# ECOWAS Regional Strategy for HIV, Tuberculosis, Hepatitis B&C and Sexual and Reproductive Health and Rights among Key Populations

*July 2020*


CEDEAO
ECOWAS


CEDEAO
OOAS
WAHO
ECOWAS


Africa Key Population
Experts Group


ENDA
SANTE


U N
D P


UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF


UNAIDS


World Health
Organization
REGIONAL OFFICE FOR
Africa

## Preface

The HIV pandemic contributes to significant ill-health and deaths as well as impedes socioeconomic development in the ECOWAS region. While the prevalence of HIV in the general population is relatively low at 0.3%-3.5%, it is up to 34.4% in some key populations. As the number of key populations increase in the region, it is likely that their contribution to new HIV infections will continue to be important if appropriate measures are not instituted. The criminalization of the sexual practices of key population groups, pervasive stigma and discrimination hinders their access to HIV programmes in the ECOWAS region. This, in part, contributes to the paucity of relevant information on key populations needed for planning service delivery.

Fortunately, with the signing of the Dakar Declaration in April 2015 at the WAHO-led regional meeting of health ministers, HIV/AIDS national leaders, security agencies, there is now increased momentum in the role of key populations in the HIV response. Besides HIV, key populations have other health problems. Tuberculosis is the leading killer in people living with HIV. Imprisoned people and people who inject drugs in the ECOWAS region have a higher risk of acquiring Hepatitis C virus than the general population.

It was to address such challenges and to promote a harmonized response that stakeholders participating in a review meeting on the implementation of Dakar Declaration in Lomé in November 2018, agreed to work with WAHO to develop an integrated regional ECOWAS strategy on HIV/TB, hepatitis B and C and SRHR programming for key populations.

The current strategy follows extensive desktop review as well as national and regional consultations. The process was coordinated by a technical working group involving the Africa Key Populations Experts Group (AKPEG), Enda Santé, WHO, UNAIDS, UNDP and representatives of Member States. I would like to thank the Consultant who put developed the plan starting in June 2019. I thank all stakeholders including Development Partners, UN agencies, civil society and regional organizations of key populations and young key populations, who provided strategic guidance and valuable inputs. In particular, I thank all Member States represented by the Ministries of Health HIV/AIDS Technical Leads and National AIDS Commissions who reviewed and enriched the document during different consultative forums. I acknowledge the financial and technical assistance from UNAIDS, UNDP, USAID, and WHO for the development of this strategy.

I expect the strategy to be owned by all our Member States and Partners. It will guide our national and regional integrated response to the sexual and reproductive health challenges of key populations. I look forward to your support in monitoring its application in the region.

Professor Stanley OKOLO,
Director General, WAHO

## Table of Contents

## Abbreviations

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AKPEG | Africa Key Population Experts Group |
| ALCO | Abidjan-Lagos Corridor Organisation |
| ART | Anti-Retroviral Therapy |
| AU | African Union |
| BBS | Bio-Behavioural Study |
| CARKAP | Consortium for the Advancement and Rights of Key Affected populations |
| CCJ | Community Court of Justice |
| COE | Challenging Operating Environments |
| CSOs | Civil Society Organizations |
| DALY | Disability-Adjusted Life Year |
| DR-TB | Drug Resistant Tuberculosis |
| EAWA | End Aids in West Africa |
| ECOWAS | Economic Community of West African States |
| EGDC | ECOWAS Gender Development Centre |
| ESA | Eastern & Southern Africa |
| FEVE | *Frontières et Vulnérabilités au VIH en Afrique de l'Ouest* |
| FSWs | Female Sex Workers |
| GAM | Global Aids Monitoring |
| GBV | Gender-Based Violence |
| GF | Global Fund |
| GHSS | Global Health Sector Strategy |
| HBV | Hepatitis B Virus |
| HCV | Hepatitis C Virus |
| HIV | Human Immunodeficiency Virus |
| IPU | Inter-Parliamentary Union |
| ITPC | International Treatment Preparedness Coalition |
| KP | Key Populations |
| LEA | Legal Environment Assessment |
| M&E | Monitoring and Evaluation |
| MSM | Men who have Sex with Men |
| NSP | National Strategic Plan for HIV and AIDS |
| OST | Opioid Substitution Therapy |
| PACTE-VIH | Regional HIV/AIDS Prevention and Care project |
| PARECO | Regional Programme of Harm Reduction about HIV, Tuberculosis and other Co-Morbidities, and Human Right Promotion for People Who Inject Drugs |
| PEP | Post-Exposure Prophylaxis |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of mother-to-child transmission |
| PrEP | Pre-Exposure Prophylaxis |
| PSE | Population Size Estimation |
| PWIDs | People Who Inject Drugs |
| PWUDs | People Who Use Drugs |
| RAME | *Réseau Accès aux Médicaments* |
| RCTO-WA | Regional Community Treatment Observatory – West Africa |
| REC | Regional Economic Communities |
| RR/MDR-TB | Rifampicin Resistant/MultiDrug-Resistant Tuberculosis |
| SADC | Southern African Development Community |
| SDGs | Sustainable Development Goals |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health and Rights |
| STIs | Sexually Transmitted Infections |
| SWs | Sex Workers |

| | |
|---|---|
| TB | Tuberculosis |
| TG | Transgender people |
| TWG | Technical Working Group |
| UHC | Universal Health Coverage |
| UIC | Unique Identifier Code |
| UNAIDS | Joint United Nations Programme on HIV and AIDS |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNGA | United Nations General Assembly |
| UNODC | United Nations Office on Drugs and Crime |
| VMMC | Voluntary Medical Male Circumcision |
| WAHO | West African Health Organization |
| WCA | West and Central Africa |
| WHO | World Health Organization |

## Definitions of Terms

**Adolescents:** Individuals between the ages of 10 and 19 years old.

**Disability-Adjusted Life Year:** One Disability-Adjusted Life Year (DALY) can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

**Differentiated Service Delivery:** Differentiated service delivery or differentiated care is a care-centred approach that simplifies and adapts HIV, STIs and HCV services across the continuum to reflect the preferences and expectations of various groups while reducing unnecessary burdens on the health system.

**Empowerment:** Community empowerment is a collective process that enables key populations to address the structural constraints to health, human rights and well-being; make social, economic and behavioural changes; and improve access to health services. Community empowerment can foster the wider reach and greater effectiveness of services for key populations. Community empowerment can take many forms, such as meaningful participation of people from key populations in designing services, peer education, implementation of legal literacy and service programmes, and fostering key population-led groups and key population-led programmes and service delivery.

**Harm reduction:** Policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of licit and illicit drugs. The harm reduction approach is based on a strong commitment to public health and human rights. Harm reduction helps protect people from preventable diseases and death from overdose and helps connect marginalized people with social and health services. For injecting drug users, the basic harm reduction package consists of needle/syringe programmes, opioid substitution therapy and naloxone for overdose management.

**Health:** A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.

**HIV-Related stigma:** Negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. the families of people living with HIV) and key populations at higher risk of HIV infection.

**HIV treatment cascade:** It is a model that monitors the number of people estimated to be living with HIV, that should be diagnosed, initiated on ART, adherent to their treatment and with an undetectable viral load compared to the official statistics of these same indicators in a given country or region.

**Key populations:** Internationally, key populations have been defined as people who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. For the purposes of this strategy, key populations are gay men and other men who have sex with men; transgender people, people who inject/use drugs; sex workers and their clients; and prisoners and other incarcerated persons.

**Men who have sex with men (MSM):** "Men who have sex with men" are males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but who have

sex with other men.

**Opioid substitution treatment (OST):** Opioid substitution therapy is the recommended form of drug dependence treatment for people who are dependent on opioids. It has proved effective in the treatment of opioid dependence, in the prevention of HIV transmission and in the improvement of adherence to antiretroviral therapy. The most common drugs used in opioid substitution therapy are methadone and buprenorphine

**People who inject drugs (PWIDs):** People who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. For this strategy, people who self-inject medicines for medical purposes—referred to as therapeutic injection—are not included in this definition.

**People who use drugs (PWUDs):** People who use psychotropic substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal or intranasal) or transdermal. For the purposes of this document, the definition does not include the use of such widely-used substances as tobacco, or beverages and foods that contain alcohol or caffeine.

**Post Exposure Prophylaxis (PEP):** Post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure (or possible exposure) to HIV. The exposure may be occupational (e.g. a needlestick injury) or non-occupational (e.g. condomless sex with a seropositive partner)

**Pre-Exposure Prophylaxis (PrEP):** Pre-exposure prophylaxis or PrEP is the use of an antiretroviral medication to prevent the acquisition of HIV infection by uninfected persons. Several studies have demonstrated that a daily oral dose of appropriate antiretroviral medicines is effective in both men and women for reducing the risk of acquiring HIV infection through sexual or injection transmission

**Prisoners and people in closed settings:** All persons detained in prison facilities and other detention facilities, including adult and juvenile persons. Detention facilities can include jails, prisons, police detention, juvenile detention, remand/pre-trial detention, forced labour camps and penitentiaries.

**Sex workers (SW):** People who regularly or occasionally receive money or goods in exchange for sexual services, whether or not that person identifies as a sex worker. Sex work is the consensual sale of sex between adults. As defined in the United Nations Convention on the Rights of the Child, children and adolescents under the age of 18 who exchange sex for money, goods or favours are "sexually exploited" and not defined as sex workers.

**Sexual and reproductive health (SRH):** A state of complete physical, mental and social well-being in all matters relating to the reproductive system and sexuality; it is not merely the absence of disease, dysfunction or infirmity. For sexual and reproductive health to be attained and maintained, the sexual and reproductive health rights of all persons must be respected, protected and fulfilled. Sexual and reproductive health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. SRH interventions include sexually transmitted infection prevention, screening and treatment, contraceptive services, safe abortion and post-abortion care, cervical cancer screening and treatment, screening for anal cancer, conception and pregnancy.

**Transgender (TG):** An umbrella term for people whose gender identity and expression do not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. It includes people who are transsexual, transgender or otherwise gender non-conforming. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual or one of many other transgender identities. They may express their genders in a variety of masculine, feminine and/or androgynous ways.

**Vulnerable populations:** Groups of people who are particularly vulnerable to HIV infection in certain situations or contexts such as adolescents, and young people, particularly adolescent girls and young women, orphans, street children, people with disabilities, migrant, refugees and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics.

**Young key populations:** Individuals between the ages of 15 and 24 who due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. They also often have legal and social issues related to their behaviours that increase their vulnerability to HIV.

**Youth:** Individuals between the ages of 15 and 24 years.

**Young people:** Individuals between the ages of 10 and 24 years.

# 1. Background

## 1.1 Global targets and commitments

### 1.1.1 Global HIV targets: African and ECOWAS commitments to achieve them

In 2015, the United Nations General Assembly (UNGA) committed to reaching the Sustainable Development Goals (SDGs) by 2030. Among the goals is SDG 3 which aims to ensure healthy lives and promote well-being for all at all ages. The SDG 3 includes ending the epidemics of AIDS, tuberculosis (TB), malaria and neglected tropical diseases and combatting hepatitis, water-borne diseases and other communicable diseases as well as ensuring universal access to sexual and reproductive health-care services and the integration of reproductive health into national strategies and programmes by 2030.

Following countries' commitments to the SDGs, the UNGA committed to urgently accelerating efforts towards ending the AIDS epidemic by 2030 in the 2016 "Political Declaration on HIV and AIDS". To end AIDS by 2030, the Joint United Nations Programme on HIV/AIDS (UNAIDS) set a series of targets, known as 90-90-90, that need to be reached by 2020 in order to meet the 2030 objective:

- 90% of people living with HIV knowing their HIV status;
- 90% of people who know their HIV-positive status on treatment;
- 90% of people on treatment with suppressed viral loads,
- a reduction in new infections and reduction in AIDS related deaths by 75% and among children by 95% and
- removal of HIV related discrimination.

UNAIDS is currently leading the process of updating targets and resources needed for 2025. The "UNAIDS 2016-2021 Strategy" prioritizes efforts to reach vulnerable and key populations in the context of HIV to ensure that no-one is left behind, in line with the 2030 Agenda for Sustainable Development.

In its 2001 Resolution on the HIV/AIDS pandemic, the African Commission on Human and Peoples' Rights called upon to African Governments, State Parties to the African Charter to allocate national resources that reflect a determination to fight the spread of HIV/AIDS and to ensure human rights protection of those living with HIV/AIDS against discrimination. In 2010 it also established a committee on the protection of the rights of PLHIV and those at risk, vulnerable to and affected by HIV with a mandate amongst others, to integrate a gender perspective and give special attention to persons belonging to key populations.

The "Model Regional Strategic Framework on HIV for Key Populations in Africa" was developed in 2014 by the African Key Population Forum on HIV, which brings together a pool of experts composed of sex workers, men who have sex with men, transgender people and people who inject drugs drawn from different parts of Africa. The Regional Economic Communities (RECs) of Africa were expected to adapt the Framework to their specific context and use it to initiate dialogue and promote the adoption of a standard package of strategies and programmes for implementation within their Member States. In addition, it was also intended for use by civil society across Africa as an advocacy tool to ensure provision of specific and focused HIV prevention, treatment, and care services for key population groups.[1]

In recognition of the high burden of HIV among key population groups (an important element in the dynamics of HIV transmission) as well as their role as essential partners in an effective response to the epidemic in the West Africa region, the Ministers of Health, Heads of National AIDS Commissions, Public Prosecutors and Inspector Generals of Police of the Economic Community of West African States (ECOWAS) adopted the

"Dakar Declaration on Factoring Key Populations in the Response to HIV and AIDS in Member States," in April 2015. The Declaration seeks to address the disproportionate burden of HIV among key populations and includes five core commitments related to: addressing stigma and discrimination, community service strengthening, health system strengthening, prioritization of key populations and strategic information strengthening.[2]

In the "Catalytic Framework to End AIDS, Tuberculosis and Eliminate Malaria" in Africa by 2030, the African Union (AU), in 2016, affirmed the commitment of Member States to eliminate HIV and agreed to strengthen rights-based approaches and protection for key populations as well as to ensure their meaningful participation in the HIV response.[3]

In 2016, the "West and Central Africa Catch-Up Plan" was endorsed by the AU Assembly to address bottlenecks to scale-up, accelerate national responses to HIV epidemics; reiterating the centrality of focusing investments on populations, including key populations, and locations most affected to ensure highest impact.[4]

### 1.1.2 Global TB targets: African and ECOWAS commitments to achieve them

The "End TB Strategy" includes targets for a 90% reduction in number of TB deaths and an 80% reduction in TB incidence rates by 2023 compared with levels in 2015, as well as zero TB-affected families facing catastrophic costs due to TB.

**Commitments of Ministers of Health, Heads of National AIDS, Commissions, Public Prosecutors and Police Chiefs in the Dakar Declaration, April 2015**

1. Invest in stigma reduction programs by:
   - Including non-stigmatization modules in basic and continuing training of judges and court officers and most especially of law enforcement officers
   - Training individual health care providers, regulators and administrators
   - Organizing information and dialogue meetings between beneficiaries and providers
2. Enhance community service provision for key populations through:
   - Support for the creation of community centres offering education, community mobilization, essential health services, social support and advocacy for political and legal changes;
   - Legal protection for community actors involved in various services for key populations
3. Streamline health systems strengthening to better meet the specific needs of key populations;
4. Relentlessly lay emphasis on key populations as a priority group in national HIV/ AIDS response strategies
5. Strengthen strategic knowledge or information necessary to plan interventions for key populations and monitor progress towards the attainment of objectives.

In 2017, World Health Organization (WHO) Member States committed, through the Moscow Declaration to end TB, to advance the TB response within the SDG agenda, ensure sufficient and sustainable financing, pursue science, research and innovation and develop a multisectoral accountability framework. The resolutions include giving special attention to key populations.[5]

In 2018, the UNGA adopted the "Political Declaration on the Fight Against Tuberculosis" that reaffirms commitments to accelerate national and collective actions, investments and innovations to end the tuberculosis epidemic globally by 2030. The UNGA Declaration acknowledged the strong association between HIV and TB, and the associated high mortality. It committed to enhancing coordination and collaboration between tuberculosis and HIV programmes, as well as with other health programmes and sectors to ensure universal access to integrated prevention, diagnosis, treatment and care services.[6]

### 1.1.3 Global commitments on sexual and reproductive health and rights

In October 2019, the Assembly of the Inter-Parliamentary Union (IPU) for the biennium (2019-2021) adopted the first ever resolution on Universal Health Coverage (UHC)[7], which also includes global health security and promoting health especially for vulnerable groups. In collaboration with the United Nations Population Fund (UNFPA) and other agencies, WHO and IPU are working on promoting women's, children's and adolescents' health, within the broader framework of UHC, including critical areas such as maternal health, child, early and forced marriage, the role of legislation in sexual and reproductive health and rights (SRHR), HIV and nutrition.

### 1.1.4 Global commitments on hepatitis

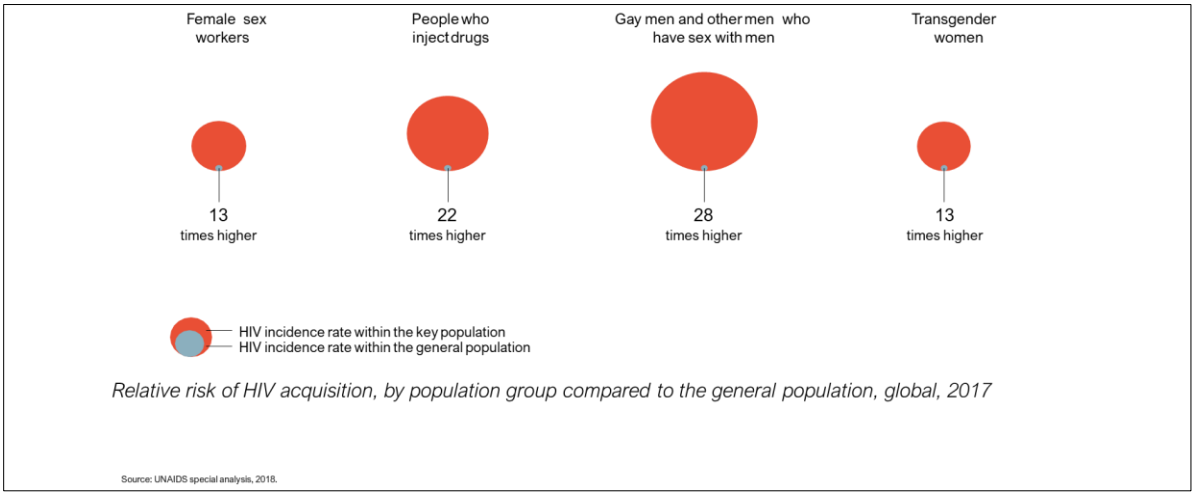
In May 2016, the 69th World Health Assembly unanimously endorsed the first Global Health Sector Strategy (GHSS) on viral hepatitis. The GHSS sets a goal to eliminate viral hepatitis as a major public health threat, defined as a reduction in i) hepatitis-related deaths by 65% and ii) new chronic hepatitis B virus (HBV) and hepatitis C virus (HCV) infections by 90%, by 2030.

## 1.2 Rationale

Key populations and their sexual partners face higher risk of HIV infection and currently account for over 50% of new infections globally and over 60% in the West and Central Africa (WCA) region.[8] Globally, gay men and other men who have sex with men are 28 times more at risk of acquiring HIV compared to the general population (Figure 1). Female sex workers, people who inject drugs, and transgender women are respectively 13, 22 and 13 times higher at risk.[9] Young key populations across all key population groups are even more disproportionately affected by HIV than adult key populations.[10] TB remains the leading cause of death among people living with HIV (TB accounts for around one in four AIDS-related deaths in the region[11]). Viral hepatitis B and C disproportionally affect key populations, particularly people who inject drugs and men who have sex with men, as a result of sexual transmission and the sharing of needles, syringes and ancillary injecting equipment[12].

Despite global progress in fighting tuberculosis, 40% of TB cases in Africa are under-detected or under-reported.[13] In 2018, 35% of tuberculosis cases were detected in the ECOWAS region (range 24% in Nigeria to 86% in Togo). 22% of tuberculosis-related deaths occurred among people living with HIV in the ECOWAS region.[14] The estimated mortality in TB/HIV co-infected patients in the WCA region is 50% higher than in the rest of Africa and rifampicin resistant TB/multidrug-resistant tuberculosis (RR/MDR-TB) is underdiagnosed and under-treated—with currently only 20% of the patients suffering from drug resistant TB (DR-TB) being diagnosed and treated.[15] 14% of the estimated 27,697 new cases of RR-MDR TB in the ECOWAS region were laboratory-confirmed and 11% were started on 2nd line treatment.[16]

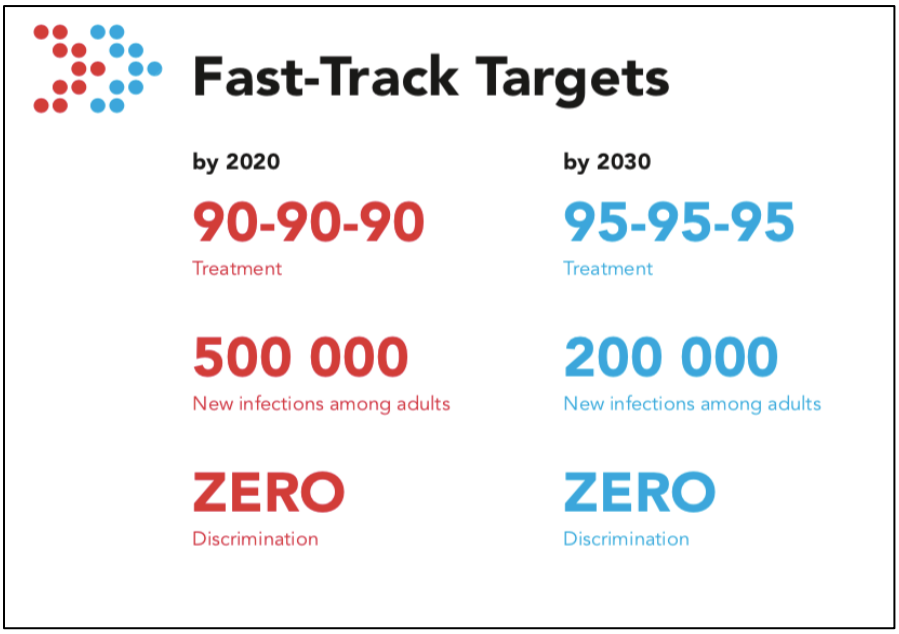
**Figure 1 Relative risk of HIV acquisition by population group compared to the general population, 2017 (UNAIDS special analysis 2018)**




Key populations have specific sexual and reproductive needs, and these are often not met by the healthcare sector. They face sexual and reproductive health rights violations, further limiting their access to SRH services.[17] Linking sexual and reproductive health and rights and HIV responses is also essential to increasing the reach of both services.

Despite the progress that has been made on interventions targeting key populations, programmes seeking to address the needs of key populations remain hard to implement and the populations remain difficult to reach. To address this and to bridge the gap in meeting the UNAIDS 90-90-90 target, in 2017, WCA countries and the international community, committed to implementing a catch-up plan to put HIV treatment on the fast track by 2018 (Figure 2).[18] This has provided an opportunity for a greater number of countries to implement their country operational plans that address policy and structural bottlenecks. However, this is still not enough as there has been no significant change in the rate of program scale-up.[19]

**Figure 2 Fast-track targets for 2020 and 2030 (Fast track ending the AIDS epidemic by 2030)**



A review of the Dakar Declaration conducted in Lomé, Togo in 2018 highlighted the continued challenges that the ECOWAS region faces in addressing HIV among key populations:

- the lack of ownership at national levels of the commitments made in the Dakar Declaration, with only four countries having developed national roadmaps for its implementation as of end 2018;
- legal, human rights and social barriers to the acceptance of key populations;
- little integration and limited access to services; inadequate funding hindering development or scaling up of programming for key populations;
- time-consuming multiple donor-driven planning processes that reduce time for implementation; and
- a lack of homogeneous and consistent standard key population interventions and data generation mechanisms throughout the region.

To address these continued challenges in the region and to build upon the existing international and regional commitments WCA countries have made, ECOWAS, through the West Africa Health Organization (WAHO), commissioned the development of a regional strategy for HIV, TB, Hepatitis B & C and SRHR among key populations. Its purpose is to guide, harmonize and upscale regional and national efforts towards key populations in West Africa. With a comprehensive set of accessible, acceptable, affordable and appropriate services readily available for key populations in the region, Member States could see their investments result in stabilizing or even turning around incidence rates.

In addition, with a regional strategy, ECOWAS countries can exploit the increasing momentum on key population programming; follow one single harmonised framework to standardize their interventions and data collection. The strategy will also be used to advocate for more supportive policies and laws, integrated TB and SRH services and increased mobilization of domestic and external funding. The region can identify and leverage on synergies and best practices to have a coherent regional response that creates visible changes in the implementation of key population interventions in each country.

## 1.3 Guiding Principles

The following principles, adapted from the Model Strategic Framework on HIV for Key Populations in Africa (2014)[20] and the World Health Organization's Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations: 2016 Update, [21] will guide the implementation of this strategy.

**Guiding Principles**

- Respect of human rights
- Sustained community participation and empowerment
- Evidence-based and people-centered interventions
- Strong political commitment

**Respect of human rights**

The protection of human rights for all members of each key population is crucial to the success of this strategy. Protective laws, based on international human rights standards should be adopted and enforced while laws that discriminate or create barriers should be reformed, to ensure that key populations are free from stigma, discrimination and violence and their vulnerability to HIV, Hepatitis B & C, TB and SRH is reduced. Health care providers and relevant institutions including in prisons and other closed settings must serve people from key populations based on the principles of medical ethics and the right to health, including sexual and reproductive health, without any stigma or discrimination. This principle includes the right to equality and non-discrimination (including on the basis of sex, sexual orientation, gender identity, disability, health condition or occupation), to privacy, family life, safe working conditions, freedom from violence, access to justice, the right to a fair trial, freedom from

discrimination, arbitrary arrest and detention, torture and cruel, inhuman and degrading treatment, the right to equality and dignity and the right to information.

**Sustained community participation and empowerment**

Effective participation through a meaningful and functional engagement of key populations, including young key populations, is central to this regional strategy. No policy will be decided without the full and direct participation of members of the key population(s) affected by that policy or programming and their contribution would be central to shaping the implementation of the policy or programming. Promoting gender equality and gender transformative interventions are also part of community empowerment. Resources should be invested in building the capacity of key populations, including on human rights and health literacy, which is also an important strategy to provide tools for decision-making on their health management. Promoting accessibility also includes adopting integrated service-delivery models, setting up regular feedback mechanisms from key populations on the services and constant monitoring of how respectful, acceptable, appropriate and affordable the services are for the recipients.

**Evidence-based and people-centred interventions**

Interventions targeting key populations should be based on accurate, reliable and comprehensive evidence. Monitoring and evaluation, as well as the development of programmes should systematically include key population representatives at all stages from data collection to analysis and decision-making. Offering high quality, patient-centred prevention, care and treatment services for the issues affecting key populations will improve their participation and their retention in care.

**Strong political commitment**

Member States commit on a national and regional level to ensure universal access to health services that address the needs of key populations. This includes ensuring that the principles of good governance, including accountability and transparency, are adhered to and that Member States translate their engagement into tangible actions at the grassroots level.

## 1.4 Methodology

**Figure 3 Summary of methodology to develop the ECOWAS KP strategic plan**


The development of this strategy was based on the following processes:

1. As part of the follow up of the Dakar Declaration, WAHO, jointly with the United Nations Development Programme (UNDP) and Enda Santé organized a regional meeting in November 2018 in Lomé, which brought together the member states, representatives from key populations (from AKPEG, the Africa Key Populations Experts Group), and other partners (WHO, UNAIDS, SADC, etc) to discuss the roadmap for the development of the regional strategy, including the recruitment of a consultant to support this process and the establishment of a multi-stakeholder technical working group to guide the process (Figure 3).
2. A desk review was conducted based on international, regional and national documents related to political commitments, policies and guidelines, national strategies, assessments and reports from

agencies implicated in the HIV response in the ECOWAS.

3. Interviews (via email or by telephone) with pertinent stakeholders from the region seeking to collect their input to the vision of the regional strategy, on what strengths/opportunities the region can draw on and what weakness/threats need to be considered for the strategy, as well as important vulnerability factors of key populations and mitigating actions.
4. National in-person consultations were conducted, when possible, in some of the ECOWAS countries[1] to further review and contribute to the draft of the regional strategy. Input from these consultations was consolidated into the draft regional strategy.
5. A regional consultation workshop with the technical working group overseeing the process of developing the regional strategy, representatives of each country, key partners and key populations[2] was held on the 10th-11th December 2019 in Abidjan to further review and consolidate the regional strategy.
6. The consolidated draft regional strategy was sent to countries for further inputs in January 2020. Between April and June 2020, the draft was finalized based on inputs from regional institutions.

# 2. Global and Regional Context of HIV, TB, Hepatitis and SRHR

## 2.1 HIV Context

In 2018, there were an estimated 37.9 million people living with HIV (PLHIV) and 770,000 AIDS-related deaths globally. The global number of new HIV infections continues to decline, down from a peak of 2.9 million in 1997 to 1.7 million in 2018 but has stabilised in recent years. The reduction in new HIV infections between 2010 and 2018 was greatest in sub-Saharan Africa driven by sharp reductions in the eastern and southern African (ESA) region (28% decline). Globally, more than half of new infections in 2018 were among key populations and their partners.[22]

With a steady scale up of antiretroviral therapy (ART), AIDS-related mortality has progressively declined. Since 2010, it has declined by 33% globally, driven largely by progress in sub-Saharan Africa, particularly eastern and southern Africa, where it declined by 44% from 2010 to 2018, reflecting the rapid pace of treatment scale-up in the ESA region.[23] AIDS-related mortality declined by 29% from 2010 to 2018 in WCA. The region also experienced a 13% decline in new infections over the same period. The region currently accounts for 16% of the world's new HIV infections and 21% of global deaths from AIDS-related illness, despite having only 6% of the global population.

HIV/AIDS & STIs were estimated to be the seventeenth leading cause of the burden of disease globally in 2017 and the fifth cause in the African region, representing respectively 2.18% and 6.02% of all disability-adjusted life years (DALYs) lost[3]. The burden of HIV in the African region compared to the global situation represents 3,812.96 v/s 862.77 DALYs lost per 100,000 population.[24] In western Africa, the ranking of HIV/AIDS & STIs in terms of their share of DALYs lost worsened from 0.82% of total DALYs in 1990 to 6.02% of total DALYs in 2017. The DALYs per 100,000 population increased from 2,210.59 to 3,812.96 over the same period. Thus, the African region is still much more heavily burdened by HIV than the other regions of

[1] Benin, Burkina Faso, Nigeria

[2] NAC Benin, NAC The Gambia, NAC Guinea, NAC Liberia, NAC Nigeria, NAC Sierra Leone, NAC Togo CNLS Niger, CNLS Senegal, OCAL, Coalition Plus, WAHO, ENDA, RAME, ANCS PARECO, OSIWA, OCEAC, UNAIDS, WHO, USAID, UNFPA, Health Policy Project

[3] DALYs are used as a key measurement of disease burden. DALYs are the sum of years of life lived with disability (YLDs) and years of life lost to premature mortality (YLLs). More details available here (https://vizhub.healthdata.org/gbd-compare/)

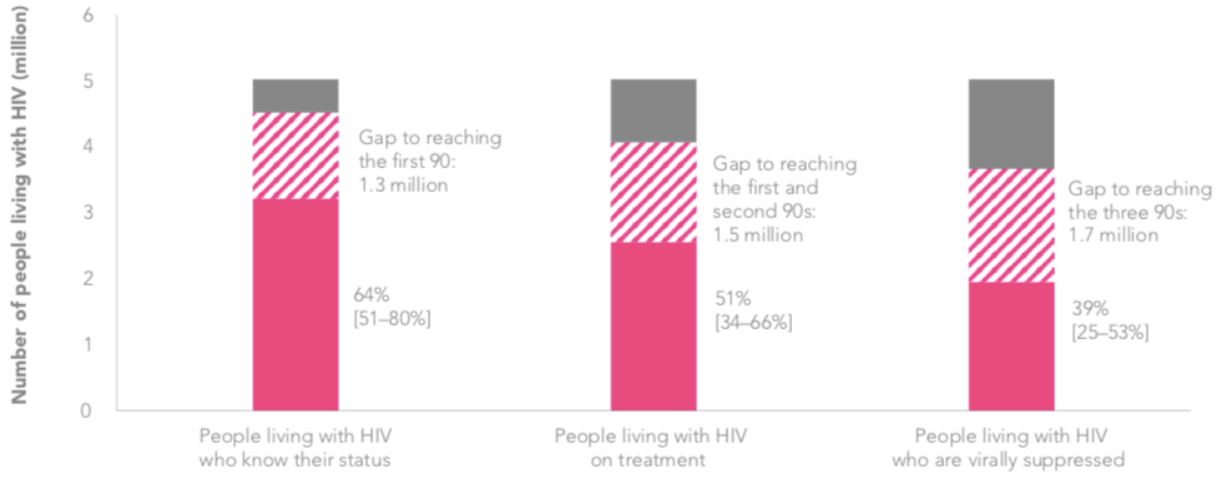
the world. Adolescents aged 10-24 years bear a high burden with respect to HIV, with HIV/AIDS & STIs being the leading cause of death among adolescents in Sub-Saharan Africa and second cause of death in West Africa (respectively 26.12 and 15.43 deaths per 100,000 population). [25]

The number of PLHIV in the ECOWAS Region increased from 3.0 million to 3.5 million from 2010 to 2018, while new infections declined by 2.3% from an estimated 217,700 to 212,800 over the same period. Similarly, the number of AIDS-related deaths declined by 23.3% from 146,470 to 112,380 over the same period. In 2018, the ECOWAS region accounted for 9.2%, 12.5% and 14.6% of the global PLHIV, new infections and AIDS-related deaths respectively.

Apart from the direct impact of HIV on life expectancy, there is significant impact on the economy through the loss of productive workforce and economic growth and development. Estimations show that a 1% increase in the HIV prevalence rate in west Africa decreased the growth in per capita income by 0.47%.[26]

Despite the gains in the HIV/AIDS response in the WCA region, significant challenges remain. Among the 5 million [4.0 million-6.3 million] people living with HIV in WCA at the end of 2018, 64% were aware of their HIV status (Figure 4). The gap to achieving the first 90 of the 90–90–90 targets in 2018 was 1.3 million PLHIV who did not know their HIV status. A little over half (51%) of PLHIV in the WCA region accessed ART in 2018, with a gap to achieving the first and second 90 of the 90–90–90 targets of 1.5 million people. The estimated percentage of PLHIV in the region who achieved viral suppression was 39% in 2018, with a gap to achieving the all three 90s of 1.7 million people. These gaps represent a significant challenge to the goal of ending AIDS by 2030 for countries in the region.[27]

**Figure 4. HIV Testing & Treatment Cascade, West and Central Africa, 2018 (UNAIDS Special Analysis 2019)**




In the ECOWAS Region, the proportion of PLHIV in 2018 who were aware of their HIV status ranged from 33% in Mali to >95% in Cabo Verde. Only about half of the PLHIV were on ART, with a gap of 1.075 million needing to be reached to achieve the 2nd 90 of the UNAIDS 90-90-90 target. Data on viral suppression was only available from seven of the 15 ECOWAS Member States. They showed that the proportion of PLHIV who were virally suppressed ranged from 26% in Sierra Leone to 48% in Benin.

The HIV epidemic in West and Central Africa has distinct dynamics compared to the other regions of sub-Saharan Africa. Key populations and their sexual partners account for 64% of new HIV infections in WCA. Men who have sex with men account for an estimated 17% of new infections in western and central Africa. Sex workers account for 14% of new infections; people who inject drugs account for 8% and sexual partners of key populations (including clients of sex workers) account for 25%[28]. There is no data on the HIV prevalence among young key populations despite their documented heightened risk and vulnerability to HIV. HIV prevalence in key populations per country, where data is available, are detailed in Table 1. Data are not available for a number of key populations and countries (Cabo Verde and Liberia).

**Table 1: Prevalence of HIV among Key Populations in ECOWAS Member States as of 2019**[29]

| Country | SW | MSM | PWID | TG | Prisoners |
|---|---|---|---|---|---|
| Benin | 8.5% | 7.0% | 2.2% | - | 0.6% |
| Burkina Faso | 5.4% | 1.9% | - | - | 2.2% |
| Cote d'Ivoire | 12.2% | 12.3% | - | - | 1.2% |
| The Gambia | 11.0% | 34.4% | - | - | - |
| Ghana | 6.9% | 18.0% | - | - | 0.4% |
| Guinea | 10.7% | - | - | - | 2.3% |
| Guinea Bissau | 18.0% | 3.0% | - | - | - |
| Mali | - | 13.7% | - | - | 1.4% |
| Niger | 17.0% | - | - | - | 1.9% |
| Nigeria | 14.4% | 23.0% | 3.4% | - | - |
| Senegal | 6.6% | 27.6 % | 1.6% | - | 2.0% |
| Sierra Leone | 6.7% | 14.0% | 8.5% | 15.3% | 8.7% |
| Togo | 13.2% | 22.0% | - | - | - |

NB: SW=Sex workers; MSM=men who have sex with men; PWID=People who inject drugs; TG=Transgender group
No data on Key populations available for Cabo Verde or Liberia

## 2.2 TB Context

In 2018, 173 countries globally notified 4.3 million new and relapse TB patients with a documented HIV test result (a 15% increase from 3.8 million in 2017), equivalent to 64% of notified TB cases. This represented a 27-fold increase in the number of people with TB tested for HIV since 2004.[30]

Decades into the HIV epidemic, globally, three in five people starting HIV treatment are not screened, tested or treated for TB, the biggest killer of PLHIV.[31] Systematic symptom screening for TB among people living with HIV is recommended by the WHO as an essential component of the HIV care package, together with linkage to diagnostic services, as necessary. Globally, the number of people living with HIV provided with TB preventive treatment by national HIV programmes and other providers reached 1.8 million in 2018 (including 747 579 people in 55 countries who were newly enrolled in HIV care), up from just under 1 million in 2017.[32]

Due to a range of social, economic, cultural and other barriers, TB key populations are unable to access health and other supportive services and thus benefit most from targeted TB interventions. The Global Plan to End TB describes key populations according to the conditions underlying their risk for TB:

- increased exposure to TB - including prisoners and people in closed settings and sex workers,
- limited access to TB services, including men who have sex with men and transgender people,

- possession of certain biological or behavioral characteristics, including people who inject drugs.[33]

Globally, people who use and inject drugs remain stigmatized and criminalized, which contributes to significant health disparities, including extremely high rates of TB often combined with HIV and viral hepatitis.[34]

Globally, more than 10.2 million people are held in penal institutions at any one time and the number of prisoners with TB is estimated to be 4,500 for every 100,000; WHO considers 250 cases per 100,000 to be an epidemic. The prevalence of HIV, sexually transmitted infections, hepatitis B and C and tuberculosis in prison populations is estimated to be twice to ten times higher than in the general population.[35]

In many settings, people who inject drugs are also vulnerable to TB through experiences with prisons and custodial settings, where TB risk is marginally higher.[36] Prisoners and people in closed settings, people living with HIV, and people at risk of MDR-TB were among the top five groups with the worst case detection and treatment outcomes in West Africa.[37]

The number of notified HIV-positive TB patients on ART has grown in recent years. In the 30 high TB/HIV burden countries, overall, 85% of the TB patients known to be HIV-positive were on ART. However, there were six high TB/HIV burden countries, including Guinea-Bissau and Liberia, in which less than 50% of HIV-positive TB patients were started on ART in 2017.

WHO estimates that a total of 646,850 people fell ill with TB in 2018 in the ECOWAS Region, with nearly 80% of them occurring in three countries – Nigeria (66%), Ghana (7%) and Cote d'Ivoire (6%).[38] About 13.6% were HIV positive, a situation which represents an improvement over the 32% who were HIV positive in 2000. The proportion of TB deaths in persons living with HIV similarly declined from 45.7% in 2000 to 22% in 2018. Nearly 122,000 PLHIV in six ECOWAS countries received treatment for latent TB infection.

### 2.3 SRHR Context

There is little specific data on the sexual and reproductive health of key populations. What is available is primarily related to female sex workers and men who have sex with men. According to the sexually transmitted infection surveillance (2018), the syphilis seroprevalence among female sex workers was 13.2% for the African region in 2016-2017 compared to the overall median reported syphilis prevalence of 3.2%.[39] The median reported syphilis seroprevalence among men who have sex with men was 6.0%, and 2.3% in the African region over the same period[40]. Although there are limitations to STI case reporting, the data give a snapshot of the seroprevalence of syphilis among key populations.

## 3. Factors increasing key populations vulnerability to HIV, Hepatitis, TB and SRHR issues

**Key vulnerability factors of key populations in the ECOWAS:**

1. Significant barriers in accessing HIV, Hepatitis B & C, TB and SRH services
2. Lack of mechanisms and tools to generate accurate and reliable data regarding key populations
3. A high reliance on an international multi-donor funded response with low domestic resources towards key population programming
4. A scarcity of programs seeking to create an enabling environment for stigma, discrimination and violence reduction and community empowerment

A range of social, political, legal and structural factors increase the HIV vulnerability of key populations and prevent their access to HIV and other services. The WHO lists a number of barriers impeding key populations' access to health services, including intense stigma and discrimination, high levels of violence, gender inequities and social marginalization; legal barriers such as punitive and discriminatory legislation and policing practices; low prioritization by the public health system that often does not meet their specific needs; poverty and homelessness; high levels of incarceration in settings that are overcrowded, involve sexual violence, unsafe drug use, unsafe sexual activity, and limited access to comprehensive HIV prevention and services.[41]

The high level of population mobility within the ECOWAS is a factor that also affects vulnerability to HIV. Although there are several on-going regional projects, such as Abidjan-Lagos Corridor Organisation (ALCO) program, "*Frontières et Vulnérabilités au VIH en Afrique de l'Ouest »* (FEVE) program, Regional HIV/AIDS Prevention and Care project (PACTE-VIH), End Aids in West Africa (#EAWA) program and the Regional Programme of Harm Reduction about HIV, Tuberculosis and other Co-Morbidities, and Human Right Promotion for People Who Inject Drugs ("*Réduction des risques VIH et tuberculose et autres comorbidités et promotion des droits humains auprès des consommateurs de drogues injectables*") (PARECO) program[4] have been and are still undergoing, there is uncertainty as to their sustainability since their funding at the level of the Global Fund is potentially going to be limited[42]. Interventions designed within one country have very little impact on mobile populations. Consequently, interventions must be directed to ensure support to mobile targets using transboundary routes.

In addition, seven ECOWAS countries[5] are considered by the Global Fund as Challenging Operating Environments (COEs), characterized as having weak governance, poor access to health services, manmade crises (such as conflict) or natural crises (such as famine). The growing political instability and insecurity of the Sahel region is also a factor that can negatively impact health services and increase the vulnerability of key populations in the region.

A study on HIV, the law and human rights in the African human rights system by the African Commission on Human and People's Rights found that key populations across Africa have received limited protective rights-based responses at the continental, regional and national levels[43]. National HIV laws tend to focus narrowly

[4] ALCO, FEVE, PACTE-VIH & #EAWA projects (regional HIV/AIDS prevention and care projects), PARECO (Harm reduction and human rights regional project for people who inject drugs)

[5] Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria and Sierra Leone as per the Global Fund's Operating Policy Manual (https://www.theglobalfund.org/media/3266/core_operationalpolicy_manual_en.pdf)

on the rights of people living with HIV, and national HIV responses often fail to include the participation of key populations or to prioritise their needs in HIV-related law and human rights programmes.[44]

Young people who belong to one or more key populations are especially vulnerable due to the particular vulnerabilities of youth, power imbalances in relationships, lack of information and misconception of the risks, engaging in high-risk behaviours, such as unprotected sex and drug and alcohol consumption,[45] and, sometimes, alienation from family and friends. These factors increase the risk that they may engage – willingly or not – in behaviours that put them at risk of HIV.[46] A recent study of men who have sex with men in West Africa[6] found that 45.9% of them received benefits from transactional sex and that the younger they were, the more likely they were to engage in transactional sex.[47] In addition, young key populations are at higher risk than adult key populations for sexually transmitted infections and experience higher rates of mental health problems when compared with their same age counterparts in the general population, or older key population peers. Young key populations also often require greater social support and have less access to such support.

Adolescent girls are prime targets of gender-based violence, which includes incest, sexual abuse, intimate partner violence, early and forced marriage, marital rape, female genital mutilation, sexual exploitation and trafficking. Women and adolescent girls belonging to key populations face elevated risks of violence, discrimination and stigma, compounding the risks of HIV. Available information shows that pregnant women from key populations experience high rates of unintended pregnancies, sexual violence, abortion and unmet need for contraception. Women who inject drugs have reported high rates of sexual violence from law enforcement officials. Sex workers are at high risk of violence from intimate partners, clients and law enforcement officials.[48]

**Table 2: Summary of key service areas for key populations, WHO Consolidated Guidelines**

| | |
|---|---|
| **Health Sector Interventions** | |
| 1 | HIV prevention (condoms, lubricant, PrEP, PEP, Voluntary medical male circumcision (VMMC)) |
| 2 | Harm reduction interventions for substance use, in particular needle and syringe programmes, opioid substitution therapy (OST) and naloxone for overdose management |
| 3 | HIV testing services |
| 4 | HIV treatment and care |
| 5 | Prevention and management of co-infections and other comorbidities, including viral hepatitis, TB and mental health conditions |
| 6 | Sexual and reproductive health interventions |
| **Critical enablers** | |
| 1 | Supportive legislation, policy and financial commitment, including decriminalization of behaviours of key populations |
| 2 | Addressing stigma and discrimination |
| 3 | Accessible, available and acceptable health services |
| 4 | Community empowerment |
| 5 | Addressing violence against people from key populations |

[6] Cohort study CohMSM, which was conducted in Burkina Faso, Côte d'Ivoire, Mali and Togo

The Catch-Up Plan for the WCA region notes that major barriers for key populations in accessing services include high levels of stigma and discrimination, high rates of gender-based violence (including in conflict and emergency situations) and gender inequities. Punitive laws and policies also deter key populations from fully using available services.[49] These factors increase the vulnerability of key populations and make them less likely to access the key service areas identified by the WHO (Table 2).

Based on information from the literature review and analysis of feedback from the key informants (see Annex 1), four key factors that are critical to the vulnerability of key populations in the ECOWAS have been identified:

1. Significant barriers in accessing HIV, Hepatitis B & C, TB and SRH services
2. Lack of mechanisms and tools to generate accurate and reliable data regarding key populations
3. A high reliance on an international multi-donor funded response with low domestic resources towards key population programming
4. A scarcity of programmes seeking to create an enabling environment for stigma, discrimination and violence reduction and community empowerment

Each vulnerability factor is discussed in detail in the following sections.

### 3.1 Significant barriers in accessing HIV, Hepatitis B & C, TB and SRH services

**Main challenges for key populations in accessing services:**

- Uneven access to a comprehensive service package by all key populations
- Concentration of services in urban areas
- Low coverage of prevention, testing and linkage to care interventions
- Lack of harm reduction interventions
- Scarcity of PEP and PrEP
- Uneven access to ART and STI services
- Unavailability of health commodities
- Issues with accessibility to health services

Although there has been progress in addressing the health needs of key populations in the ECOWAS, all key populations continue to lack access to a comprehensive service package. Further, no country provides targeted services to address the particular needs of young key populations despite them having a lower uptake and coverage of HIV services compared to adult key populations.[50] Though some key populations have access to some services from the comprehensive package of services other key populations lack access. With respect to sex workers, men who have sex with men and people who inject drugs, at least 80% of the countries in ECOWAS in their National HIV Strategic Plans (NSPs) had at least one targeted intervention activity in half of the key service areas identified by the WHO.[7] However, for prisoners and people in closed settings, this percentage decreased to 40% and for transgender persons, to less than 7%. The NSPs were least likely to have targeted interventions for harm reduction and SRH, including access to post-exposure (PEP) and pre-exposure prophylaxis (PrEP). (see Annex 4)[51]

[7] The six areas are HIV prevention, harm reduction for people who inject drugs, HIV testing services, HIV treatment and care, sexual and reproductive health, and critical enablers.

Even if key populations are recognised in NSPs, there continues to be difficulties with program implementation and services are not implemented as they are designed. The coverage of such programmes also varies widely across and within countries in the region. In 2018-19 the Global Fund commissioned an assessment of HIV Service Packages for Key Populations in Selected Countries in West and Central Africa. The report shows that there is a concentration of services in urban areas; low coverage of prevention, testing and linkage to care interventions; lack of harm reduction interventions; scarcity of PEP and PrEP and uneven access to anti-retroviral treatment (ART) and sexually transmitted infections (STIs) services.[52] It further notes the lack of specific strategies to target young MSM regarding HIV testing and counselling.

Availability of health commodities remains a challenge in West Africa. The Regional Community Treatment Observatory in West Africa (RCTO-WA) that focuses on key populations noted that between July 2017 to June 2018 frequency of stock outs of commodities was 9% for HIV test kits, 24% for anti-retroviral medications (ARVs) and 17% for viral load supplies. On average stock outs for ARVs lasted for 41 days, but in the most extreme case one health care facility recorded a 7-month stock out.[53]

Accessibility is also a factor that hinders the health access for key populations and others. The RCTO-WA report shows that distance to the nearest health facility was the most common reason for not accessing HIV testing and ART. It identifies several other factors which limit key populations' access to HIV, hepatitis, SRH and TB services. These include limited linkage to care, limited access to viral load testing, low ratings of quality of service provision by users, the lowest rating among key population groups being for men who have sex with men and highest for sex workers, highlighting potential higher levels of stigma and discrimination towards specific key populations by heath care workers.

There has been a reinforced synergy between HIV and TB programmes in the ECOWAS, but despite this progress, more efforts are required for service delivery to be reconfigured for the adequate integration of TB in HIV programming.[54] Depending on the degree of integration between a country's TB and HIV services and their respective monitoring and evaluation systems, the patient pathway for HIV-associated TB can be more complex to track, since there may be a need for referral from one program to another. Close collaboration between the TB and HIV services is therefore critical for reducing loss to follow-up and preventable mortality.[55]

Most countries include STI services as part of service packages for sex workers, men who have sex with men, and people who inject drugs. Other sexual and reproductive health interventions that may be found in some countries include family planning, cervical cancer screening, promotion of voluntary medical male circumcision, prevention of mother-to-child transmission (PMTCT), gender-based violence (GBV) prevention and related services. [56] However, more effort is needed to scale up programmes to increase the coverage of prevention and treatment services for key populations, and to include specific strategies aimed at increasing access for young key populations. In addition, there is a lack of comprehensive information on the availability and accessibility of SRH services and on how integrated SRH services are into HIV programming in the ECOWAS.

A number of initiatives, such as harm reduction pilot projects; piloting of community and facility-based services for people who use drugs, self-testing for men who have sex with men and a regional PrEP program, are being implemented in the ECOWAS Region to address the health needs of key populations.[57] However, these are still at a pilot phase and the ECOWAS will need to rapidly respond to the lack of widespread community-based facilities and lack of differentiated service delivery models if it is to increase coverage of services targeting key populations. In Nigeria for example key populations were more satisfied with the quality of services provided by peer-led organisations than with public health facilities particularly with

respect to service providers listening to respondent's problems and concerns, privacy and confidentiality and respect of rights of service recipients.[58] In Ghana, in spite of travel costs and longer waiting times, PLHIVs preferred to travel to distant clinics for fear of stigmatization rather than have care brought closer to them at their homes.[59]

### 3.2 Weak mechanisms and tools to generate accurate and reliable data regarding key populations

**Main challenges related to data regarding key populations:**

- Scarcity of accurate national PSE for key populations
- Lack of data beyond PSE, programmatic mappings and HIV prevalence (e.g. HIV incidence, coverage of HIV and other programs)
- Irregularity of key population biological-behavioural surveys (BBS) and low community involvement in the process
- Insufficient monitoring of key population access to services
- Data management systems which do not disaggregate key population data (e.g. age, sex and gender sensitive)

Since the Dakar Declaration, there has been progress in terms of generating more key population-related data in the region. For instance, programmatic mappings have been conducted or updated in Burkina Faso, The Gambia, Guinea Bissau, Liberia, Nigeria and Mali. In Togo, data generation on stigma and discrimination has led to improved access to services[60]. The RCTO-WA and RAME treatment observatories cover 12[8] of the 15 ECOWAS countries, but only four countries—Côte d'Ivoire, Ghana, Niger, Togo—have an observatory on violence, stigma, discrimination against key populations, PLHIV and other vulnerable populations.[61]

The People Living with HIV Stigma Index has been implemented at least once in 8 countries of the region since 2008. Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, Guinea, Guinea Bissau and Niger have not yet done so.[62] According to UNAIDS only 3 countries of the region have national Population Size Estimates (PSE) for any one key population. Cote d'Ivoire, Senegal and Togo have national PSE for prisoners and people in closed settings, and only Senegal as a national PSE for people who inject drugs. All other PSE conducted in the countries of the ECOWAS do not provide national level estimates (see Annex 3). They further fail to disaggregate the data based on age thus failing to provide clear information regarding young key populations. The quality and accuracy of key populations' PSE is a subject of controversy and questions about methodology have been raised. Data suggests that there are underestimations in the PSE, which can potentially be linked to the high levels of stigma and discrimination experienced by key populations in the region which limit reliability of size estimation methodology. For instance, PSE for men who have sex with men are higher when using social media as sampling method.[63] On the other hand, other studies show disproportionately high PSE.[64] HIV prevalence data for key populations in the region are available but very few are national estimates.

Even when the basic information such as HIV prevalence and sub-national PSE is available on a specific key population, data such as incidence of HIV and coverage of programmes is lacking. Data on coverage of HIV prevention programmes in the region is only available for sex workers and men who have sex with men. No country has these data on people who inject drugs, the transgender population or prisoners and people in closed settings or on coverage of HIV testing and treatment services.[65]

[8] Benin, Burkina Faso, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Senegal, Sierra Leone, and Togo

In addition, data are sometimes out of date as surveys are not done regularly and the reliability of the data generated is sometimes contested at country level. This is often the case for Bio-Behavioural Studies (BBS). Furthermore, data on HIV prevalence among key populations are not disaggregated by location, sex and age. Given the high vulnerability to HIV facing young key populations, the lack of disaggregated data by age makes it more difficult to plan for and address the needs of young key populations. There is a lack of evidence on how many of the surveys are community-led, but only 40% of the ECOWAS countries consider the degree of participation of key populations in the design, implementation, M&E of community-based interventions high.[66] Community-collaborative studies are key to increasing the relevance and impact potential of research.[67]

Key populations' access to services is not sufficiently monitored and measured mainly due to lack of appropriate tools and funding. Togo is the only country of the ECOWAS which has a Unique Identifier Code (UIC) for key populations that is used across the entire HIV prevention system and is used by all stakeholders. Even so, no country has a system by which key populations can be tracked across the full continuum of care, making it difficult to determine whether key populations are accessing ART and achieving viral suppression Monitoring of critical enabler activities is limited, as well as quality and accessibility of services for key populations.[68] Adequate programmatic service coverage levels among key populations affected by the HIV epidemic is a prerequisite to achieving overall HIV epidemic control as well as control among key population communities.[69]

Data management systems need to be age, sex and gender sensitive to provide detailed enough information for programming for sub-groups within a key population and producing strategic information such as Spectrum projections that include key population data. Up-to-date and accurate data and data management systems will enable tracking of key populations across the HIV cascade of services within one or many countries, in a manner that respects the privacy and other concerns of key populations. Without this, the region will continue to face challenges in designing and monitoring targeted and high-impact key populations programmes.

### 3.3 A high reliance on international, multi-donor funding and limited domestic resources supporting key population programming

**Main challenges related to funding of key population programming:**

- Limited domestic funding of HIV national responses
- Reliance on international donors
- Funding gaps can cause program discontinuation and prevent upscaling of programs
- Multi-donor environment creates disparities in the implementation of programs

In 2018, the availability of financial resources for HIV in west and central Africa was 10% less than in 2017, and domestic funding comprised 38% of total HIV resources. According to the latest available data, domestic (public and private) funding accounts for 12% ($91,640,293) of total spending from all sources ($760,780,839) of the national HIV response in countries in the ECOWAS. In Liberia, Guinea, Niger and Sierra Leone less than 1% of national HIV response is financed from domestic sources .[70]

In all settings, greater investment in a country's key populations is likely to improve the cost-effectiveness of the response to HIV. Projections suggest that expanding coverage of key population programmes could

stabilize or even decrease incidence rates.[71] Program resources should be allocated among populations in a way that maximally reduces downstream infections and deaths considering each country's unique epidemic situation.[72] However, the reliance on international funding in the ECOWAS region is creating major funding gaps for national responses and coupled with the unwillingness of many countries to apply domestic funding to key population programming, it is obstructing scaling-up of the latter.

Funding gaps and high reliance on international donors can cause program discontinuation. In some countries of the region, the multi-donor environment also creates disparities in the implementation of programming, such as the lack of a standardised UIC and varying incentives for peer educators. These create disparities that have a negative impact on the HIV response for key populations.

Increasing dependence on international funders to fill funding gaps for key population programmes is not sustainable. In addition to mobilizing more external funders, increasing national health budgets, prioritizing towards HIV and adequately funding key population programming is essential to reach the Fast Track targets by 2030.

### 3.4 A scarcity of programmes seeking to create an enabling environment for stigma, discrimination and violence reduction and community empowerment

**Main challenges in creating an enabling environment for key populations:**

- High levels of stigma, discrimination and violence towards key populations
- Lack of community empowerment
- Legal, policy and regulatory framework include punitive laws and policies such as the criminalization of drug use, sex work and same-sex sexual acts as well as laws criminalizing HIV transmission and exposure

HIV epidemics, particularly among key populations, continue to be fuelled by stigma and discrimination, gender inequality, violence, lack of community empowerment, and punitive laws and policies, including laws criminalizing sex work, drug use and diverse forms of sexuality. These socio-structural factors limit access to TB, HIV, hepatitis and other SRH services, constrain how these services are delivered and diminish their effectiveness. Interventions to reduce stigma and discrimination; prevent violence; review laws, policies and practices that create legal barriers for key populations and empower key population communities are critical to creating an enabling environment.[73] Key population networks can play a key role by documenting their experiences and efforts to respond to HIV and protect their human rights, and ensure that the community is playing a leadership role.[74]

Progress has been made with regards to creating a more enabling environment for key populations in the ECOWAS. In Togo, strengthening the capacities of key populations, proactively taking into consideration their needs, and the active mobilization of key populations made it possible to adopt a National Policy on key populations. In Sierra Leone, the CARKAP initiative[9] is partnering with the Government Legal Aid Board for access to justice of people living with HIV and other vulnerable groups, their communities and families; and to carry out joint legal literacy / education programmes on legal issues pertaining to HIV/AIDS. On a regional level, opportunities to create a more enabling environment include the regular key population regional meetings, the political momentum from the Dakar Declaration and emerging key population-led

[9] The "Consortium for the Advancement and Rights of Key Affected populations" is a Community Based organization operated by key populations and key population CBOs including People Living with HIV

organizations and their increasing capacity. Furthermore, there are several ongoing regional initiatives such as the ALCO, FEVE, PACTE-VIH & #EAWA projects[10], the PARECO[11] program, and observatories of access to treatment and community observatories which support key population programming.[75] Tools such as the model drug law, developed by the West Africa Commission on drugs will support law reforms related to key populations.

However, in the ECOWAS Region, key populations, especially those living with HIV, face high levels of stigma, discrimination and violence. Many factors contribute to this including traditions, religious beliefs, taboos, myths and misinformation, laws, gender norms and other social and cultural factors. Stigma and discrimination affect key populations at many levels of their lives – family and community, health, work and educational settings. Qualitative data from the RCTO-WA found fear of stigma and discrimination was one of the key factors that prevents men who have sex with men, sex workers and people who inject drugs from accessing ART.[76] Stigma Index studies conducted in 8 countries in ECOWAS—The Gambia, Ghana, Liberia, Mali, Nigeria, Senegal, Sierra Leone and Togo —show between 3% to 22% of people living with HIV reported breaches of their confidential HIV status by a health care worker. The percentage of women and men who report discriminatory attitudes towards people living with HIV is 80% in Guinea, 67.7% in Ghana and 65.5% in Senegal.[77]

Detailed data on stigma and discrimination experienced by key populations in ECOWAS are limited. Few countries collect this information, but it appears that key populations experience heightened levels of stigma and discrimination. In Cote d'Ivoire, for example, 23% of female sex workers and 22% of men who have sex with men reported avoiding health care services due to fear of stigma and discrimination.[78] The Stigma Index studies highlight the particularly vulnerable position of key populations. For instance, the Sierra Leone Stigma Index analysis found that men who have sex with men, transgender and other key populations are "a hidden group…including in the PLHIV community" making them less able to access appropriate care and support. Qualitative data from the Human Rights Assessment in Cote d'Ivoire reveal that people with TB experience significant stigma and discrimination in their communities and other settings. In health care settings, it is reported that people who use drugs seeking TB services are often refused treatment and care.[79]

Key populations experience high levels of violence, including physical and sexual violence, and harassment, intimidation, and blackmail. There is little comprehensive data regarding violence against key populations in the ECOWAS. According to the WHO technical briefs, young key populations are often more vulnerable to violence, stigma and discrimination than older key populations.[80] However, 60.6% of female sex workers in Cote d'Ivoire reported being subjected to physical violence; 84.6% of them within the past 12 months. Almost half (44.1%) of the female sex workers reported having been subjected to sexual violence, 25.5% reported being afraid to seeking health services and 23.2% reported avoiding health services, due to concern of disclosing engagement in sex work.[81]

An enabling legal, policy and regulatory framework in the ECOWAS in accordance with international and regional guidance and commitments is critical to ensuring key populations' access to HIV, Hepatitis, TB and other SRH services.[82] The criminalization of drug use, sex work and same-sex sexual acts further isolates key populations and makes them more vulnerable to stigma, discrimination and violence, as well as incarceration.[83] Decriminalization can directly affect HIV transmission among key populations. For instance, studies suggest that that decriminalisation of sex work through its downstream impacts on violence, safer work environments and sexual risks, have the potential to avert 33–46% of HIV infections in sex workers

[10] Regional HIV/AIDS prevention and care projects
[11] Harm reduction and human rights regional project for people who inject drugs

over the next decade.[84] For young key populations, the lack of laws and policies providing for the age of consent to HIV testing and accessing contraception, among others, can be a barrier to their accessing health services.

In addition, laws criminalizing HIV transmission and exposure increases stigma against people living with and vulnerable to HIV, including key populations. Although it is acknowledged that not all of these laws are enforced, their existence can be a deterrent to key populations accessing services. Table 3 outlines the status of criminalization of key population groups in ECOWAS countries.

**Table 3: Extract from the laws and policies scorecard of the ECOWAS**

| Country | Criminalization of transgender people | Criminalization of sex work among consenting adults | Criminalization of same-sex sexual acts | Criminalization of drug possession / personal use | Criminalization of the transmission of, non-disclosure of or exposure to HIV transmission |
|---|---|---|---|---|---|
| Benin | No | Any criminalization or punitive regulations of sex work | No | Yes | Yes |
| Burkina Faso | No | Any criminalization or punitive regulations of sex work | No | Yes | Yes |
| Cabo Verde | No data | No data | No | No data | Yes |
| Côte d'Ivoire | No | Any criminalization or punitive regulations of sex work | No | Yes | Yes |
| Gambia | No data | No data | Yes | No data | No data |
| Ghana | No | Any criminalization or punitive regulations of sex work | Yes | Yes | Yes |
| Guinea | No | Issue is determined/differs at subnational level | Yes | Yes | Yes |
| Guinea-Bissau | No | Any criminalization or punitive regulations of sex work | No | Yes | Yes |
| Liberia | No data | Any criminalization or punitive regulations of sex work | Yes | Yes | Yes |
| Mali | No | No | No | Yes | Yes |
| Niger | No | Any criminalization or punitive regulations of sex work | Yes | Yes | Yes |
| Nigeria | No | Any criminalization or punitive regulations of sex work | Yes | No data | Yes |
| Senegal | No | Any criminalization or punitive regulations of sex work | Yes | Yes | Yes |
| Sierra Leone | Yes | Any criminalization or punitive regulations of sex work | Yes | Yes | Yes |
| Togo | No | Any criminalization or punitive regulations of sex work | Yes | Yes | Yes |

SOURCE: Extracted / adapted from UNAIDS Data Report (2019)

Evidence shows that health policies and programmes are more effective and have a more positive impact on health outcomes when affected populations take part in their development.[85] Nonetheless, the empowerment of key populations, and their subsequent meaningful participation in the design, implementation and monitoring and evaluation of policies and programmes that affect them is low in the ECOWAS Region.

To increase key populations' access to HIV, Hepatitis B & C, TB and SRH services and lower their vulnerability to these issues, ECOWAS will invest in policies and programmes that seek to reduce stigma, discrimination and violence against key populations, to create an enabling legal and policy environment and to empower the key population communities.

# 4. Strategic orientation

## 4.1. Introduction

This regional strategy has been developed by ECOWAS, through WAHO and Member States, to address the needs and vulnerabilities of key populations regarding HIV, TB, hepatitis B and C and SRH issues to enable a comprehensive, scaled-up and sustainable response. The vision, goal and mission for the strategy are as follows:

**Vision**: An ECOWAS Community in which all key populations have universal access to comprehensive HIV, TB, Hepatitis B & C and SRH services, free from stigma and discrimination.

**Goal**: To create an enabling legal, social and economic environment in the ECOWAS to facilitate access to HIV, TB, Hepatitis B & C and SRH services that are comprehensive and designed to address the needs of each key population sub-group.

**Mission**: To guide the implementation of comprehensive HIV, TB, Hepatitis B & C and SRH services for key populations through a coordinated framework that supports regional and national leadership and ownership to enable the region towards meeting the SDG targets 3.3 (end AIDS & TB and combat Hepatitis), 3.7 (universal access to SRH services) and 3.8 (universal health coverage).

## 4.2 Strategic Objectives

The strategic objectives of the ECOWAS regional strategy are as follows:

1. **Strengthen national and regional coordination and leadership for a harmonized and sustainable regional response to HIV, TB, Hepatitis B & C and SRHR issues for key populations**

This objective focuses on improving national and regional coordination by developing strong partnerships with State Partners and by fostering high-level ownership and accountability of the regional strategy. It also includes strategies to sustain and increase resources for HIV, TB, Hepatitis B & C and SRH programming for key populations.

2. **Strengthen the management of health information relating to key populations to guide the development of evidence-based policies and programming for targeting them.**

The second objective has three key result areas as follows:

- Generate reliable data for each key population through regular population size estimates, mappings, studies and research to understand the scale of HIV, TB, Hepatitis B & C and SRHR issues among key populations and their specific needs
- Integrate all service-delivery data related to key populations into the national and a regional M&E system to track effectiveness of programmes and identify needs in re-strategizing while maintaining confidentiality and data security.
- Improve use and dissemination of strategic information by producing prevention, testing and treatment cascade for key populations and analysing national and regional data to inform policy and programming decisions.

3. **Scale-up comprehensive and targeted prevention, treatment, care and support interventions with regard to HIV, TB, Hepatitis B & C and SRH services to reduce incidence, morbidity and mortality among key populations.**

The first phase of the third objective is to identify gaps in the provision of the standard package (as per WHO Consolidated Guidelines) of services and service models targeting key populations, including young key populations. Secondly, incorporating international guidelines for integrated services, including combined

prevention, differentiated service-delivery, legal and social services and community outreach services in national HIV, TB, Hepatitis B & C and SRH protocols. Then upscale specific, comprehensive and integrated HIV, TB, Hepatitis B & C and SRH care, social and legal services and interventions, which are accessible to all key populations.

4. **Empower all key populations and promote their meaningful participation in policy and program design, implementation and monitoring to ensure more effective health policies and programmes.**

Objective four aims to increase participation of key populations in the design, implementation and monitoring and evaluation of relevant policies and programming while empowering them to meaningfully engage with stakeholders on HIV, TB, Hepatitis B & C and SRHR issues. This includes a specific focus on the empowerment of young key populations to also meaningfully engage with stakeholders on the same subjects.

5. **Ensure that the human rights of key populations are respected by addressing the social, economic and legal determinants of health, including discriminatory laws, stigma, discrimination and violence which hinder their access to health services.**

Objective five aims to improve awareness amongst stakeholders, especially policy makers on the rights of key populations to facilitate the adoption and enforcement of supportive policies, strategies and guidelines that alleviate stigma, discrimination and violence against key populations.

### 4.3 Strategic Framework

| Key Result Area | Indicator | Output/Results | Actions | Responsible party (ies) |
|---|---|---|---|---|
| **Objective 1: Strengthen national and regional coordination and leadership for a harmonized and sustainable regional response to HIV, TB, Hepatitis B & C and SRHR issues for key populations** | | | | |
| 1.1 Improve national and regional coordination by developing strong partnerships with State Partners and by fostering high-level ownership and accountability of the regional strategy | Number of countries that report having integrated the regional strategy in national strategies and action plans<br><br>Number of interventions towards the regional platform for key populations<br><br>Number of meetings/exercises to monitor progress and share best practices<br><br>Number of national best practices disseminated across the region on HIV, TB, Hepatitis B & C and SRHR | Operationalised national roadmaps/action plans in each country<br><br>Increased capacity of regional platform for key populations to contribute to the regional strategy<br><br>Progress of each country is regularly monitored, and achievements are capitalised on | Support each country in integrating this regional strategy in national level by ensuring that:<br>- The regional strategy is endorsed by the relevant local authorities<br>- The framework provided by the regional strategy is included in all national and regional discussions and forums<br>- National Strategic Plans are developed, reviewed or updated accordingly<br>- WAHO Liaison Officers have the capacity, means and resources required to support their country<br><br>Revive the regional platform for key populations, ensuring representation of each ECOWAS country and build its capacity to contribute to the implementation and monitoring and evaluation of the regional strategy<br><br>Hold accountable each country of the ECOWAS by monitoring the implementation of all strategic objectives<br><br>Hold regular forums such as the regional key population meeting to increase ownership of regional strategy, share and build on best practices, evaluate national achievements of implementation of this strategy, address bottlenecks and push the key population agenda at national level | ECOWAS through WAHO - WAHO's Liaison Officers in each ECOWAS country and other institutions of ECOWAS (EGDC, Community Parliament)<br><br>Member States<br><br>Key Population Networks and organisations<br><br>Development partners to support process |
| 1.2 Sustain and increase resources for HIV, TB, Hepatitis B & C and SRH programming for key populations | Number of countries that have specific budget allocations for key population interventions and established mechanisms for key population-related HIV, TB, Hepatitis B & C and SRHR domestic financing | Specific budget allocations for key population interventions<br><br>Established mechanisms for HIV domestic financing (including components for co-infections, Hepatitis and SRHR) | Conduct assessment on countries' key population programming cost and a mapping of resources for key population programming in the region<br><br>Conduct a social contracting diagnosis in countries of the region to assess readiness of domestic funding for key population interventions<br><br>Facilitate and coordinate High Level Dialogue forums to mobilise increased domestic funding for key population interventions | |
| | Proportion of HIV funding towards key population | Increased investment in key population programming, including on innovative | Fast track the adoption of the recommendations of High Level Dialogue on domestic financing by all the Member States | |

| Key Result Area | Indicator | Output/Results | Actions | Responsible party (ies) |
|---|---|---|---|---|
| | interventions in each country and at regional level | interventions, research on incidence among key populations | Facilitate and coordinate high level dialogue forums to mobilise increased international resources | |
| **Objective 2: Strengthen the management of health information relating to key populations to guide the development of evidence-based policies and programming for targeting them** | | | | |
| 2.1 Generate reliable data for each key population through regular population size estimates, mappings, studies and research to understand the scale of HIV, TB, Hepatitis B & C and SRHR issues among key populations and their specific needs | Number of countries with PSE and known profile data collected in cooperation with communities and disaggregated by sex and age, and covering all key populations (sex workers, men who have sex with men, transgender people, people who inject drugs, prisoners and people in closed settings) | Countries and region have an accurate understanding of their key populations disaggregated by sex and age, including size estimates, incidence, disease burden, human rights violations, access to services and specific needs. | Adapt protocols for key population PSE, mappings, behavioural & biological surveys and other research to ensure that:<br>- The methodology is based on the latest best practices to be the most reliable and accurate possible<br>- Key populations are included in the process<br>- A human rights-based approach is adopted<br>- Consensus is obtained from all stakeholders on the results of the mappings, surveys and studies<br><br>Conduct key population PSE, mappings, behavioural & biological surveys, surveillance, evaluations, research and other studies as per harmonized protocols. | ECOWAS through WAHO, the Community Parliament standing committee on health and social services<br><br>Member States (Ministries/ departments/ state agencies responsible for health and HIV, information & telecommunications/ data protection)<br><br>Key Population Networks and organisations to be part of process<br><br>Development partners to support process<br><br>The network of social marketing institutions of the ECOWAS |
| 2.2 Integrate all service-delivery data related to key populations into the national and a regional M&E system to track effectiveness of programmes and identify needs in re-strategizing while maintaining confidentiality and data security | Number of countries with national M&E systems which capture all service-delivery data related to key populations in safe and confidential manner | Countries and region can effectively track all interventions and re-strategize their programmes based on their effectiveness. | Develop a harmonized M&E framework (tools, indicators, structures, systems) for the ECOWAS to guide the integration of KP-related indicators in each national M&E system, including but not limited to the following:<br>- a UIC for key population interventions that is compatible with cross-border interventions<br>- a mechanism to feed data from NGOs (especially outreach prevention and testing services) into the national-level data<br>- a mechanism to integrate all key population data into the Health Management Information Systems at national levels<br>- data ownership by key populations<br><br>Build capacity of ECOWAS countries to improve their capacity to generate, analyse and strategically use data to inform decisions related to key population programming. | |
| 2.3 Improve use and dissemination of strategic information by producing prevention, testing and treatment cascade for key populations and | Number of countries where prevention, testing and treatment cascade for key populations is available on a yearly basis | Countries and region can analyse accurate and reliable data to inform policy and program decisions. | Adapt and/or update, in conjunction with key population community groups, standard guidelines for all five key populations including common definitions and terminology, comprehensive standard packages, especially for TB, Hepatitis B & C and SRH services, behavioural | |

| Key Result Area | Indicator | Output/Results | Actions | Responsible party (ies) |
|---|---|---|---|---|
| analysing national and regional data to inform policy and programming decisions | | | interventions, community outreach services including peer outreach and definition of coverage.<br><br>Produce a prevention, testing and treatment cascade for key populations for each country of the ECOWAS region | |
| **Objective 3: Scale-up comprehensive and targeted prevention, treatment, care and support interventions with regard to HIV, TB, Hepatitis B & C and SRHR services to reduce incidence, mortality and morbidity among key populations** | | | | |
| 3.1 (a) Identify gaps in the provision of the standard package (as per WHO Consolidated Guidelines) of services and service models targeting key populations | Number of countries that identified gaps in the provision of the comprehensive package of services for key populations through a review, including focus on social protection for key populations and opportunities to expand community-based services | Region and countries have a comprehensive knowledge of the gaps in the provision of the comprehensive package of services and service models targeting key populations. | Assess completeness and availability of the comprehensive package of services for key populations on the ground, aligned with WHO Guidance for Key Population service packages for the whole region<br><br>Review HIV, TB, Hepatitis B & C and sexual and reproductive health and STIs testing, outreach, care and support services models to guide expansion of community-based services in providing strong linkages in the whole continuum of care<br><br>Assess the existing social protection programmes and their sensitivity to key populations using the UNAIDS 'HIV and social protection assessment tool'<br><br>Identify the technical, human and financial resources required for the implementation of comprehensive packages of services towards key populations | ECOWAS through WAHO, the Community Parliament standing committee on health and social services<br><br>Member States (Ministries/ departments/ state agencies responsible for health and HIV, justice, law enforcement, finance, social security, telecommunications and members of parliament)<br><br>Key Population Networks and organisations to be part of process<br><br>Development partners to support process |
| 3.1 (b) Identify gaps in the provision of comprehensive services for young key populations. | Number of countries that have identified gaps in the provision of comprehensive services for young key populations and have developed a set of recommendations on how to best address those gaps. | Countries have a comprehensive knowledge of the gaps in the provision of the comprehensive package of services and service models targeting young key populations. | Assess completeness and availability of the comprehensive package of services for young key populations on the ground.<br><br>Review HIV, TB, Hepatitis B & C and sexual and reproductive health and STIs testing, outreach, care and support services models to guide expansion of community-based services in providing strong linkages in the whole continuum of care<br><br>Identify the technical, human and financial resources required for the implementation of comprehensive packages of services towards young key populations | |
| 3.2 Incorporate international guidelines for integrated services, including combined prevention, | Number of countries that have formally validated national protocols for integrated services, combined prevention, differentiated service-delivery, | Region and countries have national protocols to guide an effective upscaling of services to key populations | Incorporate international guidelines in national protocols for the integration of HIV, TB, Hepatitis B & C and SRHR interventions targeting key populations related to care, social and legal services, including HCW training by key | |

| Key Result Area | Indicator | Output/Results | Actions | Responsible party (ies) |
|---|---|---|---|---|
| differentiated service-delivery, legal and social services and community outreach services in national HIV, TB, Hepatitis B & C and SRH protocols | legal and social services and community outreach services | | populations and referrals and services for victims of violence (for people of all genders)<br><br>Incorporate international guidelines in national protocols for combined prevention interventions, innovative programmes and differentiated service delivery models for HIV, TB, SRH and Hepatitis B & C including short-term solutions such as key population-responsive specialised sites that provide services until adapted care is upscaled<br><br>Incorporate international guidelines in national protocols for community outreach services including a peer education curriculum (including comprehensive training for PE, role and responsibilities of a PE, security protocols, criteria for recruitment and payment scales, implication of community leaders and e-outreach) | |
| 3.3 Upscale specific, comprehensive and integrated HIV, TB, Hepatitis B & C and SRH care, social and legal services and interventions, which are accessible to all key populations | Number of countries that are providing the comprehensive package of services outlined in the WHO guidelines such that the services are accessible to all key populations. | Key populations in the region and countries are accessing specific and comprehensive integrated services equitably | Provide specific, comprehensive and integrated services and interventions to all key populations, with special attention to the underserved (specific package for transgender people, comprehensive package for prisoners and people in closed settings, harm reduction for PWUD, focus on key populations with a disability, comprehensive social and legal services including services and referrals for victims of violence accessible irrespective of gender, access for females and minors)<br><br>Scale up interventions, promote innovative models and document and share best practices | |
| **Objective 4: Empower all key populations and promote their meaningful participation in policy and program design, implementation and monitoring to ensure more effective health policies and programmes** | | | | |
| 4.1. Increase participation of key populations in the design, implementation and monitoring and evaluation of relevant policies and programming | Number of countries where programme design and implementation, data collection/monitoring activities, services or law reform activities are led by key populations or they are key participants.<br><br>Number of national and regional HIV, TB, Hepatitis B & C and SRHR meetings where key populations are represented | Geo-spatial mapping of key population organizations and linkage to opportunities for key population programming.<br><br>Mechanism for participation, coordination and engagement of key populations developed.<br><br>Key population advocates participating in regional and national HIV dialogues. | Mapping of national and regional key population organisations in ECOWAS and analysis of opportunities for key population programming.<br><br>Develop and operationalize mechanisms to ensure networking between national and regional platforms and increase participation of key populations in policy and program development, implementation, monitoring and evaluation at national and regional levels. | ECOWAS through WAHO, EGDC, the Community Parliament<br><br>Member States Ministries/ departments/ state agencies responsible for HIV and health, gender & human rights |

| Key Result Area | Indicator | Output/Results | Actions | Responsible party (ies) |
|---|---|---|---|---|
| | | | Convene regular fora to discuss HIV, TB, Hepatitis B & C and SRHR services for key populations with other key stakeholders at national and regional level. | National and regional key Population Networks and organisations, and CBOs<br><br>Development partners to support process |
| 4.2 Empower key populations to meaningfully engage with stakeholders on HIV, TB, Hepatitis B & C and SRHR issues | Number of countries that are providing technical and financial support to key population organisations/groups<br><br>Number of countries with key population organisations/groups reporting increased capacity<br><br>Number of countries where training/sensitization workshops are provided by key populations | Key population/civil society organisations have increased capacity to meaningfully participate | Increase key population participation in program design, implementation and M&E (e.g. mechanism to report human rights violations, community treatment observatory, peer education)<br><br>Foster and support (financially and technically) emerging and existing key population-led organisations in areas such as advocacy, human rights, program and financial management, health systems, health and legal literacy<br><br>Support national key population organisations in advocating for increased key population participation and countries in increasing investment in capacity building and empowerment of key populations | |
| 4.3 Empower young key populations to meaningfully engage with stakeholders on HIV, TB, Hepatitis B & C and SRHR issues, including data collection and the development, implementation and monitoring of policy and program design. | Number of countries that are providing technical and financial support to young key population organisations/groups<br><br>Number of countries with young key population organisations/groups reporting increased capacity to meaningfully participate<br><br>Number of countries where training/sensitization workshops are provided by young key populations | Young key population/civil society organisations have increased capacity to meaningfully participate in data collection and in policy and program design, implementation and monitoring. | Increase the participation of young key population in program design, implementation and M&E (e.g. mechanism to report human rights violations, community treatment observatory, peer education)<br><br>Increase the participation of young key population in data collection affecting their community. | National and regional young key population networks and organisations, and CBOs<br><br>Development partners to support process |
| **Objective 5: Ensure that the human rights of key populations are respected by addressing the social, economic and legal determinants of health, including discriminatory laws, stigma, discrimination and violence against them to facilitate their access to health services** | | | | |
| 5.1. Improve awareness amongst stakeholders, especially policy makers on the rights of key populations | Number of countries where professional training programmes include information on HIV, TB, Hepatitis B & C and SRHR and key populations as part of the curriculum in health, judiciary, law enforcement and security settings. | Relevant advocacy materials developed.<br><br>Training packages for health workers and peers developed.<br><br>Meetings on HIV, TB, Hepatitis B & C and STI burden and | Develop high-level advocacy materials such as policy briefs that include testimonials and links between rights of key populations and impact on health management of HIV, TB, Hepatitis B & C and SRHR.<br><br>Develop training packages targeting workers from health, judiciary, law enforcement settings and for grassroots sensitization by peer educators. | ECOWAS through WAHO, EGDC, the Community Parliament<br><br>Member States Ministries/ departments/state agencies |

| Key Result Area | Indicator | Output/Results | Actions | Responsible party (ies) |
|---|---|---|---|---|
| | | health rights for key populations conducted. | Mobilize, advocate to and train stakeholders (e.g. judiciary, law enforcers, health care workers, media, religious leaders, cultural leaders, political leaders, and community) on key population rights, including GBV. | responsible for health and HIV, justice, law and order, gender and human rights<br><br>Key Population Networks and organisations, and CBOs<br><br>Media<br><br>Development partners to support process |
| 5.2. Adopt and enforce supportive policies, strategies and guidelines that alleviate stigma, discrimination and violence against key populations. | Number of countries that have conducted a legal environment assessment (LEA) | Availability of LEA for each country of the region | Conduct a situational analysis with substantive participation of key populations of the punitive and repressive laws, policies, law enforcement practices applicable to key populations across the region | |
| | Number of countries that have developed a 5-year action plan to remove human rights barriers related to key populations<br><br>Number of countries that have conducted national multi-partner dialogue and participated in regional forums to ensure a more favourable legal environment for key populations | Existence and implementation of 5-year action plan promoting access to comprehensive health and HIV, TB, Hepatitis B & C and SRHR services.<br><br>National and regional dialogue to create a more enabling legal environment are conducted. | Member States conduct stigma index surveys and other relevant studies to document stigma, discrimination and violence against key populations.<br><br>Develop national 5-year action plan to respond to the results of the LEA and other studies conducted<br><br>Initiate a multi-stakeholder dialogue at national and regional levels, that include human rights organisations to ensure a favourable legal environment with regard to labour laws related to sex work, drug use, sexual orientation and gender identity. | |

## 5. Implementation arrangements

This strategy will be implemented by different stakeholders including ECOWAS, WAHO, Member States, Development Partners/Technical & financial partners, the private sector, civil society organizations and key population organizations.

Table 4 shows the main roles and responsibilities of the major stakeholders.

**Table 4: Implementation Arrangements**

| Stakeholder | Roles |
|---|---|
| WAHO Liaison Officers in each country | • Collaborate with local stakeholders of each country and WAHO head office to ensure the implementation and monitoring of the Strategy |
| WAHO Head Office | • Coordinate the regional response by providing a strong leadership for the implementation of the regional strategy<br>• Mobilise the other institutions of the ECOWAS to support the implementation of the strategy in Member States<br>• Provide oversight on and hold Member States accountable for the operationalization and implementation of this strategy.<br>• Monitor the implementation of this strategy through centralizing data in the regional scorecard and providing feedback on countries on progress<br>• Advocate to ensure increased international and national resource allocation for key population programmes.<br>• Advocate to create an enabling environment for key populations to access services across borders without stigma and discrimination, in full respect of their right to health |
| Community Court of Justice (CCJ) of ECOWAS | • Ensure the observance of law and of the principles of equity and in the interpretation and application of legal instruments adopted by the Community.<br>• Give legal advisory opinion on any matter that requires interpretation of the Community text |
| Community Parliament of ECOWAS and its standing committees | • Ensure the mobilisation of its members and standing committees (Gender, advancement of women and social protection, Health and social services, Human Rights, protection of children and vulnerable groups, Legal and justice matters) to support the implementation of the Strategy |
| ECOWAS Gender Development Centre (EGDC) | • Support the implementation of the Strategy<br>• Work with Member States to implement the strategies related to gender<br>• Advocate on key population rights, including gender-based violence |
| Ministries/Departments /Agencies responsible for Health and HIV/TB/Hepatitis and SRHR | • Adopt and operationalize this strategy.<br>• Identify technical focal points to collaborate with WAHO on implementation<br>• Develop and implement health guidelines as per the strategic framework of this strategy<br>• Fully integrate key population services for HIV, Hepatitis B & C, TB and SRH into national health systems.<br>• Monitor national progress on key population services.<br>• Support accurate and reliable generation of evidence on key populations by strengthening data collection systems and research on key populations.<br>• Create stigma-free facilities.<br>• Ensure adequate budget allocation for key population programming.<br>• Advocate and sensitise other key government and non-government departments on key population programmes. |

| Stakeholder | Roles |
|---|---|
| National HIV Technical Leads in the National AIDS Commissions or in the Ministries of Health | • Create an enabling environment for key populations to access services across borders without stigma and discrimination, in full respect of their right to health<br>• Coordinate the regional response by providing a strong leadership for the implementation of the regional strategy<br>• Mobilise the other institutions of the ECOWAS to support the implementation of the strategy in Member States<br>• Provide oversight on and hold Member States accountable for the operationalization and implementation of this strategy.<br>• Monitor the implementation of this strategy through centralizing data in the regional scorecard and providing feedback on countries on progress<br>• Advocate to ensure increased international and national resource allocation for key population programmes. |
| Ministries and other agencies responsible for Justice, Law and Order | • Facilitate the development and adoption of supportive policies and laws for all key populations.<br>• Facilitate the establishment of accessible mechanisms to protect the rights of key populations and ensure access to remedies / accountability.<br>• Ensure that international and regional commitments for the respect of human rights are enforced locally |
| Development Partners/Technical and financial partners | • Advocate for the adoption and implementation of this strategy<br>• Provide technical guidance at regional, national and sub-national levels.<br>• Provide resource support at regional, national and sub-national levels.<br>• Align regional and national priorities with the regional strategy.<br>• Generate evidence to support key population programmes and policies.<br>• Support the development of key population services in their communities.<br>• Strengthen the capacity of key populations to participate in policy and program design, implementation and monitoring & evaluation.<br>• Report on the progress being made on the various actions in the strategic framework.<br>• Mobilize resources to support key populations |
| Private Business Sector | • Support implementation of key population services through key population-led or key population friendly CBOs/CSOs<br>• Ensure their scope of social responsibility to include key population programming. |
| Civil Society Organizations | • Advocate for the adoption and implementation of this strategy.<br>• Align and support implementation of this strategy.<br>• Generate data to support key population programmes and policies.<br>• Support the development of key population services in their communities.<br>• Strengthen the capacity of key populations to participate in policy and program design, implementation and monitoring & evaluation.<br>• Strengthen the capacity of CBOs and other groups to ensure solid coordination and program implementation targeting key populations.<br>• Report on the progress being made on the various actions in the strategic framework.<br>• Hold Member States accountable for the implementation of the strategy<br>• Mobilize resources to support key population programmes. |
| Key Population Organizations | • Support service delivery for effective implementation.<br>• Support the generation of information on data with regard to key populations.<br>• Provide input on programme and policy development and contribute to implementation, monitoring and evaluation of key population programming.<br>• Develop effective networks for various key population sub-groups at all levels. |

The governance system for the implementation of the Strategy will include the setting up of a regional committee that will be representative of countries, national and regional stakeholders and of all the diseases included in the Strategy. The committee will develop the relevant plans to support the implementation of the Strategy, such as communication, M&E and resource mobilisation plans.

The monitoring of the Strategy will be done by WAHO (see details in next section). The Strategy will guide countries in their responses and their funding requests. If funding at regional level is available, the relevant operational plans and mechanisms for the management of funds will be developed by the regional committee.

During the Regional Consultation meeting 10-11th December 2019, held in Abidjan, participants developed a risk analysis to identify the major risks and mitigating actions related to the implementation of the regional strategy. These will also guide the implementation of the strategy. (See Annex 2)

## 6. Reporting mechanism

A Regional Strategy Scorecard has been developed as the reporting mechanism to track progress of the indicators from the strategic framework (see Annex 5). These are considered as the core indicators of the strategy. Countries will self-rate the level of achievement of each indicator based on standard criteria for assessing their performance.

In addition, a country model results framework will focus more on the national results of each country. A series of standard indicators from the Global Aids Monitoring (GAM) framework have been compiled to give a snapshot of country results at the levels of output, outcome and impact for each key population.

The monitoring and evaluation for this regional strategy will be integrated into the existing national, regional and international monitoring and evaluation mechanisms. The monitoring process will be driven by each country. A high level of ownership of each country of both the strategy and the monitoring of its indicators is essential for successful reporting at regional level.

WAHO will ensure that core indicators for tracking implementation of the regional strategy are agreed and adopted by ministries of health and other agencies responsible for health and HIV, TB, Hepatitis and SRHR. At national levels, the national M&E HIV system would be responsible for collecting and centralizing data with regard to the core and GAM indicators. The regional strategy reporting will be aligned to the yearly GAM reporting.

At the national level, Ministries of Health, in collaboration with all partners will be responsible for setting up and managing systems for data collection, analysis, synthesis, quality assurance and dissemination of key results. Member States will compile periodic yearly progress reports based on the standard indicators in the Regional Strategy's Scorecard and will share with WAHO through the established coordination structures for HIV.

WAHO will produce an annual regional report based on the periodic progressive reports using the Regional Strategy's Scorecard. The regional periodic reports will be disseminated to all national, regional and international partners.

Development and technical partners will support the monitoring process through providing clear guidelines on how to fill in the periodic reports, holding regular joint performance reviews and conducting a mid-term review of the strategy.

# 7. Annexes

## Annex 1: Summary of SWOT for the ECOWAS

**ECOWAS strengths, weaknesses, opportunities and threats analysis for HIV, TB and SRHR for key populations** (derived from information from desk review and key informant interviews)

**Strengths**

- HIV programs take into consideration key populations through national guidelines for them
- Emerging key populations organisations and ongoing capacity building initiatives
- Regular key populations Regional meetings
- Availability of public health care centres
- Regional initiatives supporting key population programming since 2015
- Political momentum from Dakar Declaration
- Emerging innovations & best practices

**Weaknesses**

- Funding gaps in key populations programs and high reliance on external donors
- High levels of stigma and discrimination and violence
- Inadequate data on key populations
- Non-supportive legal framework
- Poor involvement of key populations in development of interventions
- Lack of recognition of role and low capacity of CBOs
- Low coverage of interventions targeting key populations

**Opportunities**

- WCA key populations conferences & revitalisation of key populations platform opportunity to share experiences
- Donor focus on key populations
- Potential to adapt and replicate innovative best practices in region
- Upcoming declaration on universal health care
- Model Drug Law for updating or amending legislations
- Known synergy between HIV and TB programs
- Matching Funds programs

**Threats**

- Diversion of resources due to humanitarian crisis
- Social, religious and cultural resistance and non-acceptance of key populations
- Political instability
- Limited local funding and uneven access to funding of countries in the region
- Discontinuation of GF funding of regional projects

## Annex 2: Risk analysis for the ECOWAS key population Regional Strategy

(derived from the Regional Consultation meeting 10-11th December 2019, Abidjan)

| MAJOR RISKS | RISK FACTOR | MITIGATING ACTIONS |
|---|---|---|
| Resistance and contestation from policy makers and leaders | Prejudice against key populations<br>Weak sensitization towards policy makers/leaders<br>Lack of knowledge about key populations | • Identify key population friendly leaders/champions and implicate them in the implementation<br>• Ongoing, long-term and regular sensitization<br>• Develop tools to evaluate the impact of sensitization<br>• Include sensitization of policy makers in action plans/funding requests and other strategic documents |
| Stigma & discrimination at health care centres leading to avoidance of healthcare | Poor knowledge concerning key populations among healthcare workers | • Capacity building of healthcare workers<br>• Inclusion of key populations in the training and service-delivery (peer educators) |
| Low involvement of key populations in design, implementation and monitoring and evaluation of programmes | Limited political, social and cultural will to engage with key populations<br><br>Lack of ownership of key population programming by local policy makers | • Advocacy to government (executive, parliament & judiciary) and key partners<br>• Identification and use of champions with government institutions and partners to influence policy makers<br>• Advocacy for appropriate and strategic implication of key population in accessing donor resources<br>• Engagement of social, religious and cultural groups on issues of key populations |
| Avoidance of healthcare services leading to health complications | Quality of healthcare services<br>Lack of motivation of key populations to attend health care centres | • Increase quality of health services<br>• Implicate key populations in service delivery<br>• Sensitization of key populations to importance of health management |
| Programmes interruptions or discontinuations and/or programmes cannot be upscaled | Lack of funding for key population programming & high dependence on external donors | • Donor eligibility criteria should include domestic counterpart funding<br>• Observatory to access human rights funding<br>• Advocacy to government especially parliament to increase domestic funding for key population programming |
| Low mobilisation of key populations | Legal restrictions for registration of key population organisations and ability to operate | • Key population organisations to be incorporated within network/umbrella organisations<br>• Advocate and mobilize for domestication of international and regional treaties signed to by the countries |
| | Lack of structure of key population organisations and conflicts among key population organisations | • Capacity building of key population organisations<br>• Investments in key population organisations<br>• Communication and sharing information across all key population groups<br>• Develop and build capacity on code of ethics for key population organisations/initiatives |

| MAJOR RISKS | RISK FACTOR | MITIGATING ACTIONS |
|---|---|---|
| Key population programming is not appropriate for key populations that are most in need of them | Lack of tools for key population programming | • Develop, harmonise and build capacity for tools for key population programming<br>• Make programming tools KP-friendly for prevention and care cascade |
| Non application of laws, guidelines and policies to enable a favourable legal environment for key populations | Lateness of LEA<br>Difficulty in holding regular meetings<br>Change of policy makers<br>Lack of capacity (human, technical, financial) for implementation of protective laws | • Initiate a series of dialogues using a transition plan to advocate for changes and implement them step by step |
| Low or lack of domestic funding for human rights issues | Political instability in country/ies<br>Fight against terrorism causes funds to be reallocated from health/human rights towards defence | • Develop a transition and sustainability plan |
| Weak leadership to lead the implementation of the regional strategy | | • Advocate and engage policy makers to endorse the regional strategy<br>• Formal, strong leadership from WAHO |

## Annex 3: Comparative table of Member States' Situations on key components relevant to key populations and HIV, TB, Hepatitis B & C and SRH programming

(as per UNAIDS 2019 data)

**ESTIMATED SIZE OF POPULATION**

National population size estimates are only available for two key populations. PSE for prisoners are 41,000 in Cote d'Ivoire, 9,500 in Senegal and 5,200 in Togo. PSE for PWID is 3,100 in Senegal.

**HIV PREVALENCE**

| Country | SW | MSM | PWID | TG | Prisoners |
|---|---|---|---|---|---|
| **Benin** | 8.5% | 7.0% | 2.2% | - | 0.6% |
| **Burkina Faso** | 5.4% | 1.9% | - | - | 2.2% |
| **Cabo Verde** | - | - | - | - | - |
| **Cote d'Ivoire** | 12.2% | 12.3% | | - | 1.2% |
| **The Gambia** | 11.0% | 34.4%% | - | - | - |
| **Ghana** | 6.9% | 18.0% | - | - | 0.4% |
| **Guinea** | 10.7% | - | - | - | 2.3% |
| **Guinea Bissau** | 18.0% | 3.0% | - | - | - |
| **Liberia** | - | - | - | - | - |
| **Mali** | - | 13.7% | - | - | 1.4% |
| **Niger** | 17.0% | - | - | - | 1.9% |
| **Nigeria** | 14.4% | 23.0% | 3.4% | - | - |
| **Senegal** | 6.6% | 27.6% | 1.6% | - | 2.0% |
| **Sierra Leone** | 6.7% | 14.0% | 8.5% | 15.3% | 8.7% |
| **Togo** | 13.2% | 22.0% | - | - | - |

**COVERAGE OF HIV PREVENTION PROGRAMMES** (as per UNAIDS definition of at least 2 prevention services)

Data is only available for SW and MSM.

No data was available for PWID, TG and Prisoners in any countries.

The following countries did not have any coverage data for any of the five key populations: Benin, Cabo Verde, The Gambia, Ghana, Guinea Bissau, Liberia, Mali, Nigeria, Sierra Leone, Togo.

| Country | SW | MSM |
|---|---|---|
| **Burkina Faso** | 46.8% | 76.4% |
| **Cote d'Ivoire** | 96.2% | 39.1% |
| **Guinea** | - | 17.1% |
| **Niger** | 59.1% | 46.4% |
| **Senegal** | - | 6.4% |

| PERCENTAGE OF DOMESTIC (PUBLIC AND PRIVATE) FUNDING OF NATIONAL HIV RESPONSE | | |
|---|---|---|
| **Country** | **Percentage of domestic funding of national response** | |
| **Benin** | 13.8% | [2018] |
| **Burkina Faso** | 53.5% | [2017] |
| **Cabo Verde** | 63.9% | [2014] |
| **Cote d'Ivoire** | 13.4% | [2013] |
| **The Gambia** | 100.0% | [2014] |
| **Ghana** | 37.4% | [2016] |
| **Guinea** | 0.5% | [2018] |
| **Guinea Bissau** | 11.6% | [2010] |
| **Liberia** | 0.1% | [2015] |
| **Mali** | 29.1% | [2012] |
| **Niger** | 0.8% | [2017] |
| **Nigeria** | 2.4% | [2018] |
| **Senegal** | 26.0% | [2015] |
| **Sierra Leone** | 1.0% | [2011] |
| **Togo** | 19.3% | [2017] |
| **PERCENTAGE OF EXPENDITURE ON KP OF NATIONAL HIV EXPENDITURE** | | |
| Data was only available for Cote d'Ivoire (1.9%), Ghana (7.0%) and Senegal (2.3%). | | |
| **ESTIMATED NUMBER OF INDCIDENT TUBERCULOSIS CASES AMONG PLHIV** | | |
| **Country** | **Est. No of incident TB cases among PLHIV** | |
| **Benin** | 980 [630-1400] | |
| **Burkina Faso** | 860 [550-1200] | |
| **Cabo Verde** | 82 [51-120] | |
| **Cote d'Ivoire** | 7300 [4600-10000] | |
| **The Gambia** | 700 [530-900] | |
| **Ghana** | 9500 [4500-16000] | |
| **Guinea** | 5600 [3600-8100] | |
| **Guinea Bissau** | 2200 [1400-3200] | |
| **Liberia** | 2200 [1400-3200] | |
| **Mali** | 1200 [740-1700] | |
| **Niger** | 830 [530-1200] | |
| **Nigeria** | 58 000 [37 000-85 000] | |
| **Senegal** | 1200 [830-1600] | |
| **Sierra Leone** | 2800 [1800-4000] | |
| **Togo** | 580 [380-830] | |

**CERVICAL CANCER SCREENING OF WOMEN LIVING WITH HIV**

Data was only available for Guinea, who reported 55.9% [programme data 2018]

**PEOPLE COINFECTED WITH HIV AND HEPATITIS VIRUS RECEIVING COMBINED TREATMENT**

Data is only available for two countries for the indicator 'People coinfected with HIV and Hepatitis B virus receiving combined treatment'. Niger reports 8% and Senegal reports 95.5% [2018]. There is no data available for ECOWAS countries concerning people coinfected with HIV and hepatitis C virus receiving combined treatment.

**WOMEN AGED 15-49 YEARS WHO HAVE THEIR DEMAND FOR FAMILY PLANNING SATISFIED BY MODERN METHODS**

Five countries reported in this indicator as follows:
Benin: 28.8% [2018]
Cote D'Ivoire: 33.7% [2016]
Ghana: 41.2% [2014]
Senegal: 54.1% [2017]
Togo: 37.4% [2014]

**PROPORTION OF EVER-MARRIED OR PARTNERED WOMEN AGED 15-49 YEARS WHO EXPERIENCED PHYSICAL OR SEXUAL VIOLENCE FROM A MALE INTIMATE PARTNER IN THE LAST 12 MONTHS**

*No data available for Burkina Faso, Cabo Verde, Cote d'Ivoire, Ghana, Guinea, Guinea-Bissau, Liberia, Niger*

| **Country** | **Proportion of ever-married or partnered women aged 15–49 years who experienced physical or sexual violence from a male intimate partner in the past 12 months** |
|---|---|
| **Benin** | 13.9% [2018] |
| **The Gambia** | 7.3% [2013] |
| **Mali** | 26.9% [2013] |
| **Nigeria** | 11% [2013] |
| **Senegal** | 12.2% [2017] |
| **Sierra Leone** | 26.6% [2013] |
| **Togo** | 12.7% [2017] |

Source: Data 2019 (UNAIDS)

## Annex 4 Targeted interventions for key populations as described in NSPs

| | TARGETED INTERVENTIONS FOR SEX WORKERS AS DESCRIBED IN NATIONAL STRATEGIC PLAN | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | HIV PREVENTION | | | | | HARM REDUCTION | | | | HIV TESTING | | | | | | HIV TREATMENT | | | | SRH | | | CRITICAL ENABLERS | | | | | | | | | |
| | Condoms | Lubricant | PrEP | PEP | Any prevention | Needle and syringe | Opioid Substitution | Naloxone | Any harm reduction | Provider-initiated | Community-based | Lay provider | Self testing | Assisted partner notification | Any HIV testing | Equitable ART | Access and adherence | PMTCT | Any HIV treatment | STI screening and treatment | Antenatal care | Any SRH | Review laws - behaviour | Review laws - services | Train HCW | Train officers | Engage stakeholders | Health services | Community empowerment | Violence prevention | Violence monitoring | Any critical enabler |
| Benin | ■ | ■ | | | ■ | ■ | | | ■ | | | | | | ■ | ■ | ■ | | ■ | | | | | | | | | | | | | |
| Burkina Faso | ■ | | | | ■ | | | | | | | | | | ■ | | | | | | | | | | | | | ■ | ■ | | | ■ |
| Cap Verde | ■ | | | | ■ | | | | | | | | | | ■ | ■ | | | ■ | | | | | | | | | | | | | |
| Cote d'Ivoire | ■ | ■ | ■ | ■ | ■ | | | | | ■ | ■ | | ■ | | ■ | | | | | | | | | | | | ■ | | ■ | ■ | | ■ |
| The Gambia | | | | | | | | | | | | | | | ■ | | | | | ■ | | ■ | | | | | ■ | ■ | | | ■ | | ■ |
| Ghana | ■ | ■ | | | ■ | | | | | | ■ | | | | ■ | | | | | ■ | | ■ | ■ | ■ | | | | | | | ■ | | ■ |
| Guinea | ■ | ■ | | | ■ | | | | | | | | | | ■ | | | | | | | | | ■ | | | | ■ | ■ | | | | ■ |
| Guinea Bissau | ■ | | | | ■ | | | | | | | | | | ■ | | | | | | | | ■ | | | | | | | | | | ■ |
| Liberia | ■ | ■ | | | ■ | | | | | | | | | | ■ | | | | | ■ | | ■ | | | | | | | | ■ | | | ■ |
| Mali | ■ | ■ | | | ■ | | | | | | | | | | ■ | ■ | | | ■ | | | | | | ■ | | ■ | ■ | | | | | ■ |
| Niger | ■ | ■ | | | ■ | | | | | | ■ | | | | ■ | | | | | | | | ■ | | ■ | | ■ | ■ | ■ | | | | ■ |
| Nigeria | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | | | | | | | | | | ■ | | | | | | | | | ■ |
| Senegal | ■ | ■ | | | ■ | | | | | | | | | | ■ | | | | | ■ | | ■ | | | | ■ | | | ■ | | | | ■ |
| Sierra Leone | ■ | ■ | | | ■ | | | | | | | | | | ■ | | ■ | | ■ | | | | ■ | | ■ | | ■ | ■ | ■ | ■ | | | ■ |
| Togo | ■ | ■ | | | ■ | | | | | ■ | | | | | ■ | ■ | | | ■ | | | | ■ | ■ | | ■ | | ■ | | | | | ■ |

| | TARGETED INTERVENTIONS FOR MSM AS DESCRIBED IN NATIONAL STRATEGIC PLAN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | HIV PREVENTION | | | | | HARM REDUCTION | | | | HIV TESTING | | | | | | HIV TREATMENT | | | | SRH | | | CRITICAL ENABLERS | | | | | | | | |
| | Condoms | Lubricant | PrEP | PEP | Any prevention | Needle and syringe | Opioid Substitution | Naloxone | Any harm reduction | Provider-initiated | Community-based | Lay provider | Self testing | Assisted partner notification | Any HIV testing | Equitable ART | Access and adherence | PMTCT | Any HIV treatment | STI screening and treatment | Antenatal care | Any SRH | Review laws - behaviour | Review laws - services | Train HCW | Train officers | Engage stakeholders | Health services | Community empowerment | Violence prevention | Violence monitoring | Any critical enabler |
| Benin | ■ | ■ | | | | | | | | | | | | | | ■ | ■ | | | | | | | | | | | | | | |
| Burkina Faso | ■ | | | | | | | | | | | | | | | | | | | | | | | | | | ■ | ■ | | | |
| Cap Verde | ■ | | | | | | | | | | | | | | | ■ | | | | | | | | | | | | | | | |
| Cote d'Ivoire | ■ | ■ | ■ | ■ | | | | | | ■ | ■ | | ■ | | | | | | | | | | | | | ■ | | ■ | ■ | | |
| The Gambia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ghana | ■ | ■ | ■ | ■ | | | | | | | ■ | | ■ | | | | ■ | | | ■ | | | ■ | ■ | ■ | ■ | | | | ■ | | |
| Guinea | ■ | ■ | | | | | | | | | | | | | | | | | | | | | | ■ | | | | | ■ | ■ | | |
| Guinea Bissau | ■ | | | | | | | | | | | | | | | | | | | | | | ■ | | | | | | | | | |
| Liberia | ■ | ■ | | | | | | | | | | | | | | | | | | ■ | | | | | | | | | ■ | | | |
| Mali | ■ | ■ | | | | | | | | | | | | | | | | | | | | | | | ■ | | ■ | ■ | | | | |
| Niger | ■ | ■ | | | | | | | | | ■ | | | | | | | | | | | | ■ | | ■ | | ■ | ■ | ■ | | | |
| Nigeria | ■ | ■ | ■ | ■ | | | | | | | | | | | | | | | | | | | | ■ | | | | | | | | |
| Senegal | ■ | ■ | | | | | | | | | | | | | | | | | | ■ | | | | | | ■ | | | ■ | | | |
| Sierra Leone | ■ | ■ | | | | | | | | | | | | | | | ■ | | | | | | ■ | | ■ | | ■ | ■ | ■ | ■ | | |
| Togo | ■ | ■ | | | | | | | | ■ | | | | | | ■ | | | | | | | ■ | ■ | | ■ | | ■ | | | | |

| | TARGETED INTERVENTIONS FOR TG AS DESCRIBED IN NATIONAL STRATEGIC PLAN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | HIV PREVENTION | | | | | HARM REDUCTION | | | | HIV TESTING | | | | | | HIV TREATMENT | | | | SRH | | | CRITICAL ENABLERS | | | | | | | | | |
| | Condoms | Lubricant | PrEP | PEP | Any prevention | Needle and syringe | Opioid Substitution | Naloxone | Any harm reduction | Provider-initiated | Community-based | Lay provider | Self testing | Assisted partner notification | Any HIV testing | Equitable ART | Access and adherence | PMTCT | Any HIV treatment | STI screening and treatment | Antenatal care | Any SRH | Review laws - behaviour | Review laws - services | Train HCW | Train officers | Engage stakeholders | Health services | Community empowerment | Violence prevention | Violence monitoring | Any critical enabler |
| Benin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burkina Faso | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cap Verde | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cote d'Ivoire | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The Gambia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ghana | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Guinea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Guinea Bissau | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Liberia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mali | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Niger | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nigeria | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Senegal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sierra Leone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Togo | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | TARGETED INTERVENTIONS FOR PWID AS DESCRIBED IN NATIONAL STRATEGIC PLAN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | HIV PREVENTION | | | | | HARM REDUCTION | | | | HIV TESTING | | | | | | HIV TREATMENT | | | | SRH | | | CRITICAL ENABLERS | | | | | | | | | |
| | Condoms | Lubricant | PrEP | PEP | Any prevention | Needle and syringe | Opioid Substitution | Naloxone | Any harm reduction | Provider-initiated | Community-based | Lay provider | Self testing | Assisted partner notification | Any HIV testing | Equitable ART | Access and adherence | PMTCT | Any HIV treatment | STI screening and treatment | Antenatal care | Any SRH | Review laws - behaviour | Review laws - services | Train HCW | Train officers | Engage stakeholders | Health services | Community empowerment | Violence prevention | Violence monitoring | Any critical enabler |
| Benin | ■ | ■ | | | | | | | | | | | | | | ■ | ■ | | | | | | | | | | | | | | |
| Burkina Faso | ■ | | | | | ■ | | | | | | | | | | | | | | | | | | | | | ■ | ■ | | | |
| Cap Verde | ■ | | | | | | | | | | | | | | | ■ | | | | | | | | | | | | | | | |
| Cote d'Ivoire | ■ | | | | | | | | | | | | | | | | | | | | | | | | | ■ | | ■ | ■ | | |
| The Gambia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ghana | ■ | ■ | | | | | | | | | | | | | | | | | | ■ | | | ■ | ■ | | | | | | ■ | | |
| Guinea | ■ | | | | | ■ | | | | | | | | | | | | | | | | | | ■ | | | | ■ | ■ | | | |
| Guinea Bissau | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Liberia | ■ | ■ | | | | | | | | | | | | | | | | | | ■ | | | | | | | | | ■ | | | |
| Mali | ■ | | | | | ■ | | | | | | | | | | | | | ■ | | | | | | ■ | | ■ | ■ | | | | |
| Niger | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nigeria | ■ | ■ | ■ | ■ | | ■ | | | | | | | | | | | | | | | | | ■ | | | | | | | | | |
| Senegal | ■ | ■ | | | | ■ | ■ | | | | | | | | | | | | | ■ | | | | | | ■ | | | ■ | | | |
| Sierra Leone | ■ | ■ | | | | | | | | | | | | | | | ■ | | | | | | ■ | | ■ | | ■ | ■ | ■ | ■ | | |
| Togo | ■ | ■ | | | | | | | | | | | | | | ■ | | | | | | | ■ | ■ | | ■ | | ■ | | | | |

| | TARGETED INTERVENTIONS FOR PRISONERS AS DESCRIBED IN NATIONAL STRATEGIC PLAN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | HIV PREVENTION | | | | | HARM REDUCTION | | | | HIV TESTING | | | | | | HIV TREATMENT | | | | SRH | | | CRITICAL ENABLERS | | | | | | | | | |
| | Condoms | Lubricant | PrEP | PEP | Any prevention | Needle and syringe | Opioid Substitution | Naloxone | Any harm reduction | Provider-initiated | Community-based | Lay provider | Self testing | Assisted partner notification | Any HIV testing | Equitable ART | Access and adherence | PMTCT | Any HIV treatment | STI screening and treatment | Antenatal care | Any SRH | Review laws - behaviour | Review laws - services | Train HCW | Train officers | Engage stakeholders | Health services | Community empowerment | Violence prevention | Violence monitoring | Any critical enabler |
| Benin | ■ | | | | ■ | | | | ■ | | | | | | ■ | ■ | ■ | | ■ | | | | | | | | | | | | | |
| Burkina Faso | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cap Verde | ■ | | | | ■ | | | | ■ | | | | | | ■ | ■ | | | ■ | | | | | | | | | | | | | |
| Cote d'Ivoire | | | ■ | ■ | ■ | | | | | ■ | ■ | | ■ | | ■ | | | | | | | | | | | | ■ | | ■ | ■ | | ■ |
| The Gambia | | | | | | | | | | | | | | | ■ | | | | | ■ | | ■ | | | | | | | | | | |
| Ghana | ■ | ■ | | | ■ | | | | | | ■ | | | | ■ | | | | | ■ | | ■ | | | | | | | | | | |
| Guinea | | | | | | | | | | | | | | | ■ | | | | | | | | ■ | | | | ■ | ■ | | | | ■ |
| Guinea Bissau | ■ | | | | ■ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Liberia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mali | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Niger | ■ | | | | ■ | | | | | | ■ | | | | ■ | | | | | | | | | | ■ | | ■ | ■ | ■ | | | ■ |
| Nigeria | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Senegal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sierra Leone | ■ | ■ | | | ■ | | | | | | | | | | ■ | | ■ | | ■ | | | | | | | | ■ | ■ | ■ | ■ | | ■ |
| Togo | ■ | ■ | | | ■ | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Source: Focus on key populations in national HIV strategic plans in the African region (WHO)

## Annex 5 Regional Scorecard for the regional strategy for HIV, TB, Hepatitis B & C and SRHR among key populations in the ECOWAS

| Regional Scorecard for Year _____ | | ● | not achieved | | ● | partially achieved | | | ● | significantly achieved | | | ● | fully achieved | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Benin** | **Burkina Faso** | **Cape Verde** | **Cote d' Ivoire** | **The Gambia** | **Ghana** | **Guinea** | **Guinea Bissau** | **Liberia** | **Mali** | **Niger** | **Nigeria** | **Senegal** | **Sierra Leone** | **Togo** |
| Objective 1: Strengthen national and regional coordination and leadership for a harmonized and sustainable regional response to HIV, TB, Hepatitis B & C and SRHR issues for key populations | 1.1(a) Number of countries that report having integrated the regional strategy in national strategies and action plans | | | | | | | | | | | | | | | |
| | 1.1(b) Number of interventions towards the regional platform for key populations | **x** | | | | | | | | | | | | | | |
| | 1.1(c) Number of meetings/exercises to monitor progress and share best practices | **x** | | | | | | | | | | | | | | |
| | 1.1(d) Number of national best practices disseminated across the region on HIV, TB, Hepatitis B & C and SRHR | **x** | | | | | | | | | | | | | | |
| | 1.2(a) Number of countries that have specific budget allocations for key population interventions and established mechanisms for key population-related HIV, TB, Hepatitis B & C and SRHR domestic financing | | | | | | | | | | | | | | | |
| | 1.2(b) Proportion of HIV funding towards key population interventions in each country and at regional level | **x%** | | | | | | | | | | | | | | |
| Objective 2: Strengthen the management of health information relating to key populations to guide the development of evidence-based policies and | 2.1 Number of countries with PSE and known profile data collected in cooperation with communities and disaggregated by sex and age, and covering all key populations (sex workers, men who have sex with men, transgender people, people who inject drugs, prisoners and people in closed settings) | | | | | | | | | | | | | | | |
| | 2.2 Number of countries with national M&E systems which capture all service-delivery data related to key populations in safe and confidential manner | | | | | | | | | | | | | | | |

| Regional Scorecard for Year _____ | | ● | not achieved | | ● | partially achieved | | | ● | significantly achieved | | | ● | fully achieved | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Benin** | **Burkina Faso** | **Cape Verde** | **Cote d' Ivoire** | **The Gambia** | **Ghana** | **Guinea** | **Guinea Bissau** | **Liberia** | **Mali** | **Niger** | **Nigeria** | **Senegal** | **Sierra Leone** | **Togo** |
| programming for targeting them. | 2.3 Number of countries where prevention, testing and treatment cascade for key populations is available on a yearly basis | | | | | | | | | | | | | | | |
| Objective 3: Scale-up comprehensive and targeted prevention, treatment, care and support interventions with regard to HIV, TB, Hepatitis B & C and SRH services to reduce incidence, morbidity and mortality among key populations. | 3.1 (a) Number of countries that identified gaps in the provision of the comprehensive package of services for key populations through a review, including focus on social protection for key populations and opportunities to expand community-based services | | | | | | | | | | | | | | | |
| | 3.1 (b) Number of countries that have identified gaps in the provision of comprehensive services for young key populations and have developed a set of recommendations on how to best address those gaps. | | | | | | | | | | | | | | | |
| | 3.2 Number of countries that have formally validated national protocols for integrated services, combined prevention, differentiated service-delivery, legal and social services and community outreach services | | | | | | | | | | | | | | | |
| | 3.3 Number of countries that are providing the comprehensive package of services outlined in the WHO guidelines such that the services are accessible to all key populations. | | | | | | | | | | | | | | | |
| Objective 4: Empower all key populations and promote their meaningful | 4.1(a) Number of countries where programme design and implementation, data collection/monitoring activities, services or law reform activities are led by key populations or they are key participants. | | | | | | | | | | | | | | | |

| Regional Scorecard for Year _____ | | ● | not achieved | | ● | partially achieved | | | ● | significantly achieved | | | ● | fully achieved | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Benin** | **Burkina Faso** | **Cape Verde** | **Cote d' Ivoire** | **The Gambia** | **Ghana** | **Guinea** | **Guinea Bissau** | **Liberia** | **Mali** | **Niger** | **Nigeria** | **Senegal** | **Sierra Leone** | **Togo** |
| participation in policy and program design, implementation and monitoring to ensure more effective health policies and programmes. | 4.1(b) Number of national and regional HIV, TB, Hepatitis B & C and SRHR meetings where key populations are represented | | | | | | | | | | | | | | | |
| | 4.2(a) Number of countries that are providing technical and financial support to key population organisations/groups | | | | | | | | | | | | | | | |
| | 4.2(b) Number of countries with key population organisations/groups reporting increased capacity | | | | | | | | | | | | | | | |
| | 4.2(c) Number of countries where training/sensitization workshops are provided by key populations | | | | | | | | | | | | | | | |
| | 4.3 (a) Number of countries that are providing technical and financial support to young key population organisations/groups | | | | | | | | | | | | | | | |
| | 4.3 (b) Number of countries with young key population organisations/groups reporting increased capacity to meaningfully participate | | | | | | | | | | | | | | | |
| | 4.3 (c) Number of countries where training/sensitization workshops are provided by young key populations | | | | | | | | | | | | | | | |
| Objective 5: Ensure that the human rights of key populations are respected by addressing the social, economic and legal determinants of health, including | 5.1 Number of countries where professional training programmes include information on HIV, TB, Hepatitis B & C and SRHR and key populations as part of the curriculum in health, judiciary, law enforcement and security settings. | | | | | | | | | | | | | | | |
| | 5.2(a) Number of countries that have conducted a legal environment assessment (LEA) | | | | | | | | | | | | | | | |

| Regional Scorecard for Year _____ | | ● | not achieved | | ● | partially achieved | | | ● | significantly achieved | | | ● | fully achieved | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Benin** | **Burkina Faso** | **Cape Verde** | **Cote d' Ivoire** | **The Gambia** | **Ghana** | **Guinea** | **Guinea Bissau** | **Liberia** | **Mali** | **Niger** | **Nigeria** | **Senegal** | **Sierra Leone** | **Togo** |
| discriminatory laws, stigma, discrimination and violence which hinder their access to health services. | 5.2(b) Number of countries that have developed a 5-year action plan to remove human rights barriers related to key populations | | | | | | | | | | | | | | | |
| | 5.2(c) Number of countries that have conducted national multi-partner dialogue and participated in regional forums to ensure a more favourable legal environment for key populations | | | | | | | | | | | | | | | |

## 8. References


[1] African Key Populations Experts Group. Model Regional Strategic Framework on HIV for Key Populations in Africa (2014)
[2] The Dakar declaration is available here (https://www.ghanaids.gov.gh/gac1/pubs/DECLARATION_DAKAR.pdf)
[3] African Union. Catalytic Framework to End AIDS, Tuberculosis and Eliminate Malaria in Africa by 2030 (2016) available here (https://au.int/sites/default/files/newsevents/workingdocuments/27513-wd-sa16949_e_catalytic_framework.pdf)
[4] UNAIDS. The Western and Central Africa Catch Up Plan (2017) available here (https://www.unaids.org/en/resources/documents/2017/WCA-catch-up-plan)
[5] The Moscow declaration is available here (https://www.who.int/tb/features_archive/Moscow_Declaration_to_End_TB_final_ENGLISH.pdf?ua=1)
[6] The Political Declaration of the UNGA high-level meeting on the fight against tuberculosis is available here (https://www.who.int/tb/unhlmonTBDeclaration.pdf)
[7] The Resolution on Universal Health Coverage adopted by the Assembly of the IPU is available here (https://www.who.int/reproductivehealth/UHC-IPU-141/en/)
[8] UNAIDS. Reference Data (2019) available here (https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf)
[9] UNAIDS. Special analysis (2018)
[10] Baggaley, R., Armstrong, A., Dodd, Z., Ngoksin, E. & Krug, A. Young key populations and HIV: a special emphasis and consideration in the new WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. J Int AIDS Soc. 2015; 18(2Suppl 1). Available here. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4344541/)
[11] UNAIDS global update 2018 – available here (https://www.unaids.org/en/20180718_GR2018)
[12] WHO. Update on Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2016), [hereinafter WHO. Consolidated Guidelines]. Available here (https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/)
[13] The Global Fund. Best Practices on TB case finding and treatment, reflections and lessons from West Africa and beyond (2018) available here (https://www.theglobalfund.org/media/8273/core_wca-tb-best-practices_technicalbrief_en.pdf?u=63715328154000000)
[14] WHO. Global Tuberculosis Report (2019) available here (https://www.who.int/tb/publications/global_report/en/)
[15] The Global Fund. Best Practices on TB case finding and treatment, reflections and lessons from West Africa and beyond (2018)
[16] WHO. Global Tuberculosis Report (2019) available here (https://www.who.int/tb/publications/global_report/en/)
[17] Engender Health, GNP+, ICW, IPPF, UNAIDS, Young Positives. 2009. Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV: A Guidance Package. Amsterdam, GNP+. Available here. (https://www.who.int/reproductivehealth/topics/linkages/guidance_package.pdf?ua=1)
[18] UNAIDS. The Western and Central Africa Catch Up Plan (2017)
[19] UNAIDS. The Western and Central Africa Catch Up Plan (2017)
[20] Model Strategic Framework on HIV for Key Populations in Africa (2014)

[21] Available here (https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/)
[22] UNAIDS. Reference Data (2019)
[23] UNAIDS. Reference Data (2019)
[24] IHME 2020 from GBD 2017 - available here (https://vizhub.healthdata.org/gbd-compare/)
[25] IHME 2020 from GBD 2017 - available here (https://vizhub.healthdata.org/gbd-compare/)
[26] Nketiah-Amponsah, E., Abubakari, M. & Baffour, P.T. Effect of HIV/AIDS on Economic Growth in Sub-Saharan Africa: Recent Evidence. Int Adv Econ Res 25, 469–480 (2019). Available here (https://link.springer.com/article/10.1007/s11294-019-09754-3#citeas)
[27] UNAIDS. Reference Data (2019)
[28] UNAIDS. Reference Data (2019)
[29] UNAIDS. Reference Data (2019)
[30] WHO. Global Tuberculosis report (2019) available here (https://apps.who.int/iris/bitstream/handle/10665/329368/9789241565714-eng.pdf?ua=1)
[31] UNAIDS. Data Report (2019)
[32] WHO. Global Tuberculosis Report (2019)
[33] WHO. The End TB strategy (2014) available here (https://www.who.int/tb/strategy/End_TB_Strategy.pdf?ua=1)
[34] WHO, The End TB strategy (2014)
[35] WHO. Consolidated Guidelines
[36] WHO. The End TB strategy (2014)
[37] The Global Fund, Best Practices on TB Case Finding and Treatment (2018)
[38] WHO. Global tuberculosis report 2019. Available here (https://apps.who.int/iris/bitstream/handle/10665/329368/9789241565714-eng.pdf?ua=1)
[39] WHO. Report on global sexually transmitted infection surveillance (2018) – available here (https://apps.who.int/iris/bitstream/handle/10665/277258/9789241565691-eng.pdf?ua=1)
[40] WHO. Report on global sexually transmitted infection surveillance (2018)
[41] WHO. Consolidated Guidelines
[42] The Global Fund. Applicant Handbook 2020-2022 (March 2020), Geneva, Switzerland - available here (https://www.theglobalfund.org/media/4755/fundingmodel_applicanthandbook_guide_en.pdf)
[43] African Commission on Human and People's Rights Study HIV, The Law and Human Rights in the African Human Rights System: Key challenges and opportunities for rights-based responses (2017) - available here (https://www.achpr.org/news/viewdetail?id=21)
[44] African Commission on Human and People's Rights Study HIV, The Law and Human Rights in the African Human Rights System: Key challenges and opportunities for rights-based responses (2017)
[45] WHO. Technical briefs on:
HIV and young men who have sex with men (2015) - available here (https://www.who.int/publications/i/item/9789241547543),
HIV and young people who sell sex (2015) - available here (https://www.who.int/publications/i/item/WHO-HIV-2015.8),
HIV and young people who inject drugs (2015) - available here (https://www.who.int/publications/i/item/9241208902)
HIV and young transgender people (2015) - available here https://www.who.int/publications/i/item/WHO-HIV-2015.10-eng
[46] WHO. Technical briefs on:

HIV and young men who have sex with men (2015) - available here (https://www.who.int/publications/i/item/9789241547543),
HIV and young people who sell sex (2015) - available here (https://www.who.int/publications/i/item/WHO-HIV-2015.8),
HIV and young people who inject drugs (2015) - available here (https://www.who.int/publications/i/item/9241208902)
HIV and young transgender people (2015) - available here https://www.who.int/publications/i/item/WHO-HIV-2015.10-eng

[47] Kounta CH, Sagaon-Teyssier L, Coulaud PJ, Mora M, Maradan G, et al. (2019) Transactional sex among men who have sex with men participating in the CohMSM prospective cohort study in West Africa. PLOS ONE 14(11): e0217115. Available here (https://dx.plos.org/10.1371/journal.pone.0217115)

[48] UNAIDS. Women and HIV – A spotlight on adolescent girls and young women (2019) available here (https://www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf)

[49] UNAIDS. The western and central Africa catch up plan (2017)

[50] Bekker, LG. HIV Control in Young Key Populations in Africa. 3(7) The Lancet Child & Adolescent Health 442-444 (July 2019). Available here. (https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(19)30112-9/fulltext#seccestitle10)

[51] WHO Regional Office for Africa. Report on Key Populations in African HIV/AIDS: National Strategic Plans (September 2018). Available here (https://www.who.int/hiv/pub/toolkits/key-population-report-afro/en/)

[52] Perez, S., Burrows, D., Parsons, D., McCallum, L. & Falkenberry, H. (April 2019). Regional Summary of Findings of an Assessment of HIV Service Packages for Key Populations in Selected Countries in West and Central Africa. APMG Health, Washington, DC – available here (https://apmghealth.com/project/assessment-existence-and-use-hiv-packages-services-key-populations)

[53] Watch What Matters, Regional Community Treatment Observatory in West Africa, and the International Treatment Preparedness Coalition. Data for A Difference Key Findings, Analysis and Advocacy Opportunities from the Regional Community Treatment Observatory in West Africa (June 2019). Available here (https://itpcglobal.org/wp-content/uploads/2019/06/RCTO-WA-Data-for-a-Difference-Advocacy-Paper.pdf)

[54] UNAIDS. The western and central Africa catch up plan (2017)

[55] WHO. Global Tuberculosis Report (2019)

[56] Perez, S., Burrows, D., Parsons, D., McCallum, L. & Falkenberry, H. (April 2019). Regional Summary of Findings of an Assessment of HIV Service Packages for Key Populations in Selected Countries in West and Central Africa. APMG Health, Washington, DC

[57] WAHO/USAID. Review of Progress in the Implementation of the Dakar Declaration on Key Populations in ECOWAS Members States. 2018

[58] Ochonye B, Folayan MO, Fatusi AO, et al. Satisfaction with use of public health and peer-led facilities for HIV prevention services by key populations in Nigeria. *BMC Health Serv Res*. 2019;19(1):856. Published 2019 Nov 21. doi:10.1186/s12913-019-4691-z – available here (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6868772/#idm140428742648224title)

[59] Adjetey V, Obiri-Yeboah D, Dornoo B: Differentiated service delivery: a qualitative study of people living with HIV and accessing care in a tertiary facility in Ghana. BMC Health Services Research 2019, 19(1):95.

[60] WAHO/USAID. Review of Progress in the Implementation of the Dakar Declaration on Key Populations in ECOWAS Members States. 2018

[61] WAHO/USAID. Review of Progress in the Implementation of the Dakar Declaration on Key Populations in ECOWAS Members States. 2018
[62] Stigmaindex.org. (2019). *Country Analysis | People Living with HIV Stigma Index*. [online] Available at: http://www.stigmaindex.org [Accessed 5 Sept. 2019].
[63] Perez, S., Burrows, D., Parsons, D., McCallum, L. & Falkenberry, H. (April 2019). Regional Summary of Findings of an Assessment of HIV Service Packages for Key Populations in Selected Countries in West and Central Africa. APMG Health, Washington, DC
[64] WAHO/USAID. Review of Progress in the Implementation of the Dakar Declaration on Key Populations in ECOWAS Members States. 2018
[65] WAHO/USAID. Review of Progress in the Implementation of the Dakar Declaration on Key Populations in ECOWAS Members States. 2018
[66] WAHO/USAID. Review of Progress in the Implementation of the Dakar Declaration on Key Populations in ECOWAS Members States. 2018
[67] Kaida A, Carter A, Nicholson V, et al. Hiring, training, and supporting Peer Research Associates: Operationalizing community-based research principles within epidemiological studies by, with, and for women living with HIV. Harm Reduct J. 2019;16(1):47. Published 2019 Jul 18. doi:10.1186/s12954-019-0309-3 available here (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6637632/)
[68] WAHO/USAID. Review of Progress in the Implementation of the Dakar Declaration on Key Populations in ECOWAS Members States. 2018
[69] Zhao J, Garcia SA, Ngoksin E, et al. Are monitoring and evaluation systems adequate to report the programmatic coverage of HIV services among key populations in countries?. *Infect Dis Poverty*. 2019;8(1):58. Published 2019 Jul 2. doi:10.1186/s40249-019-0570-4 – available here (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6604138/#Sec10title)
[70] UNAIDS. Reference Data (2019)
[71] WHO. Consolidated Guidelines (2016)
[72] Brown T, Peerapatanapokin W. Evolving HIV epidemics: the urgent need to refocus on populations with risk. *Curr Opin HIV AIDS*. 2019;14(5):337–353. doi:10.1097/COH.0000000000000571 – available here (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6688718/#__sec16title)
[73] WHO. Consolidated Guidelines (2016)
[74] Shannon K, Strathdee SA, Goldenberg SM, et al. Global epidemiology of HIV among female sex workers: influence of structural determinants. Lancet 2015;385:55-71. 10.1016/S0140-6736(14)60931-4 available here (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6384122/#BX2)
[75] WAHO/USAID. Review of Progress in the Implementation of the Dakar Declaration on Key Populations in ECOWAS Members States. 2018
[76] Watch What Matters, Regional Community Treatment Observatory in West Africa, and the International Treatment Preparedness Coalition. Data for A Difference Key Findings, Analysis and Advocacy Opportunities from the Regional Community Treatment Observatory in West Africa (June 2019). Available here (https://itpcglobal.org/wp-content/uploads/2019/06/RCTO-WA-Data-for-a-Difference-Advocacy-Paper.pdf)
[77] UNAIDS. Reference Data (2019)
[78] Responding to HIV, Human Rights & Key Populations in ECOWAS, (Nov. 2018)
[79] APMG Health, Washington, DC. Scaling up Programs to Remove Human Rights-Related Barriers to Access, Uptake and Retention in HIV, TB and Malaria Services Baseline Assessment Report - Côte d'Ivoire – (2018)

[80] WHO. Technical briefs on:
HIV and young men who have sex with men (2015) - available here (https://www.who.int/publications/i/item/9789241547543),
HIV and young people who sell sex (2015) - available here (https://www.who.int/publications/i/item/WHO-HIV-2015.8),
HIV and young people who inject drugs (2015) - available here (https://www.who.int/publications/i/item/9241208902)
HIV and young transgender people (2015) - available here https://www.who.int/publications/i/item/WHO-HIV-2015.10-eng

[81] Lyons CE, Grosso A, Drame FM, et al. Physical and Sexual Violence Affecting Female Sex Workers in Abidjan, Côte d'Ivoire: Prevalence, and the Relationship with the Work Environment, HIV, and Access to Health Services. JAIDS 2017;75(1):9-17.

[82] Responding to HIV, Human Rights & Key Populations in ECOWAS, (Nov. 2018)

[83] West Africa Commission on Drugs. Model Drug Law for West Africa (2018) available here (https://www.globalcommissionondrugs.org/wp-content/uploads/2018/08/WADC-MDL-EN-WEB.pdf)

[84] Shannon K, Strathdee SA, Goldenberg SM, et al. Global epidemiology of HIV among female sex workers: influence of structural determinants. Lancet 2015; 385(9962): 55–71 available here (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4297548/)

[85] Potts E. Accountability and the right to the highest standard of health. Colchester, University of Essex Human Rights Centre, 2008