestion, I think we have to be careful not to have a biased dialogue. We have the tendency to go to these dialogues with preconceived notions in our heads already. We have to reinforce health services for universal access to them. Our centers should be prepared for prevention, care, and treatment.

**Togo**: In addition to dialogue, political will is important. We can use our existing data to convince leaders, only with data. In Togo, this has allowed us to discuss KP, supporting the importance of country dialogue.

**Sonia Florisse, Global Fund**: Country dialogue is great, but I don't think it really works. I don't think community systems strengthening is used enough. If we have strong groups in the country, they can help in the drafting and implementation process. Civil society should put pressure on the CCM and act as a counterweight to their systems.

**Other comments**

It is sometimes difficult to have representation from KP because they have to be willing to be recognized and identified as KP. Sometimes KP are part of dialogue as a symbol but not really part of the discussion.

Instead of focusing just on KP, have integrated services open to the broader community while ensuring that KP are still covered. For example, access to STI services is still a challenge for SW. Understand local context and work around that. In Kenya, to resist laws like the one in Uganda, community worked directly with legislators rather than publicly protesting.

4. *If a government makes a commitment to contribute over 20% to the GF, do you have any way of getting them to pay up? Governments make commitments and then quantify them in terms of staff time, infrastructure, etc. – things they would do even if GF was not there.*

"Willingness to pay" has to be cash (ARVs, bednets, etc.) and not just staff and infrastructure. GF wants to see cash from governments before it makes any further commitment. It will be monitored through grants and performance framework. Country expenditure on health and programming equals real expenditure.

5. *Can you comment some more on the issue of political will in Togo?*

**Dr. Singo**: There is political will but also it is difficulty with the KP. We are sensitizing all the stakeholders. We are working for and with the KP. That is in their interest and also helps the politicians make their decision. Politicians know that KP are a specific group for which we have to work if we wish to see improvements.

Some CNLS activities exist to inform leaders and the general public. This allows us to discuss prevalence in KP, and allows us to show that we work with and for KP in the interest of the general population

KP are a specific group and we must work for them and target them so that there is a better level of health in the country.

**Cyriaque, AMSHeR**: We have to be very careful with using data. Although its true there's high prevalence, we should not take the prevalence notions too highly because it could reinforce stereotyping and stigmatization of the KP as infectors or vectors. Thus, we must take caution when presenting these data to the population.

**Erin Papworth**: The question of a package of services is very important since we don't have a good understanding of it. We need to use pilot programs and implementation science to show outcomes in the long run. We need to think through the research, quality of data, etc.

**Dr. Thiam, Cote d'Ivoire:** We had a number of agencies working in a non-harmonized manner, so the government stepped in and organized a technical working group to coordinate this work. The issue of violence was discussed in the technical working group to try to anticipate actions to be taken in that area. We decided to put in place a crisis anticipation strategy after we studied the one in Senegal and that was the beginning of multi sectorial actions to address violence. We have also designated an observatory in case of violence against KP.
This is not easy to coordinate and we still have many weaknesses, but we believe we can improve this.
**Global Fund:** Human rights is important but a complicated entry point in our countries. Health arguments are strong and we can use health and rights in tandem. If we put the notion of human rights first, we will lose many people who do not understand the idea of human rights. Our environment is not favorable towards KP.

In terms of public health, we have to go from the bottom-up, not from the ministries, etc. on financing. Governments are not interested in showing the populations what they are going to do. Materials like condoms have to be included in budgets to attract donors. Integrated services are valuable but have challenges, we have to think of community-based approaches as key.

**Elizabeth Mziray, World Bank**: We need to engage the private sector more and use innovative financing. We need to show the population-level effectiveness of the package of services.
It's important for donors to coordinate among themselves.
The government may decriminalize KP but the stigma remains at the societal levels. We need to sensitize communities at the same time as we work with governments, otherwise violence against them will remain. Everything has to start from the bottom. Governments do not necessarily want to show KP financing but could perhaps include it under a minimum package of services in the overall budget.
They can also look more into the private sector, like the tobacco tax in Cote d'Ivoire, and see how to engage these more.

**Other comments:**
Three key points:

- Value and challenge of integrated services – clearly one of the paths forward.

- Need for frank and honest dialogue.
- Motivation of governments - governments do things either to get elected or to save money. But it's not just about the government, it's also about educating and working with the community.

Each country will be different but in Cote d'Ivoire and Togo, we have seen great ways of moving forward.

- Global Fund: Community systems strengthening should be used to strengthen the proposal process and should be included in the proposals, including KP organizations. Then we could have strong groups.
- Question to Global Fund: 15% contribution to the government; governments make promise to give that kind of contribution, quantified in staff time, government facilities, what they would naturally do even if the GF is not there. Is there a definition specific for that scenario and aims to achieve the original intent of having government put funding on the table.
    - Want to have a discussion with the government and see what they will fund i.e. programming.
- Political will: key policy document for KP; inform/sensitize government officials;
- CI MOH: formed TWG to harmonize efforts, monitor at national level.

# Section 6: KP Research Models: Innovations to address challenges of KP service delivery

**Strategic Information: Epidemiological approaches to strategic information and storage, Stefan Baral, JHU**

- Data needs to advance HIV prevention.
- Attributable fraction of prevalent and incident HIV infections is an important indicator.
- Enumeration approaches:
    - Size estimation and geographic variation
- Structural drivers are key.
- Surveillance instruments should include human rights questions, community-level and structural-level questions.

- We need to get to a place where most data are collected routinely, minimizing the need for targeted research. This should be a goal whether in five years, 10 years, or 50 years.

**Discussion**

1. *There are some examples of case surveillance in these countries. Can we use case surveillance to strengthen the continuum of care?*

HIV is often not a notifiable disease in West Africa, which makes it difficult to use case surveillance. But we have self-reported treatment coverage data.

2. *It's hard to get data on KP, but it's much harder to get data on young KP. All the reasons you've mentioned – fear, stigma, self-stigma – are multiplied for the youngest KP and there are still big gaps in the data. From the 325 interviewees, do you have the lower age group (18 to 20 years) among them?*

UNICEF considers sex workers under 18 years of age to be abused children. It is real that there are young people under age 18 who are selling sex. We ask sex workers retrospectively when they started doing it, but there are issues of asking their parents for consent to participate in the survey.

3. *Do we have any estimates of access to treatment? Are we doing better?*

We have some self-reported data, and there are countries with a breakdown on treatment coverage by age. But treatment data is not routinely collected by risk factor.

4. *How far are you going to extend the already huge questionnaires and what will be realistic?*

Each survey in each country is different with different duration based on the level of response, and there are country-level priorities. Focus on questions that matter most. Instead of 200 condom questions ask some questions about violence as well. This is a hard balance, and we want to ask so much but we want to

ensure the questionnaire is not so long as to discourage participation. This will be up to each country. There is a lot of demand for data in the region.

5. *Our denominator is often too big, and when we try to set targets, the country is not able to reach its percentage targets. Do you have any recommendations about what data we should use as the denominator when we set program targets?*

There was discussion at the country level in Ghana about which numbers to use. This was based on existing program data that showed that many FSW do not self-identify. Is the estimate a fair estimate for program targets? Yes. Four years later, we have reached 80% of the population and we believe that this was a just estimate.
The MSM estimate was likely an underestimate. It was our first time and we had lessons learned and a difficult operating environment. The important idea is to develop an estimated proportion of MSM in the population – for Ghana it was 0.48% – and this will allow a denominator.
Our program targets need to be reasonable and achievable using the denominator, otherwise this will do a disservice to national implementers.

**Population Size Estimates: Challenges and Innovations and Population Level Research**
Sam Wambugu, FHI 360; Quaye Sila, CDC-Ghana; Erin Papworth, JHU

**Case study from Ghana: Sam Wambugu, FHI 360**
Multiple methods of size estimation make for checks and balances and cross-validation. The lower limit represents the self-identifying sex workers who are likely to be in the brothels and on the streets on a given day.
Lessons learnt include:

- Need to maintain accurate service data.
- Work with the police to limit disturbance of data collection sites during field work.
- Involvement of FSWs as partners in the research process not only to prove the validity of data but also as a method of empowerment is paramount.
- Think about the weather while planning for data collection.
- Plan for technology failure, e.g. GPS receivers for geo-mapping.
- Every method has its pitfalls and is subject to bias. Meetings across sub-national areas to discuss issues in size estimation are useful for interpreting data.

**Multiple Method Approach for Estimating the Population Size of MSM, Silas Quaye**
Lessons learned include:

- Data is difficult to access and few services exist.
- Population prevalence estimates of MSM in literature is sparse.
- In terms of wisdom of the crowd, it is easy to ask of MSM how many MSM they know.
- Mapping and enumeration is labor intensive and tedious.

**Population Size Estimates, Erin Papworth**
Data from this is needed for advocacy, HIV surveillance and prevention. KP size estimation is difficult because:

- It is not measured in census and household surveys
- KP are hard to reach, less visible, highly mobile
- Stigmatized and illegal behavior
- Time and money required

Methods used to collect data are service multiplier, capture recapture, unique object multiplier, wisdom of the masses, and NSUM. Each method has its strengths and weaknesses and none are perfect. The key to population size estimation is multi-method use and triangulation of data after thorough analysis of quality of each method results.

Estimates that JHU is working on implementing specifically targets the highest risk individuals within FSW and MSM populations: i.e. women who make the majority of their annual income from sex work and men who have anal sex. This means our estimates are specifically targeting the groups of the population at highest risk of infection.

**Discussion One: Strategic Information, Population Size Estimate Methods, Surveillance Methods:**

1. *From how many towns can we reasonably extrapolate?*

The question is about data quality and methods. If we feel comfortable with the methods and the results, they can be applied and extrapolated based on the context and the population of each city or national context.

2. *When it is extrapolated on the national level, do we go by the same hypothesis as we use for the urban level?*

When we concentrate on extrapolation, we think about what the rest of the country might be like. Would it be like our rural sites or would it be like the urban sites or would it be a mix? We created different scenarios, which we discussed with stakeholders and reached a consensus.

3. *What are the key methods that could be cost effective to have a good size estimate?*

Extrapolation is very important. The scientific community is moving toward multiple method triangulations to try to better understand population size estimates. This is cost-effective because it often uses cross-sectional study tools to collect multiple types of data for estimation and then cross-analyzes for validity and utilization.

4. *How can we reach the population with HIV that is not visible in order to give actual figures?*

We need the use of media and an innovative approach. The size estimation technology is to be repeated this year.

5. *Yesterday we talked a lot about the hidden population – what can we do to find this hidden part of the community? It's hard to find MSM when we use the community, and then we have low estimates and a lot of money. Then people say that we're giving all of this HIV money to such a small number of MSM.*

Cameron Wolf follow up question: How can we use new and different methods to reach extremely marginalized populations like MSM. When we think about what's reachable sometimes things are aspirational. In Ghana, we are now reaching more MSM than our initial first estimate.
Erin Papworth: Aspirational targets are important but within contexts, we should also have achievable goals and start incrementally, ensure the contextual issues are addressed in parallel, and continuously increase our targets. I also think there is an enormous need for attributable infection calculations with the use of these population size estimates as well as modeling the epidemic using data that can trace the epidemic among KP and then into the general population. This will greatly increase our arguments that KP financing is imperative because these data can provide the structure of the epidemic.

*-- What about men older than 49? This can still be reproductive age.*

Erin Papworth and Sam Wambugu: No upper limit was imposed on age, but recruiting older men is very difficult in these types of contexts. With such high levels of stigma and discrimination, they have more to lose. JHU uses the UNAIDS age of reproductive life as a basis for analysis and to provide denominators, but we are aware sexuality spans the ages.
Older men recruited younger men according to our net draw in Ghana and our results show the relationships are interconnected.

6. *How can we ensure that our data are used for programs and not to target populations?*

In the protocol, it was specified that location names would not be shared publicly and would be used only for programming. Results are not publically disseminated. These data remain with key stakeholders, including the Ministry of Health and community partners.

**Community and Research: Data needs, usage and effects of KP, Steve Nemande, AMSHeR**
AMSHeR is not a research organization, but its objective is to facilitate the creation and dissemination of an evidence base for the promotion and protection of LGBTI people.

**Research and Data for KP Programming: Data Usage in the Field, Daouda Diouf, Enda Santé**
Epidemiological information is not enough. In 2009, we started a study on the psychological impact of treatment on these populations and found that they broke down and went into hiding.
What are the processes we have been through and how did we use results of research but also influence research? In Senegal, the process for program implementation among KP is multi-phase. In our first phase, we had the first contacts with MSM groups who came to us to see what we do and to say that they were not taken into account. We were surprised, and we thought at that point that all people were included in general population treatment programs. Then we began some timid programs for MSM.
Then we realized we didn't have any data and we did our first study with Professor Niang to understand MSM networks and risk behaviors. It showed need for services and networks outside of Dakar. After our first studies, our first programs began.
We saw that we needed more data. In 2009, we started working with JHU to see how arrests of MSM affected treatment, care, and follow-up. Then we said that programs needed an additional dimension looking at human rights and supporting community organizations.
MSM and FSW are highly mobile throughout the region. We're trying to take this into account with the OCAL project. But there is a challenge with this regarding the GF and that's the country-based funding from GF.
Another important issue to consider, is why is mortality so high in these groups? This is critical, and we need to understand why these communities have such a high level of mortality.

**Data needs and initiatives for KP under the Global Fund's New Funding Model (Financing and KP Epidemiology), Joshua Galjour, GF**
The question we need to ask ourselves is "What is the data that we have available and how recent is it?" Data needs and initiatives for KP under GF NFM. Considerations for KP:

- When designing a concept note, use available evidence on all important populations, describe country hotspots for transmission, how to lift barriers to access to treatment and care, and use data at national and district level.
- Epidemiological analysis is required as part of country dialogue.
- What does it mean if HIV prevalence goes up? Is it a good thing or a bad thing?

Conclusion: We still need an improved evidence base in terms of qualitative research in the region. A lot of this is key to understanding KP in the region in terms of gender, poverty, and sexual networking. We still have a long way to go in terms of risk analysis and vulnerability analysis. Who is at risk and who is vulnerable? We also need to put prisons back on the map.

**Discussion Two: Community-driven data needs and usage, evidence-based programming, data for funding mechanisms**
**Nigeria**:

The integrated MSM HIV prevention program is the largest sponsored by the US in West Africa. Before the 2007 IBBS there was no data for KP in Nigeria. The prevalence in MSM was 13.5%, which was higher than the national general population prevalence of 4.1%. The integrated program for prevention is the largest in the region at 7.2 million and is seeking to strengthen grassroots MSM organizations. The program seeks to have capacity building through mentorship in training. Heartland places personnel in key positions in organizations, then after a time, they leave the organization to work on its own. One of these CBOs is now getting funds from the state for HIV control. We also realized that referrals were not working and STI treatment was lacking in the program. There would be a high number of referrals and low turnout. In terms of sustainability of programs, drugs are sold very cheaply to community members who come to access these services, so we decided to put treatment centers in established community centers. This has helped us because STI diagnosis and treatment, as well as HCT, are done in the same place.
We also want to know how MSM feel about the use of female condoms and whether they are ready to accept the female condoms.

**Discussion**
Micro-planning like India has done was important in Nigeria. We developed a tool for FSW. They can start to estimate how many condoms her group members use in a month, and when the women are not taking this number, they can do counseling. We should collect data even at the individual level with things like peer education, following up on referrals, etc.
In the Gambia, we have developed a tool that helps us count the number of new women reached. These women are given unique ID codes. Peer educators also used the primary data collection tool, which has pictures of condoms, lubricants, etc. KP only tick the columns of condoms used and received, so this helps researchers properly gather data.
There was something on the involvement of the community itself. Involvement is trying to include the individuals. We have to identify the forms of organizations within these communities and use them as partners to solve any difficulties we may face.
Button: I like the emphasis on routine data collection and monitoring and evaluation. We can emphasize case surveillance and use it to strengthen the cascade of the continuum of care and get each case reported into the system?

7. *Extreme mobility between countries and two programs are trying to take that into account. GF is a country-only approach, but a regional program is needed.*

Joshua Galjour: GF proposals must use evidence, describe hotspots for transmission, and activities to address them, how to lift barriers, and describe national, sub-national, and district data.
GF – US$17 million to strengthen data systems. US$6 million KP mapping and size estimates.
Nigeria: Capacity strengthened MSM organizations in 5 states of Nigeria for sustainability. Program data collected.
Realized that referrals for STIs were not working so decided to reprogram and treat in community centers. Do HCT and STIs in community centers.
Dr. Bacha, UNICEF: We often implicate individuals from the community when we should be implication networks.

**KP research models general discussion points:**

- Discussion
    - How can we offer services to young MSM?
    - Extreme mobility of KP in the various countries; we only have country funding and not regional funding.
- Data needs…NFM
    - When designing CN, use the evidence, describe hot spots, what are the activities at those hotspots, how to lift barriers to access, describe the data.
    - $16 million for programmatic mapping and SEs.
- Discussion
    - Mentorship – second staff from high level positions to provide capacity development
    - Nigeria – developed a small tool for routine program data collection
    - Gambia – data quality tool

# Section 7: Models for KP Programming

Moderated by Ugochukwu Amanyeiwe, USAID and Johannes Van Dam, FHI 360
Two main challenges: creating enabling environments, and making sure we reach KP in the population.

**Models and package of service: community-driven approaches by Jean Paul Tchupo, FHI 360, and Raymond Sodji, ONG FAMME**
PACTE-VIH project being operated in Togo and Burkina Faso offers three models of services:

- Drop-in centers
- Hybrid model
- Integration of technology into programs for reaching MSM

Community drop in clinics and mobile clinics have worked well in Lomé.
The package of services for KP include prevention, treatment, and care and support. In addition, we have the internet to share information and are going to start sending mobile phone messages to educate beneficiaries. Recommendations for package strengthening include:

- HIV testing and counseling; reinforce the reference systems to clinical services-escort newly diagnosed individuals to referral sites
- Improve the reception of KPLHIV at HF
- Improve access to treatment, adherence and retention in care; advocacy towards government members, donors and other stakeholders; mapping for complementary services enabling environment (training of media, police, community leaders); increase partnerships

Unique ID codes are used to avoid double counting and measure the number of contacts. We have some number of clinics that we work with and can refer people to. Summarize services offered in conjunction with community, plus successes and challenges.

**Discussion**

1. *Do they refer these people with codes to outside centers?*

Once you have the code, you can use it everywhere.

2. *How do the codes function, who assigns them and at what level? And how do these codes improve data?*

The codes help to avoid double counting of people. It's not because we give codes that people can be referred. We have a number of clinics to which they can be referred.

**New Approaches to Reach KP in WCA, By Kimberly Green, FHI 360 and Joshua Akuamoah, Community Liaison Officer**

There is intense social stigma, which inhibits access to services in Ghana. The Package of services for MSM included:

- Group and individual peer education
- Drop in centers (HCT, STI, BCC and peer support) and referrals
- Access to condoms and lubricant
- Helpline counseling and SMS (text me, flash me, call me)
- Enrollment in HIV care and treatment
- Violence mitigation through protection network

Weren't reaching high risk MSM through peer educators. So worked closely with MSM leaders to find how to reach other networks of MSM. Majority of those reached were below 25 years. Had reached less than 50% in project sites so tried innovative strategies:

- The social media focal point has a page on Facebook for MSM. He visits websites like gayromeo.com and Instagram to see them and sometimes meets them at MSM hot spots in Accra. He also does peer education/counseling, mass posting, several group chats and one-on-one chats with follow up calls. This has been effective at reaching older MSM and a larger network.
- Outreach to male sex worker networks (MSM) – identified 7 brothels of MSW. Worked with pimps and organized events.
- Social networks testing – respondent driven. Sampling to identify.

Different methods to reach MSM are important in reaching people with different risk profiles: 18% of MSM were reached by both methods (social media and other). MSM living with HIV were more likely to recruit others living with HIV. Those with no contact with a peer educator were more likely to recruit those who also had no contact with a peer educator. The social network recruitment methods reached a higher percentage living with HIV while the peer educator methods reached a lower percentage living with HIV.

**The continuum of prevention, care and treatment for KP in West Africa: A case study (Clinique de Confiance and CHAMP), by Ehouman Sylvain, Espace Confiance-CI, Esso Yedmel, Heartland Alliance-CI**

- We have the aim of improving quality and extending the coverage of preventive activities of STI/HIV/ AIDS on MSMs and their stable partners.
- Links between community and services exist within the clinics themselves, and peer educators refer clients to the clinic
- Art adherence is at 82% - higher than national average of 60%
- Challenges still exist

**Continuum of Prevention, Care and Treatment by Cameroon, by Youssouf Ouattara, Care Cameroon**

Summary: Program beginning in July 2014. Five year program funded by USAID. Program purpose: To reduce HIV/STI infections and related morbidity and mortality, and ease the impact of HIV on the socioeconomic development of Cameroon. The intent is to use community-driven approaches to better develop linkages to health facilities and mitigate stigma at the community and health provider level in order to increase health outcomes among FSW/MSM in Cameroon.

Program goal: To control the HIV epidemic amongst KP who are most affected and serve as a bridging population for HIV transmission to average risk individuals of reproductive age

Intermediate results:

a) Technical competence of implementing of community and government partners to design, manage, and implement programs for KP increased

b) Enabling environment for KP HIV/AIDS programming strengthened

c) Quality assurance/quality improvement and monitoring and evaluation systems strengthened among continuum of prevention-to-care (CoPTC) implementing partners

Risky behaviors persist in Cameroon such as multiple sexual partners, low condom use, and ignorance of HIV status. Stigma and discrimination remain high. KP in Cameroon include FSW, MSM and clients of FSW.

To date: The project is beginning in the next few months. A few quantitative interviews and the final evaluation of the previous HAPP program implemented by CARE and funded by USAID have been conducted, including 42 health professionals from partner health facilities trained on syndrome management and RBA facilities.

**Discussion**

1. *Including MSM/FSW in general population service structures seems good for sustainability.. What are the constraints you're faced with integrating KP into general population compared to stand-alone services?*

Integration – it's an important question. In Ghana we started with stand-alone drop in centers because of stigma. But at the same time we put a lot of work into training HCW in Ghana, mostly nurses. We also looked at training nurses before entering svc delivery. Now we're looking for ways to integrate drop in centers to government health centers/services.

2. *Q: any type of analysis of cost-effectiveness for reaching beneficiaries using various methods? For example RDS, social media?*

First we have done costing, because cost effectiveness is hard. Social media and social networks testing are less intensive so they cost less than peer educators and SW outreach. BUT these must be complementary approaches – they work together to reach a larger population of MSM.

3. *What do you recommend as a program model for Benin? We don't even have data. Our prevalence among MSM is 12.8% in a very limited sample. Please support Benin to establish these services.*

We cannot say which one you should use. The SHARPER project started with standalone and trained health care facility staff using Desmond Tutu training. Began training in nursing school and started to integrate into Ghana health services.

4. *Unique code – easy to manage in one place, but how do you manage it in multiple places?*

Patients will receive their unique ID code during HIV testing; once the code has been received it is used everywhere. The unique ID can be recreated, and it can be created and given even by a peer educator. It is also difficult for two codes to be alike. We can develop good practices for unique ID codes in limited sites, but it is not scalable at the national level. You can't have one sole model to cover all KP or even all FSW. You need models that allow the population to have access to services when and where they need them.

5. *Referrals for a stand-alone clinic and sustainability vs. quality*

We try to go beyond prevention and bring in doctors but we also do referrals so this is not a complete package. Integrated models are desirable but there are limits. Re sustainability integrated services are likely the best option. But we need to keep in mind the reason that certain people won't go there. So when

possible as much as possible we should have combined models.

6. *Q: are there minimum packages of services, and if so are these applied to these reached through social media?*

Basically, yes. Funding is a major constraint, though.

7. *Joshua Akuamoah, are those MSW clients male or female AND how do you reach them?*

I met them on sites and struck up friendships with them and they showed me their hot spots. They are male and dress like males. They have my number, in case they need it.

8. *There was a picture of a woman who was presumably a SW getting a sample taken at a clinic shown on the screen. Was this woman consenting to being shown? If not, this is a perfect example of why FSW hesitate to go to clinics for fear of being exposed*

She was consenting. This is also a clinic not branded for FSW, any women can go there.

9. *Q: How often do you do RDS recruiting for HIV testing? And when it comes to doing studies with RDS, does this interfere with existing RDS?*

10. *How are you able to track progress?*

We are able to track progress when for example KP visit DICs, or assess health care. That is one way of tracking progress.

11. *Q: Can you talk more about the challenges working given the context of homophobia and violence in Cameroon?*

The challenges are many. They include violence, people being thrown in jail and being denounced, and people being victims of violence from the police. We in the organization help by giving advice for security and legal aid. In the course of this workshop, a program is being drawn up to access health services in some sites. It's very difficult for KP to access services so we have DICs. We advocate dialogue so we work jointly with national aids commission.

FSW are stigmatized by each other. Some would prefer to be tested in clinics so that their colleagues won't find out their status and exclude them or prevent them from finding clients.

12. *How can we ensure that those who test positive really go for treatment?*

Structural challenges for access to health services – in some sites it's really difficult to get KP to get access and this is why we have the drop in center.  We share services with the national aids commission to reduce risks of violence, etc. (Cameroon).

13. *How is sexual orientation being managed by others?*

Discrimination, shunning and violence figures here greatly.

14. *What is the level of acceptance of the person who has been HIV-positive screened and what follow up can be done to maintain that person?*

We have done mapping of the sites. Peer educators have been divided according to the sites so it makes it easy for them to track them. This helps reduce dropouts.

*Other comments:*

- Future meetings should limit the number of topics that it seeks to address, and try to go deeper into some topics.
- Structural factors and enabling environments.
- "no enabling environment, no good programming".
- Johannes van Dam lamented the fact that there was not enough time to make use of all the brains and experiences present in the room and wished for more time next time.

# Section 8: Enabling Environments: Policy and Legal Context WCA

Moderated by Rouguiatou Diallo and Jaegan Loum

**Structural factors and the enabling environment in WCA | Tools for advocacy and community engagement by Sandra Duvall and Darrin Adams, Futures Group**

*Changing policy is key to improving the response for KP. HPP has tools available to do this, and some concrete examples of recommendations we have made.*

- In Burkina Faso, there is no law criminalizing same sex relations.
- Key challenges include financing, restrictive, inadequate or absent policies, stigma and discrimination.
- The prison policy (regarding access to services) in Togo dates to 1933. There is no prison policy in Burkina Faso.
- Meaningful stakeholder engagement means active participation in policy and program advocacy, planning, implementation and monitoring; strengthen capacity to engage and network.

**Policy analysis and advocacy tools**

- Goals model supports national-level planning.
- Costing HIV services.
- Unit cost is reduced when programs are scaled up.
- Discrimination reporting systems such as that used in Ghana (can report via SMS, online or in person).
- MSM/TG/SW policy analysis and advocacy decision model.

**Key policy recommendations in Burking Faso and Togo:**

- KP stakeholder engagement; C/L and STI kits (add lubricant to essential meds list, budget line for lubricant and forecasting based on population estimates); address S&D (include KP in PLHIV S&D monitoring system in Togo), clear KP operational guidelines; and comprehensive prison policy.

- Additional recommendations: Develop law enforcement performance indicators and incentives (Togo), train service providers and law enforcement, harmonize parental consent policies, increase consistent implementation of consent and confidentiality policies, and integrate HIV and SRH.

**Roundtable discussion regarding Regional approaches for MSM engagement and advocacy, by Cyriaque Ako, AMSHeR and Grace Kamau, ASWA**

*1. What is AMSHER's approach at the regional level?*

The participation of KP is at all costs to be defended. Only Cameroon and Senegal have representatives in the CCMs. For us it important that KP participate in these fora of discussion i.e. strategic planning processes, AIDS commissions, etc. We advocate for the MSMs to be involved in the process right from the start. It is not always easy, admittedly. We want to carry out advocacy and continued support. Our offices in Dakar try to identify where training assistance can be given to them. We try to do MSM generation without aid where we try to build national frameworks where they do not exist or integrate existing ones. Another key activity is the development of observatories, which collect daily information on access of services.

Participation of KP, especially MSM in programming is important, should be systematic. The CCM says MSM must be included, but only Cameroon Ghana and Senegal have MSM representatives on the CCM. Strategic planning, calls, planning with PEPFAR (Country operation plan-COP), UN, should all include KP organizations and we should know about the processes from the beginning. If we can't be permanent members of the discussion, we should at least be taken into account. This is not always the case. MSM sometimes feel that they are invited to participate only by name (tokenism), and sometimes feel used by the system.

Scorecards help us to collect information, which we compile and use as a foundation for advocacy work both at the national and international level. Advocacy should be based on evidence and that is what we are working towards.
HIV+ MSM can feel not included in processes, they should be included as well and information should be collected for them as well and their experiences of stigma and discrimination.

*2. Question: How do you tailor the engagement in rights-constrained environments like Ghana or Nigeria?*

Establishing alert mechanisms is key; especially we have done this in francophone countries.

*3. Tell us a little more about ASWA's regional approach*

Grace Kamau: we go to a specific country and approach active or former sex workers, targeting organizations working with SW, especially peer educators. We build capacity of willing peer educators, and help establish our network as a legal organization in the country. We have groups in countries like Nigeria and Cameroon, which are building capacity. We are doing this because we want our KP to be in the new global fund model. There is the African sex workers' alliance where we want to train them on advocacy, HIV, etc. we just want sex workers to talk on behalf of their fellow sex workers.
We do this because we want our KP to be included in the GF NFM.
ASWA is coming up with SW University to train SW across Africa on advocacy, HIV and leadership.
Some organizations feel threatened by SW organizations.

*4. Do you have any examples of engagement that you'd like to share?*

We want genuine engagement – not just in meetings but partnership when it comes to implementation.

*5. Do you have any illustrations of enabling environment?*

We have seen sex workers sit at global forum and talk about their issues.
Amsher works in difficult environments and, in order to accompany this involvement, when crisis emerge, we have developed an emergency protocol in terms of security and protection.

*6. Has any of your member countries formulated the N'djamena model developed in Chad into law?*

The model included unclear aspects around willful transmission so a number of countries have/are revising HIV law to remove or modify this part of the law.
Cyriaque Ako from AMSHeR: What we know is that laws tend to limit access to services because you have to prove that transmission is voluntary otherwise you are liable to face jail term. The criminalization should be removed from the whole law.

*7. Q: can you clarify your strategy for improving the problem of coordination?*

Cyriaque Ako: We're close by most regional coordination offices in Dakar and this allows us to work with them more easily. For example when the law in Nigeria was passed we were able to quickly decide on how to continue to support existing programs in Nigeria and to limit the law's effect on ongoing work. The UN was very involved in this.

*8. How can we harmonize the discussions in the face of myriad organizations?*

We need coordination for KP. Need a clear message with solid recommendations.

*9. Structural problems are at the micro and macro level. So how can we address structural problems at the micro level too? Among FSW we asked why they don't use condom with their boyfriend and they were offended. How to address these issues?*

Many things can happen at the community level but it takes time. Some ways are to engage men, engage clients, religious leaders. Some policy changes can also impact things at the local level, such as operational guidelines that inform hips on how to interact with SW or MSM

*10. What is the content of the comprehensive prison policy?*

It is ensuring that there is a policy in place to ensure access to HIV and other Health services in prison.

*11. If we want laws and policies to change we have to act on decision makers and there is a subjective element that influences their decisions. So how far did you take this into consideration?*

In order to operationalize the roadmap, we should bring the various stakeholders and organize exercises to see who are the champions, who can we work with and who could be obstacles.
We would have pre-training meetings led by Amsher to see what was important to the community in each country. We shared this with the larger MSM community, and based on what we heard from them, we adjusted the training based on that.

12. *Mr. Cyriaque, currently Benin is changing the members of the CCM because they are not eligible. There should be clarification in representatives of the other members of the CCM*

Proximity with these agencies enables us to work together. A committee met to discuss measures to be put in place following the enactment of a law in Nigeria recently. It is true that we need one representative. We don't know very well the directives that is why they are reluctant to work with MSM. The CCM in Liberia is now willing to include two MSM. We also have partners in Benin and we continue these discussions with them.
We have to be careful to distinguish KP and vulnerable populations. We have to look at things in the context where we live. The fact that you are gay alone does not give you the right to be part of the CCM. You have to be someone who represents a group and have something to say. Let us try and know what we are talking about.

13. *What is your position on programs that provide opportunities for FSW to exit the trade, and what can we do better? A few years back we had a program for FSW to exit the trade but only 14% actually did. What do you think that we can do better to help those who really want to exit the trade?*

Grace Kamau : These programs don't really exist – they often offer services on the condition that women leave the trade. ASWA doesn't encourage people to exit. We view issues in a human rights approach. They have the free will to exit or not. If you try to induce them to leave with money, they can take it and stay or leave so it's a matter of will. If you give me two options, I'll take the money. But is it what KP want or need?
Nigerian participant's reply: this was one of our options among several.
Grace: of course if you offer either condoms or money, any SW will choose the money – but is that what they really want? The options need to come from the community as well.
*Other comments:*
We need to better define stigma and discrimination – one is personal and one is structural.

# Section 9: People who inject drugs: Regional Context: context, review of existing data, research and projects in Ghana, Burkina Faso, Senegal (WCA region)

**Dr. Rose Adjei, Knust-Ghana**
This qualitative study aimed to understand the social, economic and behavioral vulnerabilities on PWIDs in Kumasi.
Ghana team – issues related to needle sharing, use, and reuse to the point of blunt needles. Sourcing needles from hospitals: some people don't see taking needles from the trash as sharing needles, low rates of knowledge and low rates of testing.
Why address HIV prevention needs of PWID in Ghana?

- Injecting drug use is a highly efficient means of HIV transmission
- It is an emerging problem in sub Saharan Africa

**Dr. Sidibé Ndoye, NACC-Senegal**
This presentation focused on a bio-behavioral study among PWID in Senegal. HIV prevalence among the general population in Senegal is about 0.5%, whereas this study found an HIV prevalence of 38% in drug users. 60% of PWID participants had ever shared a needle. A new treatment center for drug users is being built in Dakar, Senegal.
RDS was an effective way to id the beginnings of a community intervention for needle exchange.

**Dr. Ashley Grosso, JHU**
- Very limited data available in the region
- Some overlap with other KP – up to 2% of SW and MSM in R2P surveys report injecting.
- PWID suggested services not just about drug use but also stigma, prison conditions, and psychological services.
- Harm reduction programs are particularly important to discuss.

**Discussion: PWID in the region, data gaps and existing programs**
Moderated by Cameron Wolf, USAID; Marguerite Thiam, MOH-CI, Cote d'Ivoire
Dr. Thiam Marguerite: Consumption of injectable drugs is an increasing phenomenon in Africa. There is also the question of repressive laws in Africa. We should think about risk reduction program, e.g. in Senegal where there is syringe exchange. In CDI it's hard for us to find PWID, where are they and what's the proportion of them among all drug users?

1. *What proportion of the population do drug injectors represent, and what is their social class?*

For Senegal, our sample was over 500. About 27% of participants in our study had ever injected drugs, about 13% have injected in the past 12 months. But in this study a preparatory phase had been done, and we engaged with the community, offered services, paid for services. We built a foundation of support and this prepared the community to participate in the study. You must develop empathy and confidence in order to effectively engage the community.
Problems with other studies may be because they did not take the necessary preparatory phase/steps. You have to gradually build networking, and then bring them to hospital, pay for some of their testing, etc. It is from here that you will have a willing sample for your study. You have to go where they are and gain their trust.
You find them in all the social classes. Most of them started very young and are school dropouts. Even SW, they become more active in SW to get money for drugs. Some become SW as a way to pay for drugs.
To find PWID, find champions in the community, and then be careful about who the champions work with…they are afraid of external entities, so must build trust.

- *How were you able to reach the injectors in upper classes?*

They are difficult to find and then only by using mediators. We sent psychiatrists who deal directly with such classes to handle them since they will reject lowly social workers. In Burkina, people from all classes used drugs, but they often lost their jobs due to drug use so their class will often drop.

- *Was the study able to define the reasons why people inject themselves? Also, the use of syringes from dumpsters, the problem of medical waste management- what was the study able to recommend against this?*

Many of those who started as youth reported starting because of friends or their peer group. Most PWID were middle-aged, but most had started at a young age and dropped out of school because of their drug use.

They should have access to the needles and syringes since they will still inject themselves whether they are supplied with syringes or not. A needle exchange program may be a good option. The hospital waste should be properly guarded.

- *Regarding access to injectable syringes, there is a syringe distribution program in Senegal but not so in Ghana. Would that not encourage illegal behavior (pharmacists not selling syringes or selling them at exorbitant prices)? Are these samples representative?*
- Pharmacists won't sell needles to suspected PWID because of stigma, they feel that they are allowing someone to engage in illegal/bad behavior.
- By providing syringes we are not promoting illegal behavior. It is the same as SW and MSM—if we provide condoms to them we are not promoting illegal behavior. – Dr. Grosso
- People will inject whether or not there is a syringe distribution program. The goal is to avoid HIV.

Question: How representative were these studies?

Since it is a qualitative study, we can't really say that it is representative. We know there are more of such people in Kumasi.

The qualitative study in Burkina Faso was not intended to be representative but rather used purposeful sampling. This is often the case with qualitative research.

Respondent-driven sampling was used in the quantitative studies in Togo and Burkina Faso and snowball sampling in The Gambia, but these studies were designed to be representative of the MSM and FSW populations, not the PWID populations. Interestingly, the large majority of MSM and FSW knew that HIV could be transmitted through injection drug use, which is in contrast to the findings presented from Senegal.

- *Regarding pharmacists not wanting to sell needles, is there a law against that in Ghana?*

Just as many frown on MSM and sex workers, if the pharmacist suspects an individual is going to use a syringe for drugs he won't sell it to them.

*Other comments*

- The last IBBS study was just the tip of the iceberg. We expect to find many more users this time. Many users can be found in tourist development centers.
- Drug injection is a real problem in Africa – not something from western countries

# Section 10: Day 3: Regional Coordination, Conclusions, Recommendations

The moderator opened the session by stating that the problems of KP are complex, but if we succeed in coordinating at the regional level, we can manage them.

**Coordination at the regional level: JURTA KP TWG Priorities and Updates. Effective coordination practices; Adolescents in KP, by Abdelkader Bacha, UNICEF**

Young and adolescent KP have been identified as a priority, including by JURTA, the Joint UN Team on AIDS, with in-reach training and a guide for how to work with young KP. UNESCO is also working on the advocacy effort. At ICASA, Eastern and Southern African countries made a commitment to young and adolescent KP, recognizing that these are especially vulnerable people who do not possess comprehensive HIV knowledge and may engage in unsafe behaviors. HIV-related mortality is decreasing across the region in all groups except for those age 10-19. For example, adolescents in Nigeria are the only group with increasing HIV-related mortality. Another issue discussed was that a 2012-2013 study in Nigeria and Cote d'Ivoire showed that most pregnancies among girls in school were with men outside of their age group and may include transactional sex. Still, data is lacking on young KP. There is a need to disaggregate data by age (10-14 and 15-19), but the question of how to do that remains.

The regional recommendation is to map the legal environment in relation to HIV, gender, and sexual and reproductive rights, and to review the age of consent to receive treatment and condoms. Most adolescents, nearly 80%, would like to access HIV testing, but do not, as only 12-13% are tested. Access to counseling and testing should be improved, as this allows PLHIV to be connected to treatment and care, but also allows for the provision of condoms and other prevention materials. Workshops on sex education can also be done in schools, but they may also be reached through extracurricular activities and social media. Finally, advocacy efforts must continue and human rights violations must be addressed.

**Coordination at the regional level: OCAL, by Edy Anthony and Serge Guidigbi**

OCAL specifically focuses on KP, and is principally funded by the Global Fund. OCAL offers information and distribution services and trains peer educators, as well as providing advice and HIV screening. Principal limitations are hostile environments, limited financing, and homophobia.

OCAL is driven by the CNLS of different countries, but now works at the regional level to avoid duplication. They have worked to define the different parts and roles and try to reach a complementarity of services with national programs

OCAL is working to develop data for MSM in Nigeria, but it's a very complex environment right now.

**Discussion**

2. *Is there complementarity in terms of programs and packages offered and how is it done? Is there coordination between OCAL and other organizations for better coordination?*

The organizational chart makes it possible to avoid duplications. We always work with the countries. We came to the regional level to avoid duplication. There is a complementarity that we always seek. We work with the program because we are there to complement them.

- *What is responsible for the low Lagos hub?*

We insist on the KP. We have an association of MSMs with which we work who are sometimes forced to come to Cotonou for meetings. Little by little you will see that their numbers will go up by next year. The association is called "tiers".

- *In Cote d'Ivoire, 46% of teachers have had sex with students but nothing was done to them (no response in the Ministry of Education) because there is a huge shortage of teachers.*

In Southern Africa countries, we have seen a prevalence of HIV with teachers, which has reached 35%. In Cote d'Ivoire only 4% of respondents stated that pregnancies are caused by teachers. Some girls blame other adults because they are still in school where the teacher works.

In Central Africa in collaboration with UNESCO, an interactive tool/compendium has been developed which is used by the teachers' association and students. It was well done and shows opportunities of dialogues between students and teachers. It tackles problems of pregnancy in school and sexuality; the solution should come from several angles. It has been used in Cameroon and other countries.

Dr. Vincent Pitche closed the session by stating that there should be more coordination and better synergies in funding.

**Pr Vincent Pitche, National Coordinator, NAC Togo; Dr Yeboue Kouadio, IST WHO West Africa**

# Section 11: Working Group Recommendations

## Overview of recommendations from the Workshop:

*Stefan Baral, JHU*

Concerning the provision of services, services to address violence against KP must be offered immediately. We can use hybrid and integrated service models, and to assist, social media can be leveraged. For standalone services, health care providers must have had adequate training in confidentiality and service provision when working with KP. Throughout this meeting, mobile services

have been discussed especially for SW and PWID and it will be important to find a balance and competent providers willing to do this work.

For financing, there is a need for representation at all levels so that Global Fund decisions really incorporate networks of KP.

Finally, concerning coverage of services, if the barriers to service uptake, such as stigma and violence against KP, remain high, coverage of services will be limited. We must think about service delivery models and also barriers to care.

## Specific Working Group Recommendations:

**Violence and persecution:**

- As an area of immediate response, there should be a hotline phone number where KP can call and distribute this number inside a bracelet. The hotline could have a trained team that can pick up a person in need and provide necessary services.
- Follow-up with trained lawyers and police support.

**Stigma and discrimination:**

- Build network alliances – a bottom-up approach – to create an enabling environment to reduce stigma and discrimination against KP.
- Strengthen advocacy at all levels. Institutionalizing advocacy is recommended. The plan should contain three levels: regional, country, and institutional levels, each of which can be tracked over time. Some issues are more easily addressed at regional level. ECOWAS/WAHO has clear role here.
- Continuously engage around these issues. Any plan should be informed by a situational assessment.
- Involve community members in program planning and implementation at all levels.
- Involve KP in comprehensive health for target populations
- Public health practitioners should be convincing, clear, and understandable when articulating messages about KP to other sectors in order to make change. Better relationships with other sectors should be built.

**Care and treatment**

- Identify sites with good treatment in the region at the regional and national levels. Work on developing these sites into learning sites that can be useful as resource centers.
- Address barriers to treatment access. Mobility is high in the region and is a barrier to treatment. A regional program may be able to address this.
- Cost of treatment is a barrier, and should be addressed. For example, sometimes, ART is free but patients still must pay for tests and other treatment components.
- Provide peer education and outreach activities.
- Conduct micro-planning, which allows you to take into account specific needs as well as the needs of the community.
- Use mobile outreach clinics for KP, especially SW and PWUD. Take care to get the necessary authorizations.

- Use an integrated model of services, as it is most suitable for use in health services and public health. Integrate various services in facilities which offer services to KP and other types of populations, such as family planning advice or condoms.
- Using multiple models can be useful as well as an integrated model will not meet all needs.

**M-Health:**

- Utilize social media, the internet, and web-based systems when communities use them and where there is internet.
- When the internet or web-based systems are not possible, use a phone-based system or voice/message system.
- This will vary by country context. Safety is critical so that government or police will not abuse the information.

**Stakeholder Engagement**

- Choose a representative from the KP groups to ensure that everything written at the national level, particularly the Global Fund concept note, takes into account the needs of the community, keeping in mind that most countries have punitive laws against KP.
- Train and build leadership capacity of KP community members to allow them to better participate at the national level. Keep in mind that once a member of a KP is visible, they become much more vulnerable.
- Develop tools and a roadmap.
- We need to have a similar process for research protocols for countries in the region – common research protocol for West Africa in order to obtain comparable data.

**Advocacy and Leadership Training**

- KP associations should work together, especially in countries with less stigma. People living with HIV strengthen the fight against stigma, so MSM and SW living with HIV need to become leaders to fight stigma.
- Train MSM and SW living with HIV in counseling and confidentiality. Have them identify dropouts and follow-up on loss to follow-up. Start vertical and then open to the public as integrated services, including services for mothers and children, to avoid stigma and discrimination.

**Innovative ways to improve mobile counseling among KP**

- Provide mobile HCT services.
- Involve community members and CSOs in the provision of HCT services.
- Move from clinical to rights based services provision.
- Build safe spaces e.g. using technology to improve search for services.
- Map services and train of provider.
- Use KP networks to advance provision of services and care and support.
- Link combination prevention with care and support.
- Use social networks to draw KP and provide services to them.
- Take care to enhance KP access to combination HIV prevention services.

**Enabling Environment**

- Include people at the community level, including police, lawyers, and others who are tolerant and who can be mediators, to facilitate advocacy activities.
- Involve case managers, who can help and accompany KP in engaging in different aspects of care in the health system.
- Involve community leaders to help create an enabling environment.

**Access to Services**

- Focus on KP and case managers/community counselors. These counselors will serve as links to the provision of care.
- Recruit KP patients through SMS. Use pictorial material.
- Use other models depending on the environment.

## Final Comments

*Dr. Carlos Brito, WAHO*

Some of the above recommendations are more regional than others. To this effect, I'd like to remind you of 4 interventions that were made here and see how we can link them to WAHO's activities:

- Regional advocacy.
- Take into account people who move around the corridor and their needs.
- Build capacity for health services.
- Build capacity for CBOs of these communities.

WAHO will soon have activities capitalizing on these suggestions.
There will be a meeting where the ECOWAS member countries will analyze strategic plans, take stock, review all these strategies, and find the best ways to move forward. This would be an opportunity for us to analyze the strategic plans developed 2 years ago, make plans and revise plans based on our lessons learned from the past 2 years of implementation.

Secondly, WAHO has a strong commitment to facilitate the bringing together of national representatives to find ways to move forward. Interventions will be made later in the year to improve the lot of KP. We understand the situation of laws in our countries, but we also understand that these laws can create challenges and

even facilitate HIV transmission. This gives an opportunity to keep talking about how to improve the enabling environment in our countries. This meeting report will be taken into account in revising our action plan/strategic plan.

Conclusion: Dr. Laurent gave the closing remarks in which he thanked participants for attending and bringing their ideas and expertise to bear in the conference.

# Organizing Committee:

This conference was organized through USAID West Africa and USAID West Africa funding for regional partners including, Johns Hopkins University, Center for Public Health and Human Rights; Family Health International 360 through their regional program PACTE-VIH; and the Health Policy Program (HPP) at Futures Group. The organization of the workshop consisted of leadership from all respective agencies.

**ANNEX 1: Stakeholder Technical Workshop for KP in WCA**

**Agenda**

**Accra, Ghana | May 27th – 29th 2014**

**Meeting Objective:** To share/discuss latest multi-country experiences in KP programs, specifically related to MSM, FSW and PWID; research methodologies and promising practices with key regional and country stakeholders; and develop/identify regional strategies and innovative next steps to advance HIV prevention, treatment and control in the WCA region.

| **May 27th** | | | |
|---|---|---|---|
| **Time** | **Session** | **Presenter** | **Session Chair(s)** |
| 08:00-08:30 | Registration | | |
| 08:30-09:00 | Welcome Remarks | USAID/WA \| WAHO: Xavier Crespin \| Ghana AIDS Commission: Angela El-Adas | Octave Moumpala |
| | Overview of the Agenda \| Day 1: Setting the Stage | Erin Papworth \| Virginie Etteigne-Traore | |
| 9:00 – 09:45 | **Setting the Stage: Reality and Challenges of KP Programming** | | |
| | KP Epidemiology and Context of WCA | Stefan Baral | Sonia Florisse |
| | Characterizing the context of KP Programs and Research in WCA : Multi-Sectorial Challenges | Vincent Pitche \| Marguerite Thiam \| Trudi Nunoo \| Daouda Diouf \| Jaegan Loum \| Franz Mananga | |
| **Session 1 \| 9:45 – 12:10** | **KP : Country Initiatives and Regional Strategies –** | | |
| | **A) Emerging Data and Corresponding National Strategies: Togo, Cameroon, Burkina Faso \| Regional Perspective: WAHO** | | |
| 10 minutes | Regional Approach to Policy Change and Political Support: WAHO | Carlos Brito | Laurent Kapesa Claver Toure |
| 10 minutes | Togo: Programs, Research, and National Strategy | Vincent Pitche | |
| 10 minutes | Cameroon: Second Phase Research and Programs | Jean-Bosco Elat | |
| 10 minutes | Burkina Faso : Programs, Research, and National Strategy | Sylvester Tiendrebeogo | |
| 30 minutes | Discussion regarding emerging data and programming: Liberia, Benin, Burkina Faso, Cameroon, Togo, WAHO | Moderator-led | |
| **10:55 – 11:10** | **Coffee Break** | | |
| | **B) Long-term surveillance and programming among KP: Ghana, Cote d'Ivoire and Senegal \| Regional Perspective: UNAIDS, UNICEF** | | |
| 10 minutes | Analysis of the epidemiological situation and the response to the HIV epidemic targeting KP (UNAIDS) | Moise Tuho | Peter Wondergem |
| 10 minutes | Ghana: Long-term surveillance of KP and its influence on national strategic planning and service delivery | Kyeremeh Atuahene | |

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|---|---|---|---|
| 10 minutes | Cote d'Ivoire: National Coordination ; Country Level Research ; PEPFAR-GF synergies | Marguerite Thiam | |
| 10 minutes | Senegal: Long-term surveillance of KP, Data to inform programming; National Coordination | Abdoulaye Sidibe Wade | |
| 10 minutes | Young KP, the weakest link! A strategic approach in WCA region (UNICEF) | Abdelkader Bacha | |
| 30 minutes | Discussion: Long-term surveillance, programming and national coordination for KP in the WCA region : UNAIDS, Ghana, Senegal, Cote d'Ivoire, UNICEF | Moderator-led | |
| **12:30-13:30** | **Lunch** | | |
| **Session 2 13:30 – 14:30** | **KP- Civil Society : Presentations and Roundtable discussion** | | |
| 5 minutes | Civil Society: Case Study: Successes and Lessons Learned from KP programming among MSM in West Africa: AMSHeR | Cyriaque Ako | Daouda Diouf<br>Erin Papworth |
| 5 minutes | Civil Society: Case Study: Successes and Lessons Learned from KP programming among MSM in West Africa- CEPEHRG Ghana | Mac-Darling | |
| 5 minutes | Civil Society: Case Study: Successes and Lessons Learned from KP programming among FSW in West Africa: Blety Cote d'Ivoire | Josiane Tety | |
| 5 minutes | Civil Society: Case Study: Successes and Lessons Learned from KP programming among FSW in Sub-Saharan Africa : African Sex Workers of Association (ASWA) | Grace Kamau | |
| 40 minutes | Roundtable discussion: Civil Society implication in programming, stigma reduction and national strategy: innovative successes | Moderator-led | |
| **Session 3 14:30 – 16:20** | **KP – Donor and stakeholder synergies with Regional Strategies in WCA** | | |
| 15 minutes | Strategic Vision: United States Government (USG): Global and Regional | Cameron Wolf; Laurent Kapesa | Stefan Baral |
| 10 minutes | Strategic Vision: Global Fund : West Africa | Sonia Florisse | |
| **14:55 – 15:10** | **Coffee break** | | |
| 10 minutes | Strategic Vision: World Bank | Elizabeth Mziray | |
| 30 minutes | Discussion: USG, Global Fund, World Bank | Moderator-led | |
| 15:50 – 16:30 | Financing for HIV Interventions among KP: International trends and future direction in the | Panel: Daniele Nyirandutiye \| Elizabeth | Stefan Baral<br>Sheila Mensah |

| | financing of HIV programs in Africa; Coordinated finance response in the WCA region. | Mziray \| Sonia Florisse \| Joshua Galjour \| Henri Nagai \| Daouda Diouf (Enda Sante)\| Singo Assetina (Togo) \| Holger Till (GTZ) \| Xavier Crespin | |
|---|---|---|---|
| **May 28th** | | | |
| **Time** | **Session** | **Presenter** | **Session Chair(s)** |
| 08:00-08:15 | Summary of Day 1 \| Agenda Day 2: Challenges, Innovative Solutions and Priority Setting for KP in WCA | USAID | Octave Moumpala |
| **Session 1 \| 08:15 – 10:45** | **KP Research Models: Innovations to address challenges of KP service delivery** | | |
| 5 minutes | Introduction by co-chairs | | Laurent Kapesa |
| 10 minutes | Strategic Information: Epidemiological approaches to strategic information and usage | Stefan Baral | |
| 20 minutes | Population Size Estimates: Challenges and Innovations in Population Level Research | Sam Wambugu \| \|Quaye Silas Si \| Erin Papworth | |
| 25 minutes | Discussion One: Strategic Information, Population Size Estimate Methods, Surveillance Methods | Presenters | |
| 10 minutes | Community and Research: Data needs, usage and effects of KP | Steave Nemande | |
| 8 minutes (4 Q&A) | Research and Data for KP Programming: Data Usage in the Field | Daouda Diouf | |
| 10 minutes (4 Q&A) | Data needs and initiatives for KP under the Global Fund New Funding Model (Financing and KP Epidemiology) | Joshua Galjour | |
| 25 minutes | Discussion Two: Community-driven data needs and usage, evidence-based programming, data for funding mechanisms | Presenters | |
| 09:45- 10:45 | Working Groups (50 minutes working session and 10 minutes summary) \|<br>Facilitators: Stefan Baral, Ashley Grosso, Erin Papworth, Kim Green, Marguerite Thiam, Serge Billong, Joshua Galjour, Jacqueline Papo, Cameron Wolf | Participants | |
| **(10:15 )** | **Coffee Break – will be served during working group** | | |
| **Session 2 \| 10:45 -12:45** | **Models for KP Programming** | | |

| 5 minutes | Introduction by co-chairs | | Ugochukwu Amanyeiwe<br>Johannes Van Dam |
|---|---|---|---|
| 15 minutes | Models and package of service: community-driven approaches | Jean Paul Tchupo \| Raymond Sodji | |
| 15 minutes | New approaches to reach KP in WCA | Kimberly Green \| Joshua Akuamoah | |
| 20 minutes | The continuum of prevention, care and treatment for KP in West Africa: A case study (Clinique Confiance and CHAMP) | Ehouman Sylvain \| Yssouf Ouattara | |
| 15 minutes | Q&A | Moderator-led | |
| 50 minutes | Working Group: Service models and promising approaches \|<br>Facilitators: Jean-Paul Tchupo, Virginie Ettiegne-Traore, Vincent Pitche, Kim Green, Erin Papworth, Stefan Baral, Cameron Wolf, Peter Wondergem | Participants | |
| **12:45 – 14:00** | **Lunch** | | |
| **Session 3 \| 14:00 – 16:00** | **Enabling Environments: Policy and Legal context WCA** | | |
| 5 minutes | Introduction by co-chair | | Rouguiatou Diallo<br>Jaegan Loum |
| 20 minutes | Structural factors and the enabling environment in WCA \| Tools for advocacy and community engagement | Sandra Duvall \| Darrin Adams | |
| 10 minutes | Regional approaches for MSM engagement and advocacy | Cyriaque Ako | |
| 10 minutes | Starting and expanding advocacy and support networks for SW in WCA | Grace Kamau | |
| 15 minutes | Q&A | Moderators | |
| **15:00 – 15:10** | **Coffee Break** | | |
| 65 minutes | Working Groups : Enabling Environment \|<br>Facilitators: Sandra Duvall, Darrin Adams, Cyriaque Ako, Grace Kamau, Sheila Mensah, Cameron Wolf | Participants | |
| **Session 4: 16:15- 17:00** | **People who inject drugs: Regional Context** | | |
| 16:15–16:45 | PWID session: context, review of existing data, research and projects in Ghana, Burkina Faso, Senegal (WCA region) | Rose Adjei: Ghana \| Sidibe Ndoye: Senegal \| Ashely Grosso: JHU | Cameron Wolf |
| 16:45 – 17:00 | Discussion: PWID in the region, data gaps and existing programs | Moderator-led | |

| May 29th | | | |
|---|---|---|---|
| **Time** | **Session** | **Presenter** | **Session Chair(s)** |
| 09:00- 09:15 | Agenda Day 3 : Regional Coordination, Conclusions, Recommendations | USAID | Octave Moumpala |
| 09:15-10:00 | **Coordination at the regional level**: JURTA KP TWG Priorities and Updates. Effective coordination practices. | Abdelkader Bacha | Vincent Pitche |
| 10:00-10:45 | **Summary of working group discussions Day 2:** Finalized Solutions and Recommendations for KP Programming, Research and Policy in WCA. | JHU \| USAID | |
| 10:45 - 11:00 | **Coffee break** | | |
| 11: 00– 11:45 | **Challenges to Solutions:** From Day 1 to Day 3: Solutions to address the specific challenges of KP programming in WCA | Government \| Civil Society \| Implementing Partners | Carlos Brito |
| 11:45-12:00 | Summary and Closing remarks | USAID/WA | |
| **12:00** | **Lunch- end of the meeting** | | |

**Expected Outcomes at End of Workshops:**

1) Dissemination of innovative KP research and programming in the WCA region
2) Encouragement of KP programmatic coordination and approaches per country, regionally and internationally
3) Identification and connection of hubs of knowledge or implementation science labs for KP and future collaboration
4) Identification of tangible and coordinated regional strategies for KP Interventions (Research and Programs) in WCA

## Annex 2: Meeting Evaluation Summary

Summary: There were very good lesson learned regarding the implementation and programmatic details for the meeting. Of the 80+ participants, 65 responded to a workshop evaluation provided at the end of the third day. Feedback entailed suggestions that the agenda was a bit too packed, however there was especially positive feedback regarding the content of the sessions and the discussion that emerged were reviewed as beneficial for the majority of participants (92.18%).

| Evaluation Results from Participant members (65 filled evaluations) | | | | | | |
|---|---|---|---|---|---|---|
| **General organization of workshop** | **Relevance of discussion topics** | **Presentation of expert speakers** | **Time allotted for discussion** | **Sharing of results and recommendations** | **Extent of new info acquired** | **Usefulness of information acquired** |
| **84.38%** | **92.18%** | **83.75%** | **54.69%** | **61.88%** | **81.25%** | **85.63%** |

Annex 3: **<u>Workshop Resource List</u>**

## Research to Prevention (R2P) Publications

*Epidemiology of HIV among female sex workers, their clients, men who have sex with men and people who inject drugs in West and Central Africa*
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3852130/

*HIV prevalence and factors associated with HIV infection among men who have sex with men in Cameroon*
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3852127/

*West Africa Research for Programming Project among Sex Workers and MSM in Cameroon, Burkina Faso, and Togo* (Full Report, Research Brief, Burkina Faso Brief, Togo Brief, and Cameroon Brief: English and French)
http://www.jhsph.edu/research/centers-and-institutes/research-to-prevention/research-activities/key-populations.html

## Health Policy Project (HPP) Publications

*Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers*
http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubID=79

*Policy Analysis for Key Populations at Risk of HIV Infection in Togo* (English and French)
http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=233

*AWARE II: Assessment of Gaps in Policies, Policy Implementation and Programs for Key Populations* (English and French)
http://futuresgroup.com/resources/publications/aware_ii_assessment_of_gaps_in_policies_policy_implementation_and_programs

*Costing Data Use Guide for Providing Key HIV Services to Female Sex Workers (FSW) and Men Who Have Sex with Men (MSM) in Côte d'Ivoire*
http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=293

*Rapport Final: Estimation du coût unitaire du paquet minimum de services liés au VIH pour les PS et les HSH en Côte d'Ivoire* (French version : *Costing Data Use Guide for Providing Key HIV Services to FSW and MSM in Côte d'Ivoire)*
http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=155

*Discrimination Reporting System brochure: Ghana*
http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=351

*National HIV and AIDS, STI Policy - Republic of Ghana*
http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=153

*Unit Cost of Providing Key HIV Services to Female Sex Workers and Males Who Have Sex with Males: Ghana*
http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=63

*The Impact of Different Scenarios of HIV Prevention, Treatment, and Mitigation Coverage in Ghana: Analysis Using the Goals Model*
http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=107

## Regional HIV/AIDS Prevention and Care Project (PACTE-VIH) Publications

*Rapport Final de l'Etude Exploratoire, Lomé, Togo: 6-12 janvier 2013 (*French version: *Final Report of the Needs Assessment: Lomé, Togo: January 6-12, 2013)*
http://www.fhi360.org/resource/rapport-final-de-l%E2%80%99etude-exploratoire-lome-6-12-janvier-2013

*Rapport Final de l'Etude Exploratoire, Ouagadougou: 17-24 janvier 2013 (*French version: *Final Report of the Needs Assessment: Ouagadougou, Burkina Faso: January 17-24, 2013)*
http://www.fhi360.org/resource/rapport-final-de-l%E2%80%99etude-exploratoire-ouagadougou-17-24-janvier-2013

## Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) Publications

*Strategic Investments for HIV programs*
http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

*Information note on joint tuberculosis and HIV programming*
http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

*Addressing sex work, MSM and transgender people in the context of the HIV epidemic*
http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

*Addressing Gender Inequalities and Strengthening Responses for Women and Girls*
http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

*Community systems strengthening*
http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

*Harm reduction for people who use drugs (EN only)*
http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

*Human Rights for HIV, TB, Malaria and HSS Grants*
http://www.theglobalfund.org/en/fundingmodel/support/infonotes/