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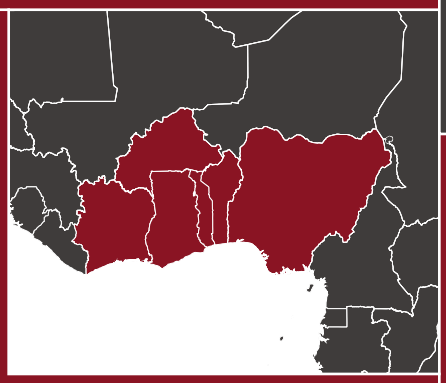
KEY POPULATIONS POLICY ANALYSIS



Countries Along the Abidjan-Lagos Corridor (Côte d'Ivoire, Ghana, Togo, Benin, and Nigeria) and Burkina Faso

This publication was prepared by Sandra Duvall, Patrice Sanon, Márcio Maeda, and Uduak Daniel of the Health Policy Project.

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Key Populations Policy Analysis

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This publication was prepared by Sandra Duvall,[1] Patrice Sanon,[2] Márcio Maeda,[1] and Uduak Daniel[2] of the Health Policy Project.

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CONTENTS

Acknowledgments ..... **iv**

Executive Summary ..... **v**
Background v
Objectives and Methodology v
Analysis Findings v
Discussion vii

Abbreviations ..... **viii**

Background **1**

Objectives and Methodology **3**

Analysis Findings **5**
Planning and Budgeting: National AIDS Strategies 5
Community Engagement 6
Legal Environment 8
Criminalization and Related Policies 9
Consent and Confidentiality 10
Stigma and Discrimination and Gender-Based Violence 12
Service Provision and Availability 13
Migration and Mobile Key Populations 16

Challenges and Limitations **19**

Discussion **20**

References **22**

Annex 1: List of Policy Documents Reviewed by Country **26**

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[1] 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/t/HIVPolicyModels.cfm.

EXECUTIVE SUMMARY

Background

Countries in West Africa (WA) have made significant progress in addressing the HIV epidemic. However, HIV prevalence among sex workers (SWs) and men who have sex with men (MSM) remains high, and data are unavailable for transgender (TG) populations. Services that meet the needs of SWs, MSM, and TG are often unavailable outside of major cities. Stigma and discrimination (S&D) against key populations impact service uptake and increase migration, making it harder to reach these populations. Policies—such as laws, national strategies, and operational procedures—impact service availability and uptake. To inform decisionmakers and improve access to HIV-related services for mobile SWs, MSM, and TG populations in West Africa, the USAID- and PEPFAR-funded Health Policy Project (HPP) conducted an analysis of key policies in countries along the Abidjan-Lagos corridor and Burkina Faso.

Objectives and Methodology

The HPP policy analysis was conducted May–July 2015 and builds on the momentum of the West Africa Health Organization's (WAHO) declaration of support to key populations. The analysis was conducted to inform advocacy for and development of national and regional policies to improve access to services for mobile key populations along the Abidjan-Lagos corridor. The analysis followed the approach of the HPP and African Men for Sexual Health and Rights (AMSHeR) *Policy Analysis and Advocacy Decision Model for HIV-Related Services (DM)*. HPP conducted an inventory and a comparative analysis to map current policies in the six countries to international best practices and human rights frameworks. HPP then identified 15 priority policy areas, selected and adapted from the *DM*, and added a short section for policies related to mobile key populations. Overarching policy areas included planning and budgeting of national AIDS strategies, community engagement, legal environment (including criminalization, consent, confidentiality, and S&D), service provision and availability, and migration and mobile populations. The HPP team reviewed 212 policy documents, including constitutional provisions, laws, national guidelines, other key policy documents, and earlier studies.

Analysis Findings

Planning and budgeting: national AIDS strategies

All national HIV strategies mention SWs and MSM; many include strategies to address HIV among these populations. Côte d'Ivoire, Ghana, Togo, and Benin have requirements for disaggregated data reporting of SWs and MSM, and specific budget line items for key populations. None of the policy documents mentioned or addressed TG persons.

Community engagement

Ghana, Togo, and Benin were the only countries to call for meaningful engagement of key populations in the development and implementation of policies and programs in their national HIV strategies, and Ghana was the only country with a specific mandate for a national key population technical working group. Nigeria's National HIV Prevention Technical Working Group, a subcommittee of the National Agency for the Control of AIDS, requires SW and MSM representation. Benin and Togo are the only countries with a policy requiring key population representation on their Global Fund Country Coordinating Mechanisms, with only Benin requiring both SW and MSM representation. None of the countries included in the analysis has an open, unrestricted operational process for registration of nongovernmental organizations (NGOs) that specifically guarantees registration for organizations comprised of or led by SWs, MSM, and/or TG persons.

Legal environment

Criminalization and related policies

All countries in the analysis except Benin have at least one law that criminalizes one or more key populations or their behavior, and soliciting for sex work is illegal in four countries; sex work itself is only criminalized in Ghana and Nigeria. Non-custodial alternatives to prison are available only in Ghana and Togo. Same-sex sexual behavior is criminalized in Ghana, Togo, and Nigeria, with non-custodial alternatives to prison unavailable in any of these countries. Nigeria has the harshest penalties, while Côte d'Ivoire and Burkina Faso have no laws regarding same-sex sexual behavior. No laws exist regarding cross-dressing or TG persons in any country. Only three countries (Côte d'Ivoire, Ghana, and Togo) had policies protecting NGOs and service providers from prosecution on charges of aiding and abetting.

Consent and confidentiality

All six countries have policies around consent and confidentiality. HIV policies generally follow best practices, but Togo, Benin, and Burkina Faso have exceptions to requiring informed consent. All countries except Nigeria have strict policies around confidentiality and have independent agencies established to address breaches of confidentiality. None of the countries protect a patient's medical and mental health records from being used in criminal charges against the patient. HIV law in Benin allows health providers to disclose a patient's HIV status without consent under unclear circumstances. Togo and Benin require sexually transmitted infections (STI) testing for SWs, but only Benin requires consent to share results with authorities. For adolescents, public health policy does not guarantee access to services without parental/guardian consent, but HIV testing and counseling (HTC) guidelines in all countries except Togo offer a lower minimum age of consent than for other medical testing and procedures. All countries except Burkina Faso call for putting the best interests of the child or adolescent first regarding parental reporting.

Stigma and discrimination and gender-based violence (GBV)

Anti-discrimination laws and public health policies in all countries—including those policies that address sexual and reproductive health (SRH) and HIV—state that they apply to all citizens. Only Ghana and Benin explicitly include SWs and MSM in anti-discrimination policies, and only Côte d'Ivoire and Ghana mention SWs and MSM in public health equal access policies. Benin and Burkina Faso are the only countries with public health anti-discrimination policies that mention equal access to public health, regardless of nationality. All countries except Burkina Faso and Côte d'Ivoire have government-led discrimination monitoring, reporting, and redress systems for people living with HIV (PLHIV), but only Ghana includes key populations. Laws in Côte d'Ivoire, Benin, and Burkina Faso include language to ensure equal application to both male and female survivors and perpetrators of gender-based violence.

Service provision and availability

All countries except Benin and Nigeria have a minimum package of services for SWs and MSM, but none has a minimum package for TG persons; Nigeria only has a minimum package of prevention services for SWs. None of the countries have "test and treat" policies, but all except Nigeria have policies outlining referrals for antiretroviral treatment and other services. Côte d'Ivoire, Ghana, and Benin call for and facilitate HIV, STI, and SRH service integration. Only HIV policies, not STI or SRH policies, in Nigeria and Burkina Faso call for integration. No countries in this analysis have written policies requiring training of healthcare providers or law enforcement around key populations or S&D. All countries have policies to guide procurement and distribution of condoms, but the pharmacy policy does not include lubricants. Lubricant and female condoms are included in HIV policy documents in Côte d'Ivoire, Ghana, Togo, and Benin, but clear procurement and distribution guidelines are needed.

Migration and mobile key populations

Public health policies in the six countries do not guarantee access to services for immigrants. HPP was unable to find any national policies or coordination mechanisms between migration or immigration and HIV, except the National Emergency Response Plan and Framework in Nigeria. None of the six countries included any national protocols for migrant-adapted HTC, patient monitoring, or treatment counseling. Côte d'Ivoire, Benin, and Burkina Faso do not have provisions for deportation of PLHIV, SWs, MSM, or TG persons. Immigration acts in both Nigeria and Ghana call for deportation of SWs and MSM, while Togo currently has no immigration policy.

Discussion

HPP found that all six countries included in this analysis have incorporated a number of policies based on international best practices and have increased programs to address the needs of key populations in recent years. Nonetheless, there are significant gaps in policies that explicitly support SWs, MSM, and TG persons, as well as laws criminalizing SW and MSM behavior.

Given the high level of mobility among key populations in the region, it will be essential to standardize supportive policies across countries and develop and implement clear policy for coordination mechanisms between HIV, STI, SRH, and migration/immigration. Data collection around key populations, including migration within and between countries, should inform programs and budgeting. Specific protocols for mobile key populations—such as confidential health passports and medication travel packs—and cross-border harmonization of policies and collaboration facilitated by regional organizations such as WAHO and the Abidjan-Lagos Corridor Organization would facilitate consistent access to HIV-related services and limit lapses in ART adherence for mobile key populations in the region.

ABBREVIATIONS

ALCO	Abidjan-Lagos Corridor Organization
AMSHeR	African Men for Sexual Health and Rights
ART	antiretroviral treatment
AWARE II	Action for West Africa Regional Project II
C/L	condoms and lubricant
CCM	Country Coordinating Mechanism
CRC	Convention on the Rights of the Child
DM	*Policy Analysis and Advocacy Decision Model for HIV-Related Services*
ECOWAS	Economic Community of West African States
GBV	gender-based violence
HPP	Health Policy Project
HTC	HIV testing and counseling
KP	key population
KP TWG	Key Populations Technical Working Group
MARP	most-at-risk population
NAC	National AIDS Commission
NACA	National Agency for the Control of AIDS
NFM	New Funding Model for the Global Fund
NGO	nongovernmental organization
NPTWG	National HIV Prevention Technical Working Group
MSM	men who have sex with men
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
SRH	sexual and reproductive health
STI	sexually transmitted infection
SW	sex worker
S&D	stigma and discrimination
TG	transgender
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
WA	West Africa
WAHO	West Africa Health Organization
WHO	World Health Organization

BACKGROUND

Countries in West Africa (WA) have made significant progress in addressing the HIV epidemic, as demonstrated by the decline in the number of new infections and AIDS-related deaths in the general population. According to data supplied by national AIDS commissions (NACs) in the region, regional HIV prevalence was reduced from 2.0 percent in 2009 to 1.6 percent in 2013 (WAHO, n.d). However, there are still considerable challenges to ending the epidemic in this region of heavy migration (United Nations, 2004; IOM, 2009).

The pooled HIV prevalence from 24 West and Central African countries was 17.7 percent among men who have sex with men (MSM) (range: 13.5–25.3%) and 34.9 percent among sex workers (SWs) (range: 25–54%) (Papworth, 2013). In Nigeria, even though HIV prevalence rates among the general population have decreased, prevalence among MSM actually increased between 2007 and 2014 (13.5–17.4%) (Charurat et al., 2015). Moreover, a recent analysis of data on SWs in WA indicates that epidemics in the region previously classified as generalized or mixed may actually be concentrated among key populations (Boily et al., 2015).

Although there are limited data on SWs and MSM in WA, with no data available at all for transgender (TG) populations, it is clear that current HIV efforts do not adequately target these populations (Wilson, 2009; MacAllister et al., 2015). Increased efforts to reach SWs, MSM, and TG persons in the region are needed to efficiently and effectively address the HIV epidemic there.

There is clear evidence on the impact of access to and uptake of HIV services for people living with HIV (PLHIV) on improved health outcomes and decreased risk of onward vertical and sexual transmission. Access to HIV-related services such as HIV testing and counseling (HTC), condom and lubricant (C/L) distribution and use, and prevention and treatment of sexually transmitted infections (STIs) are critical to reversing the epidemic among key populations. However, services that meet the needs of SWs, MSM, and TG persons are often unavailable, and reaching these populations can be challenging.

Stigma and discrimination (S&D) impede access to and uptake of essential HIV-related services. Studies from Nigeria, Namibia, Botswana, and Malawi provide evidence that S&D—or fear of potential S&D on the part of healthcare providers—negatively impacts uptake of essential HIV-related services for MSM (Charurat et al., 2015; Baral et al., 2009; and Fay et al., 2010). Moreover, studies in the region show that gender-based violence (GBV) against SWs and MSM is common and that it plays a role in uptake of prevention strategies and services (Onyango et al., 2015; Wirtz et al., 2015; SOW, 2013; Duvall et al., 2012).

Migration within and between countries is common in WA and is facilitated by the Economic Community of West African States' (ECOWAS) free movement protocols, particularly in countries along the Abidjan-Lagos corridor (Côte d'Ivoire, Ghana, Togo, Benin, and Nigeria) and other neighboring countries, including Burkina Faso (United Nations, 2004; IOM, 2009). S&D against key populations increases migration, making it harder to reach these populations with prevention services and ensure antiretroviral treatment (ART) adherence for PLHIV (Cohen and Trussel, 1996; Alary, 2002; IOM, 2012; Duvall et al., 2012; Dugas et al., 2015).

In Ghana, researchers found that 46 percent of SW respondents had traveled in the prior three months (IOM, 2012). A recent study in Benin found that 65 percent of SWs were "foreign born" and that 74 percent reported changing their work location at least once in the previous year (Dugas et al., 2015). In Burkina Faso, key informants working in a health facility indicated that MSM who fear being "outed" move between cities and neighboring countries every few months (Duvall et al., 2012).

Access to HIV-related services for mobile key populations in the region presents unique challenges, including finding "friendly" services; ART adherence; and disparate policies that impact service availability, access, and provision (including laws criminalizing sex work, soliciting, or same-sex sexual behavior) (Beardsley et al., 2014; Beyrer, 2014). Studies from Senegal and Nigeria demonstrate the negative impact of harsh criminalization laws on uptake and use of health services by MSM (Poteat et al., 2011; Schwartz et al., 2015b). In countries with such laws—particularly laws that criminalize aiding and abetting—providers may discontinue services for fear of retribution and legal arrests. Age of consent laws requiring parental permission and disclosure are another potential policy barrier to accessing services for young sex workers and MSM, represented in significant numbers in WA (Onyango et al., 2015; Grasso et al., 2015; Sow, 2013; Beardsley et al., 2014).

In contrast, supportive policies based on international best practices are essential to mandating provision of and access to services and ensuring their sustainability. Policies—including those that require participation of key population representatives on consultative committees, outline a population-specific minimum package of services, and explicitly include key populations in anti-discrimination legislation—are necessary for programs to meet the needs of key populations, increase uptake, and reduce HIV among SWs, MSM, TG persons, and their partners. Policies to mandate and guide integration of sexual and reproductive health (SRH) and HIV services increase entry points for testing, care, and treatment, particularly among SWs who may be more likely to access SRH services (Schwartz et al., 2015a; Papworth et al., 2015). Other policies such as operational guidelines, protocols, and budgets are critical to policy implementation.

OBJECTIVES AND METHODOLOGY

With support from USAID West Africa, and in collaboration with the Abidjan-Lagos Corridor Organization (ALCO) and two regional consultants, the USAID- and PEPFAR-funded Health Policy Project (HPP) conducted an analysis of essential policies impacting access to HIV-related services for SWs, MSM, and TG persons in five countries along the Abidjan-Lagos corridor (Côte d'Ivoire, Ghana, Togo, Benin, and Nigeria) and in Burkina Faso. The analysis was conducted from May–July 2015. It complements three prior analyses conducted under AWARE II and HPP (see Box 1) and builds on the momentum of the West Africa Health Organization (WAHO) declaration for support to key populations, signed by ECOWAS ministers of health at the WAHO Key Populations Regional Meeting in April 2015. The analysis was conducted to inform advocacy for and development of national and regional policies to improve access to services for key populations, particularly mobile key populations along the Abidjan-Lagos corridor. It focuses on the current legal, regulatory, and policy environment related to key populations with a focus on SWs, MSM, and TG persons.

Box 1: Prior Policy Analyses

1. An Assessment of Policy toward Most-at-Risk Populations for HIV/AIDS in West Africa (2011) under Action for West Africa (AWARE-II) Project
2. Assessment of Gaps in Policies, Policy Implementation and Programs for Key Populations in Burkina Faso (2012) under Action for West Africa (AWARE-II) Project
3. Policy Analysis for Key Populations at Risk of HIV Infection in Togo (2013) under the Health Policy Project (HPP)

The analysis followed the HPP and African Men for Sexual Health and Rights (AMSHeR) *Policy Analysis and Advocacy Decision Model for HIV-Related Services (DM)* approach in conducting an inventory and analysis of existing policies and regulations. The *DM* approach maps service-specific policies to international best practices and human rights frameworks to identify needs and opportunities for policy advocacy that will help improve access to services.

Prior to beginning the analysis, HPP identified 15 priority policy areas, selected and adapted from the *DM*, and added a short section for policies related to mobile key populations. Following the *DM's* analysis and inventory data collection tool approach,[2] HPP compared current written country policies to international best practices and assessed the extent to which the policies enable or restrict implementation of HIV prevention, care, and treatment interventions for key populations (Beardsley et al., 2013).

HPP collected relevant policy documents using the following steps:

1. Made a list of potential relevant policy documents based on prior policy analyses in Burkina Faso and Togo and HPP experience in the region
2. Conducted online searches for policy documents using country names (i.e., Côte d'Ivoire, Ghana, Togo, Benin, Nigeria, and Burkina Faso), key words identified during prior policy analyses in the region, examples from the *DM*, and country-specific websites
3. Contacted regional and in-country partners and consultants, including HPP/Futures Group country offices, ALCO, and HPP advocacy workshop participants

Overarching policy areas included planning and budgeting of national AIDS strategies, community engagement, legal environment (including criminalization, consent, confidentiality, and S&D), service provision and availability, and migration and mobile populations. The documents reviewed included 212

[2] See the *Decision Model* to access the tools, available at www.healthpolicyproject.com/index.cfm?id=HIVPolicyModels.

constitutional provisions, laws, national guidelines, other key policy documents, and earlier studies (see Annex 1).

Note: In Burkina Faso and Togo, HPP collected policy documents developed and/or validated since the previous policy analyses conducted in 2012 (Burkina Faso) and 2013 (Togo), as well as immigration/ mobile population policy documents that were not included in the prior analyses. HPP used these documents to update data from the prior reports.

ANALYSIS FINDINGS

The findings presented in this section are organized according to the following five overarching policy areas used in the analysis. For each policy area, the authors describe key policy issues and their importance. They then present current policies in a table that compares each of the five ALCO countries (Côte d'Ivoire, Ghana, Togo, Benin, and Nigeria) and Burkina Faso with an emphasis on supportive (follows best practices and/or supports access to services), restrictive (i.e., denying or impeding delivery of scientifically proven services), misaligned (i.e., different policies conflict), and/or absent (i.e., policy gaps) policies that may affect access to HIV prevention, care, and treatment and other related services for SWs, MSM, and TG persons.

Policy Analysis Table Key

Policy Classification	Corresponding Symbol
Supportive	√
Restrictive	X
Absent	O

Planning and Budgeting: National AIDS Strategies

International HIV guidelines ensure that national strategies and programming have clearly defined budgets and that program design and implementation are informed by scientific evidence. National strategies should identify key populations, and budgets should include specific budgeting for key populations programming. Moreover, population-specific data are needed to plan and implement HIV programs that adequately reach SWs, MSM, and TG persons.

All six West African countries in this analysis mention SWs and MSM in their national HIV strategies, and many included specific strategies to address HIV among these populations. TG individuals and communities are not mentioned in any of the national HIV strategies. Ghana mentions TG persons in the National Strategic Plan for Most at Risk Populations (2011), but does not include them in planning or strategies. Côte d'Ivoire, Ghana, Togo, and Benin have policies that require disaggregated data reporting of SWs and MSM. Côte d'Ivoire, Ghana, and Benin have specific budget line items for key populations. Although the document is not validated at this time, Burkina Faso has included a specific budget for key populations in the forthcoming strategic framework. Finally, none of the countries analyzed except Ghana mentioned or addressed TG persons.

Table 1. HIV Planning and Budgeting Policy in Abidjan-Lagos Corridor Countries and Burkina Faso

Policy	Abidjan-Lagos Corridor Countries					Other WA
	Côte d'Ivoire	Ghana	Togo	Benin	Nigeria	Burkina Faso
1. SWs mentioned in national HIV strategy	√	√	√	√	√	√
2. MSM mentioned in national HIV strategy	√	√	√	√	√	√
3. TG persons mentioned in national HIV strategy	O	√	O	O	O	O
4. SWs: Requires disaggregated data reporting by population	√	√	√	√	O	O
5. MSM: Requires disaggregated data reporting by population	√	√	√	√	O	O
6. TG: Requires disaggregated data reporting by population	O	O	O	O	O	O
7. Policy has designated budget line for key populations and evidence basis for funding decisions	√	√	√	√	O	√

Community Engagement

UNAIDS guidance for SWs, MSM, and TG persons calls for community empowerment and engagement in the design, implementation, and monitoring of policies and programs (UNAIDS, 2012; UNAIDS, 2014a; UNAIDS, 2014b). Formal and regular mechanisms for engaging key populations, including in donor partnership agreements and global fund applications and funding priorities, are necessary to ensure that engagement is consistent and sustainable and that programs meet the needs of key populations. At the same time, clear processes are needed for open, unrestricted access to register as a nongovernmental organization or other type of civil society association in order to ensure formal channels for participation. Although some countries engage key populations, either regularly or in an ad hoc manner without formal policies and implementation mechanisms, sustainable engagement cannot be guaranteed. For example, Burkina Faso recently added SWs and MSM representatives to its Global Fund Country Coordinating Mechanism (CCM). Although this is a major step forward in terms of meaningful engagement and ensuring that policies and programs meet the needs of these populations, there are no policy requirements. As such, their representation is not guaranteed in the future.

Although national HIV strategies in Ghana, Togo, and Benin call for meaningful engagement of key populations in development and implementation, their representation is not required on the National AIDS Commission there or in any of the other three countries. HPP found that Ghana was the only country with a mandate for a national key populations technical working group (KP TWG), although HPP staff in Côte d'Ivoire reported that a KP TWG exists there and is mentioned in the national strategic plan. Nigeria has a National HIV Prevention Technical Working Group (NPTWG), which is a subcommittee of the National Agency for the Control of AIDS (NACA) and requires SW and MSM representation.

Although a few countries have SW and/or MSM representation on the CCM, Benin and Togo are the only countries with policies that require key population representation on the mechanism. Only Benin

specifically requires SW *and* MSM representation. A 2014 report from Nigeria on engagement of SWs in the Global Fund new funding model (NFM) describes meetings with SWs and plans to "systematize and strengthen ongoing … [key populations] engagement" (Nigeria NACA, 2014).

No countries included in the analysis have an open, unrestricted operational process for registration of NGOs that specifically guarantees registration for SW, MSM, and/or TG organizations, although SW-led associations exist in Côte d'Ivoire, Nigeria, and Burkina Faso. In fact, a 1901 law in Benin specifically denies the formation of any group or organization that is for an "illicit cause, against the law, (or against) morality … " (Government of Benin, 1901). This law could potentiality be used as the basis for denying key populations registration as an organization or association, although this is unlikely since the law is misaligned with the national strategic plan, which includes "reinforcing collaboration between MSM organizations."

Table 2. Policy for Community Engagement in Abidjan-Lagos Corridor Countries and Burkina Faso

Policy	Abidjan-Lagos Corridor Countries					Other WA
	Côte d'Ivoire	Ghana	Togo	Benin	Nigeria	Burkina Faso
1. Requirements for SWs (or organizations serving them) to be on CCMs	O	O	√	√	O	O
2. Requirements for MSM (or organizations serving them) to be on CCMs	O	O	√	√	O	O
3. Requirements for TG persons (or organizations serving them) to be on CCMs	O	O	O	O	O	O
4. Requirements for SW representation on national multisectoral HIV/AIDS coordination bodies (National AIDS Council or equivalent)	O	O	O	O	O NP TWG only	O
5. Requirements for MSM representation on national multisectoral HIV/AIDS coordination bodies (National AIDS Council or equivalent)	O	O	O	O	O NP TWG only	O
6. Requirements for TG representation on national multisectoral HIV/AIDS coordination bodies (National AIDS Council or equivalent)	O	O	O	O	O	O
7. Mandate for a national and/or subnational key populations technical working group (KP TWG)	Unclear	√	O	O	O	O
8. Open, unrestricted process for registration of NGOs that specifically supports registration of NGOs comprised of SWs, MSM, and/or TG persons	O	O	O	X	O	O

Legal Environment

Although the legal environment covers many policies that impact key populations' access to HIV-related services and affect their human rights, the HPP policy analysis focused on those that have the greatest impact on service availability and uptake for these populations. Criminalization of key populations and/or their behavior are among the most analyzed and publicized barriers to accessing services and the realization of human rights. However, issues around consent for testing and care and confidentiality of healthcare and information can also play a large role in whether key populations—particularly adolescents—are able and willing to seek healthcare. Addressing stigma and discrimination, including

ensuring access to assistance for survivors of gender-based violence, is arguably the single greatest way to improve availability and uptake of services for key populations.

Criminalization and Related Policies

Benin was the only country in this analysis that did not have at least one law criminalizing one or more key populations or their behavior. Benin and Nigeria are the only two countries that do not criminalize solicitation for sex work. More broadly, sex work is only criminalized in Ghana and Nigeria. Non-custodial alternatives to prison, which are preferable in countries where behaviors are criminalized, are only available in Ghana and Togo.

Same-sex sexual behavior is criminalized in Ghana, Togo, and Nigeria, with no option for non-custodial alternatives to prison. Nigeria has the severest penalties, with the Same-Sex Marriage Prohibition Act exercising a maximum prison sentence of 14 years and Shari'a law in the northern states applying death by stoning to all Muslims. Côte d'Ivoire and Burkina Faso have no laws regarding same-sex sexual behavior. Reflecting the general lack of policy and programming for TG populations in the region, no laws exist regarding cross-dressing or TG persons.

To ensure availability of services in countries where behavior is criminalized, NGOs and providers—including health providers and outreach workers—must be protected from prosecution on charges of aiding and abetting. The HPP policy analysis revealed that three countries (Côte d'Ivoire, Ghana, and Togo) have policies guaranteeing this protection. The remaining three (Benin, Nigeria, and Burkina Faso) did not have these protective policies.

Table 3. Criminalization in Abidjan-Lagos Corridor Countries and Burkina Faso

Policy	Abidjan-Lagos Corridor Countries					Other WA
	Côte d'Ivoire	Ghana	Togo	Benin	Nigeria	Burkina Faso
1. Sex work is **not** criminalized	√	X	√	√	X	√
2. Soliciting for sex work is **not** criminalized	X	X	**X**	√	X	X
3. Same-sex sexual behavior is **not** criminalized	√	X	X	√	X	√
4. Transgender identity or gender nonconformity is **not** criminalized	√	√	√	√	√	√
5. Alternatives to prison are available for people convicted of offenses related to sex work, prostitution, or solicitation	X	√	√	N/A	X	X
6. Alternatives to prison are available for people convicted of offenses related to same-sex sexual behavior	X	X	X	N/A	X	N/A
7. NGOs and providers are explicitly protected from prosecution on charges of aiding and abetting	√	√	√	X	X	X

Consent and Confidentiality

WHO and UNAIDS guidance around HTC includes obtaining informed consent and ensuring confidentiality (WHO 2007). More broadly, the Declaration on the Promotion of Patients' Rights in Europe states that "the informed consent of patients is a prerequisite of any medical intervention" and that "confidential information can only be disclosed if the patient gives explicit consent or if the law expressly provides for this" (WHO, 1994, p. 11). For reproductive health, HIV, and STIs (particularly for key populations), fear of breaches in confidentiality can be the single greatest barrier to accessing services, including treatment and care.

All countries included in this analysis have policies around consent and confidentiality. HIV policies generally follow best practices but are often misaligned with broader public health policies, which may not require consent and/or confidentiality, or have clauses that are not aligned with best practices. For example, Togo, Benin, and Burkina Faso have exceptions to requirements for informed consent. SWs may be subjected to mandatory STI testing in Togo, while HIV law in Benin is unclear and appears to give leeway for testing of key populations without consent (see Box 2). In Burkina Faso, health providers may conduct HIV testing without consent in pregnant women or as part of a physical exam in ill patients.

Box 2. Benin HIV Law, article 13

"The State shall take all necessary measures for mandatory medical monitoring of people with high potential for transmission of HIV, such as sex workers, homosexuals and intravenous drug users, and encourage voluntary test HIV."

All countries except Nigeria have strict policies around confidentiality. Nigeria is also the only country that does not have an independent agency established to address breaches of confidentiality and related sanctions for the unauthorized release of confidential information. None of the six countries has a policy that explicitly protects medical and mental health records from being used to investigate, initiate, or substantiate criminal charges against individuals using program services. Moreover, HIV law in Benin allows health providers to disclose a patient's HIV status without consent in "cases of extreme necessity" and if the provider deems the person's behavior to be "likely to put the health of others in danger." The policy provides no guidelines for determining situations and behaviors that fall under these categories, leaving the policies open to interpretation and abuse. Finally, Togo and Benin require STI testing of SWs, but only Benin requires consent to share results with authorities.

Although the 1989 Convention on the Rights of the Child (CRC) calls for the best interest of the child as a primary consideration (CRC, Article 3), national consent and confidentiality policies often require obtaining parental consent for adolescent access to services and/or require notification of a parent or guardian of an adolescent's medical status. These policies pose additional barriers for young SWs, MSM, or TG persons' access to services. For young key populations in the six countries, policy around consent is generally unclear or misaligned across different policies. For example, wider public health consent policy does not guarantee access to services for adolescents without parental (or guardian) consent. However, HTC guidelines in all countries in this analysis except Togo include lower minimum ages of consent, with an average age of 15, and/or the maturity of the youth as a consideration. In Togo, the latest operational plan for HIV (2014–2015) includes specific strategies and outcomes for HTC among youth (ages 15–24) but does not directly address age of consent. Other than Nigeria and Burkina Faso, all countries follow best practices regarding parental or guardian reporting in terms of putting the best interests of the child or adolescent first.

Table 4. Requiring Consent and Confidentiality in Abidjan-Lagos Corridor Countries and Burkina Faso

Policy	Abidjan-Lagos Corridor Countries					Other WA
	Côte d'Ivoire	Ghana	Togo	Benin	Nigeria	Burkina Faso
1. Adolescents have the right to access information on medical services regardless of parental consent	√	√	√	√	√	√
2. Adolescents have the right to access medical services regardless of parental consent	X	X	X	X	X	X
3. Parental or guardian reporting of children's medical status requires due regard for the principle that the best interests of the child or adolescent are paramount	√	√	√	√	O	O
4. HTC guidelines allow testing without parental consent for adolescents under the age of consent	√ Age: 15	√ Age: 15 or "mature minor"	unclear	√ Age: not defined	√ Age: 16	√ Age: 15 or "deemed mature"
5. Informed consent is required for **all** medical testing and treatment	√	√	X	X	O	X
6. HCT services, including receipt of test results, are available on a **confidential basis**	√	√	√	√	√	√
7. Explicit protection of confidentiality of individual-level data	√	√	√	√	O	√
8. If mandatory testing exists for SWs, policy states that **confirmation of testing is provided to the relevant authorities, but that the test results are not disclosed** without the consent of the individual	N/A	N/A	O	√	N/A	N/A
9. Explicit protection from medical and mental health records being discoverable or admissible during legal proceedings for the purposes of proving MSM/TG/SW identities or behaviors	O	O	O	O	O	O

Policy	Abidjan-Lagos Corridor Countries					Other WA
	Côte d'Ivoire	Ghana	Togo	Benin	Nigeria	Burkina Faso
10. Independent agency established to address breaches of confidentiality and related sanctions for the unauthorized release of confidential information	√	√	√	√	O	√

Stigma and Discrimination and Gender-Based Violence

In general, S&D has decreased for PLHIV in West Africa. However, SWs, MSM, and TG persons still face extremely high levels of S&D, including violence and fear for their safety (Poteat et al., 2011; Sow, 2013; Wirtz et al., 2015; Grasso et al., 2015; Duvall et al., 2012; Duvall et al., 2013). S&D is widely accepted as one the greatest barriers to access to and uptake of health services for key populations, and the literature points to the impact of S&D on HIV prevention method and service uptake (AIDS Alliance, 2008; Rhodes et al., 2008; Koblin et al., 2006; Decker et al., 2013;Wechsburg et al., 2005; Hladik, 2012; Onyango et al., 2015; Duvall et al., 2012).

> "Taking into consideration an individual's birth, origin or national or ethnic origin, sex, religion, philosophical opinion, political or trade union or any other personal condition or social, such as a physical or mental disability, his/her way of life, customs or sexual orientation, is a discriminatory motive."
>
> Benin Penal Code: Chapter V Discrimination Infractions Article 338

All six countries in this analysis have anti-discrimination laws and public health policies, including SRH and/or HIV laws, that state applicability to all citizens. Ghana and Benin are the only countries to explicitly include SWs and MSM in anti-discrimination policies, although Côte d'Ivoire includes people "infected and affected" by HIV with no clear definition of those "affected." Only Côte d'Ivoire and Ghana mention SWs and MSM in public health equal access policies. Only Benin and Burkina Faso have public health anti-discrimination policies that mention equal access to public health regardless of nationality. Without specifically including these populations, providers, law enforcement, and others may misinterpret the definition of "all citizens" and may not provide equal access to key populations and immigrants.

All countries except Burkina Faso and Côte d'Ivoire have government-led discrimination monitoring, reporting, discipline, and redress systems for PLHIV. However, only Ghana's system includes key populations.

Although SWs, MSM, and TG persons are not mentioned in any GBV laws or other policies, laws in Côte d'Ivoire, Benin, and Burkina Faso follow international best practices in language used to ensure that laws apply to both male and female survivors of GBV and to the entire range of sexual and gender-based violence. Penalties are equal for male and female rape in these countries as well. Rape laws in Ghana, Togo, and Nigeria identify the perpetrator as male and the survivor as female, with penalties only applying to male perpetrators of female survivors.

Table 5. Stigma and Discrimination Policy in Abidjan-Lagos Corridor Countries and Burkina Faso

Policy	Abidjan-Lagos Corridor Countries					Other WA
	Côte d'Ivoire	Ghana	Togo	Benin	Nigeria	Burkina Faso
1. Country-wide anti-discrimination policy specifically includes SWs, MSM, TG persons, sex work, sexual orientation, and/or gender identity	O	√	O	√	O	O
2. Implements and monitors national approach to reduce S&D against SWs, MSM, and/or TG persons	O	O	O	O	O	O
3. Anti-discrimination in healthcare policy specifically prohibits discrimination based on SW, MSM, TG, sex work, sexual orientation, and/or gender identity	O	√	O	√	O	O
4. Anti-discrimination in healthcare policy specifically prohibits discrimination based on residency and citizenship	O	O	O	√ Nationality only	O	√
5. Public health equal access policy includes SWs, MSM, and TG persons	√	√	O	O	O	O
6. Defined processes for filing discrimination complaints exist	O	√	√	√	√	O
7. Sexual and gender-based violence laws identify non-gender-specific descriptions of the victim and perpetrator	√	X	X	√	X	√
8. Sexual and gender-based violence laws include penetration of the mouth, anus, and vagina and include insertion of any body part or object	O	O	O	√	O	√
9. Equal punishment for rape of a man or a woman	√	X	X	√	X	√

Service Provision and Availability

UNAIDS and WHO recommendations for SWs, MSM, and TG persons include population-specific minimum packages of services based on scientific recommendations; continuum of care policy; and integration of SRH, STI, and HIV services to improve uptake of services and prevent loss to follow-up. Côte d'Ivoire, Ghana, Togo, and Burkina Faso now have a minimum package of services for SWs and MSM, although elements are missing from some of the strategies. For example, Burkina Faso has a minimum prevention package for key populations, but the STI screening policy does not specifically

mention oral STI screening. Nigeria has a minimum package of prevention services for SWs, but none for MSM. HPP was unable to find a minimum package of services for SWs or MSM in Benin, but the country's recent national HIV strategic plan calls for the creation of services "adapted to the needs of SWs and MSM." None of the countries have a minimum package of services for TG persons.

Although none of the countries have "test and treat" policies to initiate immediate ART for everyone living with HIV, regardless of CD4 cell count, all except Nigeria have some type of continuum of care policy that requires referrals to ART and other HIV-related services. Policy in Nigeria is vague and only states that clients "should be referred." Detailed operational plans and specific protocols are needed to ensure policy is implemented in these countries.

Côte d'Ivoire and Ghana have multiple HIV, SRH, and STI policies calling for and facilitating integration; SRH and HIV policies in Benin also call for and facilitate integration. In Togo, Nigeria, and Burkina Faso, policies are misaligned, with HIV policy focusing on integration but SRH lacking any corresponding policies.

Training of health providers, health center staff, and law enforcement is critical to ensuring that services meet SW, MSM, and TG needs and to decrease S&D. None of the countries in this analysis had written policies requiring training on key populations' health needs, human rights, or S&D. However, the Ghana National AIDS, HIV and STI Strategy states that the government "should ensure training," and national HIV strategies in Cote d'Ivoire, Togo, and Benin include activities and indicators around capacity strengthening for health providers and/or health structures around SW and MSM health needs.

Condoms and lubricant are an essential element in prevention strategies for key populations. All countries had pharmacy and HIV policies to guide procurement and distribution of condoms. However, pharmacy policies and essential medicine lists in the countries studied did not include lubricant, except in Benin, where policy was unclear. Only Côte d'Ivoire's pharmacy policy included procurement and distribution of female condoms. HIV policy in Côte d'Ivoire, Ghana, Togo, and Benin includes procurement and distribution of lubricant and female condoms, but there are no clear procurement or distribution guidelines. Although Nigeria's pharmacy and HIV policies do not include procurement and distribution of lubricant or female condoms, the minimum prevention package policy document prioritizes the distribution of both. A draft of Burkina Faso's new national strategic plan includes lubricant, but the plan had not been validated at the time of publication.

Table 6. Service Provision in Abidjan-Lagos Corridor Countries and Burkina Faso

Policy	Abidjan-Lagos Corridor Countries					Other WA
	Côte d'Ivoire	Ghana	Togo	Benin	Nigeria	Burkina Faso
1. Minimum package of services for SWs based on internationally recognized scientific basis	√	√	√	O	O Prevention only	√
2. Minimum package of services for MSM based on internationally recognized scientific basis	√	√	√	O	O	√
3. Minimum package of services for TG persons based on internationally recognized scientific basis	O	O	O	O	O	O
4. Test and treat for all PLHIV	X	X	X	X	X	X
5. Training requirements for health providers and law enforcement include key populations and S&D	O	O	O	O	O	O
6. HIV, STI, and reproductive health integration	√	√	Misaligned	√	Misaligned	Misaligned
7. Pharmacy policy directs procurement and decentralized distribution of lubricant (including lubricant on essential medication list)	O	O	O	Policy unclear	O	O
8. HIV condom policy directs procurement and decentralized distribution of lubricant	√	√ MARPs strategy	√	√	O	√ National Strategic Plan
9. Pharmacy policy directs procurement and decentralized distribution of female condoms	√	O	O	Policy unclear	O	O

Policy	Abidjan-Lagos Corridor Countries					Other WA
	Côte d'Ivoire	Ghana	Togo	Benin	Nigeria	Burkina Faso
10. HIV condom policy directs procurement and decentralized distribution of female condoms	√	√ MARPs strategy	√	√	O	O
11. Mechanisms for SWs, MSM, and/or TG persons to participate in product selection	O	O	O	O	O	O

Migration and Mobile Key Populations

In 2001, all United Nations member states adopted the United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS, which calls for "national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrant and mobile workers" (UNAIDS, 2001, p. 7). UNAIDS points to increased HIV risk and barriers to accessing services for migrants, and calls for policy to ensure that migrants have the same rights to access healthcare, particularly HIV services (UNAIDS, 2008).

Although public health policies in the six countries do not specifically require citizenship to access health services, they do not guarantee access regardless of nationality, immigration status, or possession of a national identity card. Rights are only guaranteed to "all citizens." The Togolese constitution states that "the state has the obligation to guarantee the physical and mental integrity, life and safety of everyone living in the national territory," but contains no supporting policies. These policy gaps enable providers to refuse provision of services to mobile key populations and pose a barrier to service uptake, particularly in areas where specialized services for key populations do not exist and government health services are the only option.

As ECOWAS members, the six countries adopted the ECOWAS Common Approach on Migration in 2008. This document includes principles of free movement of persons within the ECOWAS zone, harmonizing policies, protecting the rights of migrants, and recognizing the role of gender on migration. It specifically calls for states to harmonize national migration policies with all other national sector development policies, thus encompassing public health, SRH, and HIV.

Although HPP was unable to find any national policies or coordination mechanisms between migration or immigration and HIV prevention, care, and treatment for the general population or for key populations (other than the Nigeria National Emergency Response Plan and Framework), a consultant in-country and Mieux II report provide evidence that Togo has begun planning the development of a multisectoral immigration policy (Adjei and Mayer, 2013).

HPP did not find any HIV or SRH protocols for migrant-adapted HTC, patient monitoring, or treatment counseling. Without these supportive policies, loss to follow-up, problems with ART adherence, and breaches in confidentiality are more likely.

While immigration policies in Côte d'Ivoire, Benin, and Burkina Faso do not have provisions for deportation of PLHIV, SWs, MSM, or TG persons, they do not include any supportive policies either. Immigration policy in Nigeria does not call for deportation of PLHIV, and Togo currently has no immigration policy at all. HPP in-country contacts reported that discussions are underway to develop a comprehensive immigration policy in Togo.

In Ghana, immigration policy is unclear regarding deportation of PLHIV and leaves room for interpretation (see Box 3). Immigration acts in both Nigeria and Ghana appear to call for deportation of SWs and MSM. Deportation of TG persons is open to interpretation of the ministry and/or immigration officer, with Ghana immigration authorities able to make the decision that the person's "presence in Ghana is … not conducive to the public good" (Parliament of the Republic of Ghana, 2000). Ghana also requires all immigrants to be in possession of a valid passport or other travel document.

Box 3. Ghana Immigration Act, 2000 (ACT 573)

"A Person other than a citizen of Ghana is a prohibited immigrant for the purposes of this Act if that person …
(f) has been declared by the Minister by executive instrument to be a person whose entry into Ghana is not conducive to the public good
(g) is a person whose activities are contrary to the laws of Ghana …

A person who enters Ghana while he is a prohibited immigrant … is liable … to a fine not exceeding ten million cedis or to imprisonment for a term of not less than six months and not exceeding two years or to both.

A foreign national is liable to deportation if— …
(c) he is a prohibited immigrant;
(e) his presence in Ghana is in the opinion of the Minister not conducive to the public good …"

The Nigeria Immigration Act's list of prohibited immigrants ineligible for entry and subject to deportation includes "any idiot, insane person, or person suffering from any other mental disorder"—with no clear definition of terms—anyone who "has not in his possession a valid passport," and "any prostitute." These immigration policies force migrant key populations underground and may discourage their uptake of HIV-related services, particularly in healthcare facilities requiring national identity cards and for migrant key populations fearing breaches in confidentiality. Nigeria's laws around aiding and abetting (see criminalization section) compound this issue.

Table 7. Mobile Key Populations in Abidjan-Lagos Corridor Countries and Burkina Faso

Policy	Abidjan-Lagos Corridor Countries					Other WA
	Côte d'Ivoire	Ghana	Togo	Benin	Nigeria	Burkina Faso
1. Coordination mechanisms exist between migration/ immigration and HIV prevention, care, and treatment for key populations	O	O	O	O	O Only emergency response	O
2. No explicit deportation of PLHIV	√	Unclear	√	√	√	√
3. No explicit deportation of SWs	√	X	√	√	X	√
4. No explicit deportation of MSM	√	X	√	√	Unclear	√
5. No explicit deportation of TG persons	√	√	√	√	Unclear	O
6. Guaranteed access to health services regardless of nationality	O	O	O	O	O	O
7. Guaranteed access to health services with or without possession of a national identification card	O	O	O	O	O	O
8. Protocols for patient monitoring adapted to mobile populations	O	O	O	O	O	O
9. HTC protocols include migrant-adapted treatment counseling	O	O	O	O	O	O
10. HIV treatment protocols include migrant-adapted treatment counseling	O	O	O	O	O	O

CHALLENGES AND LIMITATIONS

The main challenge HPP faced was in accessing certain policy documents. HPP hired a consultant in Nigeria and worked with in-country partners in the remaining five countries to address this challenge. In Burkina Faso, the national strategic plan is currently undergoing revisions that have not been finalized and validated; as such, it could not be included as a validated policy in this report. HIV policies in Nigeria are undergoing modifications at this time and final policies are not available.

Among other limitations, the analysis was a snapshot of selected key policies to compare across countries, rather than an in-depth policy analysis. However, the focus of the analysis was on mobile key populations and standardizing policies across countries. It focused exclusively on written policies and, as such, did not include policy implementation, which would have required key stakeholder interviews. A limitation of this approach is that even when supportive policies exist, they may not be implemented.

Although the analysis focused on international standards, it should be noted that not all policies and laws are appropriate to and applicable in all countries. The standards identified in this analysis are based on the language and context of international documents and best practices, but may need to be adapted in some instances. 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. This could be supported by in-country and/or regional validations 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 each country and across the region.

Finally, this analysis focused exclusively on SWs, MSM, and TG persons. It did not include all key populations, most notably people who inject drugs and detainees or prisoners.

DISCUSSION

This policy analysis provides insight into the current policy environment for key populations in countries along the Abidjan-Lagos corridor and in Burkina Faso, including both improvements to policies that impact SWs and MSM and policy barriers to service availability and uptake. With support from USAID West Africa and ALCO, HPP conducted this policy review and analysis of 212 policy documents from the six countries. This is the first time that such a range of policies impacting mobile key populations has been analyzed and compared across these countries.

Box 4. Policies for Mobile Key Populations

1. Cross-border, multisectoral collaboration (health and immigration) with clear coordination mechanisms
2. National policies recognizing immigrant and key population rights to access health services
   - Access to language- and culturally appropriate services
   - Access without national ID card or with any ECOWAS country ID card
3. Standardized ART protocols across countries
4. HCT and ARV/HIV treatment and care protocols adapted for mobile key populations; examples include
   - Patient-held "health passport"
   - Returning patient questionnaire
   - Development and dissemination of "road maps" for care (map of alternate treatment sites in the region)
   - Use of "safe travel packs" of medications

HPP found that the Abidjan-Lagos corridor countries and Burkina Faso have all recently incorporated a number of policies based on international best practices and have increased programs to address the needs of key populations. For all six countries, SWs and MSM are mentioned in the national HIV strategy, and all except Benin have some form of population-specific minimum package of services. All countries except Nigeria also have policies to test and treat, and Burkina Faso and Côte d'Ivoire are the only countries that lack a discrimination reporting system for PLHIV. Lubricant, a key element in prevention efforts for key populations, is mentioned in at least one HIV document in all countries.

Nonetheless, there are significant gaps in policies, particularly with regard to those that explicitly support SWs, MSM, and TG persons. Gaps remain even in countries like Côte d'Ivoire, Ghana, Togo, and Benin that have seen the addition of a significant number of supportive policies, including a total lack of policies for TG persons in any of the six countries. Moreover, S&D are still major barriers, with laws criminalizing SW and/or MSM behavior in all countries except Benin. Ghana and Nigeria also have immigration policies to deport SW and MSM immigrants, a potential impediment to accessing services for key populations who fear being "outed" and, consequently, deported. In fact, none of the countries included in the analysis require training of health providers and law enforcement around key populations and S&D.

Some of the countries in this analysis have begun to engage SWs and MSM in policy development and/or program implementation. This is the case in Burkina Faso, where SWs and MSM were invited to participate in development of the new national strategic framework; and in a number of countries, where SWs and MSM are represented on the CCM. However, with no policy to require or guarantee their participation—as is the case for all countries other than the CCMs in Benin and Togo—there is a risk that their participation will be ad hoc, or that a change in administration or leadership could result in their removal from the participatory processes.

Given the high level of mobility among key populations in the region, steps must be taken to ensure that policies and programs facilitate their access to services, both within and across countries. The following

actions would build on the results of this analysis and begin a process to improve the policy environment for mobile key populations:

- Stakeholder meetings to validate the findings of this analysis, share lessons learned across countries, and identify priorities
- In-depth analysis of ART protocols and guidelines across countries, including types of medications and regimens administered; guidelines and protocols for beginning and administering ART; and treatment of STIs and opportunistic infections to identify potential inconsistencies and standardize protocols in the region
- Identification of key stakeholders and coordination mechanisms to support cross-border collaboration moving forward
    - Include regional stakeholders, such as WAHO and ALCO
- Cross-border collaboration and advocacy to standardize policies across countries (see Box 4)

Without a coordinated cross-border, multisectoral HIV and migration/immigration approach, mobile key populations along the Abidjan-Lagos corridor and throughout the region will continue to face significant barriers to accessing HIV-related services and adopting prevention strategies. Data collection around key populations, including migration within and between countries, is needed to inform policy, programs, and budgets. For future policies, countries will need to ensure operational plans and/or protocols, along with human and financial resources to ensure implementation. Finally, monitoring and evaluation of policy and program implementation will be essential to ensuring that policies are more than just a piece of paper.

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ANNEX 1: LIST OF POLICY DOCUMENTS REVIEWED BY COUNTRY

Regional

1. ECOWAS Protocol on Free Movement

Côte d'Ivoire

2. Loi n° 2004-303 du 3 mai 2004 portant modification de la loi n° 2002-03 relative à l'identification des personnes et au séjour des étrangers en Côte d'Ivoire
3. RCI (2010) *Politique Nationale de Population*. Republic of Côte d'Ivoire: Abidjan. http://www.onp-ci.org/DOCUMENT/PNP/PNP.pdf
4. Loi n° 72-833 du 21 décembre 1972 portant Code de procédure civile, commerciale et administrative ; 21 décembre 1972
5. Code civil ; 1804
6. Loi n°62-249 du 31 juillet 1962 instituant un code de déontologie pharmaceutique; 31 juillet 1962 ;
7. Mise en œuvre du programme d'action de Beijing (1995) et des textes issus de la vingt-troisième session extraordinaire de l'assemblée générale ; 2000 ; ministère de la famille, de la femme et de l'enfant
8. Décret n° 93-607 du 2 Juillet 1993, portant modalités communes d'application du statut général de la Fonction Publique ; 2 Juillet 1993 ;
9. Loi portant régime de prévention, de protection et de répression en matière de lutte contre le VIH et le sida - 11 Juillet 2014 ;
10. Loi n° 60-315 du 21 septembre 1960, relative aux associations
11. Loi sur la protection des données à caractères personnel du 19 juin 2013
12. Loi n° 92----570 du 11 septembre 1992 portant statut général de la Fonction Publique
13. Plan national de développement sanitaire 2012-2015 ; avril 2012 ; Ministère de la santé et de la lutte contre le sida ;
14. Plan Stratégique National de lutte contre le VIH/sida 2002-2004 ; Ministère Délégué auprès du premier ministre, chargé de la lutte contre le sida ;
15. Plan stratégique national de lutte contre l'infection à VIH, le sida et les IST 2011 – 2015 - Conseil National de Lutte contre le Sida
16. Politique de population et planification familiale; 2002 ; Amoakon ANOH, Raïmi FASSASSI et Patrice VIMARD
17. Politique nationale de lutte contre le VIH/sida en milieu de travail en côte d'ivoire ; 2006 ; Ministère de la fonction publique, de l'emploi et de la réforme administrative - Ministère de la lutte contre le sida
18. Politique nationale de prise en charge globale des personnes vivant avec le VIH dans le secteur sante- novembre 2005 ; Ministre d'Etat, Ministère de la santé et de la population
19. Le Programme National de la Santé de la Reproduction et de Planification Familiale en Côte d'Ivoire : quel avenir dans un contexte post-crise- DOUMBIA Mohamed
20. Population et développement : défis et perspectives pour la Côte d'Ivoire ; 2006 ; Ministre d'Etat, Ministre du plan et du développement
21. Stratégie Nationale de Communication pour le Changement de Comportement en matière de prise en charge des personnes vivant avec le VIH/SIDA en Côte d'Ivoire - Programme national de Prise en charge du VIH (PNPEC) du Ministère de la Santé et de l'Hygiène publique

22. Traite révisé de la communauté économique des Etats de l'Afrique de l'ouest (CEDEAO) ; 11 juin 2006 ; CEDEAO
23. Code électoral ; 11 juillet 2006- Commission Electorale Indépendante de Côte d'Ivoire (CEI
24. Constitution de la République de Côte d'Ivoire du 23 juillet 2000 ;
25. Loi n° 60-366 du 14 novembre 1960 portant code de procédure pénale ;
26. Loi n° 70-483 du 3 aout 1970, sur la minorité en RCI;
27. le droit des personnes et de la famille en Côte d'Ivoire - 07 janvier 1969 ; H. RAULIN Chargé de recherches au C.N. R.S.
28. Accord de coopération en matière de justice entre la République Française et la République de la côte d'Ivoire ; Avril 1961 ;
29. loi n° 61- 416 du 14 décembre 1961 portant code de la nationalité ivoirienne ;
30. Loi n° 60-315 du 21 septembre 1960, relative AUX ASSOCIATIONS)
31. Loi du 11 juillet 2014 portant régime de prévention, de protection et répression en matière de lutte contre le VIH et le SIDA
32. Loi n° 2014-390 du 20 juin 2014 d'orientation sur le développement durable
33. Loi n°95/15 du 12 janvier 1995 ; 12 portant Code du travail
34. Stratégie de relance du développement et de réduction de la pauvreté ; Janvier 2009
35. Résumé du document de politique nationale sur l'égalité des chances, l'équité et le genre ; famille, de la femme et des affaires sociales ; Ministère de la sante
36. Loi portant regime de prevention, de protection et de repression en matiere de lutte contre le VIH et le SIDA

Ghana

37. Constitution of the Republic of Ghana
38. Public Health Act 2012 Act 851 http://faolex.fao.org/docs/pdf/gha136559.pdf
39. National HIV, AIDS and STI Policy. Ghana AIDS Commission: February 2013.
40. Republic of Ghana, National HIV/AIDS Strategic Framework II http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_126718.pdf
41. Ghana AIDS Commission, Guidelines for Antiretroviral Therapy in Ghana http://ghanaids.gov.gh/gac1/pubs/Guidelines_for_Antiretroviral_Therapy_in_Ghana_2010_NACP.pdf
42. HIV/STI Peer Educator training. http://www.ghana.gov.gh/index.php/media-center/regional-news/649-77-hiv-stis-peer-educators-undergoes-training-in-techiman-ba-r
43. Ghana AIDS Commission, Terms of Reference/Data Quality Assessment 2014. http://ghanaids.gov.gh/gac1/pubs/TOR_DQA_2014.pdf
44. 2013 HIV Sentinel Survey Report. http://ghanaids.gov.gh/gac1/aids_info.php
45. Ghana Coalition of NGOs in Health. http://www.ghanahealthngos.net/?launch=what_we_do
46. Ghana Ministry of Health 2009 Report.
47. Ghana Criminal Code of 1960
48. Ghana Criminal Offenses Amendment Act 2012 (Act 849)
49. Ghana Domestic Violence Act, 2007(Act 732).
50. Criminal Code (Amendment) Act, 2007 (ACT 741)
51. Ghana Essential Medicines List
52. Ghana National Drugs Policy, 2nd Edition (2004)
53. Ghana National Strategic Plan for MARPS 2011-2015
54. Assessment of the Policy Environment for the Integration of Reproductive Health and HIV&AIDS Services in Ghana (HPI 2010)

55. The ECOWAS Common Approach on Migration. Policy Implications for Labour Migration and Development in Ghana (2009)
56. Ghana Adolescent Reproductive Health Policy (2000)
57. Ghana Health Service Reproductive Health Strategic Plan (2007-2011)
58. Ghana Immigration Act (2000, Act 573)
59. National Migration Policy for Ghana (2014)
60. Evaluation Plan for the Ghana National Strategy for Key Populations (2013)
61. Ghana Essential Medicines List (2004)
62. CCM Ghana (2014). Ghana Country Coordinating Mechanism (CCM) Constitution. http://ccmghana.net/index.php/constitution

Togo

63. La constitution de la IVème République togolaise
64. Politique Nationale de la santé du Togo (2012)
65. Politique Nationale des interventions à base communautaire (2009)
66. Loi d'orientation décennale portant Politique Nationale de Santé (2012)
67. Politique Nationale de lutte contre le sida au Togo : Vision 2020 (2012)
68. Plan stratégique national de lutte contre le SIDA et les IST 2012-2015 (2012)
69. Plan opérationnel de lutte contre le Sida et les IST 2012-2013 (2012)
70. Plan opérationnel de lutte contre le Sida et les IST 2014-2015 (2014)
71. Loi n°2009-007 portant code de la santé publique en république Togolaise (2009)
72. Loi n°2007-005 du 10 janvier 2007 sur la santé de la reproduction (2007)
73. Stratégie national de communication pour le changement de comportement an matière des IST, VIH-sida au Togo 2011-2015 (2011)
74. Loi n° 2010 – 17 du 31 déc. 2010 portantes protections des personnes en matière de VIH/SIDA (2010)
75. Politique national de lutte contre le VIH et sida sur le lieu de travail (2010)
76. Politique migratoire et intégration régionale de l'Afrique de l'ouest (2005)
77. Manuel de suivi et évaluation du SP/CNLS (2012)
78. Decret N° 2001-173 /PR portant création du conseil national de lutte contre le sida et les IST (2001)
79. 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)
80. Stratégie nationale d'intégration du genre dans les politiques et programmes au Togo (2006)
81. Code de sécurité sociale (2011)
82. 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)
83. Loi n°2011-014 portant organisation de l'activité statistique au Togo (2011)
84. Loi n°2007-012 du 14 Juin 2007 portant modification de la loi n°2000 (2007)
85. Loi n°80-1 instituant Code Pénal (1980)
86. Loi n°83-1 Instituant Code de Procédure Pénal (1983)
87. Loi n°2010-018 modifiant la loi n°005-12 du 14 Décembre 2005 portant protection des personnes en matière du VIH/SIDA (2010)
88. Loi n°2007-017 portant Code de l'Enfant (2007)
89. Loi n°2012-014 Portant Code des Personnes et la Famille (2012)
90. Loi n°2000-019 Portant Statut de Réfugiés au Togo (2000)
91. Lutte contre le SIDA Cadre Stratégique National (2012)
92. Politique et normes en sante de la reproduction, planification familiale et infections sexuellement transmissibles du Togo (2009)

93. Protocoles de Santé de la Reproduction, Santé de la Mère, Santé de l'Enfant, Santé des Jeunes et Adolescents (es), Santés des Hommes 2ème édition T I décembre 2009 (2009)
94. Programme National de Promotion et de Protection des Droits de l'Homme 2007-2010 (2007)
95. Plan d'Action Annuel VIH/SIDA du MDHCDFC (2013)
96. Poltique, Normes et Procedures du Conseil et Depistage du VIH au Togo, deuxième édition, Juin 2010 (2010)
97. Rapport Annuel PNLS Togo (2011)
98. Etude sur la gestion des préservatifs (Rapport final) (2009)
99. Protocole de la santé de reproduction (SR) du Togo, TOME2 (2009)
100. Document cadre de politique des pharmacies (2)013
101. Draft 1 National Pharmaceutical Policy—Togo version 22 05 2012 (2012)
102. Guide de prise en charge des IST (2010)
103. Organisation et gestion des produits pharmaceutiques (2011)
104. Prise en charge syndromique (N/D)
105. Protocole dépistage Togo (2010)
106. Protocole de la santé de reproduction (SR) du Togo. TOME 1 (2009)
107. Normes Sanitaires (2013)
108. Manuel de référence formation en CDV (2010)
109. Liste révisée des médicaments (2013)
110. Organisation et gestion des produits pharmaceutiques CAMEG (2011)
111. Politique Nationale de Prévention Combinée et de Prise en Charge Globale des IST et du VIH dans les Populations Clés au Togo (2013)
112. Le code de la nationalité du 7 septembre 1978 :
113. La loi relative à la police des étrangers du 18 Novembre 1987 et le décret N°96-113
114. Le code électoral du 05 avril 2000
115. La loi N°2000-019 du 29 décembre 2000
116. La loi N°2005 – 009 du 03 Août 2005
117. Visions Solidaires (2012). *Rapport 2012 sur le Droit des Migrants au Togo.* Lomé : Juin 2013.
118. Adjei, E and E. Mayer (2013). *Rapport de la Mission Exploiratoire Relative aux Politiques de la Migration et Developpement de la Republique du Togo*. Migration EU Expertise (Mieux II)

Benin

119. Recueil de textes sur les violences faites aux femmes et le droit des enfants en république du bénin ; 01/10/2003 ; bureau de la Coopération Suisse Bénin
120. VIH et droit au bénin : ce qu'il faut savoir ; Association des femmes juristes du Benin, Association Béninoise de droit du Développement
121. Code pénal Nouveau du Benin; 21 février 2005 ;
122. Arrêté 2014-N°269/ MS/DC/SGMCTJ/SP/CNC/SA portant création, composition, attributions, organisation et fonctionnement du Conseil National de Coordination et d'Orientation des interventions financées par le fonds mondial de lutte contre le VIH/sida, la tuberculose et le paludisme en République du Bénin ;
123. Evaluation rapide de la Planification Familiale au Bénin Rapport d'étude ; Septembre 2012.
124. Loi no87-015 du 21 septembre 1987 portant code de l'hygiène publique ;
125. Cadre stratégique national de lutte contre le VIH et le sida 2012-2016 ; Mai 2012 ; comité national de lutte contre le sida (CNLS)
126. Loi n° 2008-07 portant code de procédure civile, commerciale, sociale et administrative ; Octobre 2008

127. Loi n° 2012-15 portant code de procédure pénale en République du Bénin ;
128. Loi n°98-004 du 27 janvier 1998 portant Code du travail du Benin,
129. Code de déontologie des pharmaciens du Benin Ex ; Dahomey
130. Constitution de la République du Bénin
131. Convention collective générale du travail applicable aux entreprises relevant des secteurs privé et parapublic en REPUBLIQUE DU BENIN ; 30 Décembre 2005 ;
132. Loi no 2006-19 portant répression du harcèlement sexuel et protection des victimes en République du Bénin; 17 Juillet 2006 ;
133. Loi N° 2002 – 07 Portant Code des personnes et de la famille; 14 juin 2004 ;
134. Loi n° 2005-31 du 05 avril 2006 Portant prévention, prise en charge et contrôle du VIH SIDA en République du Bénin; 05 avril 2006 ;
135. Plan d'action national budgétisé pour le repositionnement de la planification familiale 2014-2018 au bénin ; Décembre 2013 ; Direction de la Santé de la Mère et l'Enfant (DSME)
136. Programme et plan d'action pour la mise en œuvre de la politique nationale de promotion du genre au Bénin 2010-2015 ; Décembre 2009 ; Ministère de la famille et de la solidarité Nationale
137. Politique nationale de promotion du genre au bénin ; *mars 2008 ;* ministère de la famille et de la solidarité nationale
138. Textes réglementaires en vigueur au ministère de l'intérieur et de la sécurité publique
139. Stratégie nationale multisectorielle de santé sexuelle et de la reproduction des adolescents et jeunes au bénin 2010-2020 ; juin, 2010 ; DSME
140. Loi n°2011-26 du 09 janvier 2012 Portant prévention et répression des violences fait aux femmes; mars 2012;
141. Loi portant protection des données à caractère personnel. http://www.afapdp.org/wp-content/uploads/2012/01/B%C3%A9nin-LOI-SUR-PROTECTION-DES-DONNEES-A-CARACTERE-PERSONNEL-2009.pdf
142. Code de déontologie des médecins: http://cojemeb.forumgratuit.org/t4-code-de-deontologie-medicale-en-republique-du-benin
143. National HIV Strategic Plan 2015-2017

Nigeria

144. Integrated National Guidelines for HIV, Prevention, Treatment and Care (2014).
145. National HIV Prevention Technical Working Group (NPTWG) Terms of Reference: 2nd draft
146. Strengthening and Systematizing Civil Society Engagement in the NFM in Nigeria: Report of the engagement with female sex workers
147. Draft constitution of National Network of Sex Work Projects
148. National guidelines for implementation of HIV prevention programmes for female sex workers in Nigeria (2014)
149. Development of a national HIV Emergency Preparedness Response and Plan Framework – Background and justification document
150. HIV Emergency Preparedness Response and Plan Framework
151. National HIV Counseling and Testing Guidelines 2011
152. Sexual and Reproductive Health and HIV integration PIP for New Funding Model document 2016- 2020
153. Local epidemic appraisal report 2013
154. National HIV/AIDS Strategic Plan 2010-2015. http://nigeria.unfpa.org/pdf/nsp.pdf
155. National HIV/AIDS Prevention Plan 2014-2015. http://sbccvch.naca.gov.ng/sites/default/files/National%20HIV%20PrevPlan%202014-2015(1).pdf

156. HIV Control Programme under Health Programs of the Lagos State. http://www.lagosstate.gov.ng/pagemenus.php?p=620&k=242
157. HIV/AIDS Anti-Discrimination Act 2014
158. Gender and HIV/AIDS Work Place Policy in the Civil Society Legislative Advocacy Center. http://www.cislacnigeria.net/wp-content/uploads/2012/06/CISLAC-Gender-and-HIV.AIDS-Workplace-Policy2.pdf
159. National Guidelines for Implementation of HIV Prevention Programmes for Female Sex Workers in Nigeria. http://sbccvch.naca.gov.ng/sites/default/files/FSW%20Guidelines%212%20Aug%202014.pdf
160. The National HIV/AIDS Monitoring and Evaluation Plan 2011-2016. http://sbccvch.naca.gov.ng/sites/default/files/NNRIMS%20Operational%20Plan%202011-2016.pdf
161. 2010 National HIV Sero-prevalence Sentinel Survey. http://www.nigeria-aids.org/documents/2010_National%20HIV%20Sero%20Prevalence%20Sentinel%20Survey.pdf
162. Code of Medical Ethics in Nigeria https://www.mdcn.gov.ng/
163. Sodomy Sections 130-131 Sodomy (Liwat). http://www.ecoi.net/local_link/188212/306191_de.html (other northern provinces in NG have the same)
164. Report on the Status of the Nigerian National HIV Monitoring and Evaluation System. http://www.cpc.unc.edu/measure/publications/sr-10-61/at_download/document.
165. National Guidelines for Implementation of HIV Prevention Programs for Female Sex Workers in Nigeria. http://nascp.gov.ng/demo/wp-content/uploads/2014/02/National-Guidelines-for-Implementation-of-HIV-Prevention-Programs-for-FSW-in-Nigeria-2013.pdf
166. Nigeria Violence Against Person (Prohibition) Bill
167. Nigeria Essential Medicines List
168. Nigeria National Drug Policy

Burkina Faso

169. Politique Nationale de Populations du Burkina Faso (2000)
170. Examen des rapports soumis par les États parties en application de l'article 40 du Pacte : Rapports initiaux des États parties attendus en 2000, Burkina Faso. Comité des droits de l'homme de Nations Unies (2014)
171. Code de Personnes et de la Famille (1989)
172. Guide de Burkinabé de l'Etranger. Ministere des Affaires Etrangeres et de la Cooperation Regionale (2012).
173. CNLS-IST : Cadre Stratégique de lutte contre le VIH, le Sida et les IST, 2006 2010
174. CNLS-IST : Cadre stratégique de lutte contre le VIH, le Sida et les IST 2011-2015, juillet 2010
175. MS/CMLS : Etats Généraux de la Santé / Lutte contre le VIH/Sida 2001-2010, février 2010
176. Loi n° 23/94/ADP portant Code de la Santé publique
177. Décret N° 2010- 744 IPRES/PM/MS portant modalités d'application de la loi 30-2008/N du 20 mai 2008 portant lutte contre le VIH/Sida et protection des droits des personnes vivant avec le VIH/Sida.
178. Décret portant code de déontologie des médecins au Burkina Faso
179. Arrêté N°2001/0250/MS/CAB portant réglementation de la distribution des produits sous monopole pharmaceutique

180. Arrêté N° 2006 /MS/CAB portant définition de la Liste des Médicaments pouvant être détenus et délivrés par les dépôts privés de médicaments
181. MASSN/CMLS : Plan National de Prise en Charge Psychosociale des personnes vivant avec le VIH 2010-2014
182. Décret N° 2005-398/PRES/PM/MS portant conditions d'exercice privé des profession de santé
183. CNLS/MS : Normes et Protocole de prise en charge des personnes vivant avec le VIH/Sida au Burkina Faso, novembre 2008
184. MS : Protocole de santé de la reproduction/composantes communes, mai 2010
185. MS : Protocole de santé de la reproduction /Santé de la femme-Prise en charge gynécologique, mai 2010
186. MS : Document de Politique Sanitaire Nationale, septembre 2000
187. MS/DEF : Rapport relatif à l'identification des données existantes dans le Système National d'Information Sanitaire, décembre 2005
188. MS : Document de l'analyse de la situation sanitaire nationale, juin 2010
189. BASP96 : Enquête de surveillance comportementale auprès des groupes à haut risque : Travailleuses du sexe et leurs clients au Burkina Faso, Mars 2011
190. CMLS : Modes de transmission du VIH en Afrique de l'Ouest : Analyse de la distribution des nouvelles infections par le VIH au Burkina Faso et recommandations pour la prévention, mars 2009
191. MS/DGPLM : Cartographie des systèmes d'approvisionnement des médicaments et autres produits de santé au Burkina Faso, Décembre 2010
192. CNLS: Guide à l'intention des intervenants dans le milieu de la prostitution dans, cadre de la lutte contre le Sida et les IST au Burkina Faso », mars 2006
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