SEXUAL HEALTH SERVICES IN WEST AFRICA

Bold, innovative solutions for access to care for key populations!
Supported by ARCAD-SIDA (Mali), a member of Coalition PLUS, the West Africa Platform (PFAO) is setting in motion a regional dynamic to build capacities based on community expertise, community leadership and the sharing of best practices in the AIDS response. Since 2014, the PFAO has been building capacities and developing synergies between some twenty associations in eight countries in West Africa: Benin, Burkina Faso, Côte d’Ivoire, Guinea, Mali, Niger, Senegal and Togo. The PFAO’s capacity-building mainly takes the form of training courses, on-site support missions and regional workshops.

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ABBREVIATIONS AND ACRONYMS

| ACS      | Action Contre le Sida          | LGBTQI | Lesbian, Gay, Bisexual, Transgender, Queer and Intersex |
| AKS      | Association Kenedougou Solidarité | MVS   | Mieux vivre avec le sida |
| AMC      | Aides Médicales et Charité      | WHO    | World Health Organization |
| ARV      | Antiretrovirals                | SHS    | Sexual Health Services |
| ARCAD-SIDA | Association de recherche, communication, et d’accompagnement à domicile des personnes vivant avec le VIH/ sida | UNAIDS | Joint United Nations Program on HIV and AIDS |
| CESAC    | Centre d’écoute, de soins, d’animation et de conseils (counseling center for people living with HIV/AIDS run by ARCAD-SIDA in Bamako) | PEP   | Post-Exposure Prophylaxis |
| OR       | Organizational Review          | PFAO   | Coalition PLUS West Africa Platform |
| TE       | Therapeutic Education          | PrEP   | Pre-Exposure Prophylaxis |
| EVT      | Espoir Vie Togo                | PWUD   | People Who Use Drugs |
| HPV      | Human Papillomavirus           | CB     | Capacity-building |
| MSM      | Men who have Sex with Men      | GBV    | Gender-Based Violence |
| IEC      | Information Education & Communication on HIV/AIDS and STIs | HBV   | Hepatitis B Virus |
| STI      | Sexually Transmitted Infection | HCV    | Hepatitis C Virus |
|          |                                 | HIV    | Human Immunodeficiency Virus |
|          |                                 | AIDS   | Acquired Immune Deficiency Syndrome |
|          |                                 | TasP   | Treatment as Prevention |
|          |                                 | SW     | Sex workers |
The fight against HIV/AIDS has evolved greatly over the last 30 years. The vulnerable populations, however, remain the same, and despite some progress, their difficulties in accessing adequate prevention, differentiated treatment and recognition of their rights and their place within society persist.

Although HIV prevalence in the general population remains low in Mali, as in the rest of West and Central Africa, the epidemic is concentrated within so-called “key” populations with a HIV prevalence that can be up to 20 times higher. These populations, due to stigmatization and discrimination, live hidden within their identities, their professional activity and their at-risk practices. Men who have sex with men, sex workers and people who use drugs are also fathers and mothers, husbands and wives and partners. The epidemic is therefore dynamic and continues to gain ground against this backdrop.

The solutions offered by science allow for the possibility to end the HIV epidemic as of 2030. We know how to implement the community-based approach needed and we have the tools. Community testing, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), the community distribution of antiretroviral treatment and peer-based psychosocial support and therapeutic education are THE solutions to accelerate achievement of the targets of the HIV response within 10 years.

Since 2010, ARCAD-SIDA has endeavored to offer Sexual Health Services (SHS) at its Halles de Bamako clinic, against a background of numerous challenges. A service package for populations on the fringes of the health system where the community approach is based on the idea that health is a right and that it should be accessible and promoted as such among HIV-positive and HIV-negative populations alike.

We need to replicate these SHS elsewhere in Mali and in other regions of Africa, and to share them within the Coalition PLUS West Africa Platform, a region struggling to achieve the 90-90-90 goals set by UNAIDS for 2020.

This reference framework is a guide for the implementation of systems for access to prevention, care and quality follow-up. This guide is a proposal from communities to end the epidemic!
The community-based associations united within the Coalition PLUS West Africa Platform (PFAO) have joined forces to innovate and propose strategies adapted to the new challenges of the HIV response. Key populations are crucial players in these innovative strategies. Likewise, the need to build bridges between the HIV response and sexual health is well established. This incorporation of sexual health in HIV services has numerous advantages, on both a collective and individual level.

Sexual Health Services (SHS) are based on a solid set of principles such as respect for Human Rights and the holistic approach centered on the needs of persons. The right to sexual health is a universal human right. SHS are fully in keeping with international, regional and national health frameworks. Furthermore, they align existing services, having demonstrated their impact in the fight against HIV, and innovating differentiated services. As such, SHS are entirely in line with the achievement of the 90-90-90 goals set by UNAIDS, and much more! Indeed, rolled out as an outreach strategy, the community and medical services that make up SHS reach people with little access to care facilities, and thus contribute to impacting the dynamic epidemic.

Backed by a desire to improve the social and legal environment for key populations, but also to combat stigmatization and discrimination, this model is an integral part of the community-based approach and the promotion of peer education. Consequently, it is important to recall the central role that peers play in the implementation of these services, in contexts that are nonetheless hostile. Their involvement is crucial to their success, as is the development of solid and complementary strategic alliances.

These services are scalable: they need to be able to adapt to the different structural levels of the associations that provide them, and adapt to the funding opportunities that present themselves. They must also be incorporated into the political and strategic frameworks offered by the different national contexts, and draw on the most recent scientific innovations.

Objectives of the reference framework

The reference framework sets the following objectives:

- Identify the persistent obstacles and impediments to care for key populations.
- Describe the process, principles and key stages of the development and implementation of sexual health services.
- Promote the differentiated services already put in place by 10 partner associations of the PFAO.
- Set out recommendations and prospects to improve sexual health services.
Audiences targeted by the reference framework

This reference framework targets several audiences:
- Associations in the AIDS response seeking to provide quality sexual health services adapted to key populations.
- Political and institutional decision-makers responsible for proposing frameworks coherent with social and economic realities.
- Technical and financial partners who assist and support advances in sexual health and the AIDS response.

Content of the reference framework

This reference framework is composed of six sections:
- The context and reasoning behind a sexual health service dedicated to key populations in West Africa.
- The international, regional and national framework for intervention among key populations.
- The main principles of action in a sexual health service dedicated to key populations.
- The SHS model dedicated to key populations in West Africa.
- Examples of best HSH practices in West Africa and Cameroon.
- The challenges and practical recommendations to sustain advocacy for the promotion and sustainability of this model.

Development methodology

This reference framework is part of a community-based approach. It is the fruit of a collaborative and participatory initiative coordinated by the PFAO. Through this reference framework, we aspire to act as a mouthpiece for people infected with, affected by and vulnerable to HIV/AIDS and viral hepatitis, and for activists and community- and identity-based associations working on a daily basis for better access to quality SHS for key populations. This work is based on the use of qualitative methods and was structured around four key stages:
- A preparation and long-distance exchange phase with the member associations of the PFAO thanks to a questionnaire based on 6 themes.
- A consultative workshop in Bamako bringing together 10 associations in April 2019.
- Collection of qualitative data at the Halles de Bamako clinic, a flagship sexual health clinic in Mali, through a series of semi-structured individual discussions and a focus group with people from key populations, peers and health professionals at the clinic. The results collected were subsequently triangulated and analyzed.
- The results of these consultations were enriched and compared with the data collected as part of a literature review and core documents on the theme and the region.

1° Profile of the key populations, 2° Contextual factors impacting the implementation of SHS, 3° Human resources, 4° Stages, 5° Principles of action, 6° Practical aspects
2 ACS, AIDES Sénégal, Affirmative Action, AKS, Alternatives Cameroun, AMS, ARCAD-SIDA, EVT, Humanity First, MVS.
I. CONTEXT AND REASONING BEHIND A SEXUAL HEALTH SERVICE

1. SHS: community-based expertise developed by the PFAO

Through a principle of shared governance, the PFAO supports some twenty associations in their response to the needs of key populations. In total, 10 associations in 5 countries in West Africa and Cameroon have benefited from capacity-building (CB) in terms of sexual health services. The development of the reference framework is a response to the urgent need to develop quality and effective SHS in West Africa, and the ambition to propose this frame of reference. Lastly, the reference framework responds to the need to clarify the concept of "sexual health", to better define its scope and outline, so that it can be better understood and developed.

This reference framework has been developed as part of the "Access to quality health services for key populations" project, co-financed by Coalition PLUS and the 5% Initiative.

2. Epidemiological data

Today, the figures show a very high HIV prevalence within key populations, despite the recurring lack of data on HIV incidence:

<table>
<thead>
<tr>
<th></th>
<th>Cameroon</th>
<th>Mali</th>
<th>Niger</th>
<th>Senegal</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>SW</td>
<td>24.3%</td>
<td>24.2%</td>
<td>17%</td>
<td>6.6%</td>
<td>13.2%</td>
</tr>
<tr>
<td>MSM</td>
<td>37.2%</td>
<td>13.7%</td>
<td>11.5%</td>
<td>41.9%</td>
<td>22%</td>
</tr>
<tr>
<td>PWUD</td>
<td>Unavailable</td>
<td>5.1%</td>
<td>Unavailable</td>
<td>1.6%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

3 AKS and ARCAD-SIDA in Mali, MVS in Niger, AIDES in Senegal, ACS, AMC and EVT in Togo in West Africa and Affirmative Action, Alternatives Cameroun and Humanity First in Cameroon for Central Africa.
4 Extract from the interim assessment report of the "Access to quality health services for key populations" project, 21 January 2019, Maryvonne Maynard
5 https://www.initiative5pour100.fr/qui-sommes-nous/linitiative-5/  
6 http://www.aidsinfoonline.org/kpatlas/#/home (consulted 23 May 2019)
As a comparison, prevalence within the general population in West Africa and Cameroon oscillates between 0.3% (Niger) and 3.6% (Cameroon), whereas prevalence within key populations in the same region is multiplied by ten.

Key populations are therefore much more exposed to the risk of HIV acquisition. The Global Fund has estimated this risk by type of key population as below:

<table>
<thead>
<tr>
<th>Key Population</th>
<th>Risk Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men who have Sex with Men</td>
<td>28X</td>
</tr>
<tr>
<td>Sex Workers</td>
<td>13X</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>22X</td>
</tr>
</tbody>
</table>

Despite some disparity between groups of key populations, such as MSM, SW and PWUD, and between the different countries in West Africa and Cameroon, this “concentrated” HIV epidemic and dynamic is a source of concern. According to the WHO Regional Office for Africa, “Between 40% and 50% of all new HIV infections among adults worldwide may occur among people from key populations and their immediate partners.”

Lastly, key populations are less aware of their HIV-positive status. A survey on prevalence and practices at risk of HIV, HBV and HCV infection among people who use drugs in the Dakar region in Senegal in 2011 has shown that 70.6% of people questioned had never had a HIV test.

3. Cumulated vulnerability factors among key populations

The determinants of health encompass social factors that influence health, but also economic, cultural and environmental factors. These influence both health and people’s access to care, and can create major obstacles for marginalized individuals.

In addition to known physiological vulnerability factors that particularly concern women and receptive MSM during unprotected sex, specific social and environmental factors have a particular impact on key populations:

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7 https://aidsinfo.unaids.org/ (consulted 4 November 2019)
8 https://www.theglobalfund.org/fr/key-populations/
9 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, June 2016, WHO.
10 A survey on prevalence and practices at risk of HIV, HBV and HCV infection among people who use drugs in the Dakar region was conducted in 2011 by the CNLS
VULNERABILITIES LINKED TO REPRESSIVE POLITICAL AND LEGAL CONTEXTS

The impact on health of criminalizing and repressive laws targeting key populations is particularly detrimental. People are worried about being arrested when they visit prevention and treatment facilities, and in particular when they have prevention materials on them, such as condoms or lubricating gel, which could be used as proof by the police in some legal contexts that penalize key populations.

In these contexts, laws condemn them to fines and heavy sentences of up to 5 years in prison, as is the case in Cameroon and Senegal for people who have sex with someone of the same sex.

Focus on Cameroon

Article 347.1 of the new Cameroon Penal Code that punishes any person who has sex with someone of the same sex with a sentence of up to 5 years in prison. Article 83 of the law on cybercrime and cybersecurity punishes any person who makes sexual advances towards someone of the same sex through communication technologies with a sentence of up to 2 years in prison. This sentence is doubled if these advances lead to sexual relations.

Focus on Senegal

Article 319 (3) of the Penal Code (Law No. 66 of February 12, 1996) provides that “whoever will have committed an improper or unnatural act with a person of the same sex will be punished by imprisonment of between one and five years, and by a fine of 100,000 to 1,500,000 francs”. If the act has been committed with an individual aged 21 or under, the maximum sentence is applied.

Yet to date, no country in the sub-region has adopted a legal framework explicitly protecting key populations. Legal frameworks vary from one country to another, ranging between criminalization and legal vacuum, which can fuel social and cultural condemnation. For example, vague texts condemning “indecent” acts encourage social exclusion and violence towards MSM.

As an example, in Mali, the Penal Code does not directly penalize sexual relations between people of the same age and prostitution. Despite the legal vacuum, police forces use the provisions of Articles 224 and 225 to stop and detain sexual and gender minorities as well as sex workers, with the definition of public indecency (Article 224) and indecent behavior (Article 225) being left to their sole discretion.

Focus on Mali

Article 224 of the Penal Code (Law No. 01-079 DU August 20, 2001) provides that “any act committed in public that offends the decency and the moral feelings of the persons who are involuntarily witness to it, and that is capable of disturbing public order and of causing a manifest social prejudice, is a public outrage against decency”.

Article 225 of the same code provides that “Any sexually immoral act committed intentionally and directly against a person is an indecent act”.

Lastly, the lack of protection prevents key populations from having legal recourse in the event their rights are violated. When they do dare file a complaint, the lack of effective and equitable access to legal services exacerbates the injustice they already experience in exercising their rights.11

11 CR KeyPopulation meeting TOGO-Platform Novembre 2018
I. CONTEXT AND REASONING BEHIND A SEXUAL HEALTH SERVICE

VULNERABILITIES LINKED TO STIGMATIZATION AND DISCRIMINATION

Key populations are repeatedly confronted with stigmatization and discrimination. These acts of stigmatization and discrimination are widespread throughout society and occur in various spheres, whether private, familial, confessional or professional. The majority of key populations suffer increased economic vulnerability as a result of family and social exclusion.

Increasingly, key populations continue to suffer discrimination on the part of health professionals and other users of these services, further impeding their access to these very services.

VULNERABILITIES LINKED TO LACK OF ACCESS TO HEALTHCARE SERVICES

According to UNAIDS, “only 14% of men who have sex with men living in low-income countries reported having meaningful access to HIV treatment services”12. MSM, for example, may be scared of disclosing their sexual orientation and will therefore avoid visiting health service facilities, not daring to express their needs or talk about questions relating to sexuality and their practices.

“It wasn’t easy to go to other health centers. Here, at the Halles clinic, the doctors are trained to deal with us, and accept that we are homosexual. But elsewhere, it’s not easy. I never even tried to go before, out of fear.”

MSM user of the Halles de Bamako clinic, ARCAD-SIDA, Mali

In response to this vulnerability to HIV among populations, guidelines and Strategy Frameworks on HIV/AIDS have been set out at national, regional and international level.

II. INTERNATIONAL, REGIONAL AND NATIONAL FRAMEWORK FOR INTERVENTION AMONG KEY POPULATIONS

1. The international framework

The WHO consolidated guidelines for key populations state the importance of a comprehensive and combination care package for HIV prevention since 2016. As part of combination prevention, PrEP is an “additional prevention choice for key populations”. In addition, testing, diagnosis and treatment of STIs “should be offered routinely as part of comprehensive HIV prevention and care for key populations.” We also need to target efforts towards cancer screening (cervical and anal), combined with HPV vaccination insofar as people living with HIV are more likely to be diagnosed with cancer than uninfected people. Furthermore, it is important that women from key populations have effective access to family planning, safe termination and post-abortion care.

International frameworks exist and pave the way for comprehensive and quality sexual health services for key populations in West Africa. However, they are not adequately reflected in practice.

2. The regional framework in West Africa

Although the situation is improving in many world regions, it remains a source of concern in West Africa. This region remains particularly affected by the HIV epidemic, with an estimated 6.5 million people currently living with the virus, and a high number of new infections per year (almost 400,000 in 2017). The region alone bears 20% of the world’s burden of HIV (i.e. 280,000 deaths in 2017), and key populations are also disproportionately affected (more than half of new infections in the West Africa region).

To date, despite international, regional and national policies that encourage the development of SHS for key populations, only community-based associations shoulder the heavy load of implementation in some countries in West Africa.

Yet international civil society agreed on the redirecting of strategic and financial resources in the fight towards key populations at the International AIDS Conference held in Mexico City in 2008. This redirection should notably allow for the inclusion of all key populations and go hand in hand with unconditional respect for human rights. The requirement to provide structural and financial support for community-based systems and the improvement of the social and political environments that effectively protect the rights of key populations are vital, and these recommendations are reiterated in strategic national and international documents.

13 Guidelines: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, June 2016, WHO, Regional Office for Africa.
14 Guidelines: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, June 2016, WHO, Regional Office for Africa.
16 Pierre-Julien Coulaud, Besoins exprimés et comportements sexuels à risque des hommes ayant des relations sexuelles avec des hommes suivis dans une offre de prévention diversifiée du VIH en contexte communautaire [Expressed needs and risky sexual behaviors in men who have sex with men (MSM) followed-up in a combined prevention package in a community setting], Pathologie Humaine, Recherche Clinique et Santé Publique, Université d’Aix-Marseille, 2019
18 Dakar Declaration, April 2016
In view of this finding, a catch-up plan for Western and Central Africa was drawn up in 2016 to help countries propose appropriate solutions.

However, differentiated services for key populations are not systematically included in their application at national level. Promoting the community-based approach must be envisaged as a pillar of the response and must be carried out through task shifting. Despite this favorable framework and some political advances, the obstacles and reluctance to the implementation of demedicalization are still too numerous, delaying access to prevention and care for key populations. In response, the members of Coalition PLUS decided to launch a call for demedicalization and effective task shifting in 2018. A guide was also produced to encourage healthcare actors to support this call.

3. National frameworks

Despite the updating of some recent national plans, governments do not provide for sufficient means to ensure their correct implementation. For example, the plans in Senegal, Togo and Mali demonstrate the countries’ commitment in principle, notably through intentions to invest in the creation of new measures as a priority, including combination prevention with PrEP and community-based testing. The reality, however, is more complex.

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Senegal National Strategic Plan for AIDS 2018-2022, National Council for the Fight Against AIDS, Senegal

“As concerns testing, initiatives will be more strategically targeted to effectively reach the populations at high risk of HIV exposure, notably based on multi-pronged strategies (..., community-based testing and self-testing) to achieve a result that will ensure that 90% of the total number of people living with HIV know their status”.

Although these commitments represent a major opportunity for community-based associations, they remain confronted with a large number of limitations. For example, to date, only a handful of people from the key populations included in research protocols have effective access to PrEP. In 2019, it is urgent to give actors the means to act and to offer PrEP on a wide scale.

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National Strategic Framework for HIV and AIDS, National High Council for the Fight against AIDS, 2017-2021, Mali

“Combination prevention strategies and harm reduction are based on:

i) structural approaches (act to facilitate access to prevention and care), ii) biomedical approaches (encourage access to different forms of testing, vaccination, treatment as prevention (PrEP) and early prescription of post-exposure treatment).

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19 http://www.coalitionplus.org/wordpress/wp-content/uploads/2018/03/Guide-D%C3%A9m%C3%A9dicalisation-Coalition-PLUS-VF.pdf
Lastly, despite visible progress, too little attention continues to be paid to counseling and referral for individuals from key populations who test HIV-negative. In order for them to stay HIV-negative, it is vital to ensure a good referral system to other prevention services (distribution of condoms and gel, PrEP, harm reduction).

Providers still face too many difficulties in the implementation of SHS. Sufficient means urgently need to be allocated for the effective application of national frameworks.

5. Key populations central to the approach

In this reference framework, key populations addressed as a priority are SW, MSM and PWUD. The HIV vulnerability of key populations is compounded by an initial social vulnerability due to stigmatization and repressive and discriminatory policies against them. In view of this, the WHO considers their engagement as “critical to a successful HIV response everywhere—they are key to the epidemic and key to the response”.

As of 1986, the first International Conference on Health Promotion encouraged community-based action, and the Ottawa Charter subsequently signed lists the strengthening of community action as one of the key public health priorities.

As outlined by Vincent Pelletier, Executive Director of Coalition PLUS: “Community-based action in healthcare does not just mean involving the people infected or those from communities. It is a scientific approach based on theories of change, which uses front-line communication based on real or perceived identity or identities to achieve a change in health-related behavior within a community.”

This approach draws on the principle of “working with the people concerned”, while also contributing to the empowerment of people and of the community, with a view to social change. This complex approach is a vital tool within the framework of SHS, notably allowing for a greater fulfillment of individuals’ needs and support for the individuals most excluded and with most limited access to health services.

4. Sexual health: a universal human right

The WHO definition states that sexual health is not only the absence of illness, but must be understood globally as “a state of physical, mental and social well-being in relation to sexuality”. It 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.

The Guttmacher-Lancet Commission, for its part, has launched an appeal to international communities to at long last adopt an integrated definition of health and sexual and reproductive rights placing the emphasis on the capacity of people to become actors in their own health and in exercising their rights. The Commission recalls that all individuals have a right to make decisions governing their bodies and to access services that support that right.

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21 See the WHO definition of key populations: https://www.who.int/topics/sexual_health/en/
23 Guidelines: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, June 2016, WHO, Regional Office for Africa.
24 UNAIDS definition
26 Guide “Pour un monde sans Sida, Démédicalisons!” (“Demedicalize for a world without AIDS!”) Coalition PLUS, 2018
III. THE MAIN PRINCIPLES OF ACTION IN SEXUAL HEALTH SERVICES DEDICATED TO KEY POPULATIONS

The three main principles of action in sexual health services are:
• The holistic approach centered on the needs of individuals
• The community-based approach
• The defense of human rights and action against violence, stigmatization and discrimination
These three principles of action are inextricably linked and constitute SHS:

1. The holistic approach centered on the needs of individuals

This approach provides a response to interconnected health and social needs. Indeed, individuals must be considered in their entirety in order to provide an effective and coherent response. Related services must therefore be proposed and a counseling along with the structuring of a referral system. Lastly, the most marginalized populations, or the most invisible sub-groups within key populations, must also be at the heart of this approach and their specific needs must be taken into account.

“We treat the patient and the illness, whereas in public health centers, they only treat the illness”.

Healthcare professional, ARCAD–SIDA, Mali
2. The community-based approach

The community-based approach is based on building the capacities of individuals and communities, allowing them to take an active part in their own care. They are therefore both actors and beneficiaries of services. The community-based approach has proven its added value in counseling and referral, prevention, treatment and retention in care. Indeed, in all components of SHS, it enhances the quality, effectiveness and impact of actions, while forming part of a care continuum.

In counseling and referral to sexual health services, the community-based approach makes it possible to:

• improve confidence in these services
  Fear and mistrust among key populations when it comes to visiting healthcare services, as well as frequent cases of discrimination, constitute obstacles that must be overcome thanks to the involvement of community-based actors. The latter will reassure these populations, explain the services available, and create an initial link with these services.

• improve the effectiveness of referral
  Peers experienced in the sexual health system will be able to adequately support people in need of referral and will act as a guide. Indeed, these individuals are sometimes called peer navigators.

• reinforce individualized follow-up
  Peers support the members of their community in their healthcare and social procedures. Follow-up is therefore a task in which they are highly invested. By maintaining the link between key populations and healthcare services, peers ensure effective follow-up as part of comprehensive care.

In prevention, the community-based approach makes it possible to:

• overcome important challenges related to the identification of key populations
  As peers come from the communities on whose behalf they act on, their role is particularly decisive in the identification of key populations in the field, particularly hidden sub-groups at high risk of HIV infection, such as older MSM and migrant or minor SW.

“Doctors are in their offices, not in the community. They don’t know where to find these people. For example, we come across married men and marabouts who are in contact with us. They don’t go to the clinic for testing. So we provide counseling.”

Peer educator, Halles de Bamako clinic, ARCAD-SIDA, Mali
III. THE MAIN PRINCIPLES OF ACTION IN SEXUAL HEALTH SERVICES DEDICATED TO KEY POPULATIONS

• ensure higher testing rates among key populations thanks to better targeting.

Demedicalized community-based testing is a particularly effective way of reaching a larger number of people at high risk of infection, including in sub-groups of key populations.

The success recorded in testing actions within the framework of the “Access to quality health services for key populations” project (ISP/Coalition PLUS) is proof of this. The first available figures show that over a 2-year period, 5 associations in West Africa and Cameroon tested over 5,000 people (respectively 4,673 MSM and 449 SW), with a positive result rate of 8.9% among SW (40 people) and 12.3% among MSM (577 people).27

In care, the community-based approach makes it possible to:

• guarantee early initiation into treatment

Peers play a support and follow-up role for newly diagnosed individuals. Thus there is a better chance of initiating treatment after diagnosis thanks to peer involvement.

• reinforce retention in treatment and care

Peers provide treatment education, and correct false information and beliefs about HIV. Peer educators know where to find people if they miss an appointment and propose activities adapted to help them accept their HIV-positive status (support groups, for example), thus reducing the number of patients lost to follow-up.

“The community-based approach involves beneficiaries, among others, in the implementation of activities. I feel that this is a guarantee of success when it comes to keeping them in the healthcare system. As an example, counselors and peer educators tasked with guiding new users’ first steps at our treatment sites contribute greatly to creating a feeling of real belonging and accountability with regard to their treatment. This feeling of belonging within the system encourages regular follow-up and continued care”.

Dr. Cissé, medical officer, ARCAD-SIDA, Mali

• ensure community-based distribution of ARV

Community-based actors tirelessly find solutions adapted to the specific situations of the most vulnerable key populations who are not able to travel to facilities to receive their treatment.

“For them [peers], it’s important because access to healthcare is very difficult. The MSM community cannot go to public hospitals because they are stigmatized or refused treatment. If we can talk with those people, we can get them to come to treatment centers quickly. And they keep up with their treatment. Even doctors don’t get that result. Nobody can understand a MSM better than himself”.

Peer educator, Halles de Bamako clinic, ARCAD-SIDA, Mali

27 Between April 1, 2017 and March 31, 2019, the associations supported by the PFAO as part of the testing project were MVS (Niger), ACS (Togo), AIDES Sénégal, Alternatives Cameroun and Humanity First (Cameroon).
III. THE MAIN PRINCIPLES OF ACTION IN SEXUAL HEALTH SERVICES DEDICATED TO KEY POPULATIONS

3. The defense of human rights and action against violence, stigmatization and discrimination

A political framework guaranteeing the protection of key populations, combined with a non-discriminatory environment, has a positive impact on the health of individuals, encouraging them to protect themselves and to use healthcare more systematically.

"Decriminalization of sex work would reduce the number of new HIV infections by between 33% and 46% among female sex workers over the next decade". 90–90–90: An ambitious treatment target to help end the AIDS epidemic, UNAIDS, 2014.

For an impact on an individual level and at public healthcare level, it is important to systematically embed sexual health services for key populations through a rights-based approach. Advocating access to sexual health as a universal right is a powerful principle of action. Developing advocacy actions to make the political and legal framework more favorable to the implementation of SHS is vital in more intractable contexts. The actions developed can take different forms, such as consultations with civil society, raising the awareness of authorities, advocacy actions to improve the legal framework, etc. SHS can also include legal assistance for key populations.
IV. THE SEXUAL HEALTH SERVICE MODEL DEDICATED TO KEY POPULATIONS IN WEST AFRICA

1. The prerequisites for the implementation of SHS

In order to align the need for differentiated sexual health services for key populations with community-based expertise in the HIV response, the PFAO and its partners have put forward a quality, tailored model based on three key prerequisites:

1.1 COMMUNITY-BASED LEADERSHIP, POLITICAL WILL

First of all, it is vital that the implementation of SHS be led by a true political will in terms of structures, both internally and regarding decision-makers, particularly where they are pioneers in their country or sub-region. Political will also include fundraising, which must be done with the aim of covering all of the needs identified. This important stage aims to fund the minimum service package as defined in this reference framework28.

28 See Framework of intervention, a. Service package, page xx
IV. THE SEXUAL HEALTH SERVICE MODEL DEDICATED TO KEY POPULATIONS IN WEST AFRICA

“The idea of creating the Halles de Bamako clinic came from the need to fill a void. That of prevention, care and follow-up for marginalized and vulnerable populations, but above all key populations particularly stigmatized and excluded from the healthcare system. We noticed in 2004 that very few SW and MSM were listed in the Bamako CESAC active file. Firstly, it was clear that we needed to train doctors at referral healthcare centers where community-based treatment units were being set up. That is when we encountered our first obstacle: no public service doctors wanted to talk about homosexuality, and would even leave in the middle of training sessions. We thus chose to fall back on care via specific consultations twice a week at the CESAC. An assessment of this strategy in 2009 showed the utility of creating a dedicated structure to improve the facility and the use of STI/HIV prevention and treatment services for marginalized populations.

The locations, times and services were discussed with and approved by the people concerned. Like the CESAC in Bamako, the first ARCAD-SIDA treatment site, we wanted to set up this clinic at the heart of a market, a hub of activity where SW and MSM meet due to the proximity to major roads, bus stations and brothels. It took a lot of ingenuity and above all determination in a particularly unfavorable socio-cultural context where there is little (if any) domestic funding for programs targeting key populations. Although it was relatively simple to convince the technical and financial partners to back the project thanks to our structure’s leadership, we had to be accepted by the neighborhood. For almost 10 years we have been confronted with multiple, recurring challenges when it comes to the existence and operation of the clinic. Threats have been made against staff and beneficiaries of the clinic. The clinic has been condemned on social networks, and the owner of the premises (a religious zealot involved in faith-based associations) tried on several occasions to terminate the lease agreement after being contacted by a number of people regarding the “immoral” and “indecent” nature of our activities.

Whether in Mali, Burkina Faso or Togo, access for those most concerned by HIV infection is only possible through the community-based approach which ensures their support and involvement within an environment of trust and conviviality. This is the message we need to hammer home to the population and authorities. And that’s what we’ve done. We continue to advocate among national authorities and raise awareness every day to create and maintain an environment favorable to our activities.”

Bintou Dembele, Director of ARCAD-SIDA, Mali
1.2 SUPPORT OF KEY POPULATIONS
Fully in line with the community-based approach, those promoting SHS must provide a consultation framework allowing key populations to become actors of their health, that is to say to prepare and anticipate their involvement at all levels of the implementation of SHS:

Needs identification
Participation in evaluation and proposals for improvement of the service package
Definition of the service package
Response and implementation of activities (location, times, spatial organization)

That is the indispensable condition to guarantee the relevance of the project, the support of populations and the quality of the service package.

1.3 RECEPTION AND BOND OF TRUST
The convivial environment is a fundamental factor of SHS. Conviviality should not be confused with festive, but rather a “refuge”, with the aim of giving key populations a feeling of security. Structures providing sexual health services must guarantee non-judgment throughout the user pathway. Indeed, it is absolutely vital that the center is considered as a place where people can be themselves, without fear of disapproval.

“It’s about us. It’s our life. It’s our network. I don’t know if I can do it forever [about peer education]. But I’ve seen HIV-positive individuals in my community, and that’s what drives me.”
Peer educator, Halles de Bamako clinic, ARCAD-SIDA, Mali

“Some people come for 2 or 3 hours a day, so that they can be themselves, because they spend their days with people who don’t know who they are. More than just a health center, it is a social center, where people feel at home.”
Healthcare professional, ARCAD-SIDA, Mali
It is also a place where people can form bonds of trust with the staff (peer educators, social and medical personnel, etc.). This environment is therefore a prerequisite for building a patient/provider relationship.

“We are the community gateway. The added value is trust. And when you come to the clinic, you meet people like you, engaged in the same practices, so it’s easier to come here. It makes the process easier. If you’re gay, you can’t just go see a doctor. We help them feel at ease”.

Peer educator, Halles de Bamako clinic, ARCAD-SIDA, Mali

“That’s what’s missing. Even if you have problems, it’s difficult to express them. It’s more than just a treatment clinic, it’s a place to socialize. We put them [peers] at ease and if we have problems, we talk about them”.

Peer educator, Halles de Bamako clinic, ARCAD-SIDA, Mali

2. Key steps in developing a sexual health service dedicated to key populations

The implementation of SHS can be built around 5 key stages set out below:

- **Community mapping**
- **Definition of strategic areas of action**
- **Establishment of complementary partnerships**
- **Creation of a framework guaranteeing confidentiality**
- **Raising the awareness of the surrounding environment**

2.1 COMMUNITY MAPPING

Mapping makes it possible to identify and clearly index the different sites that key populations visit as well as geographic dynamics. For example, it makes it possible to identify “hot spots” for MSM meet-ups or SW’ places of practice, as well as sites used for the consumption, purchase and resale of psychoactive substances. These venues are not always visible or known, and they are not easily accessible to outsiders. This mapping is therefore done with the full participation of community-based actors.

Lastly, this mapping will make it possible to establish the socio-demographic characteristics and profiles of populations visiting these sites, their practices and therefore to estimate their number. It should be repeated over the course of a project, notably during movements of key populations, and to maintain relevant action in line with reality on the ground, and therefore with needs. Shared with other community-based organizations, mapping also helps align the activities of the different actors and thus avoid duplication in the roll-out.
2.2 DEFINITION OF STRATEGIC AREAS OF ACTION

The structure must define its strategic areas of action depending on its means, its authorization, its strategic guidelines and its network. The service package, defined to meet the specific comprehensive care needs of key populations, must first and foremost be adapted to a fixed and/or mobile strategy:

The mobile strategy, also known as the outreach strategy.

This is part of the process to delocalize access to services at community level. It is the essence of a differentiated approach to care. By drawing on community mapping, the mobile strategy makes it possible to reach key populations, which are generally hard to reach due to the social stigmatization they suffer and/or because they live in geographically areas far removed from SHS sites. This form of intervention is designed to encourage access to:

- testing
- medical consultation
- diagnosis and treatment of HIV and other STIs
- behavior change communication (awareness-raising)
- referral and support
- distribution of prevention kits

The mobile strategy can be implemented by a single counselor or a mixed team of carers/peer educators with the support of a medicalized bus.

A certain number of elements must be anticipated for the implementation of a mobile strategy:

- the availability of medicalized vehicles
- the availability of a team of peer navigators/educators or counselors
- the availability of a team of carers ready to travel to hot spots on a differentiated timetable.

"Despite a high level of testing among SW, the follow-up wasn’t working. So we thought about what sort of care strategy could be dispensed at SW site of work. A team on the left bank and a team on the right bank [of the river Niger]. I went out with a nurse and a driver, working with SW peers, brothels, cabarets... We organized a visit with the focal point there. The idea was to go to the place of work, rent a room and fit it out. We brought the SW together and talked about HIV testing, then carried out tests. Once the individuals had been tested, we brought the ARV treatment to the site and provided follow-up at their place of work. This helped bring SW back into care."

Health professional, Halles de Bamako clinic, ARCAD-SIDA, Mali

The fixed strategy

For the implementation of a clinic at a fixed center, a certain number of elements must be anticipated:

- the search for appropriate premises, where community-based care activities can be dispensed.
- the technical equipment (examination table, anoscopes, specula, electrosurgical devices) and inputs (condoms, lubricating gel, screening tests, STI and HIV treatment, etc.).

The structure will also define its framework of intervention in terms of adapted sites and schedules, and in coordination with key populations. The choice of site and times is essential and must be decided in consultation with key populations while taking into account accessibility factors (geographic and financial). Times must be adapted to the pace of life and constraints of key populations, which can sometimes be out of sync with the social habits of the rest of the population (weekends, nights).
Lastly, methods using new technologies, like prevention actions over the Internet on gay dating websites, for example, also known as cyberprevention or virtual prevention, can be used to reach the priority audience, who do not normally visit care centers.

2.3 ESTABLISHMENT OF COMPLEMENTARY PARTNERSHIPS
The construction and establishment of diversified partnerships adapted to the unmet needs of populations is an important preliminary step that can be developed over time. This complementarity of practices is a key component in quality SHS.

An extensive, solid and coherent partnership network that covers all the needs of key populations, and ensures referrals to related services. Several types of partnership can be forged in the medical, social and legal fields:

- with other health professionals (doctors specialized in addiction studies or professionals working in drug-related harm reduction, obstetricians and midwives, psychologists)
- with public or private health structures (testing laboratories, surgical or maternity hospital wards)

- with actors in the social/legal field (social workers, lawyers, paralegals), notably for cases of violence (gender-based violence, other types of violence)
- with other associations or identity groups, youth groups, or women’s groups, to break the isolation or in the case of rejection, exclusion, and complex family and personal situations

2.4 CREATION OF AN ETHICS FRAMEWORK GUARANTEING CONFIDENTIALITY
Guaranteeing respect for fundamental ethical principles by all stakeholders, from the building manager to the lab technician, and right throughout the user circuit, is essential to guaranteeing the success of the project and the quality of the services provided.

Respecting confidentiality, that is to say all medical and social information, as well as users’ identities and sexual practices, is crucial. This value of confidentiality is a reflection of the principles of autonomy, respect for others and trust.

A charter setting out the ethical principles of the structure can be displayed in the waiting room.

**ARCAD-SIDA-Halles de Bamako Clinic Code of Ethics**

- Ideological independence
- Defense of the rights of people living with HIV/AIDS
- Non-Judgment
- Voluntary and anonymous testing
- Safeguarding of confidentiality and professional secrecy

Furthermore, the structure must have tools guaranteeing confidentiality and medical secrecy (locked cabinets, secure patient medical files, etc.).

"The time was decided by the key population. The choice of site was ours, based on the process that prompted us to choose the CESAC at a time when HIV was strongly discriminated against – in a marketplace. It was also near the main bus stations and hotels, as well as brothels".

Doctor, Halles de Bamako clinic, ARCAD-SIDA, Mali

"For activities like proctology (the most complex cases), we refer our beneficiaries to Doctor A. For some cases of genital warts, we also refer them to the Congo district medical center. Lastly, for post-abortion care, family planning and contraception, we refer them to the Emile Saker hospital and for gynecology consultations to Doctor M.’s department at the General hospital."

Alternatives Cameroun
2.5 RAISING THE AWARENESS OF THE SURROUNDING ENVIRONMENT

Although it requires a huge commitment on the part of the teams and a great deal of time, this stage of raising the awareness of the surrounding social environment is absolutely essential and must be regularly repeated. It ensures greater acceptance and thus guarantees better access to services for populations.

When the environment is particularly hostile, associations must, at the very least, guarantee secure access around intervention sites (fixed or mobile units), thanks to negotiations with the police, shopkeepers and neighborhood chiefs, for example.

"Before opening the Halles de Bamako clinic, we spent a lot of time working with the locals, the shopkeepers, the police station and the association of female traders, during the first three months. I explained to them what I do and why I do it. Even the owner, an Imam, was informed. It’s a very time-consuming activity, and every year we have to start over and keep going due to changes. Every year, we invite the Head of the referral health center, the police chiefs, and the shopkeepers at Les Halles to attend a presentation of the project’s results and difficulties."

Alou Coulibaly, Doctor and Coordinator at the Halles de Bamako clinic, ARCAD-SIDA, Mali

Sometimes, it is also necessary to raise awareness among other populations benefiting from the services, like PLWHA from non-key populations, and sometimes other groups of key populations, to ensure the acceptance of these groups.

"When we first put evening events in place dedicated to MSM populations offering healthcare discussions combined with HIV testing, there was strong resistance even from other users. People living with HIV who had already been going to the treatment center for a number of years did not want the association to also open services dedicated to MSM. In order to overcome these obstacles, the association organized a series of awareness-raising actions among PLWHA on the importance of working with MSM. Discussions centered around the following questions: who are MSM? Why this population is a priority population to involve and work with? What are their priority needs? What are the HIV prevalence rates within this group? What are the challenges in terms of public health? These awareness-raising meetings helped explore prejudices that PLWHA have regarding MSM, by realizing that they were also victims of similar behavior from the general population regarding their HIV-positive status. This dialog was necessary to clarify the position of the association regarding its commitment to key populations, emphasizing the importance of providing a response to a public health problem. What’s more, it was necessary in order to refute claims that the association was “promoting homosexuality”. The reputation of ACS as a treatment center for underprivileged individuals for many years, and its good reputation in terms of the quality of services helped remove this barrier. It was a process that took time and that required a great deal of patience, but which helped truly shed light on the needs of MSM, and ultimately to facilitate the acceptance of key populations by the center’s users."

Rachele Esteve, Director of Action Contre le Sida, Togo
3. Sexual health services dedicated to key populations

The optimal package comprises all of the services offered by the minimum package plus a certain number of additional services.

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<tr>
<th>MINIMUM PACKAGE</th>
<th>OPTIMAL PACKAGE</th>
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<td><strong>Prevention</strong></td>
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<tr>
<td>• Education/awareness-raising/communication for behavior change</td>
<td>• Cancer screening (cervical, prostate, anal)</td>
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<tr>
<td>• Cyberprevention on social networks</td>
<td>• Hepatitis B screening and vaccination</td>
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<tr>
<td>• Distribution of IEC materials on sexual health and STIs</td>
<td>• Harm reduction related to drug use with the distribution of sterile drug-use equipment</td>
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<tr>
<td>• Distribution of prevention materials (internal and external condoms, lubricating gels)</td>
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<td>• PrEP</td>
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<tr>
<td>• Emergency contraception for women</td>
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<td>• Community-based HIV testing with the use of rapid diagnostic tests and self-testing</td>
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<tr>
<td><strong>Medical care and referral</strong></td>
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<td>• Syndromic management of STIs (diagnosis and treatment)</td>
<td>• PSTI treatment (genital or anal) including complex STIs</td>
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<td>• Link and care referral</td>
<td>• Treatment and care of PLWHA</td>
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<td>• Treatment of PLWHA</td>
<td>• Gynecology and proctology consultations</td>
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<tr>
<td>• Diagnosis and treatment of HIV/TB co-infection</td>
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<td>• Addiction diagnosis and referral to harm reduction and addiction treatment services</td>
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<td><strong>Biological follow-up</strong></td>
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<td>• Biochemical analyses (creatine, blood glucose, cholesterol, triglyceride)</td>
<td>• Comprehensive GBV care</td>
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<tr>
<td>• Hematology (complete blood count)</td>
<td>• Addiction treatment referral</td>
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<tr>
<td><strong>Psychosocial support</strong></td>
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<tr>
<td>• Community mobilization and self-support (self-esteem, human rights, sexual health, etc.)</td>
<td>• Prescription and follow-up of opioid substitution treatment</td>
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<tr>
<td>• Psychosocial counseling and support including adherence assistance</td>
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<td>• Adherence assistance and treatment education.</td>
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<td>• Family mediation</td>
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<td>• Referral to psychosocial care</td>
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<tr>
<td>• Referral to dedicated structures in the case of GBV</td>
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<td><strong>Legal support</strong></td>
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<tr>
<td>• Recording and documentation of cases of human rights violations</td>
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<td>• Legal assistance</td>
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Cross-functional: Advocacy and defense of rights, training and capacity-building of key populations

3.1 THE SERVICE PACKAGE (MINIMUM AND OPTIMAL)

The service package adapts to the specific needs of each individual by proposing essential services in the minimum package. This service package is scalable and can be expanded to compose an optimal service package, as presented below:
IV. THE SEXUAL HEALTH SERVICE MODEL DEDICATED TO KEY POPULATIONS IN WEST AFRICA

Oral PrEP is the use of ARV treatment by people not infected by HIV in order to prevent HIV acquisition. PrEP is therefore highly recommended for key populations at high risk of HIV exposure. This prophylaxis is combined with regular medical follow-up, along with screening for other STIs. PrEP can be taken in two ways, either continually (daily doses), or on demand (event-based dosing). “In most countries, it is set to be a pillar in the preventive arsenal among key populations to complement other tools and existing strategies. (...) The results of existing medico-economic studies show the cost efficient nature of PrEP among the MSM and PWID population at high risk of HIV infection29”.

The WHO June 2016 recommendation for key populations states that “Oral PrEP (containing TDF) should be offered as an additional prevention choice for key populations at substantial risk of HIV infection as part of combination prevention approaches”.

All of the member associations of the PFAO providing sexual health services recommend that PrEP be included in the minimum service package. Likewise, the conclusion of the scientific article in the CohMSM study on the interest in PrEP concurs with this finding: “Western African HIV-negative MSM appear very interested in taking PrEP, especially those most at risk of HIV infection. PrEP implementation in a comprehensive prevention package should be considered urgently”30.

ARCAD-SIDA has organized widespread advocacy to make this tool available in all of the countries in the sub-region. Within this framework, a series of days dedicated to PrEP were organized with the aim of improving the visibility of the gains in terms of PrEP worldwide, in the sub-region and in the different countries. A first PrEP Day was run in Bamako, Mali, in May 2018, and another in April 2019 in Dakar, Senegal, bringing together a total of over 50 participants (doctors, scientists, decision-makers, beneficiaries, service providers).

Extract from the videos explaining the PrEP approach for MSM as part of the CohMSM study: (link: https://www.youtube.com/watch?v=sohDfbAwRbY)

29 Extract from the report: Medical care for people living with HIV, recommendations of the Group of Experts under the direction of Pr. Philippe Morlat and under the auspices of the CNS and the ANRS, prevention and screening, April 2018
30 Interest in HIV pre-exposure prophylaxis in men who have sex with men in West Africa (CohMSM ANRS 12324 – Expertise France), Pierre-Julien Coulaud1,2, Luïga Sagaon-Teyssier1,2, Bakridine M’madi Mrenda1,2, Gwenaëlle Maradan1,2, Marion Mora1,2, Michel Bourety1,2, Bintou Dembélé Keita3, Abdoul Aziz Keita3, Camille Anoma4, Stéphane–Alain Babo Yoro4, Ter Tiero Elias Dah5,6, Christian Coulibaly5, Ephrem Mensah7, Selom Agbornadj7, Adeline Bernier8, Clotilde Couderc9, Christian Laurent9, Bruno Spijter12 & The CohMSM Study Group
3.2 ADVOCACY: AN INTEGRAL PART OF THE SHS PACKAGE

The combat for the creation of a favorable environment, allowing for equitable access to healthcare for key populations, is an essential component designed to make SHS more effective.

This advocacy can be approached from different angles:

- Creation of strategic alliances to condemn the negative impact of the criminalization of homosexuality, use of psychoactive substances, and sex work, as done by AGCS PLUS31 for example.
- Challenging of society to encourage a shift in attitudes with shock campaigns and testimonies from celebrities. A famous figure admired by society can, for example, deliver strong political messages.
- Organization of public consultations with civil society, opinion leaders and political decision-makers placing the health needs of key populations at the heart of the debate and the search for common solutions.
- Ensuring advances in international and national frameworks by providing concrete elements based on the field experience of community-based associations, at international conferences and meetings with the technical and financial partners.
- Challenging of health authorities and holding them accountable for the shortcomings and vacuums in the healthcare system when it comes to treating key populations, and for the limits of their involvement in decisions concerning them.
- Documentation of human rights violations suffered by key populations to render them visible (violence observatories, shadow reports, etc.).

For example, in Cameroon, several associations joined forces to highlight and condemn human rights violations. As such, Humanity First and Alternatives Cameroun published an annual report on violence and violations against sexual and gender minorities in February 201832.

31 https://www.facebook.com/AGCSPLUS/?ref=br_rs
3.3 ACTORS: A MULTI-DISCIPLINARY AND COORDINATED TEAM

The team tasked with providing differentiated sexual health services must be multi-disciplinary and can vary depending on the context, but must be based, in addition to support and coordination functions, on two central pillars: peer educators and carers.

3.3.1 Peer educators: key actors in SHS, but beset by difficulties.

Peer educators play a central role in prevention and care for key populations. The range of roles taken on by peer educators is vast:

- **Peer education and information**: Educational talks in the target’s gathering spots (grins, bars, clubs) and online.
- **Community-based prevention and testing**: They run training and distribute prevention materials, provide counseling and HIV/STI testing (rapid testing and self-testing), and provide counseling and support for behavior change.
- **Counseling and referral to healthcare facilities**: They help orientate HIV- and STI-positive individuals within the care system and with treatment through individual support.
- **Community-based distribution of ARV** for stabilized patients (that is to say compliant patients with an undetectable viral load).
- **Retention in care**: They issue reminders of appointments, look for patients lost to follow-up, run collective and individual therapeutic education sessions (adherence club).
- **DBS** testing on blotting paper for the viral load
- **Psychosocial support activities**: Self-support between peers through support groups, support for HIV-positive diagnosis, and family mediation.

“We, as MSM peer educators, are beneficiaries but above all actors at the Halles de Bamako clinic. We provide peer navigation, online prevention, kit distribution (gel, condoms), home visits, and educational talks as part of the fixed strategy here at the clinic, but also at hot spots as part of the outreach strategy. We intervene at the beginning and the end of the chain. Before coming to the clinic, as MSM, we found it difficult to visit healthcare structures, particularly public ones, for treatment. Now, the clinic provides services like testing, STI and HIV treatment, support for ARV adherence, and follow-up. The arrival of PrEP in 2018 was a real leap forward in terms of prevention.

It is a safe place, a place of hope and confidentiality for MSM, especially with the socio-cultural situation in Mali. We would like this type of facility to be available at regional level, so that our peers can easily benefit from these services, as they often have to travel many kilometers to come here.”

Testimony from an MSM peer educator during the visit by the Global Fund team for Mali and the French Ambassador for Global Health, Stéphanie Seydoux, to the Halles de Bamako clinic in July 2019.
Peer educators encounter a great number of difficulties. Actors on the front line at care facilities, they are often subject to verbal and physical violence. Likewise, taking up their role to the full makes them more visible, more exposed to the risks of arbitrary arrests, insults, violence and even assault. For example, transporting prevention material, such as condoms and gel, can lead to them being arrested as these are still used as proof in certain contexts.

“One day, I was running a talk in the field, and one of the participants asked me to bring him some gel and lubricant another day. He told me where to go. When he arrived, I asked him: ‘do you know how to use a condom?’ So I did my job, except that it was a public place. The police came and insulted me. Then they took me to the police station, and I had to spend the night there”.

Peer educator, Halles de Bamako clinic, ARCAD-SIDA, Mali

Although they receive a variety of training - from initial training to lifelong training within community-based associations - in community-based testing, self-testing, STI and hepatitis prevention, building self-esteem, and paralegal training, for example, they still have too limited access to diploma-based training and training leading to qualifications. Their status therefore remains particularly insecure and undervalued outside of community- and identity-based associations. Committed to improving the health of their communities, they testify to a substantial work overload and a lack of logistics means. They sometimes encounter difficulties in carrying out their tasks due to increased population mobility, but also the distrust of key populations when peers try to meet new, more isolated groups.
3.3.2 The medical team
The medical team is composed of nurses, family physicians and specialists (gynecologists, proctologists, addiction experts, etc.), pharmacists and technicians. In addition to their university studies, the medical team receives training on the specific reception and care of key populations. Lastly, the team works closely with peer educators.

3.3.3 Building the capacities of SHS actors
Training for health workers and peer educators is essential to guarantee specific and high-quality care for key populations. This training must be both upstream and continue throughout the implementation of the service package. As for specific training prior to the implementation of SHS, this can include the community-based approach, testing and counseling, STI diagnosis and treatment (gynecology and proctology), identification of GBV, etc. In additional to theoretical training, capacity-building can include on-the-job training through a practical placement in a clinic already providing the relevant services, and supervisory visits.

4. Monitoring and steering
Monitoring is a continuous process based on the four stages of the continuous quality improvement model (plan, implement and collect data, verify and analyze, adjust or realign, often referred to as Plan-Do-Check-Act)\(^\text{34}\). As such, the introduction of a monitoring system at service level but also at national level is vital to ensure control of the project.

The design of a monitoring system must be carried out during the project development phase. This system involves much more than simple activity monitoring. Indeed, it aims to constantly measure expected results to assess whether they are on track and to analyze the need to adjust, realign or modify activities and thus be more responsive to changing realities.

A large proportion of the team needs to be involved in the monitoring process: the operational teams for the various prevention, testing, treatment and referral components, as well as the coordination, management and support teams, and the key populations themselves.

Towards a single coding system?
With a view to improving the quality of data on SHS, and notably to resolve the problem of double counting of populations visiting several structures (either public and community-based structures or several community-based structures consecutively) to receive the services they consider they require, it is vital to carry out substantive work on the monitoring system currently in place. Serious thought must be given to the single coding system, which could partly resolve the problems encountered in monitoring. However, it would not solve everything and could even have significant negative effects. For example, particularly stigmatized key populations could be worried about being on record in the central system.

A feedback mechanism, like suggestion boxes, focus groups, and user satisfaction surveys is also a means of regularly monitoring the satisfaction of key populations.

Monitoring and steering must make it possible to follow the patient pathway from their first contact or registration with the structure up to referral.

34 Quality & Accountability COMPASS, Groupe URD, 2017
V. EXAMPLES OF BEST HSH PRACTICES IN WEST AFRICA AND CAMEROON

1. The Halles de Bamako clinic in Mali

To improve access and the use of services by key populations (SW – 24.2% HIV+; MSM – 13.7% HIV+; PWID -5.1% HIV+), ARCAD-SIDA opened a sexual health clinic in Bamako in August 2010. Accessible to the entire population, the clinic is particularly adapted to the specific needs of SW, MSM and PWUD. Its location - in the Les Halles market in Sogoniko in Commune VI of the Bamako district - and operation are adapted to all targets, and key populations in particular. It offers discretion and anonymity, while also being well connected to the city’s bus network. The clinic operates extended and adapted opening hours, from 4pm to midnight.

On site, the clinic provides prevention and treatment services with 4 medical consultation rooms, open spaces, a pharmacy, a laboratory, and a nursing and testing room. In addition to these services at the fixed center, it also runs an outreach strategy thanks to two mobile units and teams on foot. The complementarity of these approaches makes it possible to reach key populations more broadly, at their gathering places or places of work in the case of SW, and to offer an extended range of services. It ensures the continuous availability of prevention materials such as lubricating gel doses, condoms, and STI treatments.

Thanks to the on-site laboratory, a number of basic examinations can be carried out, thus reducing the waiting time for results and meaning that key populations do not have to travel to other structures.

For MSM, whose regular anal practices require preventative proctology consultations, the clinic provides services that are often lacking from classic healthcare centers. This continuum between prevention and treatment within a single setting facilitates the entry into and retention in care.

One of the specific characteristics of the clinic is building self-esteem among young MSM and SW through support groups and psychosocial support services. By placing the emphasis on the need to adapt the messages and services to the needs of the people encountered in the field, the clinic has adopted an individualized approach to prevention.

The clinic also acts as a meeting place in an adapted environment that guarantees both discretion and safety. As such, the clinic builds a bridge between prevention and treatment. It breaks with classic approaches which are often too formal.

Lastly, a multi-disciplinary team for the reception, support and care of users is composed of 4 doctors, 1 pharmacist, 1 nurse, 1 lab technician, 2 research assistants, 8 counselors and a vast network of peer educators. Peer educators play a crucial role and ensure a constant link between the different professionals at the Clinic and key populations. They provide adapted individual support, conducting home visits, being available by phone and present daily at meeting points and in the Clinic. They are also very active in the search for those lost to follow-up.
2. Family mediation in Cameroon

Legislation is particularly repressive in Cameroon regarding people who have sex with people of the same sex, which can come with a penalty of up to 5 years in prison. Against this backdrop, psychological, physical and sexual violence are frequent. 2018 was marked by a significant increase in the number of cases of gender-based violence compared with the previous year (respectively 1,134 cases reported compared to 578 cases), and ended in the tragic murder of a young MSM by members of his family.

Alternative Cameroun (AC) and Humanity First (HF), which already ran awareness-raising and information activities on the rights of people in the LGBTQI community, decided to expand their scope of action to family mediation. These two associations identified families as the core target of their actions to reduce violence, insofar as they represent one of the pillars in the prevention of this violence:

- A large proportion of violence occurs within the family circle,
- Families can also be best placed to protect and defend the rights of key populations.

In cases of violence, family mediation starts with the gathering of information and the reconstruction of the events. AC and HF endeavor to obtain the most accurate version possible in order to begin discussions and attempt to find a way to address the problem with the family.

The second important stage consists of obtaining prior detailed information on the family, and particularly on their religious faith. For example, if it is a practicing Catholic family, the mediators can easily consult the Bible and thus prepare arguments such as “Love thy neighbor as thyself, the Bible preaches tolerance and non-judgment”. For non-practicing families, they can advocate tolerance and respect for human dignity. In all cases, AC and HF emphasize family values as the bedrock for its members to thrive.

The third stage is initiating the home mediation sessions. During these meetings, a multi-disciplinary team works alongside a psychologist or psychosocial counselor, or sometimes a human rights focal point. Community-based actors always introduce themselves to the family as health workers, and inform the family that their child comes to their respective center. While at the same time prioritizing this dialog with the family, AC and HF underline the potential risks of people living on the street (assault, theft, etc.) and the importance of keeping their child within the family cocoon.

Mediation sessions can take place regularly, and it is often only after several sessions that it is finally possible to address the question of homosexuality.
3. The EVT mobile unit in Togo

The fixed STI testing and consultation strategy in Togo does not always make it possible to reach some MSM or SW who have particularly limited access to healthcare structures.

The EVT mobile unit, using a medicalized bus, not only makes it possible to seek out populations with little or no access to testing and consultations, it also provides an adequate environment: for example, the availability of examination tables. The safety it provides the teams and the confidentiality of service provision are strong arguments that contributed to the introduction of this unit in 2012.

This mobile unit has made it possible to respond to a need for proximity and accessibility when it comes to testing for the greatest number of people possible by traveling to exterior gathering points, outer suburbs, party venues, beaches, etc.

The medicalized bus is equipped for consultations (power generator for lights, consultation tables, medical equipment, curtains, etc.). A dedicated team is formed of: medical staff, psychosocial personnel, peer educators and mediators, driver.

The advantages of the mobile unit include:
- the possibility to reach a maximum number of MSM and SW including those more hidden and vulnerable, who would not otherwise travel to a fixed center,
- the ability to conduct interventions anywhere at any time of day,
- the possibility to better examine patients and to guarantee greater confidentiality, notably in disclosing results, compared to on-foot teams,
- early treatment of positive diagnoses,
- reduced costs of transport and waiting times at care centers for users,
- greater security for the EVT personnel at late hours.

Proximity to people (hot spots, remote areas, etc.) is essential to ensure access to key populations and in meeting their needs.
4. The Espace Confiance 
Addiction Treatment and 
Counseling Center (CASA) 
in Abidjan, Côte d’Ivoire

HIV prevalence within the PWUD community is estimated at 5.64% in Abidjan, and at 9.8% for Tuberculosis. In August 2018, the first community center in Francophone Africa was opened in Abidjan, dedicated to holistic care for PWUD. It is the fruit of a collaborative effort by the Ivorian Ministry of Health, Médecins du Monde (France) and Espace Confiance (Côte d’Ivoire).

Ten peer educators form the core of the strategy and intervene in all of the structure’s activities to encourage entry into care and treatment adherence. This resulted in the introduction of daily medico-community HIV and tuberculosis (TB) support, including referrals and follow-up for infected PWUD. Consequently, between April 2019 and June 2019, for example, 1,735 PWUD (of which 10% are women) used these services. 682 medical consultations, including family planning and cervical cancer screening, were conducted. Peer educators conducted 519 hospital visits, home visits, medicine dispensing, examination follow-up, family research, etc., of which 131 specifically for the monitoring of patients co-infected with HIV/TB.

Community-based care consists of accompanying PWUD from their diagnosis up to the achievement of an undetectable viral load for PLWHA and/or TB recovery. This medico-community approach therefore proves its effectiveness more and more each day in care for PWUD in particular when it comes to treatment adherence for PLWHA and/or TB recovery. This medico-community approach also represents an effective and relevant solution to care for PWUD, excluded from the family cell and with little access to the healthcare system due to heavy stigmatization and repressive policies. In light of the conclusive results, the CASA aims to expand the community-based team and to develop this approach for other interventions, such as the response to demand for breaking addiction and methadone provision.
5. Towards the duplication of the SHS model: Focus on Capacity-Building (CB) within the framework of the PFAO

The actors in the response in West Africa lack knowledge of the specific needs and care of key populations, both in terms of technical capacities and in terms of soft skills and attitudes. For example, healthcare professionals lacked the expertise for STI diagnosis and testing among MSM. Community-based associations also lacked expertise regarding the implementation of holistic care for the mobile SW population.

Since 2015, the SHS capacity-building of the PFAO partners has become one of the Platform’s most solid fields of community-based expertise. The objective of CB is to improve practices by introducing new skills and by encouraging an improvement in the holistic care of key populations. A multi-disciplinary team experienced in the implementation of sexual health services carries out CB initiatives on the following themes:

- The minimum package for SHS dedicated to key populations;
- Risk assessment, prevention, STI diagnosis and treatment, gynecology and proctology consultations (diagnosis and treatment of anal lesions, for example).

Capacity-building has been divided into four stages:

- Completion of an organizational review (OR), firstly. The OR is a type of self-assessment of the structure to identify its needs. It allows for specific and more relevant support.
- Capacity-building workshops on site, secondly, within the community-based structure using theoretical and discussion components.
- A practical placement at the ARCAD-SIDA premises at the Halles de Bamako clinic is organized as a third step to put these new skills into practice. Placements help consolidate and confirm reinforced staff capacities in providing medical consultations adapted to the needs of key populations. They take place over a period of 6 days with theoretical supplements and participation in all of the activities at the Clinic, such as awareness-raising and information sessions run by peer educators and outreach activities at the Clinic and on mobile deployments.
Lastly, the fourth step, monitoring of the quality of the services put in place, is carried out 3 to 6 months after the practical placement, in the form of post-placement follow-up visits. It is generally carried out by the placement supervisor accompanied by another doctor or a medical assistant, making it possible to gage how well the new skills have been integrated at the site itself. Between April 2015 and March 2019, the PFAO provided capacity-building in total to:

- 17 AIDS response associations trained in 12 countries in 3 sub-regions (Benin, Burkina Faso, Burundi, Cameroon, Guinea, Mali, Mauritius, Niger, CAR, Côte d’Ivoire, Senegal, Togo)
- 32 direct beneficiaries received CB training, of which 20 doctors, 3 psychosocial counselors, 2 nurses, 3 peer educators, and 4 medical assistants

The Platform’s CB actions over the last 4 years have made it possible to:

- Establish sexual health services where there were none before. A mobile clinic was set up by Alternatives Cameroun to treat MSM and SW during night visits in the field as part of an outreach strategy;
- Produce and update a mapping to ensure better targeting and a greater number of people tested;
- Sexual health services dedicated to key populations. The SHS developed by EVT in TOGO has been extended to SW, whereas MSM were previously the only beneficiaries;
- Reinforce existing services, particularly the provision of specific care: attitude towards key populations during consultations, risk assessment, proctology consultations and care (with, for example), the acquisition and mastery of anoscopes and electrosurgical devices for examination of the anal area);
- Develop online sexual health services, that is to say provide information and prevention services to key populations online, but also refer them to healthcare centers.
VI. CHALLENGES AND RECOMMENDATIONS

In order to make SHS possible in all countries in West Africa and beyond, community-based associations have warned of the limits and difficulties they encounter and the existing structural shortcomings and have put forward a series of concrete advances at political, financial and structural level.

**Difficulties of PFAO SHS providers**

- Insufficient trained human resources to cover needs. Furthermore, high turnover of teams due to the complexity of the task and the isolation, making it difficult to retain internal expertise and know-how;
- Insufficient international and domestic financial undertakings that do not cover all needs;
- Lack of specific funding dedicated to SHS, which does not allow for the purchase of suitable equipment and comprehensive technical facilities for the care of key populations and in particular STIs;
- Hostility and tightening of laws that discriminate against and criminalize key populations;
- Poor recognition of the expertise of peer educators;
- Lack of opportunities to promote the expertise of peers in other, more broader sectors of healthcare.

2. Challenge No.2: shortcomings in the healthcare system

There is a lack of will on the part of healthcare structures to integrate differentiated sexual health services for key populations. The low level of this coverage - often concentrated in capital cities and urban centers - does not allow for effective and sufficient access to all key populations in need.

Unlike the providers used by community-based associations, training health care professionals still demonstrate an attitude incompatible with the reception of key populations, sometimes to the extent of discrimination and refusal of care.

Providers also report difficulties related to stock shortages. National procurement and stock management systems need to be reinforced to significantly reduce shortages of vital stocks such as HIV and STI tests, antiretroviral treatment, and viral load tests. Furthermore, burdensome and lengthy national procedures place small structures - often the only ones with access to the most hidden populations - in difficulty as they struggle to ensure supplies and maintain equipment.

1. Challenge No.1: political and systemic shortcomings

In general, the difficulties encountered by providers are due to a lack of integration of the comprehensive sexual health approach in HIV. The lack of inclusive policies and a reference manual dedicated to the integration of sexual health services in HIV prevention and care, as well as the lack of sufficient dedicated funding, limit the development and scale-up of quality sexual health services.

Furthermore, there is an urgent need for governments to demonstrate strong leadership in favor of political changes to improve the legal framework.

An ambitious amendment of laws that criminalize and discriminate against key populations would improve access to care and also reduce the discrepancy which has developed.
Lastly, standard care protocols and procedures for key populations, particularly concerning STIs, are not always adapted. As such, the associations have drawn up a series of recommendations in response to these limits and shortcomings.

3. Recommendations

3.1 Recommendations at policy level

- **Create a more favorable operating environment**
  The fight against all forms of human rights violations suffered by key populations must be a regional and national priority, and must be accompanied by concrete measures applied in national plans. These measures must be accompanied by political messages, and substantive information work targeting opinion leaders (youth and women’s community leaders, traditional and religious leaders), but also the police and the media, in order to secure the working environment for teams in the field.

- **Guarantee respect for human rights**
  There is an urgent need to amend legal frameworks by decriminalizing homosexuality, sex work and drug use and by protecting key populations in general to ensure their effective and equal access to healthcare services. All political messages must be consistent and be addressed to opinion leaders.

3.2 Recommendations at financial level

- **Limit the dependency of current services on international donors**
  It is vital that domestic subsidies dedicated to SHS for key populations be increased so as to reduce the dependency on donors, in particular with regard to the catalytic investments of the GF. The political commitment of States to end HIV by 2030 must be accompanied by sustainable financial investment.

3.3 Recommendations at the healthcare system level

- **Strengthen the community-based system**
  Civil society organizations have developed community-based knowledge and know-how that can impact the HIV epidemic. SHS are the most successful embodiment of this. Beyond strengthening classic healthcare systems, it is vital to consolidate the community-based healthcare system managed by civil society organizations to ensure access to care for hard to reach and/or marginalized and forgotten populations such as key populations. The community-based approach is the only alternative in the HIV response, and its expertise could be duplicated in other areas of public health.

- **Create a stock management monitoring committee**
  A stock management monitoring committee (testing kits and reagents, prevention materials such as condoms, lubricating gel and injection kits) in which civil society would be represented, would allow for the following:
  - a better response in the event of shortage to limit the negative impact;
  - better anticipation for future orders;
  - a better global response.
  Depending on the aim of the actors involved, an observatory could also be created at national level to oversee service quality and the availability of materials.

“Very few civil society organizations have sufficient means or funding to set up technical facilities. Those that do manage have great difficulty in maintaining them.”

Alternatives Cameroun
• Include prevention tools and materials such as PrEP and lubricating gel in national strategic frameworks

Although PrEP is an innovative supplementary tool and eagerly awaited in the package by key populations, it is important that all strategic national frameworks give prominence to PrEP and produce the implementation decrees required for effective implementation.

Likewise, in some countries, lubricating gel is still not included on national lists of essential medicine. In order to ensure effective and quality prevention action for key populations, there is an urgent need to include lubricating gel alongside condoms on all national inputs supply lists.

• Include demedicalization in all strategic national frameworks and encourage its implementation

In addition to inclusion of demedicalization, all community-based actors must be authorized to form part of the entire care continuum.

Obtaining peer certification for community-based testing and raising the profile of this certificate at national level in the structure would allow for wider recognition of their expertise.

• Reinforce the national supply system for STI kits

The list of medicine on the national supply list must sufficiently include the molecules required to treat key populations, and more particularly for the most common STIs among MSM. It is important to remain vigilant to ensure stocks correspond to STI treatment needs and the sexual health needs of key populations, thereby avoiding stock shortages.

• Adapt STI diagnosis algorithms to the most common STIs among key populations

Lastly, in terms of care, a certain number of STI diagnosis algorithms should be developed to adapt to the sexual health needs of key populations and notably for common anal and oral infections among MSM.
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