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# THE CHANGING FACE OF HIV PREVENTION PROGRAMS IN BURKINA FASO AND TOGO

## OPPORTUNITIES AND CHALLENGES OF PROVIDING HIV PREVENTION PROGRAMS AND SERVICES FOR MOST-AT-RISK POPULATIONS IN BURKINA FASO AND TOGO

**AIDSTAR-One**  
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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BURKINA FASO AND TOGO

### **AIDS Support and Technical Assistance Resources Project**

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# ACRONYMS

amfAR	American Foundation for AIDS Research
CIDA	Canadian International Development Agency
CNLS	<i>Conseil National de Lutte Contre le SIDA</i>
EVT	<i>Espoir Vie Togo</i>
FAMME	<i>Forces en Action pour le Mieux Etre de la Mere et de l'Enfant</i>
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IPC	<i>Initiative Privée Communautaire</i>
MARP	most-at-risk populations
MSM	men who have sex with men
NAC	National AIDS Council to Fight HIV/AIDS
PAMAC	<i>Programme d'Appui au Monde Associatif et Communautaire</i>
PASCI	<i>Programme d'Appui aux Organisations de la Société Civile Impliquée dans la Riposte au VIH/SIDA au Togo</i>
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PSAS	<i>Petite Soeurs à Soeurs</i>
PSI	Population Services International
STI	sexually transmitted infections
SW	sex worker
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development



# EXECUTIVE SUMMARY

Recent recommendations for HIV programming in the context of mixed epidemic settings present the complex task of tailoring interventions to the needs of multiple populations (U.S. President's Emergency Plan for AIDS Relief [PEPFAR] 2011). In many countries, including those in West Africa, aligning prevention programming and budgets with mixed epidemics has been challenging. In March 2012, a team from AIDSTAR-One visited Burkina Faso and Togo to assess the current HIV prevention portfolios in the two countries.

This program review is a direct response to the urgent need to strengthen and expand HIV prevention for men who have sex with men (MSM) and sex workers (SW) in West Africa. This review focuses on the programmatic context, and it complements epidemiologic and policy reviews also commissioned by PEPFAR funded through the U.S. Agency for International Development (USAID). The review furthers the renewed emphasis of PEPFAR on matching interventions and investments with epidemiological trends and needs in order to improve impact.

The review examines available data on the HIV epidemic in both countries, with particular focus on prevalence among most-at-risk populations (MARPs), which has proven difficult to estimate. This translates into challenges in measuring the needs of these populations for HIV-related services.

In Burkina Faso, strong national leadership has led to progress against the fight against HIV and several important steps have been taken to promote an effective response at multiple levels. This includes the adoption of national strategic frameworks that have evolved to meet those affected by the epidemic. Togo, on the other hand, has struggled due to political challenges the country has faced. Most of the HIV programming is from international and private sources. This document examines the policy context and response of both countries, taking into account the social and structural challenges faced by MSM and SWs. Both populations face widespread stigma and discrimination and remain highly marginalized. This presents enormous challenges for the delivery of HIV services; however, successful approaches to reach those in need of them have been demonstrated.

The report also examines the role of development partners in both countries. The largest funders of HIV activities for MARPs include the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM), Canadian International Development Agency (CIDA), French AID (SIDAction and AIDES), amfAR, and USAID. Associations and nongovernmental organizations (NGOs), considered the backbone of the community-level HIV response, provide a variety of services and have proven responsive to the needs of MARPs. However, these organizations face their own financial, structural, and staffing constraints, such as high turnover of personnel.

Finally, the report offers observations on the opportunities and constraints that Burkina Faso and Togo face in scaling up services for the populations who need them. A lack of data remains a constraint, as do limited resources. Poverty and health system challenges remain overarching issues. The report concludes with several recommendations on addressing the prevention, care, and treatment needs of MSM and SWs:

- **Invest in leadership and technical capacity.** Civil society organizations can benefit from strengthened leadership for sustainability and scale up of programs to help address staff turnover and burnout. Maintaining current evidence-based practices and careful monitoring will help ensure quality is not lost when scaling up programming.

- **Perform operations research.** Meaningful involvement of MARPs and community workers in research can help programs adapt to changing needs. Operations research can help government and civil society to be innovative and responsive while developing sustainable programs that maintain quality and avoid staff burnout.
- **Improve donor coordination.** A donor roundtable can improve coordination of existing resources and attend to systemic issues such as procurement of supplies. Scale up of programming will require additional resources and strengthened coordination efforts.
- **Address stigma.** Without addressing stigma, which remains a significant barrier to programs and services, and creating enabling legal and social environments, programs will not succeed.
- **Focus on MSM and sex worker leaders.** Programs stand to benefit from the insight and experience MSM and sex workers have from grassroots level civil society engagement—they have shown it is possible to address HIV despite cultural, political, and systems challenges. MSM and sex worker leaders can benefit from leadership coaching to strengthen partnerships between civil society and national programs.

# BACKGROUND AND PURPOSE

Epidemics occurring among most-at-risk populations (MARPs) have been historically overlooked in many sub-Saharan African countries. Previously, these countries stressed HIV prevention in the general population and among youth. Increasingly, they are recognizing the need to shift program emphases to better align with the epidemic. A recent meta-analysis suggests that in low income countries, HIV prevalence may be nine times higher among men who have sex with men (MSM) than among the general adult population (Baral et al. 2007).

Although countries recognize the need to integrate programming for MARPs into existing services, competing priorities, resource constraints, and intense stigma and discrimination present obstacles. A decline in available resources for HIV prevention programming makes it increasingly difficult to balance the needs of the general population. Recent recommendations for HIV programming in the context of mixed epidemic settings present the challenging task of tailoring interventions to the needs of multiple populations (U.S. President's Emergency Plan for AIDS Relief [PEPFAR] 2011; World Bank 2008).

In March 2012, a team from AIDSTAR-One visited Burkina Faso and Togo to assess the current HIV prevention portfolios in the two countries. This program review is a direct response to the urgent need to strengthen and expand HIV prevention for MSM and sex workers (SWs) in West Africa. It is one of three studies commissioned by the U.S. Agency for International Development (USAID; i.e., on epidemiology, policy, programming). The review furthers PEPFAR's renewed emphasis on matching interventions and investments with epidemiological trends and needs in order to improve impact. The review benchmarks HIV prevention activities against the minimum package of prevention programs and services for MARPs (Fung 2009). The current epidemic situation in Burkina Faso and Togo provides an opportunity to examine how development partners USAID and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) can promote and sustain constructive approaches to address HIV epidemics occurring among MSM and SW populations.



# METHODOLOGY

This report details findings from AIDSTAR-One’s research of programs in Togo and Burkina Faso, which combined a desk review with country visits. In countries, the AIDSTAR-One team identified key stakeholders to review existing programs, services, and interventions for MARPs, especially those that are replicable, scalable, and results-oriented. The review aimed to describe the type of prevention interventions currently being implemented (especially those targeting MARPs), assess the level of access to interventions experienced by different target populations (i.e., the general population and youth, people who inject drugs, female SWs, and MSM), identify key barriers limiting access to prevention interventions, and identify opportunities to scale up effective, replicable interventions. The review focuses on programming for MSM and SW populations in response to priorities of the countries and the West Africa Regional USAID mission.

The research was structured around the PEPFAR Guidance for the Prevention of Sexually Transmitted HIV Infections “Four Knows” (PEPFAR 2011) framework. Using in-depth interviews and country reports, the team investigated the epidemiology, costs, context, and response to the epidemic. The team used this framework to inform the interview topic guide design.

Two AIDSTAR-One team members conducted the review independently in Togo and Burkina Faso using the same methodology (see Appendix 1). Although some contextual information was collected, the review focused on programs and services to complement the existing policy and synthesis documentation. Because other partners were conducting complementary policy and epidemiological studies, the team did not investigate these aspects extensively.

Participants for one-on-one interviews (n = 50) were selected through snowball sampling. One focus group was conducted at an implementing agency where clients were accessing services. The input sought from clients contributed to an understanding of the sociocultural situation and the availability and accessibility of services.

All interviews were conducted in French (with simultaneous English translation for the Burkina Faso portion). Interviewee responses were documented in writing during the interviews. Efforts were made to document responses as fully and precisely as possible. The quotations present text that has been translated from French to English. Interview notes were examined for key themes, and these were grouped and organized under subheadings. The PEPFAR guidance document was used initially as a framework as it accommodated the themes of interest with respect to quality, intensity, and coverage of services.



# THE DYNAMICS OF THE HIV EPIDEMIC IN BURKINA FASO AND TOGO

Recent survey and surveillance data indicate that HIV prevalence in Burkina Faso and Togo is declining. HIV prevalence in Burkina Faso declined from 7 percent in the 1990s to 1.2 percent (estimated range of 1 to 1.5 percent) among adults aged 15 to 49 in 2009 (Joint United Nations Programme on HIV/AIDS [UNAIDS] 2009). Although recent estimates suggest that HIV prevalence in both countries is low compared to many other countries in sub-Saharan Africa, the epidemic continues to affect many individuals and families. Among Burkina Faso's 15.8 million inhabitants, an estimated 93,000 people are living with HIV (UNAIDS 2009). In Togo, HIV prevalence remains among the highest in the western region at 3.2 percent (United Nations Population Fund 2010). In Togo, the estimated number of adults living with HIV is estimated at 110,000 among 6,961,049 inhabitants (UNAIDS 2009).

HIV experts have taken issue with both the characterization of HIV epidemics in West Africa and the historic focus of HIV prevention programs (World Bank 2008, p. 2). Put simply, the focus on overall HIV prevalence may have distorted prevention priorities and responses in West Africa during the 1990s. Prevention programs tended to focus primarily on reducing HIV infections in the general population and among youth, making comparatively few investments to protect MARPs whose rates of infection were probably several fold higher (World Bank 2008).

Over the past few years, data on HIV among MARPs in West Africa has begun to amass, suggesting that programs need to realign their activities to meet the needs of the epidemic (Baral et al. 2012). Although not of equal quality or availability, a critical mass of data from surveillance activities, special studies, and programmatic data in West Africa suggest that HIV prevalence is more than 10 times higher among female SWs than in the general adult population (UNAIDS 1996). Although data are even less available for MSM, existing evidence similarly points to HIV prevalence within this population that is 10 times higher than in the general population. In Togo, population estimations for quantifying numbers of MSM do not exist (Republique Togolaise and Presidence de la Republique 2012).<sup>1</sup> A 2010 situation analysis reported wide-ranging figures between 300 and 1,000 individuals, or 4 percent to 6 percent of the general population, concentrated in urban areas such as Lomé, Kpalimé, Kara, and Aného. Agencies that serve MSM in Togo approximate a number of about 1,000 men. The lack of reliable population estimates make it difficult to estimate HIV prevalence among MSM, although the government has reported figures as high as 20 percent (Republique Togolaise and Presidence de la Republique 2012) in Togo and 19 percent in Burkina Faso (GFATM 2012a).

Within countries, regional variations exist. HIV prevalence is much higher in urban than in rural areas in both Burkina Faso and Togo. In Burkina Faso, three urban areas have HIV prevalence in excess of 2 percent (Ouagadougou, Koudougou, Bobo-Dioulasso; UNAIDS 2010a). In Togo, HIV prevalence remains highest in the maritime region around the capital city Lomé (5.3 percent), and decreases toward the interior, with the lowest prevalence in the Sahel (1.6 percent) toward the Savanes at the farthest interior of the country (UNAIDS 2010a). As the epidemic becomes

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<sup>1</sup> This estimate appeared in a report of the African Solidarity Association (2010) and a similar estimate was used in the National Strategic Plan, 2011-2015. Currently, no better estimates are available.

increasingly concentrated among MARPs, cities carry a disproportionate burden of HIV-related diseases. Yet, members of MARPs with whom AIDSTAR-One spoke worried about access to services for MSM and for SWs who live outside of urban centers.

HIV prevalence remains an important indicator of the severity of the HIV epidemic among defined groups (Table 1). Yet the overall number of HIV infections is a product of HIV prevalence and the size of the population at risk. In the absence of more reliable and recent prevalence estimates and size estimation of SW and MSM populations, it is not yet possible to estimate the overall and unmet need for prevention services, track program coverage, or plan expanded outreach activities. There are little or no data publically available on other presumed MARPs (e.g., miners and prisoners) although these populations were referenced in the recent Round 10 GFATM proposal (GFATM 2010). People who inject drugs have been identified as a presumed MARP group in Togo, but prevalence data are not available for this group. The absence of data on key measures in Table 1 is striking.

**Table 1. Recent HIV Trends and Estimates for Most-at-Risk Populations in Burkina Faso and Togo**

Burkina Faso			Togo				
<b>HIV Trends</b>							
Total population of Burkina Faso (USAID 2011)	15.8 million		Estimated population of Togo (CIA 2012)	6,961,049			
Number of people living with HIV	110,000 (91,000–140,000)		Number of people living with HIV	120,000 (99,000–150,000) (UNAIDS 2009)			
HIV prevalence among 15- to 49-year-olds (UNAIDS 2009)	1.2% (1%–1.5%)		HIV prevalence among 15- to 49-year-olds (UNAIDS 2009)	3.2% (2.5%–3.8%)			
Antiretroviral therapy coverage among people with advanced HIV infection (USAID 2011)	35%		Antiretroviral therapy coverage among people with advanced HIV infection	29% (USAID 2011)			
<b>HIV in MARPs*</b>							
<b>MSM</b>	Estimated number of MSM	Unknown		<b>MSM</b>	Estimated number of MSM	4%–6% (UNAIDS 2010a)	
	Estimated prevalence of HIV among MSM	19% (UNGASS 2012)			Estimated prevalence of HIV among MSM	20.3% (UNAIDS 2010a)	
	Number of MSM reached by outreach services	1,610 (UNGASS 2012)			Number of MSM reached by outreach services	Unknown	
<b>SWs</b>	Estimated number of SWs	300 per town (CNLS-IST BASP 2011)		<b>SWs</b>	Estimated number of SWs	8,000 (Dometo, Togbetse, and Yawa 2009; UNAIDS 2010b)	
	Estimated prevalence of HIV among SWs	16.5% (confidence interval 95%: 14.14%–18.8%) (CNLS-IST BASP 2011)			Estimated prevalence of HIV among SWs	13.1% (UNAIDS 2010b)	
	Proportion of SWs reached by outreach activities	79.78% (CNLS-IST BASP 2011)			Proportion of SWs reached by outreach activities	82.4% (UNAIDS 2010b)	
<b>Estimated HIV prevalence among male clients of sex workers</b>	4.1% (confidence interval 95% 2.8%–5.3%) (CNLS-IST BASP 2011)		<b>Estimated HIV prevalence among male clients of sex workers</b>	5.5% (Dometo, Togbetse, and Yawa 2009; UNAIDS 2010b)			

\* The National Strategic Framework for the Fight Against AIDS, Burkina Faso, 2011–2015, identified MARPs as SWs, MSM, prisoners, and people who inject drugs.

# NATIONAL LEADERSHIP

The commitment and strong leadership of the head of state in Burkina Faso has been essential for the country's success in achieving critical results in the fight against HIV. As stated by then UNAIDS Director of Country and Regional Support Michel Sidibé, who attended the sixth annual session of Burkina Faso's National AIDS Commission, "The participation of President Compaoré is an example of truly exceptional leadership on AIDS—chairing for 10 hours of the meeting, engaging and motivating all sectors of the response and driving action forward" (UNAIDS 2007).

The Ministry of Health and the National AIDS Council to Fight HIV/AIDS (NAC) or *Conseil National de Lutte contre le SIDA et les Infections Sexuellement Transmissibles* provides leadership in coordinating the health sector response to HIV. The NAC, established October 1, 2001, reports directly to the office of the president to support the implementation of a multisectoral response. The NAC has also served as the principal recipient for GFATM HIV grants since 2005. Although the creation of the NAC under the president creates opportunities for multisectoral collaboration and conveys a strong sense of national commitment, this arrangement also leads to periodic tensions due to funding pressures on both sides between the NAC and the Ministry of Health, the agency responsible for the majority of HIV treatment services.

In 2003, the NAC worked with the United Nations Development Programme to create the *Programme d'Appui au Monde Associatif et Communautaire* (PAMAC). PAMAC was explicitly designed to build the capacity of civil society organizations and to support the HIV response at the community level.<sup>2</sup> PAMAC provides a vital link between government agencies and NGOs and associations involved in the HIV response. PAMAC also provides technical assistance and small grants to civil society organizations and associations to plan and implement HIV-related activities. Over the last few years, PAMAC led the development of a series of research papers and reports on MARPs, including behavioral studies on MSM (Moreau and Compaoré 2010), SWs, and, more recently, informal SWs in bars and other social establishments as well as reviews of programmatic approaches to prevention for MARPs.

In Togo, the HIV response has been hampered by the broader political context in the country. In the 1990s, international cooperation was suspended with a call for political reform by the international community. These reforms came in 2006, following the death of the long-time president in 2005 and calls by the international community to put human rights protections and a stronger democratic and electoral process into place. Previous post-electoral crimes and human rights abuses were addressed through a global and political agreement that was established through the intervention of regional political leadership, which sought to promote reconciliation among opposing political parties in Togo.

Togo has a National Council to Fight Against HIV, or CNLS, which is focused on funding and coordination, and a national program for the fight against HIV or *Program National pour la Lutte Contre le SIDA*, which focuses on implementation. The CNLS develops the budget and reports directly to the president, whereas the *Program National pour la Lutte Contre le Sida* is the technical body in charge of implementation. The Ministry of Health develops the national health policy. HIV is meant to fit within the national health strategy. More than 90 percent of the budget dedicated to HIV programming comes from international and private sources.

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<sup>2</sup> PAMAC has received support from a range of development partners including the Danish International Development Agency, the Dutch Ministry of Foreign Affairs, the Agence Française de Développement, the African Development Fund, GFATM, the Austrian Development Cooperation, and the Belgian Technical Cooperation (UNDP 2009).

Similar to PAMAC in Burkina Faso, the government of Togo worked with United Nations Development Programme to create an organization designed to strengthen civil society organizations' capacity to respond to HIV at the community level. The *Programme d'Appui aux Organisations de la Société Civile Implique dans la Riposte au VIH/SIDA au Togo* (PASCI) also seeks to strengthen the coordination among civil society organizations and government agencies. In Togo, several NGOs were formed to address the need for stronger coordination and capacity strengthening. The Union of Non-Governmental Organizations in Togo, or *Union des ONG du Togo*, is one of these organizations with GFATM support.

# POLICY CONTEXT AND HEALTH SYSTEM CHALLENGES

The government of Burkina Faso has adopted a series of national strategic frameworks that demonstrate a shift from broad-based multisectoral planning to a more nuanced focus on the needs of populations at higher risk of HIV infection. Since the start of the epidemic, Burkina Faso has been engaged in the fight against HIV, initiating its first strategic planning process in 1998, and further focusing national efforts through implementation of the *2001-2005 National Strategic Framework for Action Against HIV/AIDS* (National AIDS Council [NAC] 2001). This period focused on engendering a multisectoral response with increased commitment from the government of Burkina Faso, civil society organizations, and international development partners.

The second *National Strategic Framework for the Fight Against AIDS, Burkina Faso, 2006-2010*, marked a change from the earlier national strategy. From a previous focus primarily on the multisectoral response and HIV prevention in the general population, the revised strategy identified populations at high risk of HIV and included an overall goal “to reduce by at least 25 percent the percentage of new HIV infections and STIs [sexually transmitted infections] in priority target groups from 2006 to 2010” (NAC 2005). The third *National Strategic Framework, 2011-2015*, carried these objectives further:

*The key challenges that remain for the implementation of the National Strategy, 2006-2010 concerns stabilizing and reducing the prevalence of HIV with specific vulnerable groups and most at risk populations, mitigating the social and economic impacts associated with the epidemic, and promoting good management of the national response.*<sup>3</sup> (NAC 2006)

Togo’s transition toward a targeted focus on specific populations occurred more recently. A 2010 Situation Report (UNAIDS 2010a) highlighted the need to emphasize programming for MSM. A new national strategy was being finalized in Togo while this program review was underway. Programming for MSM figured prominently in the strategy, but the actual resources dedicated to this group remain extremely limited in Togo. However, the appearance of MSM in policy documents as a priority group does represent progress.

Despite the commitment of civil society associations to fill a gap in HIV services for MARPs, even in the face of challenging social contexts, the realities of a weak health system make this task even more difficult. The providers and clients interviewed in Togo highlight the ongoing health system challenges that affect the range of services available to clients:

*It would be better if we could have all our services in one place. Every day the patient load is increasing. There are not enough health workers; if the medicine is not here [at EVT], we have to go to the social affairs section. The social affairs section is supposed to give the okay to sell the medicine at a reduced price. But sometimes you go and they don’t even have the medicine.*

–EVT client

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<sup>3</sup> French translation: Les défis essentiels partant des enseignements tirés de la mise en oeuvre du CSLS 2006-2010 concernent le contrôle de la stabilisation/réduction de la prévalence en mettant l’accent sur les groupes spécifiques vulnérables et à risque, le soutien des impacts sociaux et économiques liés à l’épidémie et la bonne gestion de la réponse nationale.



# SOCIAL CONTEXT FOR MEN WHO HAVE SEX WITH MEN IN BURKINA FASO AND TOGO

Despite strong national leadership in Burkina Faso and increasing attention to the needs of MARPs in key national policy documents and from organizations and agencies offering services for these populations, Burkina Faso continues to face significant social and structural challenges. Among them are strong social stigma and inadequate legal protection for sexual minorities. In Togo, there has been a greater reluctance among policymakers to include MSM in documents and in programming, until relatively recently (PSI Togo 2012). In both countries, as in many African contexts, cultural and social norms are a profound barrier to advancing the human rights and right to health of MSM, SWs, and other MARPs.

Renamed in August 1984 by former President Thomas Sankara, Burkina means “the land of upright people” or figuratively “men of integrity”; indeed, the image of the strong, principled family man is central in Burkinabé<sup>4</sup> culture. Although this has many positive social ramifications, an unfortunate one is homophobia. Stigma and discrimination is a prevalent and dominant force shaping the lives of MSM, and affects both the spread of HIV and the effectiveness of the response.

Yet, as in many other countries, the HIV epidemic has brought attention to the situation of MSM and other marginalized groups, serving as an entry point for social change. Our interviews revealed increased commitment to varying degrees at all levels, but especially so among grassroots civil society associations. Although the road ahead may be both long and uncertain, a combination of national leadership, grassroots commitment, and globalization (e.g., through Internet communication) is resulting in signs of change, including small but concerted efforts by the government, researchers, and civil society actors to address the related problems of stigma and discrimination and HIV in the MSM and SW communities.

In Burkina Faso, the legal system says nothing negative or positive about MSM, nor does it provide special legal protections. The regulatory systems follow suit and MSM do not routinely encounter difficulties with the police or other regulatory agents. As one respondent explained, MSM exist within a “legal void,” that is, “since our culture does not recognize MSM, there is no need for special policies.” The lack of legislation also provides what a few respondents called an “opportunity for social change.” One good example of this involved a proposal for a study on MSM behavior and attitudes. Earlier efforts to conduct a behavioral study on MSM were thwarted by the government for fear of public reprisals and opposition by conservative religious leaders; yet, in 2010, the vice-chair of the national council was able to secure presidential approval for a study on MSM and it was completed under the auspices of PAMAC (PAMAC 2010).

To a great extent, MSM remain hidden in Burkinabé society. A recent study in Ouagadougou found that 76 percent of MSM interviewed identified as bisexual and 35 percent were married, some of

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<sup>4</sup> Burkinabé may refer to something of, from, or related to Burkina Faso or a person from Burkina Faso.

them with children (Moreau and Compaoré 2010). Interviewees, even those working for civil society associations and in HIV clinic settings, said that they felt incapable of identifying MSM among their membership and clientele. Many MSM prefer to remain underground. For example, a group referred to by association members as “VIPs” include wealthy and socially influential MSM. A recent survey was able to include VIPs in their sample, but only by sending self-administered questionnaires through MSM outreach workers (Moreau and Compaoré 2010). Not all MSM desire to remain hidden; a more visible group of MSM includes a group of young people who are “not intimidated.” Called the “Force Novel” by one respondent, these young men are “pushing the limits” of acceptable masculine behavior, speaking more openly, and dressing in ways that make them stand out. Men who were interviewed referred to Internet sites and “western” cultural attitudes toward same-sex relationships, and said these influences affect the way they thought about themselves. Older MSM viewed these groups as not only more visible but also more vulnerable and admitted that they sometimes “protected” them, counseling younger men to avoid risky situations or overt behaviors that might result in verbal or physical violence. Our questions regarding transgender groups produced little information, but exposed an even deeper level of stigma, as “even MSM do not want to hear about them.”

Stigma affects many aspects of the lives of MSM. To address the fears that the families of MSM will reject them, members of one association are seeking funds for transitional housing for MSM who are asked by their families to leave their homes. MSM “do not feel secure” and fear both verbal and physical abuse. They also fear being blackmailed by someone who knows about their sexual preferences. Others reported forms of discrimination are more subtle; for example, when young men who are perceived to be homosexual are harassed in school, denied health services by a provider, or feel discriminated against in a hiring decision. Stigma is tied to higher sexual risk (i.e., MSM are reportedly more likely to have multiple partners and to engage in sex without protective commodities, such as condoms or lubricants, or to engage in transactional sex). Same-sex partners are often additional to marital partners and, because there is little condom use within marriages, men can transmit HIV and other sexually transmitted infections (STIs) to their wives.

Despite their high vulnerability to HIV, African MSM were bypassed by HIV interventions until about eight years ago, and there are few available resources such as prevention materials or counseling and testing protocols. Although scattered community-based MSM organizations exist, there is limited funding for them, due in large part to social and political marginalization. Organizations providing services or advocating for MSM in Burkina Faso encounter a range of structural and contextual issues, including profound homophobia throughout society, discriminatory clinical practices, and other challenges.

One ramification of social stigma and discrimination is that it is difficult to organize MSM and host gatherings. Associations that do hold social events and group meetings consider these gatherings to be “dangerous” and choose their location and timing carefully, preferring evening or weekend hours and less visible locations. Despite these precautions, some events for MSM are reported to have led to verbal threats and, in one reported instance, physical violence. Yet, at least four of the Burkinabé associations with whom AIDSTAR-One met are running peer support groups for MSM where MSM meet, engage in facilitated exercises to increase self-esteem, ask questions of each other and share experiences, and receive information on HIV risk reduction. In Togo, a grassroots association has established Internet chat rooms targeted toward gay men. These sites provide an online forum for men to discuss and share information. A few associations in Burkina Faso, and to a more limited degree in Togo, use a full suite of approaches—peer outreach activities, drop-in centers, as well as community forums—to reach out to MSM. Staff felt that it was essential to use different approaches to appeal to and connect with a variety of men. Yet, in the clinics visited, insufficient provision of testing and counseling services was noted and, with a few notable exceptions, there were few linkages to care and treatment—nor are efforts being implemented at a scale necessary to reach a

large number of MSM. Association leaders realize these shortcomings and hope that this situation will improve when additional support from the GFATM reaches their centers.

Stigma affects health care settings and staff, and even those working in associations have been known to discriminate. MSM seek providers who are more receptive to them in civil society associations or, when they can afford it, private clinics. MSM do go to government clinics, but may not reveal their sexual orientation, which is a problem if they need related specialized services (e.g., rectal exams, treatment of anal infections or STIs). When asked if people felt it would be good to have a “gay-friendly clinic,” respondents mentioned concerns about community reprisals, saying neighbors would call the men out, saying, “What are you doing here?” Currently, no single health care organization exists that is specifically focused on MSM.<sup>5</sup>

PAMAC in Burkina Faso and PASCI in Togo have programs specifically designed to address the needs of associations providing services for MSM and SWs. PAMAC has received external support (e.g., from the American Foundation for AIDS Research [amfAR], SeroZero, AIDEFrance, and the International AIDS Alliance). Through small grants from PAMAC and other sources, some associations are currently offering integrated services that target MSM and other MARPs, including SWs. Similar attempts to reach the MSM population through government-run “adapted services”—services offered in both countries that have been adapted to meet the needs of SW and MSM clients—have too often met with frustrations. In our discussions with them, PAMAC and PASCI strongly supported the work of civil society organizations to augment services for MARPs provided by the government. “Adapted services” remain limited in the public sector, and the services often were not fully adapted to the actual needs of MARPs. In Togo, the few associations that were providing adapted services were completely overrun with clients due to a mismatch of resources and needs.

The legal and social status of MSM in Togo differs in some important respects to the situation in Burkina Faso. Although MSM groups and others stated that homosexuality is not actively prosecuted in Togo, homosexuality remains illegal in Togo. According to Article 88 of Togo’s Penal Code of 13 August 1980: “Impudent acts or crimes against the nature with an individual of the same sex are punished with three (03) years imprisonment and 100,000-500,000 franc in fine” (UN Refugee Agency 2012). Participants who were interviewed concurred that there has never been application of this code. For this reason, although some global activism and advocacy efforts are underway to change the code, many local MSM programmers explained they have attempted to make progress with caution around the legal code for fear that some of the vocal homophobic religious leaders or others might draw negative attention to MSM programs and reverse progress in this area.

Given the discriminatory legal status, it is not surprising that MSM are socially marginalized in Togolese society, and MSM who are living with HIV face additional HIV-related stigma. Findings from interviews of religious and traditional leaders and others reported in a CNLS report (UNAIDS 2010a) indicate widespread stigma of MSM. Catholic, Muslim, and Protestant religious leaders and other political leaders publicly condemn MSM. Several of the individuals interviewed by AIDSTAR-One felt the media frequently reinforced negative stereotypes of MSM and provided a voice for homophobic civil and religious leaders. Although there are laws to protect people living with HIV, respondents said they are infrequently applied. One member of the MSM community explained, “Discrimination is a huge problem, there is a big problem where your employers make you test and they want to know the result [even though it’s illegal for them to do so] but there is nothing you can do.” At the time of writing of this review, there were only seven cases of HIV-related discrimination against the tribunal for labor or domestic-related issues, and these were brought to the courts with

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<sup>5</sup> A newly registered association, Lamda, is working to change this. This organization focuses on HIV and MSM. But, in order to achieve formal government status as a nongovernmental organization, it omitted mention of MSM in its application.

help from RAS+, the Togolese association for people living with HIV that provides legal advocacy support. Because MSM are mostly hidden, cases of homophobia-related discrimination are not brought to the courts.

These realities of stigma and discrimination present tremendous challenges for HIV services. A 2006 GFATM-supported study conducted by Population Services International (PSI) identified stigma as a major barrier to HIV prevention activities, including providing condoms, water-based lubricants, and HIV counseling and testing. In 2007, PSI with support from the government of Togo, GFATM, and the Dutch Strategic Alliances with International NGOs initiated a program to reach MSM in Lomé. The program started on a small scale with the training of eight peer educators to conduct interpersonal outreach sessions using targeted health promotion methods and sales of condoms and lubricant to peers. The program began collaborating with Espoir Vie Togo (EVT) in March 2008 (Box 1).

### **Box 1. Espoir Vie Togo**

Espoir Vie Togo (EVT) was established in 1995 by a group of eight people living with HIV. EVT now serves about 5,000 clients and focuses on universal care, treatment, and anti-stigma efforts. The organization has received small grants for discrete activities, including medical consultations, psychosocial and nutritional support, and social assistance and support for HIV-positive children. In 2008, EVT started providing support for MSM, followed by a grant in 2010 from SIDA Action for peer education and prevention. EVT remains the main MSM actor in Togo. Recognizing that most MSM cannot freely express their sexual identity, EVT uses a peer education approach, which facilitates discreet delivery of HIV prevention messages, condoms, and lubricants. EVT provides mobile counseling and testing services to MSM, and addresses issues of disclosure and stigma. Social events (e.g. parties, movie nights) provide “safe spaces” where men can seek testing in a more relaxed and supportive environment. Special events such as a “Miss Gay Pageant” and a Valentine’s Day party offer venues for linkages to HIV testing and treatment, medical care, psychosocial counseling, and treatment of opportunistic infections. More recently, EVT has extended this social network to Internet-based chat rooms, where MSM who do not want to self-disclose can more freely access information and reach a broader social network (outside of Lomé). The support group has been very effective. As one client explained, “things can be isolating . . . the support group helps us to learn how to tell someone and help each other and exchange ideas on disclosure.”

# SITUATION OF SEX WORKERS IN BURKINA FASO AND TOGO

As early as the 1990s and early 2000s, sexual risk behaviors related to sex work were recognized as key drivers of the HIV epidemic in West Africa. Several regional HIV prevention interventions targeting sexual risk behavior related to sex work were implemented with support from the French and Canadian governments continue to serve as models of best practice for the region, according to those interviewed. Yet SWs continue to be highly affected by HIV and, with a few notable exceptions, current programs observed in Burkina Faso and Togo are largely in disarray. SWs continue to be the subject of stigma and discrimination. Without constant and continuous advocacy and inputs by government and other development partners, these programs in particular tend to wither and decline.

SWs come to Burkina Faso from across the region and from rural areas of Côte d'Ivoire, Ghana, Nigeria, Liberia, and Togo. These women also include “young nonprofessional or part-time” SWs, comprised of bar workers, fruit sellers, or women working in the informal sector who practice transactional sex to meet their daily living needs (Konate et al. 2011).

Just as strong national leadership has pushed efforts to include MSM programming, government leaders and programs have played a role in recognizing the HIV epidemic occurring among SWs in Burkina Faso. They have provided fairly consistent support for prevention activities for SWs. For example, a study of SW populations (Dometo, Togbetse, and Yawa 2009) was personally sponsored by the permanent secretary.

In Togo, leadership and programming targeting SWs was initiated earlier on and continues to be more robust than MSM programming. A 2009 mapping study (Dometo et al 2009) determined that about 60 percent of the SWs in Togo come from neighboring countries (Ghana, Nigeria, Benin) and most SWs were identified in Lomé (90 percent of the estimated 8,000 SWs; Dometo, Togbetse, and Yawa 2009). The study also found that 12 percent of the SWs were married and only about 1,200 of the 8,000 SWs operated in brothels whereas the others worked in bars, night clubs, the streets, and hotels. The primary targeted HIV service delivery organizations for SWs in Togo are *Forces en Action pour le Mieux Etre de la Mere et de l'Enfant* (FAMME) and *Petite Soeurs à Soeurs* (PSAS). Nationally, there are 11 “adapted services” for SWs that are functioning and operational for the provision of STIs and medical services. FAMME, which received a small grant through the USAID-funded AWARE II Project for HIV voluntary counseling and testing, and condom promotion, works with SWs in brothels along with some other hot spots. FAMME also provides adherence counseling and psychosocial and nutritional support to SWs living with HIV. Togo offers one center for health promotion and sexual and reproductive health education for SWs who are minors in Lomé.

Respondents said that SWs, like MSM, are frequently the victims of stigma and discrimination. Respondents from Burkina Faso felt that because of the nation's conservative code of ethics, SWs were particularly susceptible to community reprisals. Stigma and discrimination affects SWs' access to services. For example, staff at a few clinics visited reported that they are often unable to provide health cards or to fully register SWs at health clinics because of their desire to remain anonymous. In

Togo, respondents recounted extreme incidents of violence against SWs. Respondents explained that SWs, particularly those from other countries, were not protected by the legal system.

Attempts to provide SWs with access to medical services have been met with varying degrees of success, albeit sometimes fleeting. In Burkina Faso, examples were noted in Ouagadougou and in Bobo-Dioulasso. Clinique Zoodo provides an illustrative example of the history of SW interventions in Burkina Faso—programs that reached many SWs with HIV prevention, care, and support activities but that ultimately failed to achieve local ownership (Box 2). Because turnover in the SW community is high, histories are short, and these once successful programs are relegated to the memories of increasingly few people.

### **Box 2. Zoodo “Friendship” Clinic**

Founded through a Canadian-funded research project, the Zoodo Clinic, or Friendship Clinic, was once a large and busy operation, located in a densely populated area of Ouagadougou known for sex work, with a total registration of over 4,500 clients. Located on the grounds of a government clinic, a Canadian regional project, Canadian International Development Agency (CIDA)-3, rehabilitated a separate building to provide adaptive services to SW populations. CIDA-3 managed the project, yet there was an attempt to include the Ministry of Health and UNAIDS in a joint planning committee that met once every three months. The clinic was staffed with workers from the Ministry of Health and City Hall, and other government services were known to refer women to the clinic. Beginning in 2002, the clinic provided a limited set of basic services: clinic staff conducted basic sensitization and health education activities; distributed condoms and lubricants; provided medical checkups, including for STIs; and dispensed some generic drugs.

In 2006, CIDA-3 ended and the clinic reverted to management by the Ministry of Health. The clinic’s focus on SW populations languished between 2006 and 2011. In fact, during this period, the clinic was repurposed by the government to provide other types of services to the surrounding community.

With support from the GFATM in late 2011, the clinic is now awaiting the first tranches of funding with which to reinvigorate the clinic. Although some fresh paint was evident during our visit, the building is in obvious need of repair (although no more so than the neighboring government center), and newly assigned staff and outreach workers are struggling to mobilize women to come to the clinic for services. These community mobilization efforts are difficult because SWs are mobile; few even remember the earlier clinic or its offerings and government offices are no longer in the practice of referring clients. Indeed, in the interim period after the end of CIDA-3, some former clients found their way to other services (e.g., those provided by Keogo Association, Medicine Mondi, and a nearby center funded by the Italian government).

Staff wondered if the clinic will prove redundant with other service providers, yet the streets around the clinic remain filled with SWs at night.

# THE ROLE OF DEVELOPMENT PARTNERS IN BURKINA FASO AND TOGO

Several development partners contribute to the HIV response in Burkina and several have begun to fund HIV prevention activities for MARPs. The largest funders of HIV activities for MARPs include GFTAM, CIDA, French AID (SIDAction and AIDES), amfAR, and USAID.

## THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

GFATM is by far the most influential development partner in Burkina Faso at present, with total disbursement of HIV grants of \$67,061,475 by March 2012. The Global Fund Sexual Orientation and Gender Identity Strategy encourages African governments to include MSM in their national HIV strategies. With grants of increasing amounts covering the period from 2004 to the present, the recent history of Burkina Faso’s national HIV response is highly influenced by the GFATM.

Round 2 grants, to the United Nations Development Programme in Burkina Faso and the NAC, focused on expanding access to treatment, medical, and psychosocial support for people living with HIV, and scaling up prevention of mother-to-child transmission (PMTCT). These first grants were extended in Round 6, closed in 2011, and followed by Round 10 GFATM grants to support scale-up of treatment services, PMTCT and substantially increase programming for MARPs, including SWs and MSM (Table 2).

**Table 2. Summary of GFATM HIV Grants in Burkina Faso**

<b>Grant</b>	<b>Principal Recipient</b>	<b>Total Signed Amount/Total Disbursement</b>	<b>Grant Period and Status</b>
<b>Grants Closed or in Closure</b>			
Round 2: Project for the enhancement of HIV control	UNDP, Burkina Faso	Signed: \$8,789,010 Disbursed: \$8,789,010	December 1, 2003–July 11, 2006 Phase II closed
Round 2: Project for the enhancement of HIV control	NAC	Signed: \$5,363,024 Disbursed: \$5,363,024	October 1, 2006–February 28, 2008 Phase II closed
Round 6: Extension and strengthening of the fight against STIs and HIV	NAC	Signed: \$57,118,479 Disbursed: \$48,209,298	October 1, 2007–October 7, 2011 Phase II in closure

<b>Grants in Progress</b>			
Round 10: Universal access through securing antiretroviral treatments, strengthening of PMTCT, and strengthening HIV prevention for MARPs	Initiative Privée Communautaire	Signed: \$10,684,322 Disbursed: \$4,013,429	January 1, 2012– Phase I in progress
Round 10: Universal access through securing antiretroviral treatments, strengthening of PMTCT, and strengthening HIV prevention for MARPs	NAC	Signed: \$37,640,296 Disbursed: \$686,714	January 1, 2012– Phase I in progress
		<b>TOTAL disbursements of HIV grants: \$67,061,474</b> March 2012 (GFATM)	

Source: GFATM 2012a

**Table 3. Summary of GFATM HIV Grants in Togo**

<b>Grant</b>	<b>Principal Recipient</b>	<b>Total Signed Amount/Total Disbursement</b>	<b>Grant Period and Status</b>
<b>Grants Closed or in Closure</b>			
Round 2: Intensification of the fight against HIV	UNDP, Togo	Signed: \$14,185,638 Disbursed: \$14,185,638	October 1, 2003–March 31, 2009 Phase I in closure
<b>In Progress</b>			
Round 8: Strengthening and expansion of prevention services and overall management of people living with HIV in the context of universal access in Togo	Ministry of Health Togo	Signed: \$28,478,445 Disbursed: Phase I \$28,478,445	December 1, 2009–February 29, 2012 Phase I in progress
Round 8: Strengthening and expanding of prevention and overall management of people living with HIV in the context of universal access in Togo	PSI Togo	Signed: \$10,610,498 Disbursed: Phase I \$10,610,498	December 1, 2009–February 29, 2012 Phase I in progress
Round 4: Closing the gaps: an integrated approach to HIV prevention in Togo	PSI Togo	Signed: \$32,654,555 Disbursed: Phase I \$11,517,643 Phase II: \$21,136,912	April 1, 2008–February 28, 2011 Phase II in progress
		<b>TOTAL disbursements of HIV grants: \$85,929,136</b> June 2012 (GFATM)	

Source: GFATM 2012b

The Grant Agreement for Round 10 was signed in December 2011. Co-principal recipients for the Round 10 grants include the NAC and Initiative Privée Communautaire (IPC). As discussed previously, the NAC leads on treatment and care and support initiatives, while also making substantial contributions toward prevention for MARPs. The civil society principal recipient, IPC, was established by the International HIV/AIDS Alliance in 1994 and became a national NGO in 1998. Additionally, the International HIV/AIDS Alliance houses one of its regional technical support hubs with IPC in Ouagadougou, with a mission of “strengthening the pool of leaders able to champion the HIV response, as well as the skills and resources of civil society organizations, to enable them to take effective action on HIV” in the West Africa region. IPC brings with it considerable expertise in MARPs programming.

The first goal of the Round 10 grants is “preventing new HIV infections in populations most at risk through comprehensive prevention interventions” (GFATM 2010).<sup>6</sup> Both the NAC and IPC share responsibility for increasing services for MARPs. IPC’s GFATM portfolio includes a set of MARPs-focused prevention activities, behavioral change communication and community outreach, condom distribution, and counseling and testing, while also promising to expand PMTCT services for women and babies. Table 3 summarizes the indicators for MARPs-focused, GFATM-funded prevention activities.

## **CANADIAN INTERNATIONAL DEVELOPMENT AGENCY**

Historically, CIDA played an important role supporting HIV prevention programs for SWs through a program that supported several countries in West Africa. Some of their most successful efforts expanded HIV prevention programs for SW populations while developing the evidence base for programs targeting SWs, resulting in busy, well-run clinics, for a time, and some seminal research publications. Specialized services for SWs were delivered through adaptive services. Program planning employed findings from social science research to affect the design of service delivery options; several respondents felt this resulted in services for MARPs that more genuinely reflected the needs of these marginalized populations. Some of the effects of this careful planning and consideration of MARPs are reflected in a few associations that now try to continue their work in a radically changed funding environment.

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<sup>6</sup> Other goals of the grant include expanding access to PMTCT services, strengthening treatment services, and strengthening national coordination.

**Table 4. Summary of HIV Prevention Goal, Impact Indicators and Targets for GFATM Round 10 Grants to the National AIDS Council to Fight HIV/AIDS and Initiative Privée Communautaire in Burkina Faso**

<b>Impact Indicator</b>	<b>Baseline Value Source Year</b>	<b>Phase 1 Target Report Date</b>	<b>Phase 2 Target Report Date</b>
<b>National Council</b>			
% of young women and men aged 15 to 24 who are HIV-positive	1.3% (UNAIDS 1996)	1.2% August 2014	1.1% Year 5
% of young SWs aged 15 to 24 who are HIV-positive	8.6% (UNAIDS 1996)	11.4% May 2013	3.8% Year 4
% of MSM who are HIV-positive	19% (Association African Solidarité 2010)	18.5% May 2013	17.5% Year 5
% of female SWs reporting the use of a condom with their most recent client	98% (UNAIDS 1996)	99% May 2013	99.3% Year 4
% of men aged 15 to 49 reporting the use of a condom the last time they had sex with a SW	94.2% (UNAIDS 2010a)	97.5% May 2013	98.5% Year 4
<b>Initiative Privée Communautaire</b>			
Number of persons to be tested as part of screening (excluding PMTCT) (by general and key populations)	390,684 2011 (estimated total number of people in need of services)	273,479 2011 (70% of total number in need of services)	399,000 2015 (annual number)
Number of people tested as part of community services including fixed, mobile, campaign) and population (by general and key populations)	Unknown	224,000 2012 (annual number)	294,000 2016 (annual number)
Number of people tested through screening in health care settings (Conseil national de Lutte Contre le SIDA) (by general and key populations)	Unknown	49,479 2012 (annual number)	105,000 2016 (annual number)
% of men reporting the use of condom the last time they had anal sex with a male partner	58.1% (PAMAC/PNUD n.d.)	65% May 2013	70% Year 5

**Note:** Report dates for the different estimates reflect the year in which data are expected to be available.

CIDA also funded additional activities (e.g., two waves of integrated biobehavioral studies in 2003 and 2010 among SWs and their clients in eight West African countries). CIDA-funded services for SW populations, with their focus on involvement of affected populations in the design and conduct of service delivery, are often referred to as a “best practice” for the West Africa region, and the two consecutive biobehavioral surveillance studies demonstrated declines in HIV prevalence among SWs that occurred during the tenure of the project, attributing them in part to program activities.

Ending in 2006, in the absence of a plan for sustainability, only vestiges of these once vital clinics are evident in the major urban centers. During visits to clinics in both Ouagadougou and Bobo-Dioulasso, it was apparent that the project failed to achieve local ownership, and its activities have not been sustained. With SWs coming from rural communities in Burkina Faso, Nigeria, Côte

d'Ivoire, Ghana, and other neighboring countries, as well as a reportedly high rate of turnover, the new generation of SWs is seemingly unaware of the clinics' past and, perhaps current, potential.

Despite the lack of continuity in funding and, as a result, program activities, key staff people from these projects remain a critical reservoir of information and skills on how to successfully implement HIV programs for this population (e.g., Germaine Kasongo, Yerelon Association). Although it had similar roots in a Canadian-funded research project, the Yerelon Association in Bobo-Dioulasso continues to serve as a drop-in center for SWs, providing regularly scheduled health services such as STI screening and HIV testing. Our key informants considered Yerelon Association to be among the best ongoing services for SWs in the country.

## **THE AMERICAN FOUNDATION FOR AIDS RESEARCH**

Since 2008, amfAR has been operating a leadership development and small grants program for MSM in West Africa and Asia, the amfAR MSM Initiative, but not all countries are participants.<sup>7</sup> Togo and Burkina Faso have not yet been recipients of amfAR's MSM Initiative Community Awards, although there are examples from neighboring countries in the region. AmfAR remains in contact with Burkinabé and Togolese emerging leaders and civil society associations that have MSM-focused activities and continues to coach them to take on the challenges of addressing the needs of MSM.

## **U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT**

USAID has funded HIV-related activities in West Africa, including Togo and Burkina Faso, via the AWARE Project. However, this was focused primarily on family planning (60 percent) and to a lesser degree on maternal child health (10 percent) and HIV (30 percent). The project supported activities not specifically focused on Togo or Burkina Faso; these included PMTCT, antiretroviral therapy, and small grants.

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<sup>7</sup> The amfAR MSM Initiative is a small grants and capacity building and mentoring program that conducts community-led research and advocacy. The initiative's objectives are to address the basic needs of MSM, including employment, family and intimate relationships, and stigma and discrimination; create a safe space for MSM to meet; and offer integrated health and wellness services. To further these goals, amfAR mentors emerging leaders in the MSM community, promotes south-to-south exchanges, and is developing standards for MSM programs and services. A small grants program offers awards to civil society organizations, in the range of \$10,000 to \$20,000. Participating West Africa countries include Côte d'Ivoire, Ghana, Liberia, Mali, and Nigeria.



# CIVIL SOCIETY ENGAGEMENT AND THE ROLES OF ASSOCIATIONS AND NONGOVERNMENTAL ORGANIZATIONS

Associations serve as the backbone of the community-level HIV response in Togo and Burkina Faso, as in many other countries throughout the world, and are a preferred venue for the involvement of affected populations and people living with HIV. The majority of Burkina Faso's associations have their roots in treatment advocacy and care for people living with HIV, although more recently they are engaged as the primary implementers of prevention interventions for MARPs. With members of the highly impacted MSM and SW communities on staff, associations are perhaps best positioned to provide peer outreach to MARPs. Because some associations operate clinics on their premises, they may also directly provide HIV treatment services. In fact, some of the most successful associations in Bobo-Dioulasso maintain personal relationships with providers of treatment, legal and other services, creating avenues through which clients can be linked to the services they need.<sup>8</sup>

Association staff members are deeply committed to their work and include in their ranks national leaders in the HIV response. Because of funding that is limited, project based, and prone to periodic stoppages and interruptions, associations depend to a large extent on volunteer labor. Staff turnover is reportedly quite high (e.g., when volunteers leave for paid employment), which has reportedly frustrated some capacity building efforts. Yet, trained association members have moved on to play vital roles in government offices, in the health care setting, and other venues, contributing on an ongoing basis to the fight against HIV.

As one respondent offered, the best associations are “genuine organizations trying to provide services in a general way, to all affected by HIV,” whose clients from the very beginning have included members of MARPs, although some association members say it is “not always possible” to know who they are. Several respondents said that there is a need for association staff to be trained specifically to understand the health and psychosocial needs of MSM and to respect their rights.

Although basic HIV prevention activities, condom promotion, and sensitization are the most commonly implemented prevention interventions, some associations have branched out to provide a more comprehensive set of services. A few well-run organizations engage peer volunteers/workers in outreach activities and run periodic community meetings and social gatherings for MARPs. One center runs a drop-in center for MSM on its clinic premises. The perhaps most capable MARPs programs also link clients to testing and counseling, care and psychosocial support, and treatment

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<sup>8</sup> In Bobo-Dioulasso, clients of the University Hospital HIV clinic now provide leadership to a couple of strong local associations, including Yerelon Association and the Academy for Educational Development. Organizational leaders were seen to literally pick up the phone and talk with the doctor in charge in an effort to meet the needs of their members. The strength of these personal relationships enhances HIV service provision in Bobo-Dioulasso.

services. In order to enhance their activities for MARPs, associations have had to bring their stakeholders along by—for example—successfully advocating for the support of their governance board, including social and religious leaders. Currently, at least four of the associations stand out for their outreach activities for MSM in Burkina Faso (Association African Solidarité in Ouagadougou, Vie Positive in Ouagadougou, Rev+ in Bobo-Dioulasso, and Alavi in Zogana) and one in Togo (EVT in Lomé).

Some associations are known for their work with SWs, primarily female SWs. Among them, Yerelon Association in Burkina Faso, a local association of high-risk women in Bobo-Dioulasso that was born from a recent research initiative (Konate et al. 2011), stands out as an organization with a comprehensive approach to prevention for this population. Yerelon staff include members of MARPs. A drop-in center and clinic run by Yerelon Association has regularly scheduled peer outreach and psychosocial support activities, including education, awareness raising, and interpersonal communication activities; support groups; clinic services for diagnosis and treatment of STIs and HIV diagnosis; linkages with the local police and periodic intervention by clinic staff; and a strong network of linkages and referrals to clinics that provide patient follow-up and HIV treatment, including antiretroviral therapy. For the sake of the study, Yerelon Clinic was also opened to provide treatment services to a cohort of SWs. Although the study has ended, the clinic remains in operation, although it is not seeing many clients. Yerelon Association also has linkages to an excellent HIV clinic in the Bobo-Dioulasso University Teaching Hospital, *Hospital de Jour, Centre Hospitalier Universitaire Sour Sanou*, that provides care and treatment services. In Togo, FAMME, followed later by PSAS, has been on the forefront of work with SWs.

Especially when it comes to providing prevention services and outreach to MARPs, PAMAC and the NAC acknowledge the importance of community-based organizations that complement the role of government's predominantly facility-based care and treatment efforts. PAMAC currently provides small grants to associations to support outreach and services for MARPs. Association clinics provide general services, medical checkups, STI diagnosis and treatment, and treatment for HIV including antiretroviral therapy. In Ouagadougou also provides counseling and psychosocial support. Associations also receive small grants for community mobilization activities, to conduct peer outreach, and to distribute gel and condoms.

Although associations are uniquely well-positioned to serve MARPs, they also face challenges related to their historical, structural, and financial situations. Perhaps because associations first convened around HIV-positive people and treatment advocacy, prevention programs in general and program activities for MARPs in particular do not always get the attention or resources they need to be effective at scale. Association staff members typically include a small number of paid personnel, augmented by volunteer staff. Although associations include capable leaders of the national HIV response, they also suffer common deficiencies. There are no standard training protocols for prevention services for MARPs, for example, that increase awareness and encourage best practices. Associations have insufficient access to training opportunities and lack training materials. Without these elements in place, the quality of services varies greatly, as does the innovativeness of service offerings. New and better approaches are needed to enhance service options for MARPs. Finally, previous capacity building efforts have been thwarted by high rates of staff turnover, which happens frequently among volunteer staff, some of whom move on to paid positions in other organizations.

In Togo, EVT (see Box 1) provides a range of prevention, care, and treatment services. Established by eight people living with HIV in 1995, EVT began providing MSM services in 2008, specifically prevention care and treatment services and a range of psychosocial support. From 2008 to 2010, EVT gained support from SIDAction. The organization now provides comprehensive services including psychosocial support, counseling and testing, support for treatment, income generation programming, prevention through schools, and Internet education.

# **OBSERVATIONS ON OPPORTUNITIES/ CONSTRAINTS FOR SCALING UP SERVICES FOR MOST-AT-RISK POPULATIONS IN BURKINA FASO AND TOGO**

Burkina Faso and Togo have made significant progress toward the collection and analysis of epidemiological and social/contextual data for some key MARP groups including MSM and SWs, although the following gaps remain:

- Size estimation of MARPs was a challenge in both countries, although plans have been made for Supporting Evaluation and Research to Combat HIV/AIDS (SEARCH) to produce these estimates for the MSM and SW populations in Burkina Faso. Almost no size estimation exists for people who inject drugs. There is little anecdotal or observational data (e.g., service statistics) providing evidence of HIV epidemics occurring among injecting (or other) drug-using populations at present, but this is not considered a priority.
- In Togo, there has been some mapping of commercial sex work networks and size estimates of MSM in some areas, but respondents indicated that these numbers were probably lower than the reality. Informal sex work is not counted, and respondents indicated a gap in data (and programming) for informal sex work as well as for MSM who do not self-identify. There is some mapping of “hotspots” conducted by the stronger associations in Burkina Faso.
- Despite the availability of useful social and contextual data about MSM through recent studies (Compaore 2010; Geiss 2008), ongoing monitoring of data are considered a challenge due to major stigma of MSM and the fact that many MSM do not self-identify.
- In Burkina Faso, monitoring of service provision and outreach to SW populations is incomplete because many clients opt out of clinic registration, preferring to maintain anonymity. This, reportedly, is especially true for Burkinabé SWs because of fears of community reprisals.
- There are MARPs that have been overlooked: for example, Burkina Faso mining areas in the north are reported to have increased rates of HIV; with support from a Round 10 GFATM grant, some activities are slated for these populations.

The knowledge about the epidemiologic priorities does not seem to translate or be consistent with national budgeting priorities. Recent inputs (from, for example, GFATM, Round 10 Burkina Faso) promise to begin to shift the focus from treatment to prevention, and from prevention in the general population to prevention that includes MARPs; but as the Round 10 grant agreement for Burkina Faso was signed in December 2011, it is too soon to know how successful this refocusing

will be. MSM remain an epidemiologic concern in Togo, but budgeting priorities did not seem to reflect this—budget and strategy planning for 2012 were in progress during our visit.

Resources are inadequate to be able to achieve universal coverage for HIV care and treatment. This requires particular attention to coordination and non-duplication of services or duplication of donor funding. Coordinating pooled donor funding (e.g., through participation in donor roundtables, country coordinating mechanisms, or other forums) to maximize resources may be one way of addressing inadequate resources. Key NGOs and associations with experience working with MARPs already tend to be receiving financial support from other donors.

Promising programming features do exist, as do former programs, particularly in the areas of addressing sex work. Some of these services and programs were abandoned due to funding shortfalls or donors that pulled out. Where some vestiges of the original programs remain (e.g., Yerelon and Bobo-Dioulasso in Burkina Faso; PSAS and FAMME in Togo), it would be ideal to build on these efforts and human resource capacity but with a longer term plan for the eventuality of reduced donor funding.

- In Togo, PSAS and FAMME are well known for sex work programs, but both organizations reported reductions in funding levels.
- In Burkina Faso, successful SW programs were mentioned, but these are no longer being funded; in some instances, the services were completely abandoned (e.g., a successful adaptive center in Ouagadougou, Zoodo Clinic, once operated by the Canadians, had served 4,500 clients; although it opens its doors for business, it has extremely few clients now).
- In Togo, EVT is leading the MSM work. Much of this is in the form of outreach via the Internet. Respondents said that only about six MSM were seeking clinical services at the center at the time of the interview. In centers in Burkina Faso, there was evidence of tightly knit small groups of MSM at a few associations holding MSM dances and “tea parties,” and conducting HIV prevention activities on-site. There is room to expand these activities and the network of people they engage and serve.
- In Burkina Faso, four main MSM associations include Africain Solidarité, Vie Positive, Laafi la Viim, and Responsabilité and Espoir Vie et Solidarité.
- Some of the best functioning associations in Burkina Faso maintain active linkages to health service providers. For example, associations (Responsabilité and Espoir Vie et Solidarité and Yerelon) maintain direct communication with doctors at Centre Muraz, a clinic of the university teaching hospital, facilitating referrals and optimizing resources.

Quality and coverage remain inconsistent, particularly for government-sponsored MARPs-adapted services. Although they constitute the major approach for prevention, treatment, and care for MARPs, some of the services are labeled “adapted” but do not in fact meet the needs of these groups. It was not always clear what had been adapted in the package of services provided, and single clinics were expected to be simultaneously appealing to SW and MSM populations. In reality, the adaptive centers that do manage to attract MARPs tend to favor one group over the other. Opportunities for enhancing services include the organization of services (e.g., hours of operation that are presently very limited and not tailored to the needs of MARPs).

Stigma and discrimination of MSM is a major problem, although respondents in Togo felt cautious optimism about moving forward. Discriminatory laws are still on the books in Togo, and a small but vocal group of religious leaders and the press are promoting homophobic messages. The few MSM activists in Togo have adopted a careful strategy for moving MSM issues forward for fear that the vocal (and relatively powerful) opponents may set things back even further. In Burkina Faso, there

are no legal restrictions on same-sex activity, and respondents tended to view this as an opportunity. Although not illegal, MSM are subject to fairly intense discrimination and fear physical harm; at times, MSM reported being refused services even by association providers. Advocacy support for these groups would be useful as would broader networking with other groups in the region. Stigma remains a huge issue within the health system as well. Respondents said there is room to enact programs to limit stigma and discrimination among health workers and other staff engaging with MSM and SW populations. Within the national framework, there are some adapted services for MARPs. However, the services are in practice little different from other services. Service hours are limited and health care workers in many of the facilities are reportedly not specifically trained or sensitive to particular needs of MARPs. Sites where clients found non-judgmental service provision included a limited number of nongovernmental service organizations focusing on MARPs, notably, EVT in Togo (MSM) and PSAS and FAMME (commercial SWs). Client focus group participants at EVT reported satisfaction with the services there, whereas they spoke extensively about the stigma and negative interactions encountered at government facilities.

Civil society organizations, NGOs, and associations help meet the needs of MARPs. National leaders in the HIV response are among their ranks. They seem to share in the support of some governmental actors, and they have credibility with members of MARPs because they have members of the affected populations integrated on staff. Yet, because they rely on volunteer labor to a high degree, staff turnover is high and institutional capacity and focus may be prone to changes.

Poverty and health systems strengthening challenges are overarching issues for the provision of HIV prevention and care services in this context. Most rural populations lack access generally to primary care services, and staffing and infrastructure challenges are barriers to care of any sort. In cities where infections among MARPs are highest, and where a strong case can be made for increased service provision activities, services are not always located in places where MARPs congregate; they are geared toward care and treatment services with insufficient prevention activities, and their poor infrastructure is already taxed by high client loads. Integrating HIV services within this context entails the same barriers.



# RECOMMENDATIONS AND CONCLUSIONS FOR ADDRESSING PREVENTION, CARE, AND TREATMENT NEEDS AMONG MEN WHO HAVE SEX WITH MEN AND SEX WORKERS IN BURKINA FASO AND TOGO

**Invest in leadership and technical capacity.** Civil society organizations have been leading the efforts in MARPs, but there is a need to strengthen leadership so these programs can be sustained and brought to scale. Often, the programming effort is predicated on the commitment of founding members. Staff turnover and the need to prevent burnout of committed volunteers requires investing in leadership and strategy. Investments in technical capacity that include updates related to new evidence for what works in terms of clinical and programmatic best practices are also needed to ensure quality of services particularly in light of scaling up programming. The IPC, part of the HIV/AIDS Alliance regional initiative, is already providing some technical assistance in Burkina Faso. Increased investments in this initiative could be extended to the region and would benefit Togo. Careful monitoring is needed, particularly as programs are brought to scale.

**Perform operations research.** Intervention studies are needed to improve adaptive services. Incorporating MARPs and listening to their experiences and those of community workers will provide insight into the problems MARPs face in seeking services and an improved understanding about motivators and demand. As programs try to scale-up adaptive services, it will also be important to monitor and maintain quality. The existing services for MARPs in Togo and Burkina Faso are overextended; the staff members of these associations are underpaid or as volunteers are prone to staff burnout. Operations research can help government and civil society to innovate, be responsive, and develop sustainable programs.

**Improve donor coordination.** More resources and better coordination of existing resources are needed. Donors should participate in the donor roundtable in Burkina Faso, and it would be beneficial to initiate a similar effort in Togo. An example of emphasizing coordination efforts is the USAID-supported West Africa Health Organization, concerned with HIV prevention along the borders, trucking routes, regional issues, and standards. Donor resources and careful investments in quality programming requires attention to systemic issues as well, including procurement of basic

supplies such as condoms and lubricant. Continued investment in the West Africa Health Organization's efforts to improve the regional procurement of basic supplies is important.

Perhaps in the name of competing priorities, government financial support for HIV prevention activities has not been particularly generous. The pockets of funders in Burkina Faso are also not very deep, and even where several development partners are present, funds for scaling up successful services are lacking. Round 10 funding in Burkina Faso from GFATM may be the exception as they are providing significant funds.

**Address stigma.** There is a continued need to invest in combination prevention programming that includes new attention to neglected structural factors such as stigma. This issue must be addressed for programs to succeed. Stigma remains a barrier for programs and services—providers themselves may even be reluctant to self-identify as MARPs or MARPs service providers. Supporting MARPs-led programs and services as well as ongoing efforts to create enabling legal and social environments will continue to be important.

There is a need to start with the provision of quality, stigma-free services. As one association member interviewed stated, if “doctors accept them, provide for them, that will be change,” and services should “focus on access to health care, capacity building and decreasing stigma. Maximize access to testing [and] the link to treatment, care, and support as a way of reducing stigma.”

**Focus on MSM leaders.** The MSM leaders that were interviewed are respected and accepted, but leadership coaching could maximize their impact and help lead others toward greater inclusion of MARPs in national planning processes. National planners and policymakers likewise can benefit from the insight and experience of MSM already engaged with civil society at the grassroots level. This strengthened partnership among civil society and national planners will enhance the potential for success of MARPs programs.

Civil society associations in Togo and Burkina Faso have in many ways taken the lead in advancing programming for MARPs, and they continue to push for changes. Cultural, political, and systems challenges certainly exist, but the MSM leaders of associations that were interviewed have been forging ahead despite these challenges—and despite limited national and international support. The recognition of the importance of these groups has come about slowly. Cultural and other changes may come about slowly as well, but these groups have demonstrated that it is possible to address HIV even in the face of these challenges.

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# APPENDIX I

# INTERVIEW PROTOCOL

## TOPIC GUIDE: MIXED EPIDEMICS

Donor/policymaker/government use all; client guide focus on D (and C)

Review and validate the “Four Knows”

### **A. Characterizing the epidemiology of the epidemic**

- What HIV epidemiological data are available/being collected at national level?  
District/nongovernmental organization service area level?
- How/is strategic information being used in prioritizing programming for particular populations or services?
- What data exists in relation to the barriers, drivers, access? Specifically among particular groups? MARPs data?

### **B. Costs**

- What is the national HIV budget?
- What costing data is available on the different prevention interventions?
- If available, is it being used strategically?
- What cost is being used for what outputs?

### **C. What is the context of HIV service delivery?**

- What laws or policies exist that enable or hinder service access and delivery (particularly among marginalized and at-risk populations)?
- What sociocultural factors exist that enable or hinder service access and delivery? (probe stigma/taboo of marginalized groups, etc.; people who inject drugs, MSM, female SWs [or transactional sex])

## **D. Response**

- Who currently funds HIV prevention programs (for the general population and youth; for MARPs)?
- To what extent are effective interventions reach people at high risk of contracting the virus?
  - What groups are being targeted? (geography/coverage/risk groups/age and gender)
  - Are mapping data available (nationally? among partner organizations)?
- Who are the major prevention service providers (general population and youth; MARPs)?
- What range of services is available? When are services offered?
  - Is access to core interventions adequate? (PMTCT, voluntary male medical circumcision, comprehensive condom programs, comprehensive programs for MARPs, comprehensive programs for people living with HIV)
    - Is the package of services offered to MARPs comprehensive? What, if any, elements of the minimum package of services for MARPs are missing/under-resourced?
  - Is access to HIV testing and counseling adequate? For the general population and youth? For MARPs? How?
  - Are critical enablers addressed? How?
  - Are there any prevention activities that are promising but require further evaluation?
- How successful is delivery?
  - Sufficient coverage to have population level impact?
  - Sufficient quality?
  - Effectiveness of interventions?
  - Monitoring and evaluation?
- Weaknesses? Challenges? What could be improved? What services do you need that are not available?

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