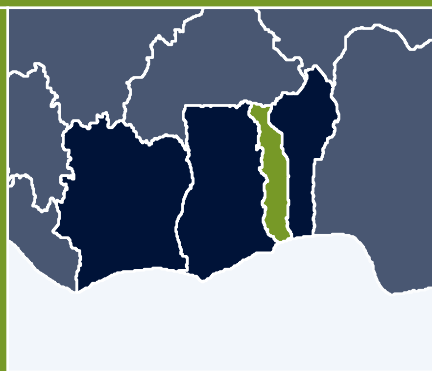


# policy

October 2013

## POLICY ANALYSIS FOR KEY POPULATIONS

At Risk of HIV  
Infection in Togo



This publication was prepared by S. Duvall, J. Agounke, S. Anato, A. Hodo, Y. Kugbe, G. Chaold, and B. Nibogora for the Health Policy Project.



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# Policy Analysis for Key Populations at Risk of HIV Infection in Togo

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**OCTOBER 2013**

This publication was prepared by S.Duvall,<sup>1</sup> J. Agounke,<sup>2</sup> S. Anato,<sup>2</sup> A. Hodo,<sup>2</sup> Y. Kugbe,<sup>2</sup> G. Chaold,<sup>2</sup> and B. Nibogora<sup>3</sup> for the Health Policy Project.

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# CONTENTS

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**Acknowledgments** ..... iii

**Executive Summary** ..... v

**Abbreviations** ..... xi

**Introduction** ..... 1

    The Decision Model: A Policy Analysis ..... 1

    Methodology ..... 2

**Policy Analysis for Key Populations in Togo** ..... 4

    Key Populations and HIV in Togo ..... 4

    Assessment Findings ..... 5

    Challenges and Limitations ..... 24

**Conclusion** ..... 26

**Annex 1. Decision Model Policy Framework** ..... 29

**Annex 2. List of Documents Reviewed** ..... 32

**Annex 3. Policy Assessment Interview Guide** ..... 35

**Annex 4. Summary of Findings** ..... 51

**References** ..... 75

This report represents initial findings from a rapid assessment of available policy documents and a limited number of interviews with individuals in their professional or official capacity. The findings have not been validated or prioritized with stakeholders in Togo. The authors recommend that further interviews be undertaken with individuals of these key populations and that these data be confirmed and corroborated before making any assumption or taking action on them.

## ACKNOWLEDGMENTS

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The authors would like to thank Sue Perez and Laurent Kapesa at the USAID/West Africa Regional Health Office for commissioning the application of the Decision Model<sup>1</sup> in Togo and for their technical guidance and commitment to its completion. The application could not have been completed without the support of Professor Vincent Pitché, the Permanent Secretary of the National Council for the Fight Against AIDS and STIs (SP/CNLS-IST); the generous advice, assistance, and coordination from Dr. Jean François Somé at the Support Programme for Civil Society Organizations Involved in the Response to HIV and AIDS in Togo (PASCI); and the collaboration of key informants and key stakeholders in Togo. We are also grateful for the support and collaboration of Virginie Traoré and Dr. Hortense Me-Tahi of the Regional Project for the Prevention and Care of HIV/AIDS in West Africa (PACTE-VIH) project.

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The team would also like to thank HPP staff in Washington, DC, for their input and work behind the scenes, with a special note of appreciation to Lori Merritt for her meticulous editing and suggestions for the final report.

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<sup>1</sup> The model, titled *Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers*, was developed by HPP and AMSHeR and is available online at [www.healthpolicyproject.com/index.cfm?id=HIVPolicyModels](http://www.healthpolicyproject.com/index.cfm?id=HIVPolicyModels).

# EXECUTIVE SUMMARY

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## Background

Although Togo has a generalized HIV epidemic with a prevalence of 3.2 percent (PNLS, 2011a; UNAIDS, 2012) and HIV rates in the general population decreased by 57 percent between 2001 and 2011 (UNAIDS, 2012), HIV rates among sex workers (SWs), males who have sex with males (MSM), and detainees are significantly higher, with estimates at 13.1 percent (PNLS, 2011a), 19.6 percent (PNLS, 2011b), and 4.3 percent (PNLS, 2011c), respectively. Although SWs, MSM, and detainees are disproportionately affected by HIV in Togo, data regarding these populations are limited. Further, data and information are unavailable for transgender people (TG), also considered a key population.

Evidence clearly supports the cost-effectiveness and positive global impact of adequately allocating resources for HIV prevention in key populations, among whom the majority of new infections are likely to occur (Case et al., 2012; World Bank, 2012; Beryer et al., 2011; World Bank, 2011; UNAIDS/World Bank, 2010). Availability and accessibility of prevention, care, and treatment services for these populations are affected by policies, including laws, codes, directives, and operational procedures. Although policy in Togo is undergoing positive changes with regards to key populations and lessons can be extracted for other countries in the region, policy gaps and barriers to accessing services for key populations remain.

## Objectives and Methodology

From 2010–2012, the global USAID-funded Health Policy Project (HPP), in partnership with the African Men for Sexual Health and Rights (AMSHeR), developed the *Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers* (Beardsley et al., 2013, hereafter referred to as the Decision Model). It provides country stakeholders—such as advocates, policymakers, and service providers—with tools to inventory, assess, and advocate for policies that affect access to and sustainability of key services for MSM, TG, and SWs. The model

- Identifies the existence of restrictive, inadequate, or absent enabling policies<sup>2</sup> regarding sexual and reproductive health and rights and HIV/sexually transmitted infection (STI)-related programs
- Maps service-specific policies to international human rights frameworks to identify needs and opportunities for policy advocacy that will help improve access to services
- Provides local stakeholders and advocates with a template to build a customized, targeted advocacy approach—specific to the needs and environment of each jurisdiction

This customizable, in-depth, and standardized approach will build the capacity to identify incremental, feasible, near-term opportunities to improve the legal environment and the resulting quality of and access

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<sup>2</sup> Restrictive policies are policy document provisions that explicitly deny or rule out scientifically proven services (e.g., a policy that expressly outlaws the distribution of condoms in prison settings). Inadequate policies are those that are unclear or do not respond to current science, current accepted guidelines, or international best practices. The absence of explicit policy provisions can hamper the implementation and sustainability of services.

to HIV and HIV-related services for MSM/TG/SWs—while long-term human rights strategies are implemented.

This assessment in Togo is the second country application of the Decision Model. In 2011, the United States Agency for International Development (USAID), through the Action for West Africa Region II project (AWARE II), supported a regional assessment to uncover policy challenges that may hinder high-quality HIV prevention, care, and treatment of key populations (Dutta and Maiga, 2011). Based on the findings, in 2012, the project conducted a pilot application of the Decision Model in Burkina Faso for SWs, MSM, and prison populations (Duvall et al., 2012).

Using the same methodology, HPP and AMSHeR applied the Decision Model to uncover policy gaps and practical challenges to policy implementation in Togo. Beginning in June 2013, the HPP principal investigator, a legal expert from AMSHeR, and a team of local consultants conducted a document review and assessment. The team collected an inventory of 116 source policy and program documents and previous policy and program research related to HIV and/or key populations. The assessment team also conducted 21 key informant interviews to examine the policy environment<sup>3</sup> and assess the dissemination and implementation of current policies—particularly to identify gaps that pose barriers to service access for key populations.

## Application Findings

The policy analysis and key informant interviews confirmed that positive changes related to HIV prevention, care, and treatment, including those related to key populations, are occurring in Togo. Initial steps are being taken to develop policies that recognize key populations and aim to improve access to services for them; and significant opportunities exist to further progress, including the USAID-funded Regional Project for the Prevention and Care of HIV/AIDS in West Africa (PACTE-VIH) project, Rounds 4 and 8 under the Global Fund to Fight AIDS, Tuberculosis and Malaria that include a focus on MSM for the first time, and statements of support from the President of Togo and the Permanent Secretary of the National Council for the Response to AIDS and STIs (SP/CNSL-IST). Moreover, a number of current policies follow international best practices. However, critical gaps remain; supportive policies directly aimed at key populations are limited, and general policies that impact key populations are not always effectively and consistently implemented.

Major **gaps** and **barriers** in policy and implementation in Togo include the following:

- Few strategies for addressing HIV among key populations beyond the National Strategic Plan for the Response to HIV and STIs (PSN) 2012–2015 (SP/CNLS-IST, 2012a) and a new policy framework for the key populations (Guiard-Schmid, forthcoming)
- Laws that criminalize same-sex sexual relations (as “acts against nature”) and solicitation by SWs
- A lack of detailed mechanisms, such as operational guidelines or standards, to support policy implementation
- A lack of inclusion of key populations in key committees and consultative bodies, although discussions are underway to include representatives in the STI Targeted Intervention Technical Working Group of the National Program for the Response to HIV and STIs (PNLS), which has a focus on key populations

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<sup>3</sup> The policy environment includes legal and regulatory environments as well as level of political support.



- A lack of awareness and acceptance of legal protections for vulnerable groups and professional codes of conduct among key stakeholder groups, including law enforcement and healthcare providers
- Insufficient dissemination of many policies and policy documents

Below is a summary of the specific gaps and barriers identified, categorized according to the Decision Model’s four policy components (framework, community partnership, legal environment, and intervention design, access, and implementation).

### **Framework**

**Coordination and integration:** Ministry and program policies for the multisectoral and decentralized response to AIDS are not always aligned with the PSN 2012–2015 (SP/CNLS, 2012a). A number of ministries have not developed policies or lack implementation strategies. Other than SP/CNLS and PNLS policy documents, policies, including national development strategies and ministry action plans, are generally silent on SWs, MSM, and TG. For detainees, adequate HIV and STI policies exist, but a lack of prison policy and misinterpretation of the penal code has led to denial of sexual and reproductive health (SRH) services, and, in many cases, HIV and STI services in prison settings. Coordination between agencies and the alignment of SRH and HIV/STI policies are limited.

**Data-informed planning and budgeting:** Policy related to and implementation of MSM and SW data collection are improving, but data remain insufficient, particularly for detainees, clients of SWs, and TG. There are no policies regarding data collection requirements for sexual violence in prison. HIV budgeting is insufficient and relies heavily on donor financing.

### **Community Partnership**

**Community engagement and participation:** While policy supports the establishment of community organizations serving SWs and MSM, it fails to mention nongovernmental organizations comprised of SWs, TG, or MSM. MSM-identified, non-profit organizations cannot apply for official status due to criminalization of same-sex sexual behavior and discrimination. Policy does not require the involvement of SWs, TG, or MSM in HIV, STI, or SRH decision making, policy design, and evaluation of policy implementation. Criminalization laws pose an obstacle to their participation.

### **Legal Environment**

**Authorization:** Public health officials have oversight and coordination of HIV prevention programs and other services for SWs and MSM. However, laws are not always widely known and understood by law enforcement. Detainees’ access to HIV, STI, and SRH services is inhibited by the lack of a prison policy and limited funding, which present barriers to implementing HIV policy.

**Consent:** HIV policy guarantees free and informed consent for all adult citizens, but public health law is misaligned<sup>4</sup>. It requires anyone with an STI to be examined and treated and subjects SWs to mandatory medical supervision. Policy allows providers to treat patients despite their refusal if it is to save the life of the patient. Misaligned policies regarding parental consent of minors for HIV counseling and testing (HCT) and access to medical services represent potential barriers for young SWs, TG, and MSM.

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<sup>4</sup> Throughout this document, the terms “misaligned” and “misalignment” refer to two or more policies that contradict each other and/or have conflicting definitions and/or procedures that may lead to confusion around policy implementation.

**Privacy and confidentiality:** Strong privacy and confidentiality policies exist, but gaps remain in their implementation. Breaches of confidentiality occur, particularly in prison settings. Disclosure of medical data of a minor to parents/guardians, sanctioned under Togolese law, may not always align with what is in the child’s best interest.

**Stigma and discrimination:** Stigma and discrimination of key populations in Togo pose a major barrier to the HIV response. Although strong policies exist to prohibit discrimination based on HIV status, protect patient confidentiality, and guarantee equal rights for people living with and affected by HIV, no specific mention is made of sexual orientation or sex work. Religious and customary beliefs and laws create a highly stigmatized environment for SWs and MSM.

**Criminalization:** Same-sex sexual behavior (“acts against nature”), soliciting for sex work on public streets, and pimping are illegal in Togo, although sex work per se is not. MSM have not been arrested or prosecuted under the “acts against nature” law, but reports of harassment and arrest for other false pretexts, including soliciting, exist. SWs offering services in brothels are commonly victims of misinterpretation of these texts.

**Gender-based violence (GBV):** Sexual violence against sex workers, including perpetration by law enforcement, is common. Violence reduces sex workers’ ability to negotiate condom use and access adequate healthcare, as well as increases the risk of HIV transmission. Although policy does not prohibit SWs from pursuing rape or sexual abuse in court, many SWs do not know their rights and are afraid to report cases to law enforcement. MSM in Togo also experience GBV. Cases of GBV against SWs and MSM generally go unreported. New policies identify SW-focused GBV prevention and treatment activities. Policy does not guarantee post-exposure prophylaxis for rape victims.

**Monitoring and enforcement of human legal rights:** Togo has ratified major international conventions related to human rights, and the constitution guarantees rights for all citizens. However, these rights are not specific to SWs, MSM, and detainees and are often limited in their application. Key informants reported cases of police harassment of SWs and MSM.

### ***Intervention Design, Access, and Implementation***

**Procurement and supply management:** Stockouts of condoms, lubricants, and medications—particularly antiretrovirals and STI kits—present major barriers for key populations and are attributed to (1) budgeting shortfalls during interruptions in donor funding, (2) uneven policy implementation at the health facility and district levels, and (3) unreliable data for forecasting STI kits. Recent changes to procurement policy have caused medication shortages in prisons. Finally, policy does not identify mechanisms for SWs, TG, or MSM to participate in product selection or other decision making.

**Overarching services design:** HIV and STI services tend to be clustered in urban centers, with most services for SWs and MSM based in Lomé. SRH policy includes protocols for GBV risk assessments, but STI and HIV policies do not. No clear mechanisms exist to include MSM, SWs, TG, or detainees in program conception, design, and evaluation. Current policy does not address training requirements for law enforcement and healthcare providers that would help improve access to services for key populations.

**HIV counseling and testing:** Policy does not identify mechanisms that involve MSM, SWs, or TG in the development of HCT protocols or monitoring and evaluation—even though it identifies MSM and SWs as vulnerable groups to which providers should offer HCT. Free HCT is guaranteed to all citizens, but SWs, MSM, TG, and detainees are not specifically mentioned. The provision of free HCT in prison settings in Togo has been hindered by significant barriers. Stigma and discrimination are major barriers to HCT uptake by key populations due to fear of involuntary disclosure of HIV results.

**Antiretroviral treatment (ART):** There are significant obstacles to achieving the policy goal of universal access to ART. Related or required services to access ART—such as CD4 count testing, provider fees, and medications for opportunistic infections—are generally not free of charge and can be costly. Decentralization of services for CD4 count testing and ART delivery is limited, with currently only 25 CD4 machines countrywide. ART stockouts pose additional barriers.

**Sexually transmitted infections:** Although policy does not guarantee free STI treatment for MSM or TG, other policies for STIs generally follow best practices. Policy implementation is impeded by frequent stockouts of STI kits and a shortage of specialized services for key populations, particularly outside of Lomé. Other barriers to STI service uptake and treatment include the cost for MSM, who do not qualify for free treatment, and for SWs during stockouts, as well as lack of transportation to facilities, lack of equipment for mobile units to identify STIs, and fear of stigma and discrimination.

**Condoms and lubrication (C/L):** Policy in Togo fails to guarantee free C/L services for SWs, TG, and MSM. Current policies neither cover the procurement or distribution of lubricants, nor provide mechanisms for SWs, TG, or MSM to participate in the selection of condoms and lubricants for HIV prevention programs. While no written prison policy exists, prison authorities do not allow C/L services for inmates. Reported stockouts of condoms and lubricants pose a major barrier to effective HIV prevention among key populations.

**Information, education, and communication (IEC):** While HIV policy includes IEC strategies for MSM and SWs, public health policy does not guarantee funding of IEC programs. MSM-specific IEC is only available through nongovernmental organizations.

**Outreach:** Recent policies developed to address outreach in Togo follow international best practices. Stigma and discrimination are reported to be the greatest barriers to outreach among key populations in Togo. However, insufficient policy dissemination, criminalization of same-sex sexual behavior and soliciting, inadequate coordination with law enforcement, and stockouts of lubricants are also barriers to outreach.

**Alcohol and substance abuse harm reduction:** Access to alcohol and substance abuse harm reduction programs for key populations is essential to HIV prevention efforts. HIV policy in Togo includes programming for people who inject drugs but does not directly address alcohol consumption and substance abuse. A policy currently being validated includes free syringe distribution and recommends IEC, outreach, and programs related to alcohol reduction but does not include specific alcohol or substance abuse harm reduction programs or implementation mechanisms.

**Sexual and reproductive health:** Policy guarantees the reproductive rights of all citizens under all conditions, but specific approaches for SWs, MSM, and TG are not identified. Detainees are denied access to services. Service integration in HIV/STI policy is not entirely harmonized in SRH policy.

## Recommendations

Although a number of critical policy gaps remain, and policy dissemination and implementation remain challenging, Togo is undergoing exciting policy changes that, if funded and implemented, will significantly improve the response to HIV and facilitate access to services for key populations. The current level of government and donor support fosters new possibilities to close policy gaps and develop effective mechanisms to support the implementation and enforcement of HIV-related policy. Recommendations to help address the identified policy gaps and barriers to implementation include the following:

- Increase coordination between PNLs, CNLS, and government ministries and agencies, including developing and disseminating policies that address SWs, MSM, TG, clients of SWs, and detainees.
- Harmonize misaligned policies, particularly SRH, HIV, and STI policies.
- Fully integrate HIV and STI services with SRH programs to ensure that more SWs and TG, who may avoid HIV and STI clinics due to stigma and discrimination, are reached.
- Widely disseminate and allocate adequate resources to implementation of the new policy framework for key populations (Guiard-Schmid, forthcoming).
- To support recent HIV policy calling for HIV, STI, and key population data collection, establish clear implementation mechanisms, with data collection methods standardized for accurate forecasting and planning.
- Improve procurement, coordination, forecasting, budgeting, and the distribution of condoms and lubricants, STI kits, and antiretrovirals—the priority being free C/L and STI kits for SWs, MSM, and TG.
- Establish formal mechanisms to engage key populations in government decision making, policy and program development, culturally-appropriate IEC development, and monitoring and evaluation for HIV and HIV-related services.
- Harmonize misaligned parental consent laws, particularly to ensure the best interest of the child, and reinforce proper implementation of consent and confidentiality policies through increased training and accountability of providers and outreach workers.
- Although changes to laws criminalizing same-sex sexual relations and solicitation by sex workers are needed in the long run, first lay the groundwork by addressing stigma and discrimination (S&D) and supporting policies that lend themselves to quiet implementation or modification without inciting a backlash.
- Develop a prison policy that ensures access to all HIV services for detainees.
- Foster greater access to HIV services by increasing the number of locations offering free or subsidized services, with sympathetic health mediators available in these health facilities.
- Develop national S&D policies that include actively measuring and addressing S&D, as well as offer comprehensive training to sensitize healthcare providers, law enforcement, judges, and educators.
- Through policy, provide legal remedies for customary laws, teachings, or practices that negatively affect the status and treatment of SWs, TG, or MSM.
- Establish outreach/programs for alcohol and substance abuse harm reduction that could, at the same time, help to support HIV prevention among SWs, MSM, TG, clients of SWs, people who inject drugs, and the general population.

## ABBREVIATIONS

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AIDS	acquired immune deficiency syndrome
AMSHeR	African Men for Sexual Health and Rights
ART	antiretroviral treatment
ARV	antiretroviral
AWARE II	Action for the West Africa Region II
CAMEG	Central Purchasing Agency of Generic Essential Drugs and Medical Commodities
CBO	community-based organization
CD4	cluster of differentiation 4 (cell count)
CHALN	Canadian HIV/AIDS Legal Network
C/L	condoms and lubrication
CCM	country coordinating mechanism
CNLS-IST	National Council for the Response to AIDS and STIs
CSO	civil society organization
FP	family planning
GBV	gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOT	Government of Togo
HAV	Hepatitis A vaccine
HCT	HIV counseling and testing
HIV	human immunodeficiency virus
HPP	Health Policy Project
IEC	information, education, and communication
MOH	Ministry of Health
MOJ	Ministry of Justice
MSM	males who have sex with males
MSAPW	Ministry of Social Affairs and the Promotion of Women
NGO	nongovernmental organization
PACTE-VIH	USAID/West Africa Regional Project for the Prevention and Care of HIV / AIDS in West Africa
PASCI	Support Programme for Civil Society Organizations Involved in the Response to HIV and AIDS in Togo
PEP	post-exposure prophylaxis
PLHIV	person/people living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
PNDS	National Health Development Plan
PNLS	National Program for the Response to AIDs and STIs
PPT	periodic presumptive treatment (used to manage STIs)
PSI	Population Services International
PSN	National Strategic Plan for the Response to AIDs and STIs
PWID DM	person/people who inject drugs—Decision Model
R2P	Research to Prevention
RH	reproductive health
S&D	stigma and discrimination
SCADD	Accelerated Growth and Sustainable Development Strategy
SP/CNLS-IST	Permanent Secretariat of the National Council for the Response to AIDS and STIs

SRH	sexual and reproductive health
STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
TG	transgender
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

# INTRODUCTION

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## The Decision Model: A Policy Analysis

Policies, including laws, codes, directives, and operational procedures, affect the availability and accessibility of HIV prevention, care, and treatment services for males who have sex with males (MSM), sex workers (SWs), transgender people (TG), and detainees. While effective policies can create a framework that supports HIV objectives and addresses the needs of key populations, they can also adversely affect access to services by these populations. Policies determine legal rights and recourse, affect funding, and authorize or block public health services. Government laws and policies in several West African countries criminalize same-sex sexual relations and sex work, making it more difficult for MSM and SWs to access HIV prevention and treatment services. Even in countries that have not formally criminalized same-sex sexual relations and sex work, public health authorities and policymakers have largely ignored the needs of MSM, SWs, TG, and detainees. While “policy silence” may be necessary early in a country’s policy evolution in order to avoid codification of a punitive or criminal approach, it also poses a barrier to sustainability and the scale-up of high-quality prevention, care, and treatment services.

From 2010–2012, the global USAID-funded Health Policy Project (HPP), in partnership with the African Men for Sexual Health and Rights (AMShE), developed the *Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers* (Beardsley et al., 2013, hereafter referred to as the Decision Model). It provides country stakeholders—such as advocates, policymakers, and service providers—with tools to inventory, assess, and advocate for policies that affect access to and sustainability of key services for MSM, TG, and SWs. The model

- Identifies the existence of restrictive, inadequate, or absent enabling policies regarding sexual and reproductive health and rights and HIV/sexually transmitted infection (STI)-related programs
- Maps service-specific policies to international human rights frameworks to identify needs and opportunities for policy advocacy that will help improve access to services
- Provides local stakeholders and advocates with a template to build a customized, targeted advocacy approach—specific to the needs and environment of each jurisdiction

Annex 1 presents the Decision Model’s policy framework, which includes four components (framework, community partnership, legal environment, and intervention design, access, and implementation) that map to the Human Rights Framework of the Joint United Nations Programme for HIV/AIDS. This customizable, in-depth, and standardized approach will build the capacity to identify incremental, feasible, near-term opportunities to improve the legal environment and the resulting quality of and access to HIV and HIV-related services for MSM/TG/SWs—while long-term human rights strategies are implemented.

This assessment in Togo is the second country application of the Decision Model. In 2011, USAID, through the Action for West Africa Region II project (AWARE II), funded a regional assessment to uncover policy challenges in West African countries that may hinder effective HIV prevention, care, and treatment of key populations (Dutta and Maiga, 2011). Based on the findings, in 2012, the project conducted a pilot application of the Decision Model in Burkina Faso for SWs, MSM, and prison populations (Duvall et al., 2012).

Using the same methodology, HPP and AMShE applied the Decision Model to uncover policy gaps and practical challenges to policy implementation in Togo. This application complements the USAID-funded Research to Prevention (R2P) study, being led by the Johns Hopkins Center for Global Health, to estimate

the size of the MSM and SW populations and implement integrated HIV serological and behavioral surveillance in Togo; the stigma index being conducted by the Network of People Living with HIV in Togo and the Global Network of People Living with HIV; and the joint UTETEZI project's workshop in July 2013 (AMSHeR, HPP, United Nations Development Program [UNDP] and Southern African AIDS Trust) to support stakeholders in identifying priority policy actions to improve HIV prevention, care, and treatment services for MSM in Togo.

While policy in Togo is undergoing a number of positive changes and lessons about the process can be extracted for other countries in the region, gaps in policy and barriers to increasing access to services for key populations remain. Togo's recent completion of the National Strategic Plan for the Response to AIDS and STIs (PSN) 2012–2015 (SP/CNLS-IST, 2012a), which includes MSM, SWs, and detainees, and the recent development of a policy framework for the prevention and care of HIV and STIs for key populations (validation underway) demonstrate the Government of Togo's (GOT) potential political will to address the issues identified in a policy assessment. This country-specific application of the Decision Model, the first of its type conducted in Togo, is designed to help public health officials and organizations working in Togo better understand the policy barriers to effective public health programming for key populations. The lack of synthesized information on legal and regulatory issues and on gaps between policy and implementation is a challenge advocates and policymakers face in bringing about essential reforms to improve public health programming.

## Methodology

In June 2013, the assessment team (see Box 1) traveled to Lomé to complete an in-depth inventory and assessment of policies, laws, and regulations and their development and implementation related to access to HIV prevention, care, and treatment services among MSM, SW, TG, and detainees. Before beginning the application of the Decision Model, the AMSHeR partners and local consultants underwent training in data collection methods and assessment procedures. While applying the model, the assessment team coordinated and collaborated closely with PASCI (a support program for civil society organizations involved in the response to HIV and AIDS in Togo, a joint program of SP/CNLS-IST and UNDP). The team also coordinated with SP/CNLS-IST and PACTE-VIH (FHI 360) and collaborated with key stakeholders through a workshop to present the Decision Model protocol and solicit feedback and through a follow-up presentation of preliminary findings.

The assessment included (1) extensive data collection, (2) key informant interviews, and (3) data analysis and synthesis. The team conducted a desk review and analysis of 116 HIV-related documents and available data, with particular focus on MSM, SWs, TG, and detainees. The documents reviewed included constitutional provisions, laws, regulations, national guidelines, other key policy documents, and earlier studies (see Annex 2). The team used the Decision Model's assessment and inventory data collection tools<sup>5</sup>

### Box 1. Assessment Team

- 1 HIV field research specialist, HPP
- 1 MSM policy and law specialist, AMSHeR
- 1 regional HIV public health advisor
- 1 lawyer, human rights specialist
- 1 key populations' technical advisor
- 1 demographer/policy expert
- 1 research assistant, MSM project coordinator
- 1 research assistant, SW project coordinator

<sup>5</sup> See the Decision Model to access the tools, available at [www.healthpolicyproject.com/index.cfm?id=HIVPolicyModels](http://www.healthpolicyproject.com/index.cfm?id=HIVPolicyModels).



to (1) compile and classify a reference library of country documents, (2) compare current country policies to international best practices, and (3) assess the extent to which the policies enable or restrict implementation of HIV prevention, care, and treatment interventions for key populations (Beardsley et al., 2013).

The assessment team conducted 21 key informant interviews with government officials, judges, service providers, and civil society organizations (CSOs) representing MSM, SWs, and detainees,<sup>6</sup> as well as media representatives. Most interviewees were national actors. The interview guide developed for the study complemented the inventory tool, aligned with international best practices, and focused on understanding the legal, policy, and program environment for MSM, SWs, TG, and detainees (see Annex 3). It was designed to collect the opinions and experiences of key informants in order to assess the dissemination and implementation of Togo's current policies and programs, with a focus on gaps between policy language and implementation. It also addressed related barriers to service access for key populations, including stigma and discrimination and human rights violations.

As part of the overall analysis, the team reviewed responses to the interview questionnaires and then linked the findings to the analysis of the policy, legal, and regulatory documents and policy/program implementation. The assessment team then conducted further analysis of the inventory, data, and reports collected in-country to complete the gap/opportunity analysis of existing policies and determine barriers to service access among the key populations. The team documented the analysis using the Decision Model data collection tool and also prepared separate summaries of the policy assessment and key informant interviews for each subject area (policy, program, and legal).

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<sup>6</sup> There are currently no CSOs specifically working with transgender people in Togo.

# POLICY ANALYSIS FOR KEY POPULATIONS IN TOGO

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## Key Populations and HIV in Togo

Although countries in West Africa have lower rates of HIV in the general population than in Southern and Eastern Africa, they tend to exhibit evidence of either *concentrated* epidemics (in which the vast majority of HIV infection occurs among specific populations) or *mixed* epidemics (in which a significant portion of HIV infections occurs among specific populations with some sustained level of HIV transmission in the general population) (Dutta and Maiga, 2011). Biological, behavioral, and structural factors place key populations at higher risk for HIV transmission than other individuals (Beyrer et al., 2012; Scorgie et al., 2012; UNODC, 2007). Research in West African countries with *mixed* epidemics suggests that transmission between key populations—including MSM, SWs, and detainees—and sexual partners from populations at lower risk of infection represents a significant proportion of new infections in the general population. For example, 81 percent of new infections among the general male population in two towns in Senegal were attributable to sexual contact with a sex worker (Wilson and Fraser, 2011). Moreover, evidence suggests that stigma, discrimination, and violence against key populations may cause members of these populations to hide their occupation, gender identity, or behavior. Stigma and discrimination may also result in fear and distrust of health services, affecting use of HIV prevention, care, and treatment (Larmarange, 2010; Fay et al., 2010; WHO, 2011a; WHO, 2011b; UNAIDS, 2009b). Finally, criminalization of certain behaviors and a lack of appropriate services discourage these populations from accessing HIV counseling and testing (HCT) and other prevention services (Odendal, 2013; Beardsley et al., 2013).

Evidence clearly supports the cost-effectiveness and positive global impact of adequately allocating resources for HIV prevention in key populations, among whom the majority of new infections are likely to occur (Case et al., 2012; World Bank, 2012; Beyrer et al., 2011; World Bank, 2011; UNAIDS/World Bank, 2010; Wilson and Halperin, 2008; Wilson and Challa, 2009; Sarkar et al., 2009). Despite this evidence, on average, West African countries have not been specifically targeting key populations with HIV prevention; furthermore, spending per capita on HIV prevention is generally lower there than in other subregions of sub-Saharan Africa. Given the region's scarcity of resources, strategically focusing supportive HIV policy and resources on key populations would enable the region's countries to efficiently and economically attenuate HIV rates and improve health outcomes.

Although Togo has a generalized HIV epidemic with a prevalence of 3.2 percent (PNLS, 2011a; UNAIDS, 2012) and HIV rates in the general population of 7,154,237 (United States Government, 2013) decreased by 57 percent between 2001 and 2011 (UNAIDS, 2012), HIV rates among SWs, MSM, and detainees are significantly higher with estimates at 13.1 percent (PNLS, 2011a), 19.6 percent (PNLS, 2011b), and 4.3 percent (PNLS, 2011c), respectively. HIV prevalence among clients of SWs is lower at 2.5 percent (PNLS, 2011a). Although SWs, MSM, and detainees are disproportionately affected by HIV in Togo, data regarding these populations are limited. Further, data and information are unavailable for TG.

Policy in Togo is undergoing positive changes with regards to key populations. The Government of Togo has developed a number of policies that follow international best practices, and donor support for key populations in the country has increased. Unlike for many countries in the region, the 2010 report of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) for Togo included indicators for MSM and SWs, and the President of Togo expressed his support for the inclusion of MSM in HIV prevention efforts during a speech at the 2<sup>nd</sup> session of the National Council for the Response to AIDS and STIs in 2008.

Nevertheless, laws against “acts of nature” (including same-sex sexual relations) and soliciting by sex workers exist. Previous studies point to high levels of stigma and discrimination (S&D), including gender-based violence (GBV), blackmail, societal and family rejection, and S&D from health providers and police—all with psychological, economic, and health consequences (PSI, 2006; FHI 360/ACI, 2013). This level of S&D negatively affects health-seeking behaviors among these populations, including decreased HIV prevention measures and uptake of services and increased drug and alcohol abuse.

## Assessment Findings

The assessment findings presented in this section are organized by the Decision Model’s four policy components. Under each component, current policies in Togo are presented with an emphasis on supportive, restrictive, inadequate, and/or absent enabling policies that may affect access to HIV prevention, care, and treatment services for SWs, MSM, TG, and detainees. The findings also address the availability of policy implementation mechanisms, such as operational guidelines or standards, and the level to which key populations are included in policy and program development, implementation, and/or monitoring and evaluation. Key informant interviews and the debriefing workshop informed the findings, which describe the level of policy dissemination and implementation as well as barriers to improving policies and increasing access to HIV services for SWs, MSM, TG, and detainees.

Table 1 (see next page) summarizes the current policy environment in Togo as it relates to key populations’ access to and participation in HIV-related policy making, programs, and services. Note that check marks do not necessarily indicate 100 percent achievement in the relevant category but rather an indication of progress. Areas of relatively weak or absent progress have been noted.

Table 1. Current Policy Environment in Togo

Policy component and themes	Number of relevant policy documents examined	Evidence of engagement of stakeholders in policy development <sup>1</sup>	Evidence of ongoing data collection related to policies	Government endorsement of policy	Implementation mechanism outlined	Policy implementation <sup>2</sup>	Evaluation of policy implementation
<b>Framework</b>							
Multisectoral Coordination and Integration	29	None	Weak <sup>3</sup> data	√	Limited <sup>4</sup>	Limited	None
Data-Informed Planning and Budgeting	33	None	Weak data	√	Limited	Limited	None
<b>Community Partnership</b>							
Community Engagement and Participation	12	Limited inclusion of key populations	Weak data	√	Limited	√	Limited
<b>Legal Environment</b>							
Authorization <sup>5</sup>	6	None	No data	√	√ Gaps in prisons	Strong, but with gaps	None
Informed Consent	27	None	No data	Strong, but with gaps	√	Strong, but with gaps	None
Privacy and Confidentiality	24	None	No data	√	√	Strong, but with gaps	None
Registries <sup>6</sup>	19	None	No data	√	√	Strong, but with gaps	None
HIV and Key Populations-related Stigma and Discrimination	16	None	No data	Strong HIV, but unclear for key populations	Strong HIV, but gaps for key populations	Limited	None
Criminalization <sup>7</sup>	16	None	No data	Major gaps for MSM and SW	N/A	N/A	None
Gender-Based Violence	22	None	No data	Strong, but with gaps	Limited	Inconsistent and barriers exist	None

Policy component and themes	Number of relevant policy documents examined	Evidence of engagement of stakeholders in policy development <sup>1</sup>	Evidence of ongoing data collection related to policies	Government endorsement of policy	Implementation mechanism outlined	Policy implementation <sup>2</sup>	Evaluation of policy implementation
Torture, Cruel, Inhuman, or Degrading Treatment or Punishment	4	None	No data	Gaps exist	None	Unclear	None
Monitoring and Enforcement of Human Legal Rights	10	None	No data	Gaps exist	Unclear	Inconsistent and barriers exist	None
<b>Intervention Design, Access, and Implementation</b>							
Procurement and Supply Management	14	None	Weak data	Strong, but with gaps	Strong, but with gaps	Inconsistent and barriers exist	Limited
Overarching Services Design	20	None, but discussions underway with PNLs for inclusion in working group	Weak data	Strong, but with gaps	Strong, but with gaps	Inconsistent and barriers exist	Limited
HIV Counseling and Testing	11	None, but discussions underway with PNLs for inclusion in working group	Weak data	√	√	Programs operating, but barriers exist	Limited
Antiretroviral Treatment	15	None, but discussions underway with PNLs for inclusion in working group	Data Collection ongoing	√	√	Programs operating, but barriers exist	√
Sexually Transmitted Infections	24	None, but discussions underway with PNLs for inclusion in working group	Weak data	√	√	Inconsistent and barriers exist	None

Policy component and themes	Number of relevant policy documents examined	Evidence of engagement of stakeholders in policy development <sup>1</sup>	Evidence of ongoing data collection related to policies	Government endorsement of policy	Implementation mechanism outlined	Policy implementation <sup>2</sup>	Evaluation of policy implementation
Condoms and Lubrication	26	None	No data	Unclear	Limited	Inconsistent and barriers exist	None
Information, Education, and Communication	16	None	No data	√	Limited	Programs operating, but barriers exist	None
HIV Prevention Outreach	17	Limited	No data	√	Limited	Programs exist, but barriers exist	None
Alcohol and Substance Abuse Harm Reduction <sup>8</sup>	17	N/A	N/A	N/A	N/A	N/A	N/A
Sexual and Reproductive Health	19	None	Weak data	√	Limited	Programs operating, but barriers exist	None

<sup>1</sup> SWs, MSM, detainees, and organizations serving these populations are considered stakeholders for purposes of this analysis. At this time, only organizations serving key populations are engaged in policy decisions. However, discussions are underway with PNLS to include SWs and MSM in the STI Targeted Intervention Technical Working Group.

<sup>2</sup> "Weak" refers to an insufficient availability or use of data.

<sup>3</sup> "Limited" refers to a minimal but insufficient or inadequate level to meet best practices.

<sup>4</sup> For purposes of this table, policy implementation was defined as implementation of policies that are favorable to key populations. This was measured by analyzing whether policies favorable to key populations, where they exist, are currently being implemented and whether barriers exist. Data for this analysis came from key informant interviews.

<sup>5</sup> Authorization refers to the agency authorized to implement services for key populations, e.g. public health officials, law enforcement or judicial agencies. Authorization can have a major impact on policy implementation and access to services.

<sup>6</sup> Registries are used in public health for epidemiological purposes and at the health clinic or provider level to record patient information. Government sex offender registries exist in many countries and are used to keep records of individuals involved in and/or accused of sexual activities prohibited under current laws. Policies can prohibit use of certain types of registries or inclusion of certain information, explicitly lay out regulations for data protection and confidentiality, or remain vague with few or no guidelines to protect patients.

<sup>7</sup> Criminal law establishes definitions and parameters of behavior that reflect a criminal justice perspective and identify options for enforcement and remedy. Criminalization here addresses criminal law related to HIV transmission, sexual behavior, and sex work.

<sup>8</sup> There are currently no programs in place in Togo for alcohol and/or substance abuse harm reduction. Policy is silent on this issue.

Specific gaps and barriers identified through the Decision Model application in Togo include the below (see Annex 4 for a brief summary of the findings).

## Framework

### *Coordination and Integration*

International guidelines highlight the need for a “coordinated, participatory, transparent and accountable approach” to HIV prevention, care, and treatment services (Beardsley et al., 2013) in which programs are integrated across all branches of government and align with international standards (UNAID, 2006). Support of international initiatives and dissemination of knowledge and information are also indicated. In Togo, the response to AIDS receives political support from high-level authorities (see Box 2). The National Council for the Response to AIDS and STIs (CNLS-IST) was established in 2001.

In line with international guidelines and an initiative supported by the UNDP, the Permanent Secretariat for CNLS-IST (SP/CNLS-IST) elaborated its first multisectoral and decentralized approach with the PSN (2001–2005), followed by subsequent strategic plans and other policy documents, including the National Strategic Plan for Children and AIDS Campaign (2007–2010) and the Operational Plan to Respond to AIDS and STIs (2012–2013). Although some policy documents, including those mentioned and the National Health Policy (2009), refer to the multisectoral approach and mention coordination between agencies and ministries, policy does not specify which government sectors or ministries and do not detail coordination mechanisms. Numerous ministries—including the ministries of commerce, transport, immigration, and prison and uniformed services—have yet to develop policy documents addressing HIV and STIs. Among those ministries that have, the policy is often vague and generally does not mention STIs, sexual and reproductive health (SRH), or key populations. Although HIV and STI policies emphasize coordination with SRH programs, SRH policy does not mention coordination with HIV and STI programs other than permitting SRH programs to offer HCT. In practice, there is a lack of coordination. Key informants stated that coordination between agencies is extremely problematic in Togo and that it is only recently that SP/CNLS-IST and the National Program for the Response to AIDS and STIs (PNLS) have begun to work together to coordinate efforts. Policy does not clearly delineate the roles of each, thus posing a serious problem.

The majority of national health and development policy documents in Togo—such as the United Nations Development Assistance Framework (UN, 2010), the Accelerated Growth and Sustainable Development Strategy (SCADD) (GOT, 2010b), and individual sector strategies for education, labor, commerce, transportation, immigration, prisons, and military/uniformed forces—make no mention of key populations. Although some policies refer to vulnerable or at-risk groups in general or mention global access for the entire population without discrimination, they do not specify MSM, SWs, clients of SWs, TG, or detainees. The latest PSN (2012–2015) includes these key populations and follows several international best practices that emphasize HIV prevention among SWs and MSM and universal care and

### **Box 2. Relevant Supporting Policies and Plans in Togo**

National Health Policy

National Plan for Health Development

National Council for the Response to AIDS and STIs

National Strategic Plan for the Response to AIDS and STIs

National Program for the Response to AIDS and STIs

Operational Plan to Respond to AIDS and STIs

National Strategic Plan for Children and AIDS Campaign

National Communication Strategy for Behavior Change related to STIs, HIV, and AIDS

treatment of all people living with HIV (PLHIV). The National Communication Strategy for Behavior Change related to STIs, HIV, and AIDS (2011–2015) also specifically mentions SWs, MSM, and detainees. Objective 3 of the National Health Policy (2009) also includes a target (6) to reduce new cases of HIV infection by 50 percent in the general population and in groups “at risk” and specifies SWs, MSM, people who inject drugs (PWID), and detainees. The policy does not, however, include a focus on STIs. The National Plan for Health Development, which is the national strategy to implement the National Health Policy, includes capacity strengthening in the public, private, and community sectors for HIV prevention outreach among key populations. Finally, the absence of a policy framework to identify programmatic priorities and specific approaches for key populations is currently being addressed by SP/CNLS, with the development of a policy framework for the prevention and care of HIV and STIs in key populations (now being validated). According to key informants, **coordination for SW programs exists to some degree, but there is no coordination for MSM programs**. Aligning the various policies to improve coordination and include key populations can improve access to services for these populations.

Detainees are specifically identified as a key population in national health and HIV policy documents, and their rights are guaranteed under SR law and in HIV policy. However, the inexistence of prison policies, the division of prison management and security between the Ministry of Justice and the Ministry of Security, misinterpretation of the penal code, human and financial resource deficits, and gaps in HIV and SR policy implementation impede detainees’ access to HIV and other health services. Key informant interviews confirmed the occurrence of same-sex sexual relations within prison populations. Although no written policy exists, in practice, condom and lubricant distribution is prohibited in prison. HIV testing, care, and treatment in prison settings in Togo must be delivered by CSOs because even basic medical needs are not met due to a lack of human resources, medications, and materials—the latter of which is affected by recent policy procurement changes that have had the unintended consequence of discouraging pharmacists to bid on calls for tender to deliver medications to prisons.

*For example, in the civil prison in Lomé, one nurse and two volunteers treat at least 2,000 detainees... Resources for medical expenses in the 12 prisons are \$60,000 a year which is only \$15 a year per detainee... Treatment for detainees suffering from chronic illness must be paid by their families because the resources are insufficient to offer them adequate care.*

~ Key informant, prison services officer

#### *Data-Informed Planning and Budgeting*

Current SRH policy does not address key populations or services for them. HIV and STI policy identifies services and coverage targets for SWs and MSM, references international coverage recommendations, and identifies coverage targets, government commitment to scale-up services, and data reporting requirements for disaggregating data for these two populations. However, policy does not require services for key populations to be determined by scientific evidence, nor does it address engaging key populations in validating population size estimates. Although policy identifies data and methodologies for estimating SW and MSM population size and identifies population behavioral surveys as the methodology and evidence basis for funding decisions for SWs and MSM, according to key informants, data are often imprecise and unreliable. The situation has improved significantly in the last few years with a series of studies for SWs, MSM, PWID, and detainees conducted by the PNLs in 2011, and R2P studies of SWs and MSM conducted in 2013. The latest PSN (SP/CNLS 2012) and its operational plan call for regular data collection for MSM and SWs. None of the policies in this section specifically mention TG, detainees, or clients of SWs.



*The only available data are usually from activity reports, but these reports do not have sufficient data to develop a program. Also, no assessment was made before the action planning. The level of funding is determined by referencing the size of the target population...the severity of their problem.*

~ Key informant, national-level public health official

According to another key informant, HIV budgeting is insufficient, little financing comes from the government, and financing for key populations is not guaranteed.

In the most recent United Nations General Assembly Special Session on HIV/AIDS (UNGASS) report (2010), Togo provided indicators for MSM and SWs. The Monitoring and Evaluation Manual (SP/CNLS, 2012c) and the PSN 2012–2015 (SP/CNLS, 2012a) also include target indicators for SWs, MSM, and detainees based on international recommendations. There are currently no policies regarding data collection requirements for the incidence and context of sexual violence in prison.

### **Community Partnerships**

#### *Community Engagement and Participation*

Human rights and intervention guidelines emphasize the importance of engaging priority populations in policy and program design, implementation, and evaluation (Beardsley et al., 2013). Moreover, there is strong evidence of a positive correlation between community engagement and health outcomes (Green et al., 2006; Manandhar et al., 2004; Barnett and Whiteside, 2006). The World Health Organization's HIV program guidelines (2011) call on governments to include MSM and TG in the development of health plans, as supported by medical ethics and human rights models. The Joint United Nations Programme on HIV/AIDS (UNAIDS) Advisory Group (2011) has highlighted the crucial role of SWs and their organizations in HIV prevention, care, and treatment efforts.

The government of Togo signed the UNGASS Declaration of Commitment that includes guidelines for the participation of stakeholders in the HIV response. While a national network of CSOs involved in the response to AIDS was launched in 2011 and government HIV policy (SP/CNLS, 2012a) and the National Policy for Community-Based Interventions (2009) call for the active participation of nongovernmental organizations (NGOs) to achieve national objectives, the GOT has not established any formal mechanisms for engaging key populations in government decision making or policy development. There are currently no representatives from key populations in the Country Coordinating Mechanism (CCM). According to key informants, SWs were invited once to participate in a workshop evaluating the PLHIV law. Currently, the PNLIS is working with key stakeholders to establish a mechanism to include members of key populations in the STI Targeted Interventions Technical Working Group. However, criminalization laws (see *Criminalization* section under *Legal Environment* below) pose barriers to official recognition of MSM NGOs that could participate in the group, and SWs have not organized or applied for NGO status, thus limiting options for official inclusion in the working group and other government groups and meetings.

*Integration in the group is done by ministerial decree, and only organizations that are registered with the state can take part. It is therefore difficult for MSM and SWs to join the group because the law does not allow them to be registered as MSM or SW organizations.*

~ Key informant, national-level public health official

A limited number of organizations (N=15) in Togo provide services to MSM, SWs, and detainees, including some that include MSM as members or leaders and MSM and/or SWs as peer educators (Tchagafou et al., forthcoming). Representatives of key populations are actively engaged in these organizations and other unregistered organizations and are working behind the scenes to affect positive changes for key populations. However, there are currently no SW-led CSOs, and MSM-led CSOs have had to apply for official status citing “HIV prevention for key populations” as their focus without specifically mentioning MSM or human rights.

*For the time being, official permission is denied to the MSM organizations... To express their concerns, MSM have created a consultative framework called ‘Friendly Center.’ But there is no formal framework for these groups. It is therefore necessary to find the legal means to improve their status ... and their health and HIV prevention of HIV in their communities.*

~ Key informant, NGO representative

## **Legal Environment**

### *Authorization*

Policies can authorize oversight and coordination of programs, laws, and/or services by public health agencies, law enforcement, and/or judicial agencies, which can in turn profoundly affect implementation (Beardsley et al., 2013). In Togo, policy empowers public health authorities to provide a comprehensive range of prevention and treatment services for family planning (FP)/reproductive health (RH), STIs, and HIV (GOT, 2009; MOH, 2009a; GOT, 2005). Policy also explicitly grants public health agencies—rather than law enforcement—the authority for oversight and coordination of MSM and SW services (SP/CNLS, 2012a).

Policy that grants healthcare decision-making authority for detainees to law enforcement, prison, or detention officials rather than to healthcare providers can adversely affect detainees’ health. Although public health policy in Togo does not explicitly mention responsibility for general health services in prison and does not provide for independent health provider decisions in prisons, HIV law provides for special protections for detainees, including HIV prevention, care, and treatment. Togo does not have a specific prison policy other than a colonial legal decree from 1933, which does not address health policy. Key informant interviews revealed that healthcare in prison settings does not receive the same level of funding or human resources as community health services. This lack of concrete prison policy, including policies requiring specific levels of funding, negatively impacts HIV prevention, care, and treatment in prison settings.

*Being a prisoner in Togo means no longer being a citizen or even being a human being. There are no materials or human resources in prison, and it is considered a punishment to be sent to work there.*

~ Key informant, senior country AIDS advisor

### *Consent*

Informed consent and counseling are two of the three “Cs” of HIV testing, along with confidentiality of test results (WHO, 2007). Obtaining a patient’s informed consent is a prerequisite for any medical intervention under the declaration on the promotion of patients’ rights in Europe, adopted by the European Meeting on Patient Rights, Amsterdam (WHO, 1994). Obtaining informed consent is particularly important for pregnant women, including pregnant sex workers who may avoid prenatal care if they fear HIV testing without consent, as well as for MSM and SWs who may self-medicate or avoid treatment altogether, at least in the early stages of illness.

Although HIV consent policy in Togo follows international best practices, the public health law (law # 2009/007) and improper implementation of the HIV law may pose barriers to HIV and STI outreach for SWs as well as efforts for the prevention of mother-to-child transmission (PMTCT) (see Box 3). On the one hand, HIV law (GOT, 2010a) and the HCT Training Reference Manual (PNLS, 2010a) are consistent in requiring free and informed consent, identifying the key elements required for consent. The HIV law (GOT, 2010a) also includes policy to “encourage SW[s] to partake in periodic HIV testing.” On the other hand, public health law (law # 2009/007) requires anyone with an STI to be examined and treated and states that SWs are subject to mandatory medical supervision. MSM, TG, and detainees are not specifically mentioned, although HIV law requires consent of “all people.” Moreover, consent is not required to save the life of the patient if the health provider has tried to convince the patient and the patient still refuses care. These contradictory policies compromise free and informed consent, particularly for SWs, and may discourage them from seeking healthcare. According to key informants, consent is generally obtained, but healthcare providers, who are not culturally used to obtaining consent, do not always take time to properly inform patients and often “pressure” patients to consent, particularly in the case of PMTCT.

**Box 3. Law 2009/007 of Public Health Code**

**Articles 77, 78, and 570 state:**

Any person with a sexually transmitted infection must be examined and treated by a health care professional until cured.

**Article 78 states:**

Any person engaging in the practice of prostitution shall be subject to appropriate medical supervision.

**Article 570 states:**

No medical procedure or treatment can be carried out without free and informed consent. This consent may be revoked at any time. However, the practitioner does not violate the freedom of the patient if, after every effort to convince him [the patient], he [health provider] performs an act essential to his [patient’s] survival and commensurate with his health status

Policy (law 2007/017) in Togo guarantees access to information and counseling for HIV, STIs, and RH, as well as the right to reproductive health irrespective of a child’s age and regardless of parental/caregiver consent. Legal code regarding children (law 2007/017) states that all children living with or affected by HIV should receive care “corresponding to his/her needs and in conditions that guarantee his/her dignity and promote his/her autonomy” but does not specifically reference whether parental or guardian consent is required for testing, care, or treatment. Despite this, the same law states that sex workers who are minors must be subjected to STI testing and treatment. The HCT Training Reference Manual (PNLS, 2010a) does not provide the age of consent for HCT but requires consent from a parent, guardian, or legal appointee. At the same time, it states that the child’s opinion should be considered, depending on his or her degree of maturity, and that what’s in the best interest of the child should be the primary consideration. Finally, policy in the new policy framework for key populations (Guiard-Schmid, forthcoming) calls for minors to provide consent for HCT without parental consent in cases when the minor is “sufficiently mature.” The various policies are misaligned, with some being unclear and not following best international practices. SWs, MSM, or TG youth may be unable to or afraid of seeking parental/guardian consent due to fear of abuse, stigma, and/or discrimination from their family.

*Confidentiality*

Public health law (GOT, 2009) and HIV law (GOT, 2010a) guarantee confidentiality and provide for sanctions, including prison and fines, as directed under both the HIV law and Penal Code. Confidentiality in HCT is also addressed in the HCT Training Reference Manual (PNLS, 2010a). Confidentiality of individual data for research and aggregated statistics is guaranteed by law as well (law # 2011-014). Nevertheless, disclosure of HIV status required for judicial proceedings poses a risk for SWs, MSM, and

TG given the current legal and social environment. Policy is also silent regarding detainees. Key informants reported sporadic incidences of breaches in confidentiality, particularly suspicion of breaches from peer educators providing HCT. According to key informants, confidentiality in prison settings is not always respected. Even when confidentiality is not breached per se, inmates must leave prison for HIV care and treatment, which, de facto, reveals their serostatus to others.

### *Registries*

Registries are used in public health for epidemiological purposes and at the health clinic or provider level to record patient information, including sensitive health records (Beardsley et al., 2013). Whenever data are linked to personal identifiers, such as name or address, it is essential to adhere to regulations that protect data and confidentiality.

Policy in Togo supports the fundamental principles of medical confidentiality and patient rights, requiring public and private health facilities to follow national health information system standards—many of which are based on international recommendations. Policy includes sanctions for violating regulations regarding the collection, recording, and storage of personal data. According to key informants, Togo is moving to a policy of using codes instead of names in health registers. In practice, policy implementation often depends on the technical capacity of those working in the health facility.

In many countries, government sex offender registries compile records of individuals involved in and/or accused of illegal sexual activities. In countries where sex work and same-sex sexual relations are illegal, the registries can maintain records on MSM and SWs; in extreme cases, law enforcement can use the information in the registries to remove children from their custodian and deny the offending party access to state services such as housing, education, and employment (Beardsley et al., 2013). There are no policies regarding these types of registries in Togo, and the assessment team did not find evidence of their use.

### *Stigma and Discrimination*

Policies that address stigma and discrimination are particularly important in a country such as Togo where religious beliefs and customs, including gender norms for men and women, and laws that criminalize same-sex sexual relations and the solicitation of sex create a highly stigmatizing environment for MSM, TG, and SWs.

*MSM and SWs are deviant and delinquents because [their behavior is] punished by criminal law. All three [MSM, TG, and SWs] are a disease in my opinion, because we must live according to our sex of at birth. The bible says....*

~ Key informant, senior civil servant

The Togolese constitution (1992) states that all citizens are equal and prohibits racist, regionalist, or xenophobic acts. HIV law (GOT, 2010a) also prohibits discrimination of all PLHIV, including detainees, with specific sanctions for discrimination that include imprisonment and fines. Neither document specifically mentions sexual orientation, gender identity, or sex work. Nonetheless, the National Strategic Plan for the Response to HIV (2012–2015) and the National Policy for the Response to HIV: Vision 2020 both recognize S&D as an issue and include a call for the government to reduce or eliminate S&D of MSM and SWs. The assessment team was unable to find any policies that actively measure or address stigma and discrimination among key populations (MSM, SWs, TG, and detainees) or any policies that provide legal remedies for customary laws, teachings, or practices that affect the status and treatment of MSM, SWs, or TG. According to key informant interviews and research reports, religion and culture in Togo impact high levels of S&D around same-sex sexual activity and sex work (FHI360/ACI, 2013; PSI, 2006; Me-Tahi and Anato, 2010).

*A Togolese pastor even sent a letter to Togolese authorities urging them to punish homosexuals.*

~ Key informant, NGO representative

Anecdotal evidence indicates verbal and physical aggression against MSM, including insults, beatings, and public humiliation by family members and discrimination by employers, landlords, and healthcare providers that leads to high levels of unemployment, homelessness, and barriers to accessing health services. Key informants reported incidents of violence against MSM, TG, and SWs and NGO outreach workers trying to reach MSM. In the case of sex workers, key informants corroborated previous anecdotal evidence of SW harassment, gender-based violence (see *GBV* section), and extortion (see *Criminalization* section) at the hands of law enforcement.

Key informant interviews also confirmed accounts of healthcare providers' violating their code of ethics by refusing to deliver care to MSM and SWs and/or insulting them. As a result, MSM and SWs often hide their occupation, sexual behavior, or sexual orientation from healthcare providers or choose not to seek health services.

*When MSM, SWs, and TG go to a health center, their reception changes as soon as they reveal their identity. This is caused by social constructs.*

~ Key informant, public health official

*If you give services without respecting human rights, it's like giving food to a dog while beating him with a stick.*

~ Key informant, senior country AIDS advisor

Some CSOs in Togo have addressed S&D in healthcare settings by recruiting sympathetic health mediators to accompany MSM and SWs to healthcare facilities or by offering separate, adapted services for these populations.

As in other countries in West Africa (World Bank/NACA 2008), fear of stigma and discrimination also leads to bisexual behavior and heterosexual marriage as a social cover among MSM. This is not surprising given key informant reports of extortion of MSM who fear being "outed" by both MSM and others. One study in Togo found that 67.5 percent of MSM had also had sexual relations with women—although the study did not report whether this was by choice or as a social cover (PNLS, 2011b).

Regrettably, Togo's media also propagates stigma and discrimination through incendiary radio emissions and news articles. CSOs and "friendly" journalists are working together to build a network of journalists to positively influence the situation.

International best practices suggest that policies related to national SRH, STI, and HIV programs should identify and measure the causes of stigma and discrimination among key populations. Although current policy in Togo does not address these issues, key informants reported that discussions are underway for putting an S&D monitoring system in place. As long as efforts are made to include reporting and responding to stigma and discrimination against key populations, this would be an important first step in addressing it in Togo.

### *Criminalization*

As in many West African countries, Togo criminalizes same-sex sexual behavior and defines it as an “act against nature,” (GOT, 1980). Reproductive health law (Act # 2007-005) defines homosexual identification as “a sexual pathology.” While sanctions include imprisonment for one to three years, no cases have been prosecuted in recent years. Key informants report cases of soliciting and pedophilia used as false charges against MSM in place of the same-sex sexual behavior law.

#### **Article 88, Togolese Penal Code (1980)**

He/she shall be punished by imprisonment for one (01) to three (03) years and fined 100 000 to 500 000 F CFA anyone who commits an indecent act against nature with an individual of the same sex.

Although sex work is not illegal, soliciting on public streets and pimping are criminalized under Togolese law (GOT, 1980). According to key informants, MSM and SWs are commonly victims of misinterpretation and misuse of these laws. Anecdotal evidence (FHI36/ACI, 2013)—confirmed by key informant interviews for this analysis—indicates that police violence against SWs occurs during raids of brothels and on public streets, including gang rape and extortion, with misinterpretation of the solicitation laws used as the basis. According to key informants, sex workers never report the incidents because they do not know the law or their rights and are afraid of law enforcement. Criminalization laws and police harassment of MSM and SWs reduce the probability that victims of abuse will file police complaints, discourage MSM and SWs from accessing HIV services, and put SWs in unsafe and exploitative working conditions that make condom negotiation more difficult, while legitimizing general stigma and discrimination.

In 2010, Togo updated its HIV law to remove the N’Djamena-type model law, which provided for criminalization of willful transmission of HIV. The current law follows the World Health Organization’s (WHO) guidance and protects the human rights of PLHIV. Evidence demonstrates that service referral in lieu of prosecution can ensure that key populations obtain needed services.

### *Gender-Based Violence*

Reporting and prosecution of rape is influenced by how rape is defined under the law and in policies addressing rape victims and their perpetrators. Although laws in many countries are expanding to cover any gender of victim and attacker, they typically consider victims as female and perpetrators as male. In countries where physical resistance is required, the law may not cover instances in which the victim is incapable of giving consent due to the influence of drugs, alcohol, or age. Some laws may limit the definition of insertion and penetration to specific body parts (e.g., penis and vagina) or recognize other forms of rape.

In Togo, rape policies are vague and/or misaligned regarding the sex of the perpetrator and the victim. According to the Constitution (1992), the state recognizes its “obligation... to guarantee the physical and mental integrity, life, and safety of everyone living in the country.” Penal Code (law #80-1, 1980) and Child Law (2007-017) define rape as imposing “sexual relationships with others against their will by using fraud or violence.” HIV law poses sanctions against “anyone [who is] knowingly HIV positive

#### **Reproductive Health Law 2007/005**

No woman, for reasons related to sexuality and reproduction, should be subjected to torture, stress, and/or violence such as rape.....

[who] committed rape of a person that caused HIV transmission.” Under the Penal Code, “any author or accomplice of rape is punishable by five to ten years’ imprisonment.” “Rape” and “sexual relationships” are not clearly defined, and the laws do not define the gender of the perpetrator or the victim, thus leaving them open to interpretation. In contrast, the

Reproductive Health Law (2007–005) and gender policy (MSAPW/UNDP 2006) clearly define the victim as female, and the HIV law (GOT, 2010a) expands the definition to include sexual violence of children. Application of these laws could potentially limit the ability of MSM and male detainees to press charges against perpetrators of GBV against them. The Child Law (2007-017) and Personal and Family Code (2012-04) consider any forced sexual act in marriage as rape with no specification of gender. Multiple terms are used depending on the policy, many of which have no clear definition, and no mention is made of penetration. Aggravating factors, including fraud, violence, and the age of the victim, are defined. Policy is generally silent regarding MSM, TG, SWs, and detainees, as well as silent on honor killings.

Sexual violence against sex workers is common and may be perpetrated by, for example, clients, pimps, members of the community, or members of law enforcement. Anecdotal evidence (FHI360/ACI, 2013)—confirmed by key informant interviews for this analysis—point to high levels of sexual violence against sex workers in Togo. Sexual violence against SWs may reduce their ability to negotiate condom use and increase the risk of HIV transmission. In theory, sex workers in Togo have the right to pursue rape or sexual abuse in court, but, according to key informants, most are afraid to report incidents to law enforcement and are unaware of their rights; as a result, cases go unreported. In response to the issue, recent HIV policy (SP/CNLS, 2012a; SP/CNLS, 2012b) identifies activities for awareness raising and care of GBV victims, including specific mention of activities for SWs. However, current policy does not guarantee post-exposure prophylaxis to rape victims. The only policy addressing post-exposure prophylaxis (PEP) for rape victims is for detainees in the HIV/TB Prison Nurses' Manual (MOJ/UNODC, 2010). However, key informants reported that this policy document is not followed and “holds no weight.”

A major concern with any harm reduction program aimed at MSM, TG, SWs, and other detainees is to address sexual violence in detention and prison settings; such violence represents additional opportunities for human rights violations and disease transmission (Beardsley et al., 2013). The only prison policy in Togo is Order #488 dating from 1933. This policy, reorganizing the prison system in Togo, ensures that prisoners undergoing disciplinary punishment and youth should always be separated from other detainees; women should always be separated from the men. Given that the policy dates from 1933 and is obsolete, it is not surprising that it does not address SWs, MSM, or TG. Policy is also silent on the education of prisoners regarding their rights and reporting and redress in cases of sexual violence, as well as on the identification of independent and external mechanisms to monitor and review cases of sexual violence in prisons. The prison nurses manual (MOJ/UNODC, 2010) provides a protocol for addressing HIV prevention among victims of sexual violence in prison, including recommending the administration of PEP, but according to key informants, the protocol is not followed. HIV law (GOT, 2010a) does provide for appropriate information and communication regarding social programs and education for behavior change among inmates.

#### *Monitoring and enforcement of human and legal rights*

Torture and cruel, inhuman, and humiliating treatment are illegal, and policy protects against these acts—although there are no specific provisions for sanctions. Policies do not mention sexual orientation, gender identity, or prison settings with regards to these acts.

Togo has ratified major international conventions related to human rights, including the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights; and Convention on the Elimination of All Forms of Discrimination against Women. According to the National Program for the Promotion and Protection of Human Rights (2007–2010) and article 140 of the Constitution, even though international conventions or treaties signed by the GOT supersede any contradictory laws or policies in place in the country, in

practice, their implementation is extremely limited. Much of current legislation dates to before 1992 and is misaligned with the Constitution and international instruments, with instruments not being disseminated or applied during legal proceedings. According to the document, “domestic legislation must be harmonized with their contents to determine the scope of their implementation and enforcement mechanisms for control and monitoring.”

Corruption, including bribery and extortion, can include illegal detention and bribes in sex or fines (Beardsley et al., 2013), which can impact access to services and agency for key populations. Policy gaps in Togo exist with regards to corruption. Although the team was unable to find anti-corruption policy documents, key informants stated that a government anti-corruption commission had been put in place. Nevertheless, key informants commented that it was not operational. Moreover, key informants reported that civil servants, including police, do not receive equal pay to those in similar posts in the private sector. Key informants highlighted cases of police requiring sex and/or money from SWs in exchange for not arresting them and cases of citizens requesting payment from MSM for not disclosing their sexual orientation to others.

Even though Togo’s constitution and HIV and RH laws guarantee the rights of all citizens, they do not specifically mention MSM, TG, or SWs and therefore are often limited in their application. According to key informants, stigma, discrimination, and outright verbal and physical abuse of MSM and SWs are common (FHI360/ACI, 2013). Even when MSM and SWs are aware of their rights, fear of stigma and discrimination prevent them from demanding their rights, including access to essential services and housing. The implementation of policies that (1) ensure the protection of human rights and development of policies that put an end to police abuse, (2) enlist police support to protect key populations from abuse and violence, and (3) provide legal aid to abused MSM, SWs, TG, and detainees can help ensure that HIV prevention, care, and treatment efforts reach key populations.

### ***Intervention Design, Access, and Implementation***

#### *Procurement and supply management of medicines and medical commodities*

A functioning system for the procurement and supply management of medicines and medical commodities, including policy for approved drugs and essential drugs, is essential to providing HIV prevention, treatment, and care. The Directorate of Pharmacies, Laboratories and Technical Facilities (DPLET) in Togo is the national drug regulatory authority and responsible for implementing national drug policy. Overall, national policy in Togo follows international best practices and provides a framework to ensure the efficient procurement and supply management of medicines and medical commodities (MOH, 2012a; MOH, 2013). In reality, critical policy gaps and inefficiencies in policy implementation negatively affect the system. For example, the roles of supervisory bodies for CAMEG, the organization responsible for the central purchasing of essential drugs, are not clearly defined, and CSOs are not represented on supervisory bodies.

Following best practices, drug coverage standards and medical products are identified, and drugs purchased with public funding include those for STIs and HIV. However, the country essential medicines list does not include all medications identified in the WHO Model List of Essential Medicines for STIs and HIV, and current policy does not permit the importation or local manufacture of all STI and HIV medications in the WHO model list (MOH, 2012b).

Regarding financing and forecasting, the pharmaceutical budget is global and does not break down storage, distribution, and logistics. Although policy identifies mechanisms to calculate order quantities based on reliable estimates of need and leaves leeway for the decentralized supply of medications (MOH, 2012a; MOH, 2013), stockouts of antiretrovirals (ARVs) and STI kits have been a recurring issue due to a combination of budgeting shortfalls during interruptions in donor funding and uneven policy



implementation at the health facility and district levels. STI kits have been problematic because of a lack of reliable data on the number and type of STIs, making forecasting virtually impossible. Key informants gave the example of centrally stocked medications expiring while stockouts occurred at the health facility level because health facility and district staff failed to complete paperwork to re-order medications. During key informant interviews and the in-country debriefing for this application of the Decision Model, informants pointed to severe shortages of medication in prison settings as a result of new procurement policy using a tender system that has had the unforeseen effect of discouraging applicants that deem the system risky and unprofitable.

#### *Overarching service design*

Best practices in intervention design and the protection of human rights can mitigate obstacles to accessing services for key populations (Beardsley et al., 2013). Integrating STI and HIV services into SRH and other health services and developing referral mechanisms can increase access to services, including STI and HIV screening. Addressing domestic and sexual violence is also an important component of the HIV response, particularly for MSM, SWs, and TG, who are often at high risk for such violence.

Policy in Togo ensures equal access to SRH, STI, and HIV health services for all citizens and for women and men equally but provides no specific provisions for SWs, TG, or MSM (GOT, 2009; GOT, 2010a). Current policy does not include any protocols to evaluate the risk of alcohol abuse, substance abuse, or mental health. SRH policy includes protocols for GBV risk assessment, including domestic violence, but STI and HIV policies do not. While they are not required conditions for accessing services, SRH, HIV, and STI policy does not specifically prohibit mandatory contraceptive use, mandatory sterilization, or eligibility criteria requiring sex workers to leave sex work, leaving a gap in the protection of SWs. Access to services for pregnant women and availability of services at times convenient to clients are also not addressed in current policy. Togo's health system generally follows regular business hours that may not meet the needs of key populations.

There are currently no clear mechanisms in place to include MSM, SWs, TG, or detainees in the conception, design, and evaluation of programs, which is crucial to ensuring that services are accessible and appropriate. Key informants reported that plans are underway to include MSM and SWs in the PNLS-STI Targeted Interventions Technical Working Group, which has a focus on key populations; this would be a major step forward, particularly if policies are developed to guarantee their continued and consistent participation.

HIV and STI services in Togo tend to be clustered in urban centers, with the majority of services for MSM and SWs being provided by CSOs based in Lomé, thus hindering access to services outside the capital. According to key informants, service barriers exist because of geographic distance and inconvenient opening hours outside of major urban centers, particularly with respect to ARV services.

With no official prison policy in place and major gaps in SRH, HIV, and STI policy around prison services, CSOs are generally the only means for detainees to receive health services, with major implications for HIV and STI testing, care, and treatment. Key informants highlighted problems with gaining access to inmates in prison settings.

*I was turned away by a prison officer when I went to deliver the ARVs to our HIV-positive MSM patient in prison.*

~ Key informant, CSO representative

A perceived lack of medical confidentiality, coupled with fear of stigma and discrimination, frequently prevents key populations from seeking out needed services. Research in Senegal (Larmarange, 2010) and Botswana (Fay, Baral et al., 2010) indicates that MSM delay or neglect medical treatment, including treatment for STI symptoms, because of a supposed lack of medical confidentiality and a fear of stigma and/or abuse. Key informants reported that healthcare providers refuse to treat MSM and SWs on moral or religious grounds, and cases of breaches in confidentiality exist.

UNAIDS and WHO recommendations call for training prison staff, law enforcement, and healthcare providers in ethics and various aspects of human rights, including informed consent, confidentiality, and avoidance of stigma and discrimination. With proper policies and training, police can be enlisted to protect MSM, SWs, and TG from abuse and violence. Policies and programming to sensitize healthcare workers can be a first step in reducing stigma and discrimination while supporting integrated services in reaching more MSM, SWs, and TG. Given the level of S&D in Togo and reported treatment of SWs and MSM by health providers and law enforcement, the lack of a policy requiring regular training for law enforcement, criminal justice staff, prison staff, healthcare providers, and others on key issues—including human rights, S&D, GBV, HIV, and protocols for referrals—is of particular concern.

#### *HIV counseling and testing*

Policy in Togo guarantees free HCT services to the general population, with no restrictions on the frequency of HIV testing, and authorizes a model for integrated services (SP/CNLS-IST, 2010). However, policy does not specifically mention MSM, TG, or SWs with regards to free HCT services. HIV law (GOT, 2010a) does make the general statement that HIV prevention and treatment should be “assured for prison populations” without specific reference to HCT or cost. Although policy does not provide for saliva-based rapid testing, it does allow rapid testing algorithms to diagnose HIV infection in community settings with no clear policy for prison settings (SP/CNLS-IST, 2012a). Policy guarantees that HCT services, including receipt of test results, are available on a confidential and anonymous basis (GOT, 2010a).

With regard to key populations, policy does not identify mechanisms that involve MSM, SWs, or TG in the development of HIV testing and counseling protocols—although it identifies MSM and SW as vulnerable groups to which providers should offer HCT. The PSN 2012–2015 identifies indicators for monitoring HCT outcomes for MSM and SWs but does not identify mechanisms for monitoring or for involving MSM, SWs, or TG in monitoring and evaluating HIV testing and counseling programs. Among the most significant barriers to HCT are stigma and discrimination. Key populations may fear increased stigma and discrimination if they are found to be HIV positive. For example, key informants stated that only a small part of the MSM and SW communities participate in HCT due to fear of discrimination and fear of involuntary disclosure of HIV status, sexual identity, or occupation. Loss to follow-up following HCT is also a major concern in Togo, as well as reaching MSM and SW outside of Lomé. Involvement of MSM, SWs, and TG in the development of HIV testing and counseling protocols can ensure that HCT meets the needs of key populations, encourages HCT uptake, and ensures PLHIV access to care and treatment services.

#### *Antiretroviral treatment (ART)*

Policy in Togo has pledged free access to ART for all PLHIV since November 17, 2008, but does not specifically mention MSM, TG, or SWs. Article 48 of the HIV law (GOT, 2010a) states that PLHIV in prison and detention settings should “benefit from psychosocial and medical treatment required for their physical state” but does not mention ART or cost. Following best practices, policy does not restrict eligibility for ART due to alcohol or other illegal substance addictions or based on mental health. However, policy does not provide for free ART-related services, such as CD4 count testing, provider fees, and medications for opportunistic infections. The financial cost of these related services poses a major

barrier for key populations, and policy implementation has faced serious challenges. In fact, there were only 25 CD4 count devices in the entire country as of 2011 (PNLS, 2011c). For many MSM and SWs, particularly those living outside major urban centers, free ART services may be financially out of reach due to travel and other related expenses.

As stated by key informants, major stockouts of ARVs and other materials in 2012 and 2013 due to an interruption in funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) led to a break in ART services, with potentially serious consequences for PLHIV on or needing to begin ART. According to one key informant, the impact was worse for sex workers due to S&D.

*During the stockouts, the general population was put first. In many cases, SWs were made to wait longer.*

~ Key informant, CSO representative

Finally, policy gaps exist for related services that are crucial to the health of key populations and PLHIV, such as protocols for HIV/hepatitis A, HIV/hepatitis B, and HIV/hepatitis C co-infections.

#### *Sexually transmitted infections*

Like many countries in Africa, STI diagnosis and treatment in Togo is based on the syndromic approach. Policy authorizes presumptive periodic treatment (PPT) and syndromic treatment of STIs (MOT, 2009) by health providers, with facilities offering STI services authorized to conduct HCT. While policy does not specifically authorize PPT or syndromic STI treatment by pharmacists, a previous SIDA 3 project trained pharmacists to this end. Although policy does not guarantee public financing of STI services or free STI treatment for SWs, MSM, or TG, financing from the United Nations Population Fund has enabled free STI treatment for sex workers when STI kits are available. Key informants report stockouts of STI kits as a major barrier to accessing STI treatment, and attributed the stockouts to a combination of limited funding and difficulties in forecasting, particularly forecasting of medications for specific STIs, due to insufficient data of STI prevalence and service uptake.

*STI kits are only available in health centers with specialized SW services, and even then, it is rare to have them in stock.*

~ Key informant, civil servant

Other barriers to STI service uptake and treatment for sex workers include cost of treatment or having to return to the health facility due to STI kit stockouts, lack of transportation to facility, lack of equipment for mobile unit assessment of STIs, and fear of S&D. Barriers to STI service uptake and treatment for MSM reported during key informant interviews include cost of treatment, lack of equipment and provider training for anal exams, fear of S&D, and involuntary disclosure of sexual behavior in the community. Almost all services specifically for MSM and SWs are located in Lomé, posing a serious barrier to those populations living in other parts of the country.

Overall, RH policy guarantees the reproductive health of all citizens without discrimination (GOT, 2007a), and the PSN 2012–2015 identifies STI treatment among sex workers as a priority. However, STI policy fails to identify free services for MSM or SWs or provide for specialized clinics to serve these populations. In practice, adapted services for sex workers that engage “friendly” health mediators and specialized services in CSOs for MSM and SWs exist. While policy fails to guarantee free access for Hepatitis A and B vaccinations for key populations, reproductive health protocol (TOME II, 2009) identifies and recommends a protocol for oral and anal STI screening in men but does not identify training or the provision of medical equipment for this purpose.

### *Condoms and lubrication*

HIV prevention must be informed by evidence and based on proven methods (UNAIDS, 2009a). Consistent use of condoms and water-based lubricants has a direct impact on reducing HIV risk and transmission (UNAIDS, 2011a; UNAIDS/UNFPA/WHO, 2009). Prevention efforts cannot succeed without guaranteed, uninterrupted access to reliable and affordable high-quality condoms and water-based lubricants. Sex workers sometimes cite lack of availability of free condoms as a reason for unprotected sex (WHO, 2011a), and research studies in Togo identified lack of access to condoms and lubrication (C/L) as barriers to HIV prevention among MSM (FHI 360/ACI, 2013; Me-Tahi and Anato, 2010).

The HIV policy in Togo (SP/CNLS, 2012a) includes indicators around distribution of C/L to SWs and MSM but fails to guarantee free C/L services for MSM, SWs, or TG and fails to direct distribution of water- and/or silicone-based lubricants in condom programs. Moreover, there are currently no policies regarding commodity procurement or distribution of lubricants. Current policy does not provide mechanisms for SW, TG, or MSM involvement in the selection of condoms and lubricants for HIV prevention programs. Policy is silent regarding the impact of alcohol, narcotics, mental health, and depression on the use of condoms. HIV policy (SP/CNLS, 2012) addresses access to condoms in prison settings. However, there is no prison policy in Togo, and prison authorities do not allow C/L services for inmates.

Key informants cited frequent stockouts of C/L, including cases of C/L shipments being held at port of entry until they expired. Extensive C/L stockouts in 2011 and 2012 were also impacted by a GFATM funding interruption during negotiations. Key informant interviews corroborated previous findings regarding the inaccessibility of water- or silicone-based lubricants due to stockouts and high prices in pharmacies.

Programs that focus on empowering sex workers to negotiate condom use and on increasing client acceptance of condoms have succeeded in increasing condom use in many communities (UNAIDS Advisory Group, 2011). These programs are particularly important in Togo, given research in which only 8.8 percent of sex workers interviewed in Togo stated they had used a condom during their last sexual intercourse (Pitché et al., 2013). Following international best practices, condom programs for sex workers in Togo provide support and guidance but allow SWs to retain control over their decision regarding condom use. In keeping with international best practices, public health authorities rather than law enforcement monitor the uptake and effectiveness of condom programs.

### *Information, education, and communication (IEC)*

Basic IEC activities for MSM, SWs, and clients of SWs must include focused communication and education efforts adapted to the needs of these populations (UNAIDS, 2011a; WHO, 2011a; WHO, 2011b), which can be extremely heterogeneous. Studies in West Africa indicate that some MSM work in the sex industry (Mah and Dibba, 2008; World Bank/NACA, 2008) while others have sex with women, are married, and/or have children (Larmarange, 2010; Larmarange et al., 2010). Studies in the region also point to heterogeneity among sex workers and their clients with respect to country of origin, location of sex work, frequency of sex work, and client types (Lowndes et al., 2008; WHO 2011a). Anecdotal evidence from Togo mirrors these findings (FHI 360/ACI, 2013; PNLS, 2012a; PNLS, 2012b). Access to IEC must be specific to a given population and stipulate protocols for the delivery of IEC services (WHO, 2011b), including relevant information on HIV transmission.

In Togo, policy does not guarantee public funding of IEC programs or access to IEC information specific to MSM, SWs, or TG (SP/CNLS, 2012a; SP/CNLS, 2012b). Togo has a National Communication Strategy for Behavior Change (2011) as well as a National Policy for Community-Based Interventions (2009). However, these documents do not identify IEC strategies or HIV prevention information specific

to MSM, TG, or SWs. On the positive side, policy does not specifically place any restrictions on IEC content with regards to sexual orientation, gender identity, or criminalized behavior. The new policy framework for key populations (Guiard-Schmid, forthcoming) identifies IEC strategies for MSM and SWs. MSM-specific IEC is only available through NGOs in Togo. Findings of previous studies and key informant interviews revealed that many MSM do not know that HIV transmission can occur during same-sex sexual relations (Capo-Chichil and Kassegné, 2007; PSI, 2006).

### *Outreach*

Outreach activities increase the impact of basic programs (UNAIDS, 2011a), and outreach through networks, communities, and peer educators is often the best or even the only way to reach populations that may be forced to hide their behavior or are afraid to access services. Policies that guarantee access to tailored protocols for outreach services (CHALN, 2007) and that ensure the safety and engagement of key populations are needed.

Although policy in Togo does not guarantee public funding for outreach, the PSN 2012–2015 (SP/CNLS, 2012a), its operational plan (SP/CNLS, 2012b), and the Policy Norms and Procedures for HCT document (2010) identify outreach activities for MSM and SWs and in prison settings. Once it is officially validated, the new policy framework for the key populations (validation underway) includes recommendations and implementation mechanisms for outreach activities with each key population. Screening protocols in prison settings have also been developed. According to the National Policy for Community-Based Interventions (MOH, 2009b), peer educators and other community-based outreach workers must be provided with education materials, training accessories, and identification and must be compensated for their work. Community-based organizations (CBOs) are the main means for reaching key populations in Togo, and although policy supports this work, key informant interviews revealed that the combination of insufficient policy dissemination, high levels of S&D, and inadequate coordination with law enforcement poses a potential barrier to outreach with key populations.

*During a campaign to raise HIV awareness among MSM and SWs last year, police stopped outreach workers under the false pretext of trafficking blood. Another outreach team working with MSM in [town outside of Lomé] had stones thrown at them.*

~ Key informant, NGO representative

Among key populations in Togo, the greatest barriers to outreach are stigma and discrimination. However, criminalization of same-sex sexual relations and solicitation; stockouts of lubricants; lack of MSM-specific IEC materials; and barriers to HIV and STI care and treatment also impact outreach. Among minors, including street youth, MSM, and SWs, age of consent laws that require parental or guardian consent for HCT represent a potential barrier for members of key populations who are minors.

### *Alcohol and substance-abuse harm reduction*

Alcohol use among sex workers and their clients is common. Among all populations, alcohol and drug use hamper condom negotiation skills and adversely affect sexual decision making and judgment (WHO, 2011a). Policies addressing alcohol and substance abuse have an impact on HIV services for MSM, TG, and SWs. Reported substance use from one study in Togo was 18 percent among MSM interviewed (Me-Tahi and Anato, 2010) and drug and alcohol use has also been reported among SWs (FHI 360/ACI, 2013). National Health Policy (2009) includes a call to reduce risk factors, including alcohol and drugs, and the PSN (SP/CNLS 2012a) identifies HIV prevention activities for PWID but does not identify alcohol or substance-abuse harm reduction approaches or programs. The assessment team was unable to find evidence of any such programs. The new policy framework for key populations (Guiard-Schmid, forthcoming) identifies free syringe distribution in the minimum packet of services and recommends

alcohol reduction IEC, outreach, and programs but does not include specific alcohol or substance abuse harm reduction approaches, programs, or implementation mechanisms.

*There aren't any substance-abuse programs in Togo, only S&D, arrest and a couple of organizations offering prayer as the solution.*

~ Key informant, CSO representative

Regarding the regulation of alcohol, policy exists under the Public Health Law, but it is not implemented. Key informants report an inexistence of regulations and lack of control, with contraband common-place.

#### *Sexual and reproductive health*

Access to SRH services structured around approaches specific to SWs, MSM, and TG is not only essential to human rights and health but can also be a point of entry for HIV prevention, care, and treatment. Integrating HIV and STI services into reproductive health programs can help expand SRH service delivery to key populations who may avoid HIV and STI clinics due to stigma and discrimination. Moreover, service integration has been shown to reduce HIV infection significantly (IPPF/UNFPA/Young Positives and the Global Coalition on Women and AIDS, 2007). In Togo, public financing of reproductive health is not guaranteed, and SRH is financed under the global health budget. Policy authorizes STI and HCT services in SRH health centers as part of service integration in health centers (MOH, 2009c; MOH, 2008). Although RH Law guarantees the reproductive rights of all citizens under all conditions (GOT, 2007a), specific approaches for SWs, MSM, and TG are not identified, and detainees are denied access to services. Policy allows use of emergency contraception but does not permit abortion except in cases of rape or incest, when continued pregnancy puts a pregnant woman's life or health in danger, or when diagnostic testing reveals a strong probability that the child will be born with a specific, serious condition (GOT, 2007a).

#### *Transgender people*

Policy documents in Togo make no mention of TG; no data on TG have been collected. Key informant interviews revealed that, despite rare cases of males (who may or may not self-identify as women) publicly dressing as women, Togo has no recognized cases of TG. Denial of TG in Togo and severe S&D exist.

*I had to sit and watch while they severely beat a man for wearing a woman's wig and having an effeminate walk. I was not allowed to intervene.*

~ Key informant, NGO representative

*They are just copying white people and can change if we force them to change.*

~ Key informant, technical and financial partner

## Challenges and Limitations

The main challenges the assessment team faced were the inaccessibility of certain key policies—primarily due to the lack of a national repository of all HIV-related policies—as well as the absence of policies (e.g., the only existing prison policy document is an administrative decree from 1933, when Togo was under French rule).

While interviews with clients of programs would have shed further light on gaps in policy implementation and barriers to HIV service access, such interviews were not feasible because of the assessment's limited timeframe and the time involved in securing approvals for the participation of human subjects.

Nonetheless, the team compensated by undertaking key informant interviews with CSO representatives working with the populations of interest and by reviewing studies featuring data from interviews with MSM, SWs, and detainees.<sup>7</sup>

Finally, not all policies and laws are appropriate to and applicable in all countries. International standards must reflect the country context. The standards identified in the inventory are based on the language and context of international documents and best practices and are not intended to be either restrictive or comprehensive (Beardsley et al., 2013). The inventory and analysis of country policy documents helps to identify policies that require additional attention; subsequently, a broad range of local stakeholders must identify country-specific policies that best meet the needs of local key populations. The assessment team plans to conduct an in-country validation of the findings in this report with key stakeholders, including representatives from key populations, to identify priority recommendations specific to the needs of key populations in Togo.

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<sup>7</sup> None of the studies reviewed included interviews with transgender people. This is likely due to the fear of stigma and discrimination among this key population.

## CONCLUSION

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This application of the Decision Model marks the first time a comprehensive analysis of the policy environment and practical implementation challenges has been conducted in Togo. With support from USAID and in collaboration with key stakeholders, the team conducted an in-depth policy review and analysis of 116 national source policy documents. While a number of the findings confirm those from past assessments, others are new to this report due to the unique, wide-ranging scope of the Decision Model. Results in this report regarding policy implementation and barriers to accessing services represent the views of policymakers, service providers, donors, and CSOs working with key populations who were interviewed and/or participated in a debriefing workshop in Lomé.

Recent positive policy changes coupled with renewed donor support have set Togo on course for improving access to services for key populations and halting the HIV epidemic there. Togo is the recipient of a Global Fund grant under Round 8, which includes a strong focus on key populations. The USAID-funded PACTE-VIH and R2P concentrate research and intervention efforts on MSM, SWs, and clients of SWs. The president of Togo and Permanent Secretary for CNLS have publicly expressed support for and acknowledged the need to address key populations. Although policy gaps still exist and beneficial policies are not always known or implemented, the country is currently incorporating a number of international best practices into official policy related to HIV and key populations.

Nonetheless, the Government of Togo and key stakeholders will not be able to manage the HIV epidemic among key populations without further pro-active formal measures aimed at protecting and providing prevention, care, and treatment to key populations. Critical gaps in policy remain, particularly related to SWs, TG, MSM, and detainees, and the discrepancy between written policy and policy implementation needs to be addressed. Removing barriers to service access for key populations is essential to ensure that HIV prevalence continues to decrease or remains stable.

To strengthen the response to HIV, reported improvements in coordination and collaboration between SP/CNLS and PNLs should be built on and formalized. For the multisectoral approach initiated in Togo to work, increased harmonization of the PSN 2012–2015 (SP/CNLS, 2012a) and other policy documents across key government sectors will be needed, along with widespread dissemination, availability, and implementation of new policies issued by each ministry. Misaligned policies should be harmonized, particularly SRH, HIV, and STI policy. Prison policy needs to be developed and aligned with SRH, HIV, and STI policy to ensure access to service for detainees. Adequate implementation mechanisms, funding, and human resources will be essential.

Currently, same-sex sexual relations, referred to as “acts against nature,” and solicitation are illegal. Although changes to these laws are needed in the long run, the groundwork must first be laid to ensure that a backlash due to cultural and religious beliefs, as seen in other countries in the region such as Senegal, does not occur. In the meantime, several supporting policies lend themselves to quiet implementation or modification without attracting the attention that changes to major laws could precipitate.

For example, formal mechanisms can be put in place for engaging key populations in government decision making and policy development for HIV and HIV-related services. For instance, key populations’ engagement in monitoring and evaluation and development of HCT and ART guidelines for key populations can contribute to improved service uptake and improved health outcomes. Although policies are developed following international guidelines, members of key populations and/or their representatives should be invited to participate in all stages of policy and program development and monitoring and evaluation to ensure that impediments particular to the local context are addressed.



International guidelines and best practices should inform policies, but they must be adapted to the needs of key populations in Togo by modifying them or including additional directives to ensure open access to services. For example, standard protocols for ART should be followed, but key populations may have barriers to accessing ART unknown to technical teams developing the guidelines and thus additional directives or minor modifications to current protocols are required.

Togo is in the process of validating a policy framework that identifies specific activities for key populations, includes minimum service package guidelines, and loosely recommends implementation mechanisms for relevant policies and services. A policy and program focus on SW clients will balance efforts to manage HIV among sex workers. Adequate funding and human resources must be allocated to ensure policy and program implementation. Moreover, policy dissemination and training for health providers, peer educators, and other community-based outreach workers will be essential. Scale-up will require increased government activities for key populations or the creation and implementation of policies that assist CBOs with scale-up, including access to C/L and medications. Policies around data collection to inform programming for key populations have been developed, but data use must be formalized and data collection methods must be standardized for accurate forecasting and appropriate planning.

Crucial to key populations, Togo should address challenges to improved coordination, forecasting, and distribution of medication and medical supplies, including condoms and lubricant (C/L), STI kits, and ARVs. Policies should be updated to address and safeguard commodity procurement and distribution of water- and/or silicone-based lubricants. Reallocation of funds and policy to support horizontal checks and cross-stocking for redistribution of medicines and medical commodities are instrumental in preventing stockouts, overstock, and expiration. HIV prevention can be supported by policy to ensure free C/L services for MSM, SWs, and TG and to engage these populations in C/L product selection and by avoiding stockouts of C/L. These policy recommendations align with and bolster the PSN 2012–2015 and its operational plan (SP/CNLS, 2012). To meet policy objectives for free ARVs and free STI treatment for sex workers, order quantities must be based on reliable estimates of need, with budgets set accordingly; and healthcare facility and district health workers responsible for recording STI kit use and ordering kits should be trained and held accountable for circumventing stockouts. Ideally, policy should include free treatment of STIs for SWs, MSM, and TG and offer free testing and vaccinations for hepatitis A and B.

To protect the rights of citizens and increase voluntary HCT uptake and informed consent, Togo must guarantee confidentiality for all clients, particularly key populations facing increased S&D. All healthcare providers and peer educators authorized to conduct HCT should undergo training in HIV counseling and confidentiality. Parental consent laws should be revised to ensure that they do not pose a serious barrier to HCT and HIV care and treatment, particularly among street youth and adolescent SWs, TG, and MSM.

Barriers to ART, such as cost of HIV-related testing and distance to services, can be addressed by increasing the number of locations offering free or subsidized services. Access to services for key populations can also be addressed by increasing the engagement of sympathetic health mediators to accompany key populations to healthcare facilities that offer services unavailable in CBO clinics.

Finding ways to address stigma and discrimination of key populations is crucial in countries like Togo. Developing national S&D policies that include actively measuring and addressing stigma and discrimination are a critical step in ensuring access to HIV and other services for key populations. Offering comprehensive training and sensitizing healthcare providers, members of law enforcement, judges, and educators can increase access to services that meet the needs of key populations, improve service coordination, and decrease stigma and discrimination. Formal coordination among healthcare authorities, healthcare providers, and law enforcement, accompanied by police support to protect key populations from abuse and violence, can reduce stigma. For example, the use of performance indicators

can provide incentives for responding to reports of violence against MSM, SWs, and TG. Changing norms can be addressed through the media and, where possible, by working with willing religious and traditional leaders to recast perceptions. Changing policies or finding other ways to include representatives of key populations in decision-making bodies and working groups is an important first step toward mitigating stigma and discrimination.

The involvement of key populations in the development of population-specific IEC that takes the heterogeneity of populations into account can help ensure the availability of appropriate prevention outreach materials. Even a country such as Togo that severely stigmatizes MSM and SWs can and should develop IEC materials relevant to these populations. For example, prevention information should point out that transmission can occur during same-sex sexual relations and anal sex and that condoms with lubricants can minimize transmission. MSM and SWs can be invited to help develop materials that meet their needs and respond to the local culture, ensuring that materials are socially acceptable but also accurate and useful. Such an approach should be possible in Togo, as policy places no formal restrictions on IEC content related to sexual orientation or gender identity.

Although prison staff prohibit sexual relations among detainees, evidence indicates that consensual and non-consensual sexual relations occurs in Togo's prisons and that detainees must have the right to protect themselves from HIV and STIs. Moreover, given that many detainees leave prison and re-integrate into the community, HIV prevention efforts must include detainees to curb the spread of HIV in the general population. For detainees, the key issues are access to condoms and lubricants as well as access to general healthcare, HCT, and in-prison care and treatment. Prison policy that ensures access to services is urgently needed.

Other than recognizing the negative health impact of alcohol and drugs and inclusion of free syringe distribution in the minimum packet of services outlined in the new policy framework for key populations, Togo has no policies or programs in place to reduce alcohol consumption or address alcoholism or substance abuse. Given the reported prevalence of alcohol and drug use among key populations and the negative impact of alcohol on sexual decision making and condom negotiation skills (WHO, 2011a), the addition of alcohol and substance abuse harm reduction outreach/programs would benefit key populations.

Togo has incorporated several policies based on international best practices that facilitate access to services for key populations. Addressing the remaining gaps and challenges outlined in this report could have a significant impact on Togo's HIV policy environment for key populations and potentially remove barriers to service access. Key stakeholders in Togo must decide which issues are the most critical to them; the findings of this application of the Decision Model can help facilitate dialogue and identify priority issues.

## ANNEX 1. DECISION MODEL POLICY FRAMEWORK<sup>8</sup>

Policy Components	Policy Themes	Issues to Consider
Framework	i. Coordination and integration	<ul style="list-style-type: none"> <li>i. The levels of integration of responsibilities for HIV services across various levels of government</li> <li>ii. Integration of HIV services into national development documents such as the National Development Plan</li> <li>iii. The level of coordination among related health programs (e.g., HIV prevention, care, and treatment services and STIs diagnosis and treatment services)</li> </ul>
	ii. Data-informed planning and budgeting	<ul style="list-style-type: none"> <li>i. Is programming for key populations informed by scientific evidence (e.g., epidemiologic profile, disaggregated data reporting, accurate size estimation, UNGASS indicator reporting, and community services assessment)?</li> <li>ii. Is there a clearly defined budget for programming for key populations and is this allocation informed by data?</li> </ul>
Community Partnerships	i. Community engagement and participation	<ul style="list-style-type: none"> <li>i. Membership of key populations and key populations organizations of CCMs and multisectoral HIV coordination bodies</li> <li>ii. Role of CSOs and NGOs in service delivery</li> <li>iii. State support of the establishment and funding of CSOs and NGOs</li> </ul>
Legal Environment	i. Authorization	<ul style="list-style-type: none"> <li>i. What agencies are authorized to provide HIV services?</li> <li>ii. What services require specific authorization and from who?</li> <li>iii. What are the roles and responsibilities of public health and law enforcement?</li> </ul>
	ii. Consent for treatment and testing	<ul style="list-style-type: none"> <li>i. What are the policy provisions on consent for medical testing and treatment?</li> <li>ii. Are there provisions requiring spousal consent? Age restrictions? Who grants consent for minors and for what services?</li> <li>iii. Do policies spell out the requirement for informed consent on the nature of testing and treatment, risk and benefits, and the right to refuse intervention at any stage without punishment?</li> <li>iv. Are there provisions requiring mandatory testing and treatment?</li> </ul>

<sup>8</sup> Adapted from the policy framework developed by HPP and AMSHeR for the multi-country UTETEZI Project training on policy and advocacy, held in 2013. The framework is used to assist organizations of key populations and national stakeholders with identifying policies that hinder or facilitate access to HIV services for key populations and using the findings for advocacy and policy change.

iii. Privacy and confidentiality	<ul style="list-style-type: none"> <li>i. Who has access to clients' medical records?</li> <li>ii. Are there policies protecting disclosure of medical records and data?</li> <li>iii. Are there provisions requiring parental/guardian/spousal notification?</li> <li>iv. What is the procedure for granting access to an individual medical record to employers, court proceedings?</li> </ul>
iv. Registries	<ul style="list-style-type: none"> <li>i. Are there policies that regulate data collection by medical and non-medical registries, (e.g., for research or law enforcement databases)?</li> </ul>
v. Stigma and discrimination	<ul style="list-style-type: none"> <li>i. Are there explicit anti-discrimination policies, and what are the protected categories?</li> <li>ii. Are there clear channels for challenging discrimination in accessing services—medical and legal?</li> </ul>
vi. Criminalization	<ul style="list-style-type: none"> <li>i. Is consensual same-sex sexual activity and behavior criminalized?</li> <li>ii. Is sex work criminalized? MSM sex work? TG sex work?</li> <li>iii. Is HIV transmission criminalized?</li> <li>iv. Are there aiding and abetting laws that target those who provide services to criminalized groups?</li> </ul>
vii. Domestic, sexual and gender-based violence	<ul style="list-style-type: none"> <li>i. Are there policies dealing with domestic, sexual, and gender-based violence?</li> <li>ii. Do policies protect male victims/survivors of domestic, sexual, and gender-based violence?</li> <li>iii. Can key populations access post-violence medical services, including PEP?</li> </ul>
viii. Torture, cruel and inhuman treatment and punishment	<ul style="list-style-type: none"> <li>i. Are there policies prohibiting torture, etc., and punishing perpetrators?</li> <li>ii. Is there recognition of torture in healthcare settings, and are there clear legal processes for redressing this?</li> <li>iii. Is reparative and correction therapy for homosexuality legally prohibited and punished?</li> <li>iv. Are there rehabilitation services for torture survivors?</li> </ul>
ix. Monitoring and enforcement of human rights	<ul style="list-style-type: none"> <li>i. What rights are protected in the constitution, including health, work, privacy, and nondiscrimination?</li> <li>ii. Are there national and provincial bodies with a human rights protection mandate, and what is the attitude of these bodies to key populations?</li> <li>iii. Are human rights enforcement mechanisms available to key populations?</li> <li>iv. Access to legal aid?</li> </ul>

Intervention Design, Access, and Implementation	i. Procurement and supply management (PSM) of medicine and commodities	<ul style="list-style-type: none"> <li>i. What agency has oversight of PSM, and are key populations involved?</li> <li>ii. Does the essential drug list include commodities such as condoms (male and female) and lubricants?</li> <li>iii. Are key populations involved in the selection of commodities?</li> <li>iv. Are there efficient processes for quantification of supplies and dealing with stockouts?</li> </ul>
	ii. Overall SRHR, STI, and HIV services design	<ul style="list-style-type: none"> <li>i. How integrated are SRHR, STI, and HIV services?</li> <li>ii. How efficient are inter-service referral systems? Continuity of care?</li> <li>iii. Does training content for relevant officers and service providers (law enforcement, healthcare workers, social workers, etc.) include HIV, human rights, inter-services referral?</li> </ul>
	iii. HIV counselling and Testing	<ul style="list-style-type: none"> <li>i. Voluntary testing</li> <li>ii. Confidentiality and anonymity of services</li> </ul>
	iv. Antiretroviral therapy	<ul style="list-style-type: none"> <li>i. Do ART protocols provide access to key populations?</li> <li>ii. Do the eligibility criteria for ART services inadvertently exclude key populations?</li> </ul>
	v. Condoms and lubrication	<ul style="list-style-type: none"> <li>i. How accessible are condoms and lubricants?</li> <li>ii. Are these commodities planned for, budgeted, and funded by the state?</li> <li>iii. Is access to these commodities designed to be non-stigmatising?</li> </ul>
	vi. Sexually transmitted infections	<ul style="list-style-type: none"> <li>i. Do the eligibility criteria for STI services inadvertently exclude key populations?</li> <li>ii. Are there free STI services?</li> <li>iii. Availability of, and access to, hepatitis A, B, and C vaccination</li> </ul>
	vii. Information, education, and communication	<ul style="list-style-type: none"> <li>i. Do HIV IEC materials contain appropriate messaging for key populations?</li> <li>ii. Does policy place restrictions on content of IEC materials?</li> <li>iii. Key population involvement in developing national and provincial IEC content</li> </ul>
	viii. Outreach programs	<ul style="list-style-type: none"> <li>i. Do policies provide for outreach programs to key populations? state funding of key population outreach programs?</li> <li>ii. How does the legal environment (especially criminalization) impact outreach programs?</li> </ul>

## ANNEX 2. LIST OF DOCUMENTS REVIEWED

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1. Politique Nationale de la santé du Togo (2012)
2. Politique Nationale des interventions à base communautaire (2009)
3. Loi d'orientation décennale portant Politique Nationale de Santé (2012)
4. Plan National de Développement Sanitaire [PNDS] 2012-2015 (2012)
5. Politique Nationale de lutte contre le sida au Togo : Vision 2020 (2012)
6. Normes Sanitaires du Togo (2013)
7. Plan stratégique national de lutte contre le SIDA et les IST 2012-2015 (2012)
8. Plan opérationnel de lutte contre le Sida et les IST 2012-2013 (2012)
9. Document stratégique du pays 2011-2015 (2011)
10. Loi n°2009-007 portant code de la santé publique en république Togolaise (2009)
11. Loi n°2007-005 du 10 janvier 2007 sur la santé de la reproduction (2007)
12. Stratégie national de communication pour le changement de comportement an matière des IST, VIH-sida au Togo 2011-2015 (2011)
13. Plan National de Développement sanitaire 2009-2013 (2009)
14. Loi n° 2010 – 17 du 31 déc. 2010 portant protections des personnes en matière de VIH/SIDA (2010)
15. Politique national de lutte contre le VIH et sida sur le lieu de travail (2010)
16. Loi n°2006-010 du 13 décembre 2006, portant Code du Travail (2006)
17. Examen des politiques commerciales au Togo (2006)
18. Les principes et règles équitables pour le contrôle des pratiques commerciales restrictives, Togo (2010)
19. Politique migratoire et intégration régionale de l'Afrique de l'ouest (2005)
20. ARRETE N° 11 / 91 / MSP Portant Organisation des Services des Directions Centrales, Régionales et Préfectorales de la Santé (1991)
21. Cartographie du SR au Togo (2009)
22. Organigramme Ministère de la santé (2012)
23. Manuel de suivi et évaluation du SP/CNLS (2012)
24. Decret N° 2001-173 /PR portant création du conseil national de lutte contre le sida et les IST (2001)
25. Decret N°2004-054/PR du 28 janvier 2004 modifiant le Decret N° 2001-173 /PR portant création du conseil national de lutte contre le sida et les IST (2004)
26. Prise en charge du VIH, de la tuberculose et de la co-infection TB/VIH en milieu carcéral au Togo : Manuel de l'infirmier en prison (forthcoming)
27. Proposition du Togo au fond mondial, serie 8 (2008)
28. Stratégie nationale d'intégration du genre dans les politiques et programmes au Togo (2006)
29. Stratégie d'interventions des cellules sectorielles genre (2006)
30. Plan cadre d'assistance des nations-unies au Togo (2002-2006)
31. Document complet de stratégie de réduction de la pauvreté 2009-2011 (2010)
32. Annexe DSRP-C : Matrice des mesures (2010)
33. Réforme de l'Enseignement au Togo (1975)
34. Plan sectoriel éducation Togo (2010)
35. Protocole à la Charte Africaine des Droits de l'Homme et des Peuples Relatif aux Drotis des Femmes
36. Code de sécurité sociale (2011)
37. Note de politique agricole, Ministère de l'agriculture de l'élevage et de la pêche (2006)
38. Constitution de la IV République, révisée par la loi n°2002-029 du 31 Décembre 2002 et modifiée en son alinéa 1er par la loi n°2007-008 du 07 Février 2007 (2007)
39. Loi n°2011-014 portant organisation de l'activité statistique au Togo (2011)
40. Loi n°2007-012 du 14 Juin 2007 portant modification de la loi n°2000 (2007)
41. Loi n°2000-007 du 05 Avril 2000 modifiée par la loi n°2002-001 du 12 Mars 2002 (2002)

42. Loi n°2003-01 du 07 Février 2003 (2003)
43. Loi n°2005-001 du 21 Janvier 2005 et la loi n°2007-009 du 07 Février 2007 du code électoral (2005)
44. Loi n°80-1 instituant Code Pénal (1980)
45. Loi n°83-1 Instituant Code de Procédure Pénal (1983)
46. Loi n°2010-018 modifiant la loi n°005-12 du 14 Décembre 2005 portant protection des personnes en matière du VIH/SIDA (2010)
47. Loi instituant un régime obligatoire d'Assurance des Agents Publics et assimilés (2011)
48. Loi n°2007-017 portant Code de l'Enfant (2007)
49. Convention Collective Interprofessionnelle du Togo n°64/TT/L Ministère du Travail et de la Fonction Publique (1978)
50. Loi n°2012-014 Portant Code des Personnes et la Famille (2012)
51. Loi n°96-11 Fixant Statut des Magistrats (1996)
52. Loi n°2000-019 Portant Statut de Réfugiés au Togo (2000)
53. Arrêté n°0021/2013/MS/CAB/SG Portant Organisation des Service du Ministère de la Santé (2013)
54. Décret n°82-50 Portant Code de procédure Civile sur rapport du Garde des Sceaux, Ministre de la Justice (1982)
55. Ordonnance n°78-35 Portant Organisation Judiciaire (1978)
56. LOI N°488 -du 1ER Septembre 1933 instituant organisation de Régime Pénitentiaire Indigent au Togo (1933)
57. Suivi de la déclaration d'engagement sur le VIH Bilan et Défis (2008)
58. Lutte contre le SIDA Cadre Stratégique National (2012)
59. Lutte contre le Sida : un cadre de concertation des SP/SE de la Zone UEMOA (N/D)
60. Cartographie de l'offre de surveillances de Santé- Rapport d'études (2011)
61. Cadre des Dépenses à Moyen terme- Secteur Santé 2012-2014 (2012)
62. Enquête auprès des apprenants des personnels administratifs et Enseignant. Rapport Général 2009)
63. Politique et normes en sante de la reproduction, planification familiale et infections sexuellement transmissibles du Togo (2009)
64. Protocoles de Santé de la Reproduction, Santé de la Mère, Santé de l'Enfant, Santé des Jeunes et Adolescents (es), Santé des Hommes 2ème édition T I décembre 2009 (2009)
65. Protocoles de Santé de la Reproduction Composantes Communes, Composantes d'Appui, 2ème édition T II décembre 2009 (2009)
66. Programme National de Promotion et de Protection des Droits de l'Homme 2007-2010 (2007)
67. Note des Elements Strategiques Prioritaires pour la Mise en Œuvre de la SCAPE de 2013-107 (2013)
68. Plan d'Action Annuel VIH/SIDA du MDHCDFC (2013)
69. Strategie de Croissance Acceleree et de Promotion de l'Emploi (SCAPE) 2013-2017 (2013)
70. Poltique, Normes et Procedures du Conseil et Depistage du VIH au Togo, deuxième édition, Juin 2010 (2010)
71. Rapport Annuel PNLIS Togo (2011)
72. Les comptes nationaux de sante – période 2002, rapport final de synthèse (2002)
73. Etude sur la gestion des préservatifs (Rapport final) (2009)
74. Système d'information sanitaire du Togo, plan directeur (2001)
75. Protocole de la santé de reproduction (SR) du Togo, TOME2 (2009)
76. Analyse de la situation du secteur de la santé au Togo (2011)
77. Document cadre de politique des pharmacies (2)013
78. Draft 1 National Pharmaceutical Policy—Togo version 22 05 2012 (2012)
79. Evaluation du Droit à la santé (2008)
80. Family Health international. Analyse Situationnelle des Soins et Prise en Charge du VIH/SIDA et des Infections Sexuellement Transmissible : Burkina Faso, Cameroun, Cote d'Ivoire, Togo (2001)
81. Guide de prise en charge des IST (2010)
82. Historique CAMEG (2011)

83. LINME VF 01 22 05 13 (2013)
84. Organisation et gestion des produits pharmaceutiques (2011)
85. Plan National de communication final (2013)
86. PNLS INFO (2009)
87. Prise en charge syndromique (N/D)
88. Protocole dépistage Togo (2010)
89. Togo Fonds Mondiale R8 (2012)
90. Politique et Norme validées 20 01 2010 (2010)
91. SPSR TOGO 2008\_2013 validé (2008)
92. Protocole de la santé de reproduction (SR) du Togo. TOME 1 (2009)
93. Cartographie nationale Santé (2007)
94. Principaux indicateurs (2006)
95. Principaux indicateurs (2007)
96. Principaux indicateurs (2008)
97. Principaux indicateurs (2009)
98. Principaux indicateurs (2010)
99. Principaux indicateurs (2011)
100. LN MEG (2012)
101. Normes, Standards : Axes stratégiques du SIS (N/D)
102. Normes Sanitaires (2013)
103. Arrêté n°11/91/MSP portant Organisation des Services de Directions Centrales, Régionales et Préfectorales de la Santé (1991)
104. Manuel de référence formation en CDV (2010)
105. MICS4\_final\_Togo (2010)
106. Rapport de l'étude de la gestion des préservatifs (2009)
107. Rapports UNGASS (2010)
108. REDES 2006-2007 (2009)
109. Fiche d'information sur les médicaments au Togo (2011)
110. ECHO DE L'OMS Togo N° 110 (2012)
111. Evaluation des systèmes de gestion des achats et des stocks de médicaments antirétroviraux en Afrique de l'Ouest et du Centre (2011)
112. Liste révisée des médicaments (2013)
113. La CAMEG-TOGO (Centrale d'Achat des Médicaments Essentiels & Génériques du Togo) (2002)
114. Organisation et gestion des produits pharmaceutiques CAMEG (2011)
115. Extrait du Journal Officiel de la République Togolaise, 52e Année, N° 2 (2007)
116. Politique Nationale de Prévention Combinée et de Prise en Charge Globale des IST et du VIH dans les Populations Clés au Togo (en validation)



## ANNEX 3. POLICY ASSESSMENT INTERVIEW GUIDE

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### Key Informant Interview

#### Informed consent instructions

Good morning/afternoon/evening. My name is \_\_\_\_\_ and I work with \_\_\_\_\_. We are interviewing knowledgeable people such as you to learn about the availability of services for males who have sex with males/transgender people/sex workers in [country], the policies around services for these populations and the groups that participated in developing the policies, and attitudes toward MSM/TG/SWs. The purpose of our work is to make recommendations to expand access to HIV prevention and treatment services and improve the quality of services provided in [country]. This work is funded by the U.S. Agency for International Development (USAID) [or other donor]. We invite you to take part in a survey about these topics.

- **All information will be kept confidential.** We will not ask for your name or for any other information that could identify you. We will not share your answers with anyone outside of the project. Our report will combine all of the interviews we collect and not single out any individual.
- **Taking part in this activity is entirely voluntary.** The interview should take no more than 30 minutes of your time. You are free to decline to answer any question or terminate the interview at any time.
- **We anticipate no risk to you as a result of your participation in this survey,** other than the inconvenience of taking the time to complete the questionnaire.
- Do you consent to participate in the survey?
  - Consent to participate
  - Decline to participate (Thank client and terminate interview.)

Identification number: \_\_\_\_\_

City/Country: \_\_\_\_\_

I. Framework			
	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets

1. HIV coordination with the continuum of services	(circle letter corresponding to respondent's opinion - #a-c left blank to align with PWID DM)		
<b>For MSM</b>	(d)	(e)	(f)
<b>For TG</b>	(g)	(h)	(i)
<b>For SWs</b>	(j)	(k)	(l)
1.2 STI coordination with the continuum of services			
<b>For MSM</b>	(d)	(e)	(f)
<b>For TG</b>	(g)	(h)	(i)
<b>For SWs</b>	(j)	(k)	(l)
1.3 Reproductive health/family planning coordination with the continuum of services			
<b>For MSM</b>	(d)	(e)	(f)
<b>For TG</b>	(g)	(h)	(i)
<b>For SWs</b>	(j)	(k)	(l)
#2-5 left blank to align with PWID DM			
6. Please cite one example of good coordination			
7. Please cite one example of poor coordination			
8. Left blank to align with PWID DM			
9. Notes:			

<b>B. How would you describe the coordination between health services for MSM/TG/SW and law enforcement programs?</b>			
	Aligned regulations and outcome targets	No coordination	Contradictory regulations and outcome targets
1. At the national level	(circle letter corresponding to respondent's opinion - #a-c left blank to align with PWID DM)		
<b>For MSM</b>	(d)	(e)	(f)
<b>For TG</b>	(g)	(h)	(i)
<b>For SWs</b>	(j)	(k)	(l)
2. At regional/state levels			
<b>For MSM</b>	(d)	(e)	(f)
<b>For TG</b>	(g)	(h)	(i)
<b>For SWs</b>	(j)	(k)	(l)
3. At the local level			
<b>For MSM</b>	(d)	(e)	(f)
<b>For TG</b>	(g)	(h)	(i)
<b>For SWs</b>	(j)	(k)	(l)
4. Please cite one example of good coordination			
5. Please cite one example of poor coordination			

6. Notes:		
<b>C. What would you describe as your understanding of the differences between community and prison services for hepatitis, TB, HIV, drug and alcohol treatment and harm reduction, STI, and reproductive health/family planning programs?</b>		
1. National program guidelines and protocols apply equally between community settings and pre-trial detention and prison settings	Pre-trial detention vs. community	Prison vs. community
HIV (Y/N)	(g)	(h)
Drug treatment (Y/N)	(m)	(n)
Drug harm reduction (Y/N)	(p)	(q)
Alcohol treatment (Y/N)	(r)	(s)
Alcohol harm reduction (Y/N)	(t)	(u)
STI (Y/N)	(v)	(w)
Reproductive health/family planning (Y/N)	(x)	(y)
2. Identify any services that are available in the community that are not available in the following settings		
a) Pre-trial detention		
b) Prison		
3. Identify any levels of financial resources that are different between community settings and the following settings		
a) Pre-trial detention		

b) Prison
4. Left blank to align with PWID DM
5. Notes:

<b>II. Data used in the decision-making processes</b>
A. Describe your perception of how the government sets funding-level and service-delivery targets or performance targets (select all that apply)
1. <input type="checkbox"/> Historic funding levels/support for existing physical infrastructure and staffing levels
2. <input type="checkbox"/> Data on utilization or need
3. <input type="checkbox"/> Community-level epidemiological or census data
4. <input type="checkbox"/> Do not know
5. <input type="checkbox"/> Other, please describe:
6. Notes (especially if more than one of the above is selected):

B. If applicable, describe how you use the following data in programming and funding decisions (circle letter corresponding to respondent's opinion)			
	Use data regularly	Would like to use data but not available	Don't need this level of data
1-4 left blank to align with PWID DM			
5. Data specific to MSM	(a)	(b)	(c)
6. Data specific to TG	(a)	(b)	(c)
7. Data specific to SWs	(a)	(b)	(c)
8. Data specific to clients of SWs	(a)	(b)	(c)
9. Notes:			

III. Government/community partnerships and engagement of key populations in decision						
	MSM		TG		SWs	
	Ind	Org	Ind	Org	Ind	Org
#1-4 left blank to align with PWID DM						
HIV						
5.	(a)	(b)	(c)	(d)	(e)	(f)
6.	(a)	(b)	(c)	(d)	(e)	(f)
Drug Treatment						
7.	(a)	(b)	(c)	(d)	(e)	(f)
8.	(a)	(b)	(c)	(d)	(e)	(f)

**III. Government/community partnerships and engagement of key populations in decision making**

A. Please list any advisory bodies/processes for services for MSM/TG/SWs and indicate (Y/N) if they include membership of individual MSM/TG/SWs or organizations that serve MSM/TG/SWs

	MSM		TG		SWs	
	Ind	Org	Ind	Org	Ind	Org
Drug Harm Reduction						
9.	(a)	(b)	(c)	(d)	(e)	(f)
10.	(a)	(b)	(c)	(d)	(e)	(f)
11-12. left blank to align with PWID DM						
Alcohol Treatment						
13.	(a)	(b)	(c)	(d)	(e)	(f)
14.	(a)	(b)	(c)	(d)	(e)	(f)
Alcohol Harm Reduction						
15.	(a)	(b)	(c)	(d)	(e)	(f)
16.	(a)	(b)	(c)	(d)	(e)	(f)
STI						
17.	(a)	(b)	(c)	(d)	(e)	(f)
18.	(a)	(b)	(c)	(d)	(e)	(f)
Reproductive Health/Family Planning						
19.	(a)	(b)	(c)	(d)	(e)	(f)
20.	(a)	(b)	(c)	(d)	(e)	(f)

### III. Government/community partnerships and engagement of key populations in decision making

A. Please list any advisory bodies/processes for services for MSM/TG/SWs and indicate (Y/N) if they include membership of individual MSM/TG/SWs or organizations that serve MSM/TG/SWs

	MSM		TG		SWs	
	Ind	Org	Ind	Org	Ind	Org

21. For areas above that have no participation from individuals or organizations, please describe barriers to engaging MSM/TG/SWs in the decision-making process

22. Notes:

### VI. Privacy and confidentiality of personal medical and drug treatment/services utilization data

A. Describe your understanding of the protections given to individual-level medical data

1. **Collection** of personal medical data is prohibited without the individual's consent  
Don't know (DK)

Community			Pre-trial Detention			Prison		
a) <input type="checkbox"/> Yes	b) <input type="checkbox"/> No	c) <input type="checkbox"/> DK	d) <input type="checkbox"/> Yes	e) <input type="checkbox"/> No	f) <input type="checkbox"/> DK	g) <input type="checkbox"/> Yes	h) <input type="checkbox"/> No	i) <input type="checkbox"/> DK

2. **Disclosure** of personal medical data is prohibited without the individual's consent  
Don't know (DK)

Community			Pre-trial Detention			Prison		
a) <input type="checkbox"/> Yes	b) <input type="checkbox"/> No	c) <input type="checkbox"/> DK	d) <input type="checkbox"/> Yes	e) <input type="checkbox"/> No	f) <input type="checkbox"/> DK	g) <input type="checkbox"/> Yes	h) <input type="checkbox"/> No	i) <input type="checkbox"/> DK



**VI. Privacy and confidentiality of personal medical and drug treatment/services utilization data**

**A. Describe your understanding of the protections given to individual-level medical data**

3. **Publication** of personal medical data is prohibited without the individual's consent  
Don't know (DK)

Community			Pre-trial Detention			Prison		
a) <input type="checkbox"/> Yes	b) <input type="checkbox"/> No	c) <input type="checkbox"/> DK	d) <input type="checkbox"/> Yes	e) <input type="checkbox"/> No	f) <input type="checkbox"/> DK	g) <input type="checkbox"/> Yes	h) <input type="checkbox"/> No	i) <input type="checkbox"/> DK

4-5 left blank to align with PWID DM

6. Identify any exceptions to the general answers you gave above:

**B. Left blank to align with PWID DM**

**C. Are there any circumstances in which personal medical data indicating criminalized behaviors (e.g., MSM/SWs) or testing/disease status are used for the initiation or documentation of criminal charges or investigations?**

1.  Don't know
2.  No
3.  Yes (please describe)

4. Notes:

**VIII. HIV and drug-use stigma and discrimination**

A-B. Left blank to align with PWID DM

C. Describe the mechanisms that the government uses to measure stigma and discrimination against MSM/TG/SWs

D. Describe any government-supported activities that are being undertaken to reduce stigma and discrimination against MSM/TG/SWs

**X. Criminal/administrative law**

A. Left blank to align with PWID DM

B. How would you describe sex work?

Check all that apply

- 1.  sex work is a legitimate occupation
- 2.  sex work is a criminal activity
- 3.  sex work is socially unacceptable

4.  other \_\_\_\_\_

**C. How would you describe homosexuality?**

- Check all that apply
- 1.  consensual same-sex behavior is a naturally occurring, normal expression of sexual behavior
  - 2.  consensual same-sex behavior is deviant or criminal
  - 3.  consensual same-sex behavior is an illness
  - 4.  other \_\_\_\_\_

**D. How would you describe individuals who don't conform to gender norms?**

- Check all that apply
- 1.  the expression of gender is based on an individual's internal experience and may not correspond with the sex assigned at birth
  - 2.  gender nonconformity is deviant or criminal
  - 3.  gender nonconformity is an illness
  - 4.  other \_\_\_\_\_

E. Notes (especially if more than one of the above is selected):

**XIII. Human and legal rights**

**A. Please describe the steps that the government is taking to address corruption**  
(check as many as apply)

- 1.  We have independent anti-corruption bodies in charge of preventive measures and policies
- 2.  Anti-corruption activities include the participation of civil society
- 3.  We undertake public information campaigns on the threats, causes, and consequences of corruption
- 4.  We undertake public information campaigns on the mechanisms for reporting corruption
- 5.  other \_\_\_\_\_

<b>B. Please describe your perception of compensation of civil servants and political leaders compared with similar positions in the private sector</b>	
1.	<input type="checkbox"/> Compensation levels are about the same
2.	<input type="checkbox"/> Compensation levels are lower, but individuals are allowed to supplement their income through formal or informal supplemental fees collected from members of the public
3.	<input type="checkbox"/> Compensation levels are lower and individuals are forbidden to supplement their income through formal or informal supplemental fees collected from members of the public
4.	<input type="checkbox"/> other_____
<b>C. Please describe the role that adopted international conventions/treaties play in the legislative process</b>	
1.	<input type="checkbox"/> Do not know
2.	<input type="checkbox"/> Adopted international conventions/treaties have overall supremacy over country legislation
3.	<input type="checkbox"/> Country legislation attempts to align with adopted international conventions/treaties
4.	<input type="checkbox"/> I am not aware of any international conventions/treaties that we have adopted
5.	<input type="checkbox"/> There is no role for international conventions/treaties in country legislation
6.	<input type="checkbox"/> other_____

<b>XIV. Overall intervention design</b>	
<b>A. Please describe where MSM/TG/SWs can access the following services and barriers to access to services experienced by MSM/TG/SWs</b>	
1. HIV risk assessment/ screening	
2. Client-initiated HCT	
3. Provider-initiated HCT	
4. ART	

#### XIV. Overall intervention design

A. Please describe where MSM/TG/SWs can access the following services and barriers to access to services experienced by MSM/TG/SWs

5. CD4/viral load testing	
6. Testing for hepatitis A	
7. Vaccination for hepatitis A	
8. Treatment for hepatitis A infection	
9. Testing for hepatitis B	
10. Vaccination for hepatitis B	
11. Treatment for hepatitis B infection	
12. Testing for hepatitis C	
13. Treatment for hepatitis C infection	
23. Condom distribution	

#### XIV. Overall intervention design

A. Please describe where MSM/TG/SWs can access the following services and barriers to access to services experienced by MSM/TG/SWs

24. Lubricant distribution	
25. STI screening	
26. STI treatment	
27. Information on HIV prevention	
28. Alcohol harm reduction services	
29. Substance abuse harm reduction services	
30. Family planning/ reproductive health services	

XV. Please describe any barriers not previously mentioned that MSM/SWs/TG/prison populations have to accessing HIV, STI, and other medical and psychosocial services in this country, including logistical, cultural, religious, or other barriers

XVI. Those are all the questions I have. Before we finish, is there anything you would like to tell me on any of the topics discussed today?



## ANNEX 4. SUMMARY OF FINDINGS

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### Framework—Coordination and Integration

The HPP assessment team examined 29 Togolese policy documents—including laws, codes, regulations, national strategic frameworks, strategic plans, guidelines, and evaluations—to assess whether policies, mechanisms, and coordinating bodies at the national level (1) support the linkage of HIV programs with STI and SRH programs and (2) follow international best practices to address the needs of SWs, MSM, TG, and detainees. The documents were also reviewed to determine whether HIV sector policies align with non-health sectors, such as education and transportation.

#### Strengths

- **Multisectoral and decentralized approach** outlined in the National Strategic Plan for the Response to AIDS and other HIV policy documents
- **HIV and STI service coordination** with SRH services highlighted
- **Government and nongovernmental organization** roles and responsibilities are defined for HIV, STI, and SRH; policies support involvement of and government collaboration with civil society and the private sector
- **Key populations (SWs, MSM, and detainees) and universal care of PLHIV** included in the National Strategic Plan for the Response to AIDS, other key HIV policy documents, and the National Plan for Health Development
- **Policy framework for prevention and care of HIV and STIs in key populations** currently being validated
- **HIV and STI programs** identify services and government commitment to achieve coverage targets for SW, MSM, detainees, and clients of SWs (HIV program only)

#### Specific Policy Gaps

- **Multisectoral response**
  - Policy does not specify which sectors or ministries are included
  - Non-health sector HIV policy documents either do not exist or do not include SWs, MSM, TG, and detainees and/or do not address STIs or SRH
  - Operational guidelines or standards with detailed implementation mechanisms do not exist in non-health sectors addressing HIV and STIs as a rule
  - Key committees and consultative bodies do not include key populations
- **SRH programs**
  - Not coordinated with relevant non-health sectors in either general population programs or prison settings
  - Only address HCT with no inclusion of other aspects of HIV and STI program integration
- **Prison settings**
  - Obsolete/inexistent prison policy misaligned with HIV and SRH policy
  - Equitable levels of resources and services between community and prison programs are not promoted in policy documents

- Do not mention HIV, STI, and SRH programs for SWs, clients of SWs, TG, or MSM
- **Holistic programming and program rationale**
  - Scientific basis or international standards not referenced in HIV, STI, or SRH program design
  - National development or poverty reduction strategies do not identify needs and initiatives for SWs, TG, or MSM
  - Human rights of SWs, TG, and MSM are not identified or addressed in HIV, STI, and SRH programs, neither in general population programs nor prison settings

#### Other Barriers

- Inadequate coordination between programs and services
- Gaps in implementation of HIV and STI service integration in SRH services
- Misinterpretation of penal code denies detainees access to SRH services, including condom and lubricants

## Framework—Data-Informed Planning and Budgeting

The HPP assessment team examined 33 Togolese policy documents—including decrees, codes, national strategic frameworks, strategic plans, and guidelines—to assess whether they help ensure data-informed planning and budgeting of HIV/AIDS programs.

### Strengths

- **HIV and STI programs** identify services and government commitment to achieve coverage targets for SWs, MSM, and detainees (HIV program only)
- **Size estimation and evidence basis for funding decisions** for SWs and MSM follow international standards
- **UNGASS indicators** for most-at-risk populations are reported on

### Specific Policy Gaps

- **SRH programs**
  - Do not identify services, coverage targets, or outcomes for MSM, SWs, SW clients, and TG
- **No data collection requirements** for incidence and context of sexual violence
- **Clients of SWs and TG**
  - Services, coverage targets, or outcomes are not mentioned in HIV, STI, or SRH programs
  - No policies or activities on size estimation

### Other Barriers

- Weak data on MSM, SWs, SW clients, TG, and detainees
- HIV budget insufficient; limited government financing

## Community Partnership

The HPP assessment team examined 12 Togolese policy documents—including decrees, codes, national strategic frameworks, strategic plans, and guidelines—to assess whether they facilitate participation of the private sector and civil society in the development and implementation of HIV/AIDS programs.

### Strengths

- **Establishment and support of nongovernmental organizations serving SWs, MSM, and detainees** in community settings is supported by HIV and STI policy
- **Discussions** underway to include representatives of key populations in PNLs STI Targeted Interventions Working Group. Nothing formalized

### Specific Policy Gaps

- **Engagement of SWs, TG, and MSM in decision-making processes**
  - Involvement of SWs, TG, and MSM in decision making, policy design, and evaluation of policy implementation is *not defined or required*
  - Representation on CCM of SWs, TG, or MSM is *not required*; the CCM does not include representatives from any of these populations
- **Nongovernmental organizations**
  - Policy fails to support establishment of nongovernmental organizations serving TG; as well as organizations serving SWs, TG, and MSM in prison settings

### Other Barriers

- MSM-led and comprised associations may not apply for official status/recognition due to the criminalization of same-sex sexual behavior

## Legal Environment—Authorization

The HPP assessment team reviewed six Togolese policy documents—including laws, the penal code, national public health strategies, and national strategic frameworks and programs—to identify the agency or agencies authorized to implement services for SWs, TG, and MSM in community and prison settings.

### Strengths

- **Broad authorization** for the provision of a comprehensive range of prevention and treatment services for HIV, STI, and SRH
- **Public health agencies** have the authority to coordinate and deliver health and harm reduction programs in community settings
- **HIV and STI policy** developed and being validated that identifies the range of services for SWs, TG, and MSM

### Specific Policy Gaps

- **Policy to direct oversight of prison health services and medical protocols does not exist** but oversight appears to rest with prison authorities instead of health authorities and doctors
- **TG are not mentioned** in HIV, STI or SRH policy

### Other Barriers

- Stockouts of medications and testing materials affect ability of public health officials to offer a complete range of HIV, STI, and SRH services

## Legal Environment—Consent

The HPP assessment team examined 27 Togolese policy documents—including HIV laws, norms and protocols, national strategic frameworks, action plans, and codes of professional conduct—to assess the extent to which they support patients’ rights and international best practices regarding informed consent.

### Strengths

- **Individual consent for medical testing and treatment** for HIV, STI, and SRH
  - Consent is required and follows international standards (exceptions below)
  - Mandatory or compulsory medical testing and treatment are prohibited (exception below)
- **Access to information and counseling** for HIV, STI, and SRH is guaranteed regardless of age and parental consent
- **SW eligibility for services** is not dependent on leaving sex work

### Specific Policy Gaps

- **Individual consent for medical testing and treatment unclear** for STIs and to save a patient’s life
- **Mandatory medical supervision allowed for SWs**
- **Age-appropriate information on sexual orientation and gender identity** is not authorized for school curricula
- **No clear guarantee of access to testing and medical services** for HIV, STI, and SRH for adolescents without parental consent; contradictions exist between HCT guidelines and new policy framework for key populations
- **Mandatory or compulsory medical or psychological procedures or confinement** are not specifically prohibited for treatment of sexual orientation or gender identity
- **Policy is silent on regulations for obtaining consent of individual SW** for all interventions for SW (e.g., 100 percent condom use and raid and rescue interventions)

### Other Barriers

- Reported cases of “pressure” to consent by healthcare provider, particularly in pre-natal care settings

## Legal Environment—Confidentiality of Personal Data

The HPP assessment team reviewed 24 Togolese policy documents—including laws, the penal code, norms and protocols, national strategic frameworks, and action plans—to assess their adherence to international best practices regarding the confidentiality of personal data.

### Strengths

- **Individual-level personal medical data**
  - Collection, use, disclosure, and/or publication prohibited without individual consent in community and prison settings
- **Breaches of confidentiality and sanctions** for unauthorized release of confidential information are addressed by independent agency

### Specific Policy Gaps

- **Individual-level personal medical data**
  - **No guaranteed access to and ability to request correction** to personal medical records
  - **Partner notification protocols unclear** regarding protecting the identity of individual with communicable disease
  - **Policy silent on detainees**
- **Disclosure of personal data**
  - **Disclosure of medical data of a minor to parents/guardians** does not allow for prioritization of the best interest of the child
  - **Medical data can be disclosed** at the request of a court of law; policy does not explicitly protect MSM, TG, SWs, or anyone else from admission of medical records as a means for initiating or substantiating criminal behavior or criminal charges

### Other Barriers

- Breaches in provider confidentiality exist
- Confidentiality for detainees extremely problematic

## Legal Environment—Registries

The HPP assessment team reviewed 19 Togolese policy documents—including laws, norms, and protocols—to assess restrictions, directives, and personal data protection regarding the use of medical registries and sex offender registries.

### Strengths

- **Medical registries**
  - Follow strict rules of data protection and confidentiality
  - Focus on ensuring quality of services
  - Are managed by public health authorities
- **Sex offender or other non-medical registries for SWs, TG, and MSM**
  - Do not exist in Togo



## Legal Environment—Stigma and Discrimination

The HPP assessment team reviewed 16 Togolese policy documents—including articles of the Constitution of Togo, reproductive health laws, HIV laws, and national strategic frameworks—to identify measures that offer protection from stigma and discrimination to PLHIV and key populations.

### Strengths

- **Stigma and discrimination of SWs and MSM are mentioned** in national HIV and STI policies
- **National discrimination protections** (population-wide and PLHIV-specific, no mention of SWs, TG, or MSM)
  - Include education, housing, employment, and health services
  - Include actual or perceived health conditions
  - Include residency/citizenship
  - Explicitly include detainees and PLHIV
- **It is unlawful to incite hatred** toward someone on the basis of actual or perceived HIV infection

### Specific Policy Gaps

- **No policies to actively measure or address S&D** among key populations
- **Stigma and discrimination are not addressed** in national SRH programs
- **National discrimination protections**
  - Do not explicitly include SWs, TG, MSM, or relatives or associates of detainees
  - Do not include protections for individuals who file discrimination complaints
  - Do not include source of income
  - Do not include sexual orientation
  - Do not include gender identity
- **Policy provides no legal remedies for customary laws, teaching, or practices** that affect the status or treatment of SWs, TG, or MSM
- **There are no clear prohibitions against incitement of hatred** toward SWs, TG, and MSM

### Other Barriers

- Religious and cultural beliefs and norms condemning sex work and same-sex sexual relations
- Endemic stigma and discrimination of SWs and MSM, including verbal and physical aggression
- Violations of healthcare provider code of ethics in the form of verbal assaults against SWs and MSM and refusal to deliver care, resulting in SWs and MSM foregoing healthcare and/or self-medicating
- Reports of SWs and MSM experiencing S&D by law enforcement
- Pressure for heterosexual relationships as a social cover
- Stigma and discrimination of SWs and MSM in the media

## Legal Environment—Criminalization/Definitions

The HPP assessment team reviewed 16 Togolese policy documents—including codes, laws, and the national strategic framework for HIV and STIs—to evaluate the use of definitions that may impact the application of laws and policies.

### Strengths

- **No criminalization of HIV transmission**
- **Human trafficking** is defined as acquisition of people by improper means
- **SWs**
  - Silence\* on the legality of selling or purchasing sex, except in the case of soliciting and pimping
  - Alternatives to incarceration are identified
  - Protection from prosecution for SWs who have been trafficked or otherwise coerced into transactional sex
- **TG**
  - Silence\* on the legality of TG identity or gender non-conformity
- **Extra-marital sexual conduct** is not regulated through criminal or financial sanctions
- **HIV prevention, care, and treatment**
  - Policy strongly supports IEC, prevention, care, and treatment efforts

\*Policy silence may be a strength or weakness depending on the broader political context

### Specific Policy Gaps

- **Laws criminalizing same-sex sexual relations and solicitation by sex workers exist**
  - Escalating penalties for repeated convictions for SWs are identified
- **Medical or psychological treatment** for the purpose of curing homosexuality or gender non-conformity is not clearly prohibited

### Other Barriers

- Law enforcement use of solicitation laws to harass and detain SWs and MSM who are not soliciting
- Reports of police violence and extortion against SWs and MSM
- Prison policy obsolete or does not exist

#### Note

Supportive legalization for SW, TG or MSM and the addition of supportive definitions in penal code could lead to backlash given the cultural context in Togo. Significant strides in addressing stigma and discrimination need to be made prior to affecting changes in this type of legislation.

## Legal Environment—Gender-Based Violence

The HPP assessment team reviewed 22 Togolese policy documents—including laws, the penal code, programs, guidelines, and national strategic frameworks for HIV and STIs—to assess the current legal and regulatory framework for attention and response to GBV.

### Strengths

- **Equal punishment** of rape in and out of marriage
- **Access to complaint processes for sex workers** who experience sexual abuse by their employers or clients (but see other barriers)
- **Access to medical treatment and counseling** for prisoners clearly defined in HIV law (but implementation barriers due to lack of prison policy)
- **Domestic violence reporting regulations** do not require universal reporting of incidents to law enforcement
- **Access to domestic violence shelters** is not restricted for MSM, TG, and SWs (policy is silent)
- **Female detainees are housed separately** from male detainees
- **Non-consensual sex** is prohibited in prisons

### Specific Policy Gaps

- **Rape is not clearly defined** and does not clearly include both male and female perpetrators and victims and does not clearly include oral, anal, and vaginal penetration; misalignment across documents
- **Honor killings** based on sexual orientation or sexual identity not clearly prohibited
- **Access to medical treatment not clearly provided** for SWs, TG, and MSM who experience sexual violence
- **Access to post-exposure prophylaxis not guaranteed**
- **Housing of TG detainees** with females not clearly directed
- **Structures to punish and/or segregate sexual predators** in prisons not provided
- **Lack of prison policy** poses barriers to implementation of GBV and HIV policy

### Other Barriers

- SWs do not pursue cases of sexual abuse
  - Unaware of rights
  - Embarrassed or fearful of law enforcement

## Legal Environment—Cruel, Inhuman, or Degrading Treatment or Punishment

The HPP assessment team examined four policy documents—including the Constitution of Togo and the Penal Code—to identify protections for key populations against cruel, inhuman, or degrading treatment or punishment.

### Strengths

- **Cruel, inhuman, or degrading treatment or punishment is prohibited** in both community and prison settings

### Specific Policy Gaps

- **Sexual orientation and gender identity are not identified as protected** from torture and ill-treatment
- **No redress systems or sanctions** identified for cruel, inhuman, or degrading treatment or punishment

### Other Barriers

- Acts of cruel, inhuman, or degrading treatment go unreported due to stigma and discrimination
  - Religious and cultural beliefs and norms leading to stigma and discrimination
  - Cruel, inhuman, or degrading treatment of MSM and SWs within family and community

## Legal Environment—Monitoring and Enforcement of Human and Legal Rights

The HPP assessment team examined 10 policy documents—including the Constitution of Togo, codes and articles of law, and international treaties and conventions signed by Togo—to examine the existence, monitoring, and enforcement of human and legal rights.

### Strengths

- **International human rights**
  - Broad ratification of international conventions and treaties
  - Acknowledgement of supremacy of adopted international law over national legislation
  - Recognition of international human rights bodies
- **Independent anti-corruption bodies** are authorized
- **Bribery, coercion, and extortion by a public official** are illegal

### Specific Policy Gaps

- **Same-sex relationships not recognized** in any way (illegal under Togolese law)
- **Sexual orientation or gender identity not recognized as justification for granting asylum**
- **Sex workers not provided legal protections or benefits** of other occupations
- **Financial and professional incentives for law enforcement officials** not identified for enforcing crimes against SWs, TG, or MSM or referring these individuals to services
- **Definitions of disability do not include** loss of function or ability to earn a living based on HIV infection
- **Rights to education** for TG and MSM not guaranteed and **bullying not prohibited** on the basis of sexual orientation or gender identity
- No clear process for **gender aligned residency papers for TG**
- **Anti-corruption bodies** do not provide for civil society participation
- **Anti-corruption public awareness campaigns** are not identified
- **Education on legal rights** is not provided by the state for SWs, TG, MSM, or prisoners
- **Commensurate compensation of civil servants with private sector is not identified** as a goal
- **Unclear residency paper** requirements and process

### Other Barriers

- Police abuse of SWs, MSM, and detainees

## Intervention Design, Access, and Implementation—Procurement and Supply Management

The HPP assessment team examined 14 Togolese policy documents—including ministerial decrees, laws, regulations, strategic plans, guidelines, evaluations, and national strategic frameworks—to assess the government’s Procurement and Supply Management (PSM) system for HIV drugs and commodities. The assessment focused on the status of the general supply chain, procurement, and forecasting systems in Togo and the PSM system for medications and supplies relevant to HIV prevention, care, and treatment for key populations, including ARVs and laboratory tests to monitor ART.

### Strengths

- **PSM oversight bodies** are identified
- **Quality assurance standards** are identified
- **Decentralized procurement and international tendering** are allowed

### Specific Policy Gaps

- **PSM oversight bodies** do not have representation from nongovernmental organizations and do not make procurement records open to the public
- **Essential medicines do not** align with the World Health Organization’s list of medicines
- **Mechanisms do not exist for the participation of SWs and MSM** in selection of harm reduction commodities
- **Commodity forecasting** is not based on estimated or reported need
- **Storage, distribution, and logistics** are not budgeted for

### Other Barriers

- Poor implementation of quality assurance standards
- Stockouts of ARVs, STI kits, and lubricants common
- Inefficient completion of commodity use and order forms at the facility and district levels
- New procurement policy using tender system for prison has discouraged applicants and led to stockouts in prison

## Intervention Design, Access, and Implementation—Overarching Services Design

The HPP assessment team examined 20 Togolese policy documents—including laws, the Penal Code, strategic framework, norms and protocols, guidelines, and evaluations—to evaluate service design with a particular focus on integration of HIV and STI services in SRH, measures to address domestic and sexual violence, availability of services, and HIV-related training.

### Strengths

- **Services directed to have protocols** to assess SRH, STI, and HIV need
- **Referral mechanisms** to other services identified
- **Equal access for women and men** guaranteed

### Specific Policy Gaps

- **Domestic and sexual violence risk assessment protocols** for SWs, TG, and MSM not identified
- **Equal access for SWs, TG, and MSM** not specifically guaranteed; RH law guarantees equal access for all citizens but does not specify these populations
- **No mechanisms to ensure continuity of care** between and within community and detention/prison/custodial settings
- **No mechanisms to include SWs, TG, and MSM** in protocol design and monitoring and evaluation
- **Fails to prohibit mandatory use of family planning** as a condition of receiving services
- **Does not guarantee access** for females who are pregnant or have children
- **No clear training requirements** for law enforcement, judges, prison staff, teachers, or healthcare workers on
  - Ethics and human rights
  - Stigma and discrimination
  - Domestic and sexual violence
  - Human sexuality
  - Specific needs of SWs, TG, and MSM
  - Referral between law enforcement, medical, and harm reduction services
  - Hepatitis, TB, and HIV (except for professional curricula for healthcare workers)
- **Services not guaranteed at times convenient to all clients**
- **Lack of clear prison policy other than HIV policy**

### Other Barriers

- Financial barriers to accessing services
- Services for SWs and MSM only in major urban centers, mainly Lomé
- Emergency pharmacies, clinics, and hospitals may not be accessible to SWs, TG, and MSM due to stigma and discrimination

- MSM sub-populations fear being recognized at MSM-specific healthcare facilities; refusal to disclose STI symptoms at healthcare facilities serving the general population; fear of stigma and discrimination
- Lack of confidentiality coupled with S&D in prison settings
- S&D of SWs and MSM
- Healthcare providers refuse to treat SWs and MSM, citing religious and moral grounds



## Intervention Design, Access, and Implementation—HCT

The HPP assessment team reviewed 11 Togolese policy documents—including HIV laws, national strategic frameworks, funding reports, and reference manuals—to assess quality of HCT services and inclusion of specific components in Togo. The assessment team also evaluated access to HCT services for key populations.

### Strengths

- **Free HCT** for everyone (but no mention of SWs, TG, or MSM)
- **Rapid testing algorithms** available to diagnose HIV infection in community settings
- **Confidential and anonymous** testing available (but see specific policy gaps)
- **Government and nongovernmental providers** authorized
- **International protocols** adopted for counseling, consent, and referral (but see specific policy gaps)

### Specific Policy Gaps

- **SW, TG, and MSM**
  - Not involved in development of protocols
  - Not involved in monitoring and evaluation of programs
- **Saliva-based rapid testing** is not authorized
- **Exceptions to informed consent**, including unclear policy for minors regarding parental/guardian consent
- **Prisoners not guaranteed access** to voluntary confidential HIV testing and counseling

### Other Barriers

- Stigma and discrimination of SWs, MSM, TG, and PLHIV discourage them from accessing HCT services
  - Double stigma for SWs and MSM living with HIV
  - SWs fear loss of clients

## Intervention Design, Access, and Implementation—ART

The HPP assessment team examined 15 Togolese policy documents—including laws, strategic frameworks, and guidelines—to assess availability and accessibility of ART for key populations and identify barriers to ART uptake.

### Strengths

- **Free ART** authorized for all people living with HIV/PLHIV (see specific policy gaps and other barriers)

### Specific Policy Gaps

- **SWs, TG, and MSM** not specifically identified as ART recipients; policy for all PLHIV
- **Silence on detainee** access to ART
- **Silence on alcohol and drug use** restrictions to ART access
- **Fees for related services**
- **Gaps in related services**, including protocols for HIV and Hepatitis A, B, and C co-infection

### Other Barriers

- Stockouts of ARVs
- Only 25 CD4 count devices in the entire country
- Decentralization limited
  - Cost and time for travel to ART clinics
- Stigma and discrimination of PLHIV, SWs, MSM, TG, and detainees discourage them from accessing ART services

## Intervention Design, Access, and Implementation—STI

The HPP assessment team reviewed 24 Togolese policy documents—including RH laws, national strategic frameworks, norms and protocols, and guidelines—to assess the quality, availability, and accessibility of STI services for key populations.

### Strengths

- **Syndromic management** services authorized
- **Periodic presumptive treatment** authorized
- **Limited number of specialized services for SWs**
- **HCT available in STI clinics**

### Specific Policy Gaps

- **State funding not guaranteed**
- **SWs, TG, MSM**
  - Not prioritized for free services (other than SWs through UNFPA funding)
  - No specialized services for MSM and TG (limited number of CBOs in urban centers)
- **No free HAV/HBV (hepatitis A/B) vaccination**
- **Presumptive Partner Treatment not authorized**
- **No provider liability protections** for implementing syndromic, periodic presumptive, or expedited partner protocols
- **Oral, vaginal, and anal screening** not included in all protocols (new framework under validation)
- **Pharmacists and other informal healthcare providers** not authorized to provide syndromic management or periodic presumptive treatment (available under SIDA III but no policy)
- **Services unavailable** in prison settings

### Other Barriers

- Frequent stockouts of government subsidized STI kits
  - Cost of treatment during stockouts
- Stigma and discrimination of SWs, MSM, TG, and people with STIs discourage them from accessing STI services

## Intervention Design, Access, and Implementation—Condoms and Lubrication

The HPP assessment team examined 26 Togolese policy documents—including pharmacy, SRH, and HIV policies—to assess supply and access to condoms and lubrication. Condoms and lubricants are instrumental in preventing HIV among key populations.

### Strengths

- **Eligibility not restricted** based on criminalized status
- **SWs retain control** over decision regarding condom use
- **Public health authorities monitor** uptake and effectiveness of programs
- **Use with regular and casual sexual relations and in addition to other birth control is emphasized**
- **WHO/UNFPA specifications** referenced

### Specific Policy Gaps

- **State funding not guaranteed**
- **SWs, TG, MSM**
  - Not prioritized for free services
- **Lubrication not provided**
- **Detainee access denied**

### Other Barriers

- **Frequent stockouts of condoms and lubricants**
  - Unavailable outside of urban centers
  - Large tubes available in pharmacy
    - Difficult to transport
    - Costly
- **Stigma and discrimination of SWs and MSM discourage them from carrying C/L and accessing services offering C/L**

## Intervention Design, Access, and Implementation—IEC

The HPP assessment team reviewed 16 Togolese policy documents—including HIV laws, national communication policy, and national strategic frameworks—to identify policies that enable or pose challenges for IEC that is appropriate for key populations.

### Strengths

- **Eligibility not restricted** based on criminalized status
- **SWs, TG, MSM** specific information not restricted

### Specific Policy Gaps

- **State funding is not identified**
- **SWs, TG, MSM** specific information not guaranteed

### Other Barriers

- MSM- and TG-specific IEC unavailable
- Stigma for SWs, MSM, and TG poses a barrier to the development and distribution of IEC

## Intervention Design, Access, and Implementation—Outreach

The HPP assessment team examined 17 Togolese policy documents—including the National Policy on Community-Based Interventions, HIV laws, and HIV strategic frameworks and guidelines—to identify policies that enable or pose challenges to HIV prevention outreach. Outreach is instrumental in preventing HIV among key populations and providing information regarding available HIV services.

### Strengths

- **Broad and comprehensive outreach services authorized** (but see specific policy gaps)
- **Strong government support of CBO outreach**
- **Include best practices for outreach workers**

### Specific Policy Gaps

- **Detainees not guaranteed access to services**

### Other Barriers

- Stigma and discrimination of SWs and MSM force these populations to remain hidden
- Criminalization of same-sex sexual relations and soliciting sex work on public streets
- Stockouts of condoms and lubricants
- Lack of SWs and MSM-specific IEC materials
- Heterogeneity of populations
- Safety concerns for outreach workers

## Intervention Design, Access, and Implementation—Alcohol and Substance Abuse Harm Reduction

The HPP assessment team was unable to find any harm reduction programs in Togo. The National Health Policy includes a call to reduce risk factors, including alcohol and substance abuse, and the PSN identifies activities for PWID but does not include alcohol and substance abuse harm reduction activities.

### Strengths

- Recognition of alcohol as a risk factor
- Mention of alcohol harm reduction IEC, outreach, and programs in new policy framework for key populations (under validation)
- Free syringe distribution identified in minimum packet of services in new policy framework for key populations (under validation)

### Specific Policy Gaps

- Alcohol and substance abuse harm reduction services unavailable

### Other Barriers

- Criminalization and S&D of substance use

## Intervention Design, Access, and Implementation—SRH

The HPP assessment team examined 19 Togolese policies—including laws, strategic frameworks, and guidelines—to assess the availability and accessibility of SRH services that follow international best practices.

### Strengths

- **Comprehensive services authorized** (but see specific policy gaps)
- **HCT authorized in SRH services**
- **Emergency contraception authorized**

### Specific Policy Gaps

- **State funding not guaranteed**
- **SWs, MSM, and TG** not specifically identified to receive services; policy for all citizens
- **Detainees lack access** resulting from lack of prison policy and interpretation of penal code
- **Abortion access limited**
  - Rape
  - Incest
  - Threat to health or life of mother
  - Diagnosis of “specific, serious” condition in fetus

### Other Barriers

- Stigma and discrimination for SWs, MSM, and TG
  - Healthcare providers refuse care, citing religious and moral grounds
- Cost



## REFERENCES

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- Barnett, T., and A. Whiteside. (2006). "Chapter 3, Responses." *AIDS in the Twenty-first Century: Disease and Globalization, Second Edition*. Pp. 316–346. New York: Palgrave Macmillan.
- Beardsley, K., et al. (2013). *Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers*. Washington, DC: Futures Group, Health Policy Project.
- Beryer, C., AL. Wirtz, D. Walker, B. Johns, F. Sifakis, and S.D. Baral. (2011). *The Global HIV Epidemics among Men Who Have Sex with Men (MSM)*. Retrieved May 22, 2013, from <http://elibrary.worldbank.org/content/book/9780821387269;jsessionid=26096h15ujcrm.z-wb-live-01>.
- Beryer, C., F. van Griensven, S.D. Baral, S. Goodreau, S. Chariyalertsak, A. Wirtz, and R. Brookmeyer. (2012). "Global epidemiology of HIV infection in men who have sex with men." *The Lancet* 280(9839): 367–377.
- Case, K., P. Ghys, E. Gouws, J. Eaton, A. Borquez, J. Stover, P. Cuchi, L. Abu-Raddad, G. Garnett, T. Hallett, and on behalf of the HIV Modelling Consortium. (2012). *Understanding the modes of transmission model of new HIV infection and its use in prevention planning*. WHO Bulletin. Retrieved on June 10, 2013, from <http://www.who.int/bulletin/volumes/90/11/12-102574/en/index.html>.
- CCM-Togo. (2008). *Renforcement et extension des services de prévention et de la prise en charge globale des PVVIH dans le cadre de l'accès universel au Togo*. Togo Proposal for GFATM Series 8.
- CHALN. (2007). *A Human Rights-based Commentary on UNAIDS Guidance Note: HIV and Sex Work (April 2007)*. Retrieved January 9, 2012, from <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=780>.
- Dutta, A., and M. Maiga. (2011). *An Assessment of Policy toward Most-at-Risk Populations for HIV/AIDS in West Africa*. Accra: Action for West Africa (AWARE-II) Project.
- Fay, H., S.D. Baral, et al. (2010). "Stigma, health care access, and HIV knowledge among men who have sex with men in Malawi, Namibia and Botswana." *AIDS Behavior*. DOI 10.1007/s10461-010-9861-2.
- FHI 360/ACI. (2013). *Projet régional de prévention et de prise en charge du VIH/SIDA en Afrique de l'Ouest : Needs Assessment*. PACTE-VIH.
- Government of Togo (GOT). (1980). *Loi n°80-1 instituant Code Pénal*. National Assembly Togo.
- GOT. (1992). *Constitution de la IV République, révisée par la loi n°2002-029 du 31 Décembre 2002 et modifiée en son alinéa 1er par la loi n°2007-008 du 07 Février 2007*. National Assembly Togo.
- GOT. (2007a). *Loi N° 2007 – 005 du 10 janvier 2007 sur la Santé de la Reproduction*. National Assembly Togo.
- GOT. (2007b). *Loi n°2007-017 portant Code de l'Enfant*. National Assembly Togo.
- GOT. (2009). *Loi n°2009-007 du 15 mai 2009 portant Code de la Santé Publique de la République Togolaise*. National Assembly Togo.

- GOT. (2010a). *Loi n°2010-018 modifiant la loi n°005-12 du 14 Décembre 2005 portant protection des personnes en matière du VIH/SID*. National Assembly Togo.
- GOT. (2010b). *Accelerated Growth and Sustainable Development Strategy (SCADD)*. Government of Togo.
- GOT. (2011). *Loi n°2011-014 portant organisation de l'activité statistique au Togo*. National Assembly Togo.
- Green, E., D. Halperin, et al. (2006). "Uganda's HIV prevention success: the role of sexual behavior change and the national response." *AIDS Behavior*, 10 (4): 335–346.
- Guiard-Schmid. (forthcoming). *Politique Nationale de Prévention Combinée et de Prise en Charge Globale des IST et du VIH dans les Populations Clés au Togo*. Prepared for SP/CNLS with support from PACTE-VIH.
- International Planned Parenthood Federation (IPPF), United Nations Population Fund, Young Positives and the Global Coalition on Women and AIDS. (2007). *Make It Matter— 10 Key Advocacy Messages to Prevent HIV in Girls and Young Women*. London: IPPF.
- Larmarange, J. (2010). "Homosexuality and bisexuality in Senegal: a multiform reality." *Population (english edition)* 64(4): 635–666.
- Larmarange, J., A.S. Wade, et al. (2010). "Men who have sex with men (MSM) and factors associated with not using a condom at last sexual intercourse with a man and with a woman in Senegal." *PLoS ONE* 5(10): e13189.
- Lowndes, C.M., M. Alary, et al. (2008). *West Africa HIV/AIDS Epidemiology and Response Synthesis*. Global AIDS Monitoring and Evaluation Team (GAMET). Washington, DC: The Global HIV/AIDS Program, The World Bank.
- Mah, T.L., and F. J. Dibba. (2008). *HIV/AIDS in The Gambia: A Qualitative Assessment of Most-at-risk Populations*. Banjul: National AIDS Secretariat, United Nations Program on HIV/AIDS (UNAIDS), and United Nations Development Program.
- Manandhar, D., D. Osrin, et al. (2004). "Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial." *The Lancet*, 364: 970–79.
- Me-Tahi, B., and S. Anato. (2010). *Analyse de la Situation sur l'Homosexualité Masculine et le VIH/SIDA dans le contexte du Togo*. Retrieved July 28, 2013, from <http://www.snu.tg/bonus/sites/default/files/Homosexualite%20Masculine%20et%20le%20VIH-SIDA%20dans%20le%20Contexte%20du%20Togo%20-%20Fevrier%202010.pdf>.
- Ministry of Health (MOH). (2008). *Strategic Plan for Reproductive Health in Togo 2008–2012*. Lomé: MOH.
- MOH. (2009a). *National Health Policy*. Lomé: MOH.
- MOH. (2009b). *National Strategy for Community-based Interventions*. Lomé: MOH.
- MOH. (2009c). *Reproductive Health Protocol in Togo: TOME II*. Lomé: Ministry of Health.

- MOH. (2012a). *Politique Pharmaceutique Nationale*. Lomé: Ministry of Health.
- MOH. (2012b). *Liste Révisée des Médicaments*. Lomé: Ministry of Health.
- MOH. (2013). *Plan Stratégique Pharmaceutique Nationale 2013–2015*. Lomé: Ministry of Health.
- Ministry of Justice (MOJ) and United Nations Office on Drugs and Crime (UNODC). (2010). *Prise en Charge du VIH, de la Tuberculose et de la co-infection Tuberculose/VIH en milieu carcéral au Togo : Manuel de l’Infirmier de la Prison*. Lomé: MOJ and UNODC.
- Ministry of Social Affairs and the Promotion of Women (MSAPW) and United Nations Development Program (UNDP). (2006). *National Strategy for the Integration of Gender in Policies and Programs in Togo*. MSAPW and UNDP.
- Odendal, L. (2013). “How can most-at-risk populations be encouraged to seek HIV testing?” AIDSmap July 3, 2013. <http://www.aidsmap.com/How-can-most-at-risk-populations-be-encouraged-to-seek-HIV-testing/page/2692136/>.
- Pitché, P., K. Gbetoglo, B. Saka, S. Akakpo, D. Essoya Landoh, S. d’Almeida, A. Kere Banla, D. Sodji, and K. Deku. (2013). “HIV prevalence and behavioral studies in female sex workers in Togo: a decline in the prevalence between 2005 and 2011.” *The Pan African Medical Journal* 15: 62.
- Population Services International (PSI). (2006). *Case Study Togo : Improving Access to HIV Prevention Messages and Services among Men Who Have Sex with Men in Togo*. Washington, DC: PSI. Retrieved July 25, 2013, from [http://www.engagingmen.net/files/resources/2011/frutayisire/Togo\\_Case\\_Study.pdf](http://www.engagingmen.net/files/resources/2011/frutayisire/Togo_Case_Study.pdf).
- Programme National de Lutte contre le Sida et les IST au Togo (PNLS). (2010a). *HCT Training Reference Manual*. Lomé: PNLS.
- PNLS. (2010b). *Policy, Norms and Procedures for HCT in Togo*. Lomé: PNLS.
- PNLS. (2010c). *National Guide for Treatment of STIs*. Lomé: PNLS.
- PNLS. (2011a). *Enquête comportementale et de séroprévalence du VIH chez les prisonniers Togo en 2011*. Lomé: PNLS.
- PNLS. (2011b). *Enquête comportementale et de séroprévalence du VIH chez les hommes ayant des rapports avec d’autres hommes (HSH) Togo en 2011*. Lomé: PNLS.
- PNLS. (2011c). *Enquête comportementale et de séroprévalence du VIH chez les professionnels du sexe (PS) Togo en 2011*. Lomé: PNLS.
- Sarkar, S., N. Menser, et al. (2009). *Cost-Effective Interventions that Focus on Most-at-Risk Populations*. Washington, DC: Results for Development Institute and aids2031.
- Scorgie, F., M.F. Chersich, I. Ntaganira, A. Gerbase, F. Lule, and Y.R Lo. (2012). “Socio-demographic characteristics and behavioral risk factors of female sex workers in sub-saharan Africa: a systematic review.” *AIDS Behav.* 16(4): 920–33. Retrieved May 22, 2013, from <http://www.ncbi.nlm.nih.gov/pubmed/21750918>.

Secrétariat Permanent du Conseil National de Lutte contre le Sida et les Infections Sexuellement Transmissibles (SP/CNLS-IST). (2006). *National Strategic Plan for the Response to AIDS 2001–2005*. Lomé: SP/CNLS-IST.

SP/CNLS-IST. (2007). *National Strategic Plan for Children and AIDS Campaign 2007–2010*. Lomé: SP/CNLS-IST.

SP/CNLS-IST. (2011). *National Communication Strategy for Behavior Change related to STI, HIV and AIDS 2011–2015*. Lomé: SP/CNLS-IST.

SP/CNLS-IST. (2012a). *National Strategic Plan in the Response for HIV and STIs 2012–2015*. Lomé: SP/CNLS-IST.

SP/CNLS-IST. (2012b). *Operational Plan in the Response for HIV and STIs 2012–2013*. Lomé: SP/CNLS-IST.

SP/CNLS-IST. (2012c). *Monitoring and Evaluation Manual*. Lomé: SP/CNLS-IST.

SP/CNLS-IST. (2012d). *National Policy for the Response to HIV and AIDS in Togo: Vision 2020*. Lomé: SP/CNLS-IST.

Tchagafou, M., S. Duvall, and A. Chen. (forthcoming). *Rapport de l'Analyse des Capacités des Organisations de la Société Civile intervenant auprès des Populations Clés au Togo*. Washington, DC: Health Policy Project.

United Nations. (2010). *United Nations Development Assistance Framework for Togo*. United Nations System.

United Nations Office on Drugs and Crime (UNODC). (2007). *HIV in Prisons in Sub-saharan Africa*. Retrieved July 20, 2013, from [https://www.unodc.org/documents/hiv-aids/Africa%20HIV\\_Prison\\_Paper\\_Oct-23-07-en.pdf](https://www.unodc.org/documents/hiv-aids/Africa%20HIV_Prison_Paper_Oct-23-07-en.pdf).

United Nations Program on HIV/AIDS (UNAIDS). (2006). *International Guidelines on HIV/AIDS and Human Rights*. Retrieved from [http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub07/jc1252-internguidelines\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub07/jc1252-internguidelines_en.pdf).

UNAIDS. (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

UNAIDS. (2009a). *UNAIDS Guidance Note on HIV and Sex Work*. Geneva: UNAIDS.

UNAIDS. (2009b) *HIV-Related Stigma and Discrimination: A Summary of Recent Literature*. Geneva: UNAIDS.

UNAIDS. (2011a). *The Report of the UNAIDS Advisory Group on HIV and Sex Work*. Geneva: UNAIDS.

UNAIDS. (2011b). *A New Investment Framework for the Global HIV Response*. Geneva: UNAIDS.

UNAIDS. (2012). *Country Statistics*. Retrieved July 18, 2013, from <http://www.unaids.org/en/dataanalysis/>.

UNAIDS Advisory Group. (2011). *The Report of the UNAIDS Advisory Group on HIV and Sex Work*. December 2011.

UNAIDS, United Nations Population Fund, and World Health Organization. (2009). *Condoms and HIV Prevention: Position Statement by UNAIDS, UNFPA and WHO*. Retrieved January 18, 2012 from <http://www.unaids.org/en/resources/presscentre/featurestories/2009/march/20090319preventionposition/>.

UNAIDS and World Bank. (2010). *New HIV Infections by Mode of Transmission in West Africa: A MultiCountry Analysis, March 2010*. Retrieved May 25, 2013, from [http://www.unaids.org/en/media/unaids/contentassets/documents/countryreport/2010/201003\\_MOT\\_West\\_Africa\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/countryreport/2010/201003_MOT_West_Africa_en.pdf).

United States Government (USG). (2013). CIA The World Factbook. 2013. Retrieved June 4, 2013, from <https://www.cia.gov/library/publications/the-world-factbook/geos/to.html>.

World Health Organization (WHO). (1994). *A Declaration on the Promotion of Patients' Rights in Europe. European Consultation on the Rights of Patients. Amsterdam. 28–30 March, 1994*. Retrieved August 1, 2011, from [http://www.who.int/genomics/public/eu\\_declaration1994.pdf](http://www.who.int/genomics/public/eu_declaration1994.pdf).

WHO. (2007). *Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities*. Retrieved from <http://www.who.int/hiv/pub/vct/pitc2007/en/>.

WHO. (2011a). *Preventing HIV in Sex Work Settings in sub-Saharan Africa*. Geneva: WHO.

WHO. (2011b). *Prevention and Treatment of HIV and Other Sexually Transmitted Infections Among Men Who Have Sex with Men and Transgender People*. Retrieved from [http://www.who.int/hiv/pub/populations/msm\\_mreport\\_2008.pdf](http://www.who.int/hiv/pub/populations/msm_mreport_2008.pdf).

Wilson, D., and S. Challa. (2009). "Ch.1 HIV Epidemiology: Recent Trends and Lessons." *The Changing HIV/AIDS Landscape: Selected Papers for the World Bank's Agenda for Action in Africa, 2007–2011*. Washington, DC: World Bank Publications.

Wilson, D., and N. Fraser. (2011). *Mixed HIV epidemic dynamics: Epidemiology and program implications*. Accra: PEPFAR Technical Consultation on HIV Prevention in Mixed Epidemics, AIDSTAR-One.

Wilson, D., and D.T. Halperin. (2008). "Know your epidemic, know your response: a useful approach, if we get it right." *Lancet* 372(9637): 423.

World Bank and National Agency for Control of AIDS (NACA). (2008). *Nigeria Epidemiology and Response Synthesis Report*. Abuja: The World Bank and NACA.





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