



**USAID/SENEGAL HIV/AIDS STRATEGY
2002-2006**

DRAFT

Dec 31, 2002

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I. COUNTRY SITUATION

A. Background

The former capital of French West Africa, Senegal is a semi-arid country located on the westernmost point of Africa. Predominantly rural and with limited natural resources, the country earns foreign exchange from fish, phosphates, peanuts, tourism and remittances. Its economy is vulnerable to variations in rainfall and changes in world commodity prices. Senegal depends heavily on foreign assistance, which in 2000 represented about 32% of overall government spending.

Senegal ranks low on the 2000 United Nations' Human Development Index (145th out of 162 countries). Widespread rural poverty, urban unemployment, and weak institutional capacity are major challenges confronting the country. A prolonged, low-intensity conflict in the southern Casamance region continues to inflict hardship on the population and to disrupt social and economic development in one of the country's most productive agricultural regions.

Senegal has a population of over 9 million, with approximately 20% percent aged 15-25 years. With a population growth of 2.7%, the population is expected to double in 26 years. Senegal's under-five mortality is estimated at 1439/1000 in 1999 and; although it is among the lowest in Sub-Saharan Africa, it remains high by international standards. Illiteracy remains high at 67 percent in males and 77 percent in females. The population is largely Muslim, with a 5 percent Christian minority.

The country is divided into 11 regions and 50 health districts. In 1996, the Government of Senegal took a major step to expand citizen participation by transferring many key public sector authorities to locally elected representatives. The current availability and deployment of medical personnel is well below WHO standards. While the assignment of MOH personnel was not transferred to local authorities, local communities are beginning to use their own tax revenues to hire additional health care personnel directly.

Over the past 20 years, the United States has invested over \$100 million in population and health activities in Senegal. These investments have contributed to the development of health policies, the provision of preventive and curative health care services, and the education and empowerment of communities.

B. Status of the Epidemic

The HIV/AIDS epidemic in Senegal is categorized as "concentrated" due to its relatively low prevalence in the general population contrasted by relatively high levels of infection among high-risk groups. While other African countries have seen their HIV prevalence soar over the past decade, Senegal has successfully maintained its rate around 1%. HIV prevalence among pregnant women was measured at 1.7% in 1996, 1.4% in 1998 and 1.0% in 2001. It is likely that the apparent decrease in prevalence in Senegal is more related to an expanded and more representative surveillance system than an actual

decrease in population prevalence. Currently, there are an estimated 70,000 HIV positive persons in Senegal but fewer than 10% are aware of their status. Only about 1000 HIV positive persons are under ARV treatment. UNAIDS estimates that some 2,500 people died of AIDS in 2001 and that an estimated 15,000 AIDS orphans under the age of 15 were alive at the end of this same year.

Despite an overall low and stable level of infection, pockets of high prevalence persist and represent a real threat to the general population. Approximately 12% of tuberculosis patients in Dakar are HIV positive. Although the average prevalence rate among Commercial Sex Workers (CSW) is estimated at 17%, this rate reaches between 20% to 36% in cities like Kaolack, Saint-Louis, Mbour and Ziguinchor. Prevalence rates among high-risk groups such as CSW, TB patients and STI patients have increased over the past decade.

To date, the HIV/AIDS in Senegal is largely an urban phenomenon. Areas in which there are concentrations of high-risk populations include major trading cities such as Kaolack, areas of the country where inward and outward migration are common such as Louga and Matam, and the southern area of the country in which conflict has raged for over 20 years.

While HIV prevalence has remained low and stable in the general adult population over the past decade, its high and increasing rate among vulnerable and mobile bridge populations and the fact that some 70,000 HIV-positive persons are unaware of their sero-status and hence not practicing safe sex creates a situation that could, if not effectively checked, lead to an explosion in the next decade similar to what has happened elsewhere in the past decade.

C. Factor influencing the spread of HIV in Senegal

This section examines the factors which have successfully impeded the spread of the epidemic in the general population as well as those factors which threaten the further spread of HIV as a basis for determining the types of interventions required.

C.1 Factors that have slowed the spread of HIV in Senegal

Senegal's success in maintaining its prevalence rate at around 1% is largely due to the confluence of strong political leadership, stabilizing social norms and early and appropriate public health interventions. Since the first confirmed case of HIV in Senegal in 1986, Senegalese authorities have taken preventive actions and adopted a comprehensive strategic approach for the control of the epidemic. This approach has involved all sectors of society and drawn the support of political, religious and community leaders. Quality technical assistance, provided largely by USAID and CDC, has led to a strong surveillance system, targeting at-risk populations with both information, preventive and curative services and the care and treatment of persons living with HIV/AIDS.

A meta-analysis conducted in Senegal by UNAIDS in 1997 attributed the low prevalence rate of HIV/AIDS among the general population to the following factors:

- conservative cultural norms regarding sex;
- the early and consistent involvement of political, religious and community leaders;
- the immediate creation of safe blood supply for transfusion;
- the registration and regular medical check-up of commercial sex workers;
- active community involvement of NGOs in the promotion of Information, Education and Communication (IEC) on HIV/AIDS;
- monitoring of HIV seroprevalence on a continuous basis through a national sentinel surveillance system tailored to the nature of the epidemic;
- Increased access to condoms through both public and private sectors

Senegal's socio-cultural environment presents other favorable conditions to mitigating the spread of HIV namely, low alcohol and illegal drug consumption, universal male circumcision, and a tradition of community organization and participation in health issues. Also, the relatively high proportion of HIV2 among sero-positive persons early in the epidemic *may* have slowed the spread of infection.

C.2 Factors predisposing the spread of HIV in Senegal

Senegal is faced with the possibility of an expanding epidemic if it does not remain vigilant in preventing the spread of HIV into the general population. Experiences in other countries have shown that rapid increases in infection rates among high-risk groups is often a precursor to the transfer of HIV/AIDS from these high risk groups to the general public. Other factors which seriously compromise this country's continued success include:

- **Sexual risk perception is low among certain bridge groups:** The recent BSS (2001) cites figures that most men and youth do not perceive themselves at risk of acquiring HIV. Only 20% of merchants and less than 20% of youth consider themselves at risk because of their past or current sexual behavior
- **Marriage practices and gender relations:** With median age at first marriage of 18 years, women tend to marry early in life and marry older men, thus inheriting the sexual history of their partners. Although HIV/AIDS affects both men and women, women are more vulnerable because of biological, social, cultural and economic factors. Inequality between the sexes limits women's access to care and services. There is also a large difference in attitudes towards men and women's sexuality, both within and outside of marriage. Promiscuity in men is much more acceptable. This exposes men to an increased risk of infection, and increases the possibility that they will transmit HIV/AIDS to their partners. In addition women do not have the capacity to negotiate sexual relations and develop the skills to protect themselves from HIV.
- **Internal and external migration.** The Senegalese society is very mobile. Many live overseas and within Senegal young people move considerably in search of economic opportunities, particularly toward the cities. Young people live away from their families and the social constraints of traditional society. In cities, they have independence, money and opportunities for multiple partners.

- **Poverty.** Senegal is a very poor country with limited natural resources. The illiteracy rate is 62%.
- **Political instability in the South.** The south-western part of Senegal, an area called the Casamance, has suffered from continued social instability and military conflict, and is also burdened by the increase in refugees from other countries. This region registers the highest prevalence among pregnant women (3%) as well as among CSW (36%) (2002 EPI bulletin).
- **Regional instability.** Senegal is surrounded by countries with higher prevalence rates some of which are experiencing political turmoil that increases the flow of immigrants/refugees into Senegal. In addition, Senegalese armed forces are frequently solicited to participate in Peace keeping missions where it sends young soldiers into countries with high HIV prevalence levels.

D. The National Response

Senegal's first HIV case was diagnosed in 1986 and was followed by an immediate response by the government. Within one year, HIV blood transfusion units in all regions of the country could screen for HIV antibodies. High level government support was generated early on with senior officials calling for commitment on the part of political, religious and community leadership in the fight against AIDS. Political support for AIDS prevention has continued to expand with recent efforts to involve all concerned Ministries and civil society in a multi-sectoral approach.

The GOS has identified a strategy that intensifies prevention activities, including the promotion of VCT services, an expansion of anti-retroviral treatment under ISAARV (Senegalese Initiative for Access to ARVs), and community-based care and support programs to PLWHA. The approach is based on a strengthened partnership with civil society and communities, which will be enlisted to participate in key IEC interventions, the promotion of VCT, the prevention of mother to child transmission (MTCT), access to condoms, and care and support for PLWHA and their families.

Well before the arrival of HIV, Senegal was one of the first countries in Africa to establish a national STI control program that integrated STI care into primary health services. The GOS' efforts to regulate prostitution through the registration and medical monitoring of CSWs preceded the AIDS epidemic. Behavior change and advocacy activities have contributed to changing social norms such as delayed sexual activity, increased condom use during casual sex (and especially commercial sex), and a high level of adhesion to the national program objectives by religious leaders and decision makers in the public and private sectors.

Since 1989, the national program has been implemented under the leadership of the National AIDS Control Program (PNLS) attached to the MOH. The management of the program is undergoing an important transition as it re-engineers itself to address the epidemic on a multi-sectoral basis. In 2002, the PNLS gave way to the National HIV/AIDS Council (CNLS) chaired by the Prime Minister with broad representation from all sectors and civil society, including people living with HIV/AIDS. The Minister

of Health serves as Vice Chair and a high-level MOH official has been seconded to serve as Executive Secretary. HIV/AIDS Units have been created in nine ministries, along with Regional and Departmental committees to assist in the decentralization of the program. The HIV/AIDS Division, Department of Public Health, is the implementing body within the Ministry of Health.

Senegal's National HIV/AIDS Strategy (2002-2006) was developed and adopted through a multi-sectoral consultative process in 2001. The Strategy aims to maintain HIV prevalence below 3%, to improve the quality of life of PLWHA, and to reduce the socio-economic impact of HIV/AIDS. The National Strategy is comprised of the following specific objectives:

1. Promote safe sexual practices to reduce HIV infection
2. Strengthen STI care
3. Strengthen monitoring and care of CSWs
4. Strengthen blood safety
5. Strengthen MTCT program
6. Promote access to VCT
7. Improve psycho-social and medical care of PLWHA
8. Strengthen STI and HIV surveillance
9. Promote research and strengthen ethical and regulatory norms.
10. Strengthen coordination, management and advocacy

Other key thrusts of the strategy include decentralization and integration of activities in social and health services to increase access, blood screening for HIV and syphilis, participation of PLWHA and their increased access to care and support services within a human rights framework. Over the period of this Strategy, the CNLS will promote safe sex behaviors among high risk groups (out-of-school youth, uniformed services, vulnerable women, commercial sex workers, mobile populations); support efforts to develop an enabling political, legal, economic and social environment; expand MTCT and VCT services; support implementation of ISAARV; and strengthen the national HIV and STI surveillance system.

In 2000, Senegal introduced anti-retroviral drug therapies on a pilot basis in the public health system, and has negotiated favorable prices with five ARV drug manufacturers. ART is currently available in the city of Dakar, with plans to expand to the cities of Saint Louis, Kaolack, Ziguinchor and Tambacounda. At present, 1,000 persons are under ARV treatment. The National AIDS Plan envisions that 7,000 will be under ARV treatment by 2006.

Prevention of MTCT was introduced on a pilot basis in June 2000 and achieved a testing acceptance rate of 51% among pregnant women. As of September 2002, 23 of the 86 newborns enrolled in the cohort have passed their 18th month and all are sero-negative.

Public Sector

Under the multi-sectoral strategy, the public sector will be targeted through a variety of Ministries and parastatals that include the Ministries of Health, Education, Women, Youth, Labor, etc. The MOH manages all medical/clinical aspects of the program from surveillance, to STI diagnosis and treatment to support to persons living with HIV/AIDS. This component is implemented through the following key institutions: the Fann University Hospital's Outpatient Treatment Center (PLWHA), the National Center for Blood Transfusion (blood security), and the National Reference Laboratory of Le Dantec Hospital (surveillance). To ensure quality, MOH/HIV-AIDS unit focuses on the development and dissemination of norms and protocols, training of health personnel, and oversight of STI and HIV/AIDS activities in Health Districts. The MOH HIV/AIDS Unit is also responsible for the coordination of all these different institutions and NGOs involved in the implementation of care and treatment activities.

NGOs and Civil Society

NGOs and CBOs have been valuable partners in the fight against HIV/AIDS as they have been instrumental in reaching the high-risk groups targeted by the national program, and mobilizing civil society. There are currently some 200 NGOs and 400 women's groups actively supporting HIV/AIDS related activities. A Catholic NGO, SIDA Service, has pioneered VCT services in Senegal. Two NGO umbrella organizations represent the NGO sector: CONGAD for health NGOs, and ICASO for HIV/AIDS NGOs. Religious leaders have been involved in the national response since the 1980s. Christian and Islamic leaders have been enlisted as advocates through sensitization and education campaigns. Religious leaders' understanding of and involvement in the program has generated acceptance of condom use for prevention, and they openly discuss HIV/AIDS issues with their congregations. In 1998, the National AIDS Control Program in collaboration with religious organizations expanded the religious response to HIV/AIDS epidemic by establishing an international religious Alliance on HIV/AIDS for Africa which is based in Dakar.

Private/commercial sector

Industrial and business leaders have instituted prevention and a few treatment programs for their employees. The National Council of Employers, is a member of the CNLS, and in collaboration with ILO, is introducing prevention programs within the workplace. The NCE regroups 600 companies with 80,000 employees. The five largest companies have already designed a comprehensive health program that incorporates HIV/AIDS prevention activities. The National Phosphate Mining Company has introduced a treatment program for its affected staff.

National media have also been key partners in advocacy by keeping the public at large informed of key issues related to the epidemic.

Lastly, in the GOS has entered into agreements with five international pharmaceutical companies to procure ARVs for treatment of PLWHAs.

Weaknesses and challenges

The Senegalese program has been quite successful to date at containing the epidemic. Nonetheless, there are weaknesses within it that could undermine efforts in the future. The multi-sectoral approach creates additional pressures and complications in the implementation of effective interventions. A nascent and still weak coordinating mechanism, at the technical and managerial level, results in divergent and often incompatible approaches to similar problems by implementing Ministries, agencies or donors. Despite progress, the current role and involvement of the private/commercial sector is minimal especially in smaller companies. While the policy foresees considerable decentralization of the national program, the effective decentralization of power and resources is yet to be achieved.

In the context of a multi-sectoral program and increased funding, a major challenge is to install an efficient inter-sector coordination as to not build over capacity in responding to the need of expansion of components like care and treatment, PMTCT in a low prevalence country.

E. The USAID Program of Assistance

USAID is presently and has been for many years the largest donor in HIV/AIDS in Senegal. The USAID/Senegal HIV/AIDS program is implemented at three levels.

1) National/central level interventions.

To strengthen health systems, USAID provides technical assistance to national level structures that focuses on key elements of quality of services. This TA helps to develop and implement service delivery norms and protocols, training programs, supervision systems, research, disease surveillance, monitoring and evaluation, and information dissemination and communication. To develop a favorable environment for HIV/AIDS programs, USAID supports policy development and dialogue, and advocacy activities that identify and mobilize key change agents within Senegalese society. USAID currently supplies the majority of condoms required for the national program. These are made available through the AIDS Program itself, the national reproductive health division and via a social marketing activity.

2) District/community level SO3 concentrated support Health Districts.

This component supports the GOS decentralized quality health services program, and provides an integrated package of services for child survival, safe motherhood, family planning, STI/HIV/AIDS and community health planning and financing. The concerned Districts are referred to as our "Matching Grant" Districts. In 2002, fifteen Districts are enrolled in this program. In 2003, an additional six are scheduled to be enrolled and a total of 29 Districts will be enrolled by 2006. USAID seeks to ensure in each of these Districts the effective diagnosis and treatment of STIs and to ensure the populations of

these Districts are adequately informed about STI/HIV/AIDS. With the exception of the districts in Dakar and the Ziguinchor region, health promotional/social mobilization activities are conducted via an Association of Local Community Health Promoters.

3) Targeted interventions for high risk groups across the country.

This third level targets high-risk groups with information, prevention and treatment services. The beneficiary groups include CSWs, MSM, transportation workers, fishermen, in-school youth, apprentices, and domestic servants.

Using its comparative advantage, USAID supports the following technical inputs:

Current Interventions

Behavior change:

USAID, through its program has been supporting a comprehensive Behavior Change Communication (BCC) program through NGOs and community based organizations targeted specific groups whose behavior, vulnerability or mobility put them at higher-than-average risk of infection. These include: commercial sex workers, youth, low-income women, truck drivers/transportation workers, spouses of migrant workers, and men and women in the informal and formal sectors. In addition to mass media campaigns and massive production of IEC materials, significant efforts have been made to reach youth and women through special events such as World AIDS Day, Youth Week against AIDS, and Women's Week against AIDS.

80 Community-based organizations and 5 local NGOs are supported to develop outreach activities to reach these groups. In 2001, USAID estimates these interventions reached 200,000 persons.

STI:

Since 1979, USAID has supported activities to strengthen the quality and availability of STI services. In 1994, USAID provided technical assistance to implement the use of the syndromic approach to the treatment of STIs. Major activities have included a district-level needs assessment and ethnographic studies, training and intensive supervision of health personnel, and continuous evaluation of the quality of STI management services at the health district level. The syndromic approach to STI treatment has contributed to improving service quality and increasing knowledge of STIs. In 2001, 730 health personnel points have been trained or retrained. A bi-annual evaluation of the quality of STI services is conducted to ensure quality of services. Additional efforts are being undertaken to introduce syphilis diagnosis in 15 health centers and 45 health posts of the "Matching Grant" districts.

Advocacy

Specific objectives of the USAID program include the enhancement of high-level political support for HIV/AIDS prevention and the reinforcement of high-level policy dialogue within neighboring countries. USAID works with members of Parliament to address the legal and regulatory framework surrounding HIV/AIDS.

Activities in the workplace consist of operations research to integrate micro-credit activities with HIV prevention among fisherman and transportation workers, and publication of an information bulletin for widespread distribution among business leaders, ministries, and labor unions. USAID also works with private companies to ensure HIV/AIDS activities and services are made available to employees and their families. USAID works with various media to enhance their role in increasing public awareness and supporting advocacy for HIV/AIDS prevention. 45 journalists and editors received an orientation on HIV/AIDS and are participating actively in a process to foster a partnership between the media and key players in HIV/AIDS prevention. A “media chart” that provides key and consistent information for the use of the media when writing or talking about HIV/AIDS has been developed and disseminated to all media organizations. Several national and four community radio stations are participating in a media campaign that targets Youth.

In addition, in 1999, USAID supported the Initiative Health for Peace, a sub-regional organization including Senegal, Guinea Bissau, Guinea and Gambia. The Dakar meeting of decision makers and opinion leaders from these countries and Mauritania to build linkages between organizations implementing HIV prevention activities and promote a favorable environment for HIV/AIDS prevention at the regional level.

Care and support

Linking prevention and care is an effective way to reinforce community responses to HIV and to increase the involvement of people living with HIV/AIDS. The linkage between these services and community participation for care is an essential component of the USAID strategy as are increased access to care for people living with HIV/AIDS and increased involvement of people living with HIV/AIDS in prevention activities.

USAID provides assistance to the National AIDS Council to assess the care and support situation in Senegal and design a national strategy for decentralization of the care continuum. In addition, USAID programs reinforce the national unit of the center for ambulatory care for people living with HIV/AIDS. USAID puts a special emphasis on the psycho-social and nutritional aspects of this care package. USAID is working to support and strengthen groups of people living with HIV/AIDS, geographically expand the model support network for people living with HIV/AIDS developed by USAID’s community mobilizing partners, and link them to voluntary counseling and testing services.

USAID has begun a dialogue with private sector pharmaceutical firms to explore ways in which USAID can better leverage its resources via the formation of Alliances with these firms.

SO3 is also in discussions with the Senegal Food For Peace Office to explore ways whereby FFP food supplies might be provided via structures providing support to PLWHA.

Condom promotion

Since 1985, USAID has provided the National AIDS Control Program with more than 10 million condoms. These have been distributed primarily for CSWs, STI patients, youth, military and adults who because of their employment or vulnerability are particularly at risk of infection. In addition to this “free” distribution, several hundred thousand condoms have been distributed via family planning services within both the public and private sectors. Finally, since 1995, USAID has implemented a social marketing of condoms program through a local NGO. Today, *Protec* brand condoms are sold in 3400 sites around the country. In 2001, 3.5 million *Protec* brand condoms were sold, 12% more than in 2000. **NB 2002 data will be included as soon as they are available.**

Surveillance, Monitoring and Evaluation

In collaboration with the Centers for Disease Control and Prevention (CDC), USAID is assisting the National AIDS Program to build its capacity and infrastructure to more effectively monitor and evaluate the evolution of the epidemic, the implementation of planned activities and the effectiveness of various interventions. CDC’s efforts focus on the establishment of an effective disease surveillance system, the implementation of “second generation” surveillance that will combine both behavioral and epidemiological surveillance within targeted high-risk groups and to establish correct quality assurance norms for the national and regional level laboratories. The HIV surveillance system covers ten of the country’s eleven regions.

Reaching in-school youth

As youth are a high-risk group upon whose behavior will depend the future course of the epidemic in Senegal, USAID has focused on this vulnerable population since the beginning of its involvement in STI/HIV/AIDS. In 6 regions, USAID-funded programs have focused on peer education using role models to increase the understanding of STI/HIV/AIDS and support risk-reducing behaviors: abstinence, delay of sexual debut, monogamous relationships and condom use. HIV/AIDS prevention committees are established in 100 schools. In these schools, 1661 students were trained as peer educators and conducted activities that reached 28,000 students.

The current program includes both public and private schools. Messages are communicated via peer educators and these are reinforced by parallel mass media and social mobilization campaigns. These campaigns have been successful in increasing knowledge but less so in enabling youth to correctly assess their personal risk and change risky behavior. The 2001 BSS data show that more than 90% of students know two means of HIV prevention and cite condoms as the main HIV prevention method. However, among students who have had at least one sexual encounter in the past 12 months, condom-use ranged from 66% in Dakar to 73% outside of Dakar. Future programs need to be strengthened in this regard and also need to link mass media campaigns with activities designed to improve access to quality STI care services among youth.

USAID also conducts policy dialogue aimed at education personnel to institutionalize HIV/AIDS in all public and private schools. Currently, HIV information is included in family life and science classes. Experience to date has shown the importance of collaboration between parents and teachers and all stakeholders in the school setting. Key lessons of this intervention a real need for parents and teachers collaboration, coordination among different stakeholders involved in activities in school setting. A main challenge is to develop an intervention integration a combination of institutionalization of HIV classes linked to life skill approach for behavior change.

Voluntary counseling and testing

USAID supported the establishment of the first three VCT centers in Dakar, Thies and Kaolack. At the national level, USAID, in collaboration with CDC, has provided technical assistance to develop norms and guidelines for VCT services and guidelines for counseling. 2477 persons used VCT services in 2002.

Other sector HIV/AIDS

USAID/Senegal is supporting other strategic objective's initiative for HIV/AIDS prevention. The private sector strategic objective through its main contractor DYNA has funded the reproduction and distribution of copies of the CD version of the "Scenarios of the Sahel", a set of HIV/AIDS prevention sketches. In close collaboration with FHI the HIV/AIDS contractor, this activity will evolve to a long-term intervention targeting the informal private sector through the extended network of decentralized financial services and UNACOIS, a network of 15000 members in the informal sector. USAID is also supporting a study targeting locally elected officials and HIV. The results are expected to be a starting point of collaboration with the democracy and good governance objective for HIV/AIDS prevention at local level.

Other USG Support

Centers for Disease Control, Global AIDS Program (CDC/GAP) is providing a variety of technical assistance to the national program. It conducts operational research to evaluate rapid HIV tests, and studies to monitor cotrimoxazole resistance in the treatment of opportunistic infections; builds capacity in surveillance; and strengthens the quality of VCT interventions.

The Peace Corps Program deploys 135 volunteers throughout the country to work in forestry, health, and small business development. The Program works at the community level and has introduced a "Life Skills" education tool into the school curriculum that includes HIV/AIDS prevention. Peace Corps was recently involved in the organization of a large social mobilization activity along the Senegal river, in 10 villages in the Matam and Saint Louis regions. The approach that was taken involved religious leaders, elders, youth, women, health workers, local musicians and an important celebrity musician, native to the region. This event has increased public knowledge, and generated considerable interest in continued AIDS education activities. A few mosques have started

broadcasting AIDS messages around Friday prayers and teachers have devised AIDS games to play with their students.

The Department of Defense is conducting an \$150,000 HIV/AIDS program with the Senegalese Armed Forces. The DOD supports HIV surveillance among military groups, training of military health personnel and communication activities for behavior change. It is unknown whether DOD assistance will be provided into the future or how much assistance will be provided.

Food for Peace distributes food through Catholic Relief Services and Counterpart. USAID is currently in discussions with CRS to explore possibilities of expanding food aid, including artificial milk, to PLWHA.

F. Lessons learned

The lessons learned from the past decade of USAID assistance in Senegal should guide the future direction of the HIV/AIDS program. Some key lessons are:

- Building the capacity of local institutions to ensure quality is essential and requires a long-term commitment and adequate resources.
- The effective development of policies, norms and protocols requires the active involvement and consensus of all stakeholders.
- The involvement of NGOs/CBOs, under the normative guidance and direction of the MOH, is critical to effective program implementation.
- Interventions need to be targeted to groups according to their relative risk and information and services provided in a manner most appropriate for their particular circumstances and environment. For this, a surveillance and M&E system is critical.

G. Main Partners and their contributions

Senegal is likely to benefit from substantial increases in donor funding to address HIV/AIDS. Two significant funding sources will enable the national program to consolidate and scale up its current capacity and interventions: The World Bank/MAP 2, and the Global Fund for AIDS, Tuberculosis and Malaria.

- The World Bank recently approved a \$30 million credit to the Government of Senegal under MAP 2. Project support to the National Strategic Plan (2002-2006) will: strengthen the capacity of HIV/AIDS Units of line ministries; provide support to civil society and community-based initiatives in prevention, care, social support and mitigation; strengthen governmental agencies' multi-sector programs; and build capacity in project management and administration.
- The GOS has submitted a proposal to GFTTM. The HIV/AIDS component has been approved for \$11,714,286 over five years. This Grant will help the Program expand its ART, VCT, and MTCT activities and to increase support for behavior

change programs. Activities include the implementation of an integrated communications plan, increased community participation in the care and support of PLWHA, and operations research. The country coordinating mechanism (CCM) has been established and includes the MOH, other concerned Ministries, civil society/NGOs, private sector and donors. The role of the CCM is to promote partnership within a multisectoral approach, assure coordination among sectors, and oversee the monitoring and evaluation of interventions. USAID like other major donors participates actively in the CCM.

- In 2001, Senegal qualified for approximately \$31 million in debt relief under the Highly Indebted Poor Countries (HIPC) Initiative. Under the Poverty Reduction strategy, the GOS seeks to improve efforts to prevent and combat HIV/AIDS. Within these funds, priority will be given to equipment, the expansion of care and treatment activities, including HIV-infected children. The National HIV/AIDS Council projected \$800,000 for 2002 and one \$1.6 million for 2003 that will be invested in HIV/AIDS.
- KFW will support the GOS through a local NGO to implement a communication program targeting youth and the procurement of male and female condoms for the social marketing program.
- At present, Senegal is considered by most to be a strong candidate country to benefit from the Millennium Challenge Account. USAID understands that funds provided to beneficiary countries would be used largely to fund activities outlined in the HIPC poverty reduction strategy budget.

H. Assessment of Senegal's needs.

This brief summary of Senegal's response to the epidemic demonstrates a pro-active Government which has moved quickly, with assistance from donors, to galvanize civil society, cultural and religious leaders to form an effective national coalition in the fight to prevent the spread of HIV/AIDS. Donors have rallied behind Senegal's political leadership and provided resources including technical assistance which has contributed to Senegal's exemplary response to the epidemic up to this point.

Senegal is now poised, with significant donor assistance in the pipeline, to expand and intensify its response with a full range of services appropriate for a low prevalence epidemic. Program managers are planning to decentralize and intensify preventive, care, and support services to critical groups and regions of the country where the epidemic remains a threat. The multi-sectoral and regional decentralization conditionalities that come with the funding, will put the managers of the program to test.

With a prevalence of 1.4%, program managers will be challenged to program over \$60 million (World Bank, Global Trust Funds and USAID only) in the next four years to expand prevention, care and support services nationwide without sacrificing the technical quality of the current program as well as its financial integrity. In response to this

challenge, the USAID strategy is designed to focus on assisting the GOS to maintain the technical quality of the program and to ensure an effective response to meet the national objective as stated in the following sections.

- **Needs in prevention, care and support in the Senegalese context**

USAID's assessment of needs is structured around the needs of four particular groups: PLWHA, STI patients, pregnant women, and high-risk populations. These groups are separated out from the population at large as their needs will require particular interventions above and beyond what is done for the general population.

PLWHA. Senegal estimates 80,000 HIV positive persons are living in Senegal. Of these, relatively few are aware of their sero-prevalent status and only 1,000 are currently under ART. PLWHA need better access to VCT in order to know their status and what to do to prevent themselves from infecting their partners. Further, the structures for ART need to be expanded to cover at least major regional capitals outside of Dakar and other high prevalence areas. The nutritional aspects of the services these persons receive also need to be improved. In addition, some greater provision for financial support for the costs of medical tests and laboratory work needs to be found to prevent HIV from ruining the finances of families with one or more persons living with HIV.

STI Patients: Most health providers have been trained in the application of the syndromic approach but the algorithm is properly applied in only about 5% of cases. The number of facilities able to test for syphilis is limited. STI patients need greater access to quality STI/HIV diagnosis and treatment services.

Pregnant Women: Although on average one in every hundred pregnant women in Senegal is HIV positive, few know it and fewer still have access to prevention of MTCT services. HIV testing services need to be made more available and the right to know one's status a more integral part of ongoing antenatal care services. MTCT services are currently being pilot-tested in two facilities in Dakar. These need soon to be expanded to include regional hospitals.

High-Risk and Vulnerable Groups: Most of the USAID-targeted groups such as transportation workers, fishermen, apprentices, in-school youth and women simply need better coverage of currently ongoing activities to inform them and make the means of prevention and STI treatment available to them. Several other groups such as CSW, MSM, domestic servants, street vendors and uniformed service members have special needs the satisfaction of which requires innovative and targeted interventions.

CSW need better STI diagnosis and treatment facilities and better access to female condoms. *MSM* need a network of STI service providers that is sensitive to this population's particular circumstances, better access to condoms and lubricant, information and for the groups involved in the fight against AIDS to better understand and incorporate MSM-related issues into their activities. *Domestic servants and street vendors* need information, condoms and training on how to more effectively negotiate

sexual relations. *Uniformed service members* need information and condoms but also training to better inform them of the important role they play in society and how an abuse of their power can lead not only to their own HIV infection but to the increased spread of the disease in society.

I. The socio-economic Impact of HIV/AIDS in Senegal

To date, no Senegal-specific study on the socio-economic impact of HIV/AIDS has been done. Approximately 80,000 people in Senegal are sero-positive and thousands may have died from the HIV/AIDS leaving equally thousands of children orphaned. Approximately 50,000 families are directly affected by reduced productivity and earning power of at least one family member as they see more and more of their limited resources devoted to the increasing health care costs of keeping the sero-positive member alive. Due to its success at maintaining a low HIV prevalence, the socio-economic effect on the larger economy has not been as devastating as it has been in other countries of the Continent. Nonetheless, in certain key sectors, the effect is beginning to be noted.

For large employers in Dakar, in the mining, fishing and sugar transformation industries, the effects of declining productivity and increased health care costs are being felt. This is increasingly true in the education and health sectors, as well.

II. THE USAID/SENEGAL HIV/AIDS STRATEGY

A. Strategic Objective

USAID's strategy to assist the CNLS to maintain a quality program will be implemented at various levels and via a variety of processes and mechanisms related to planning, implementation, monitoring and evaluation. USAID is already involved in many of these activities but will need to intensify its activities in some technical areas.

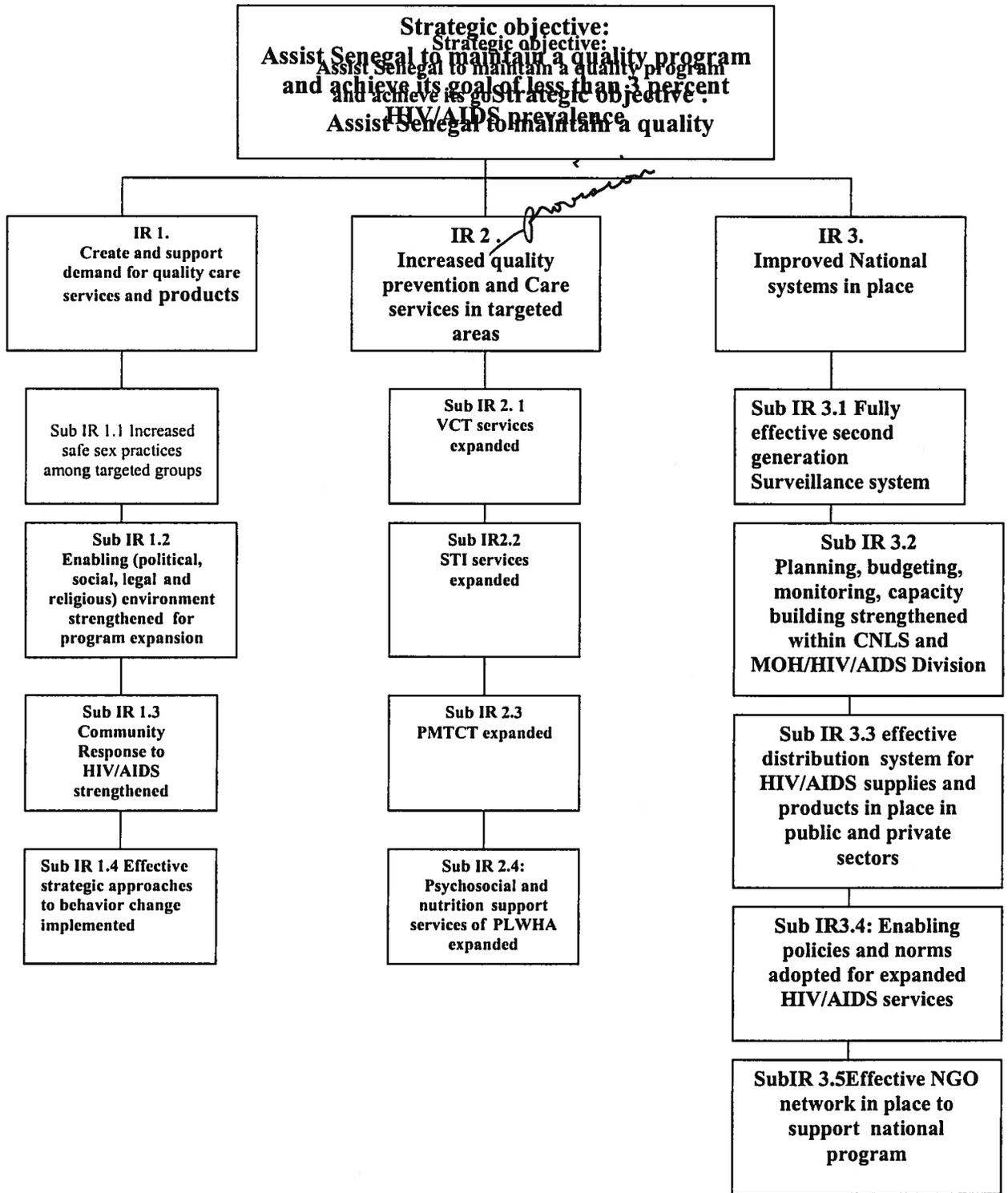
As a long and trusted partner in its HIV/AIDS program, USAID and CDC will continue to provide high quality technical assistance for strategy development in program sub-components particularly in the areas of IEC (BCC), VCT, MTCT, second generation surveillance, etc. Although the decentralized and multi-sectoral program will be now implemented by non-health sectors, the MOH and specialized international agencies will probably continue to be the point of reference for the CNLS with regard to the technical excellence of the overall program. USAID will assist the MOH to develop its sectoral strategy with the current reorganization and ensure that the MOH retains the capability and disposition to assist the CNLS in making sure that prevention, care and support activities in all sectors are state-of-the art.

With regard to implementation strategy, USAID is party to several pilot activities, including the integration of HIV/AIDS services at community level with other health services, developing care and support services linking community support groups and medical services etc which can be refined for scaling up by the CNLS. USAID will also advocate the strengthening of the role of NGOs in total program implementation.

With regard to monitoring and evaluation, USAID and CDC will maintain the lead role in assisting the CNLS. The trend will be to share this role with the World Bank, UNAIDS, WHO in an effort to harmonize performance indicators. For example, USAID is taking the lead to organize a multidonor trip in January 2003 to work with the CNLS to develop a joint longterm TA plan to assist the CNLS develop its monitoring and evaluation plan.

USAID will advocate a special focus on high risk groups as well as a focus on the general population in areas where prevalence is known to be very high in the country such as Matam, St Louis, Kolda and Ziguinchor, security permitting.

Over the past 15 years, USAID has been working in close collaboration with the GOS in the implementation of its HIV/AIDS program. In recognition of this relationship and the leadership exercised by the CNLS, the Mission has developed the following objective for its 2002-2006 strategy:



B. Rational

The National HIV/AIDS program is poised to receive a funding injection of approximately \$64 million from GTFAM, World Bank and USAID/CDC/DOD to strengthen and scale up interventions within a multi-sectoral approach. It is critical to ensure the absorptive capacity of the national program and to preserve the quality of current systems and interventions during expansion. USAID's expertise and proven track record in Senegal make it particularly well placed to provide technical and managerial support to assure that the proposed expansion is implemented in a coherent and effective way in order to maintain and improve the quality prevention and care services. Sound managerial and technical systems will enable Senegal to maintain its quality program and retain its place among the "success stories".

USAID has also supported a vast network of local implementing agencies, NGOs and CBOs, that have a clear understanding of local needs, opportunities and constraints and has developed a solid appreciation for the strengths, weaknesses, costs and optimal conditions for success of an array of tailored strategies through the experience over the past decade and a half. One of the program's greatest strengths has been selecting activities appropriate mixes of interventions which are culturally acceptable and cost-effective.

C. Linkage to Mission Country Strategy, SO3 and other SOs

The current USAID Country Strategic Plan, covering the period 1998-2006, is founded on the key concept of empowerment and focuses on a three-faceted objective of promoting economic, political and social empowerment. Its health objective, SO3 is formulated as follows:

Increased and sustainable use of reproductive health services (child survival, maternal health, family planning, and sexually-transmitted infections/AIDS), in the context of decentralization in targeted areas.

Social empowerment, including greater private sector choice in health care, is the primary purpose of this Strategic Objective.

For the purposes of this strategy and to better redefine its focus interventions, USAID/Senegal has developed a results framework for HIV/AIDS. The HIV/AIDS Strategy retains the principles of the country level framework, while providing a structure which captures the different levels of the HIV/AIDS interventions. The priorities identified in this strategy also take interventions beyond the 29 districts targeted by USAID's integrated health activities. Emphasis is placed on high prevalence geographical areas as well as functional activity areas critical for reducing the spread of the epidemic.

D. Critical Assumptions

- The MOH policy of decentralization will continue.
- The USAID HIV/AIDS Commodities Fund will continue to make male and female condoms available for the national program.
- The socio-cultural environment will remain favorable.
- Political will is sustained at current levels or above.
- Health partners (GOS, donors the private sector, and local governments) meet their commitments and execute their interventions in a timely manner.
- Interventions advocated under this strategy are based on current best practice and international guidance, such as the discouragement of breastfeeding for seropositive mothers. Should changes occur in such guidance or technology, USAID will adjust its interventions accordingly.
- Donors will deliver on their funding commitments.
- Policy and regulatory constraints will be effectively addressed in a timely manner.

E. Guiding Principles

Human rights and stigma reduction: Several fundamental rights are threatened in the context of HIV/AIDS, including the right to non-discrimination, the right to privacy, the right to appropriate protection in social security and the right to work. The protection of fundamental rights will continue to bear an integral part of the fight against HIV/AIDS if the epidemic is to be overcome. Effective prevention is much enhanced in an environment where human rights are respected. Prevention of transmission depends on people adopting behavior to avoid infection, how to practice safe sex, and to act responsibly. Certain disadvantaged individuals or groups marginalized by society are particularly vulnerable to infection, as they have limited access to HIV/AIDS prevention and care and support activities. Finally, stigmatization and discrimination of PLWHA greatly magnifies the tragic impact the disease has on their lives. This principle will be observed throughout the implementation of this strategy to protect the rights and dignity of the individuals and groups addressed by the interventions.

Involvement of PLWHA: In the implementation of this strategy, USAID will adhere to the principles set out in GIPA (Greater Involvement of People Living with HIV/AIDS). PLWHA groups currently participate in the program, and are represented at the highest level of the national program, by virtue of their seat on the CNLS. They need to be supported to contribute meaningfully to various aspects of the response to the epidemic.

Gender: Gender inequalities and gender violence breed vulnerability, dis-empowerment, oppression and isolation. The design of targeted interventions for the different groups is driven by the specific needs and constraints faced by men and women in their various occupations or situation in society. MSM have different needs and challenges than their heterosexual counterparts. The gender dynamics between monogamous and polygamous couples must be taken into account in counseling a seropositive mother.

Public-private partnerships: USAID believes that the strength of its approach is based on the relative strengths of the public and private sectors, partners working together. Further, USAID has a good history of implementation and results with the NGO and commercial sectors that will be emphasized in the implementation of this strategy. The strategy describes a set of interventions designed to build on the strengths of each sector and to promote the comparative strengths of the public, NGO and commercial sectors in responding to the epidemic. USAID will seek to form formal Alliances with private US companies particularly in the areas of MTCT and care for PLWHA.

Complementarity with other donors: The USAID Strategy along with other donor programs is committed to working under the umbrella of the National Strategy. As described under Section I.G, USAID has included other key donor commitments in its analysis and will support interventions that not only complement their activities but will also support the implementation of their programs.

Multi-sectoral activities such as communication for behavior change and advocacy activities will involve sectors and Ministries beyond health and the MOH. While respecting its primary relationship with the MOH, USAID will work with all concerned Ministries within the context of the National AIDS Council to facilitate greater involvement of all stakeholders and the effective implementation of the national strategic plan.

F. Policy Environment and Implication

At a national level, Senegal was quick to put in place a system to address the policy and regulatory aspects of the AIDS epidemic. Discussions involved the highest level of government, donors, civil society, the private sector and religious leaders. From this has developed an overriding consensus in Senegal that the problem exists and must be addressed as a concerted effort of all concerned parties and sectors of society.

The advent of the Global Fund and the creation of a National AIDS Council to coordinate the multi-sectoral effort will provide an even more effective forum for continued policy dialogue.

Given the consensus on the existence and nature of the problem, the policy issues that remain to be addressed today are more technical in nature. They center around the problems of how Senegal will make prevention, care and support services more available to persons infected and affected by HIV/AIDS. There are preliminary efforts to provide ART, VCT and MTCT services that need to be expanded and decentralized. Clear policy choices will need to precede this expansion. There are also several key human rights issues to be addressed over the course of this Strategy.

USAID will ensure that USG policies and laws are applied by all organizations that receive USG funds in conformity with the cable STATE 267675.

G. Major planned Interventions

The USAID/SENEGAL HIV/AIDS Strategy proposes interventions that will build upon current well established and high quality STI/HIV/AIDS prevention and care initiatives and is consistent with the current stage of the HIV epidemic. The ultimate goal of the strategy is to solidify gains made through quality prevention and care interventions and to extend these services to more people in existing program sites and to priority communities or high-risk areas not currently supported by USAID.

Intervention level

National level support will continue to be normative assuring high quality systems frameworks, leadership, guidelines and training materials to ensure that quality is maintained throughout regional, district and local level services.

In areas where quality services exist, USAID will reinforce these services and expand them to reach a greater number of people.

In new geographic areas, activities will concentrate on building the capacity of health personnel and community groups to develop an appropriate mix of high quality STI/AIDS prevention and care strategies.

Target groups and zones

While efforts to ensure that all Senegalese are adequately informed about HIV/AIDS and have access to means of prevention, the Strategy will concentrate its interventions on the core, bridge and otherwise vulnerable groups that constitute the majority of the population and the portion of the population most at risk. The Strategy envisions activities that cover the entire country, those that concern particular Health Districts and those that are directed toward at-risk or otherwise vulnerable groups. A special efforts will also be made to focus USAID activities on high prevalence portions of the country such as the Ziguinchor with a reported prevalence of 30% among CSW, more than twice the national average.

USAID will continue to conduct nation-wide mass media campaigns to inform the general public about HIV/AIDS and will continue to make condoms available nationwide via the social marketing activity.

Within the Health Districts where USAID implements an integrated and comprehensive package of promotional, preventive and curative services, USAID will provide information to the general public via local Associations of Community Health promoters and will help to ensure the more effective diagnosis and treatment of STI. Further, USAID in close collaboration with CDC will seek to expand VCT centers, include MTCT activities and make HIV testing more available to pregnant women to the extent possible.

Outside of these Health Districts and specially in the high prevalence areas such as Podor , Matam and Ziguinchor, USAID will conduct HIV IEC/BCC activities via Community Based Organizations and will continue to assist to improve the diagnosis and treatment of STI generally.

The at-risk targets for the Strategy are broken down into two categories: those for whom an effective model exists and where geographic expansion is proposed; those that are relatively “new” and for which an access strategy needs to be developed.

CSW : For those who register, improvements in the quality of care and treatment by the forces of order are needed to entice a greater percentage of CSW to register. While these improvements are key to the success of this intervention, USAID will expand the number of sites where services are provided from seven to ten. These sites will serve as focal points for reaching CSW who do not (and may never) register as such. Reaching these non-registered CSW will require new and innovative approaches.

MSM: The provision of STI services will be concentrated in regional capitals and key information will be provided via local NGOs and within MSM associations. While socially marketed condoms are widely available presently, if and how free condoms and lubricant will be provided remains to be determined.

Transportation Workers: Information and condom distribution is key to this critical group. Presently, USAID is working with transportation workers in public transportation stations around the country. In this Strategy, the number of sites where we intervene will be increased. This is true for fishermen and apprentices, as well.

Domestic Servants: This component will concentrate on the larger regional capitals where the majority of domestic servants is employed.

Market Vendors: The Strategy is targeted toward the market vendors associated with the truck/bus stations where the transportation workers are found and targeted.

Youth: Activities currently underway with private sector schools will continue and additional efforts will be concentrated on improving HIV/AIDS activities in public schools around the country. The primary target for out-of-school youth will remain the apprentices, domestic servants and market vendors described above.

Non-military Uniformed Services: The DOD program addresses many of the issues confronting uniformed military personnel and is limited to military personnel. USAID will provide assistance to the non-military services such as customs, prisons and the police. While the exact nature and locations of this intervention are yet to be decided, this will certainly include IEC activities, condom distribution and will concentrate on cities.

H. Proposed Results and Interventions

This section details the results to be achieved and activities USAID proposes to undertake in pursuit of those results. Proposed indicators for these results are discussed in the next section.

IR 1. Create and support demand for quality prevention and care services and products

Early and aggressive communications campaigns targeting both high-risk populations and the general public have been a key factor in maintaining the low prevalence rate in Senegal. Such initiatives will be strengthened to address the new high-risk groups and bridge populations being targeted by the strategy. The current strategy aims to develop innovative targeted interventions and community-based responses to stimulate demand for quality prevention and care services and products. The expansion of VCT and MTCT services described under IR 2 will be supported under this IR with promotion activities geared at increasing demand and decreasing stigma.

In order to achieve this Intermediate Result, the following illustrative activities will be coordinated under each sub IR.

Sub-IR1.1 Increased safe sex practices among targeted groups

Proposed Activities

- Expand the geographic reach of BCC activities targeting registered CSWs, fishermen, transport workers, students and out-of-school youth
- Introduce BCC activities targeting unregistered CSWs, MSM, men in uniform, merchants
- Extend condom promotion activities in both the public and private sectors
- Promote innovative behavior change strategies such as social marketing, community mobilization, entertainment for education
- Introduce linkages between communication activities (i.e., hotline, social marketing) and services such as VCT, MTCT, STI treatment, care and support

Sub-IR 1.2 Enabling (political, social, legal and religious) environment strengthened for program expansion

Influential leaders will continue to be mobilized if appropriate to build positive public dialogue and strengthen community actions for HIV/AIDS prevention and to create a supportive environment in which people can access services to quality prevention and

care services. Resource will be designed to enable managers to define their own STI/HIV/AIDS prevention and care policies and programs in the Private Sector

Proposed Activities

- Build the capacity of religious, political and opinion leaders to lead social mobilization and advocacy activities in support of programs
- Sponsor and coordinate dialogue sessions among these leaders to discuss emerging issues such as stigmatization and discrimination of PLWHA, promoting access to MTCT, etc.
- Document legal and social barriers to effective HIV/AIDS prevention and care activities and lobby for policy change to improve the legal and social environment
- Expand capacity building activities with media
- Develop and/or adapt existing program development tools for use in workplace-based HIV/AIDS programs
- Identify innovative ways to ensure dissemination of surveillance data to opinion leaders involved in advocacy and policy issues

Sub-IR. 1.3 Community response to HIV/AIDS strengthened

Proposed Activities:

- Strengthen the capacity of community organizations to develop, implement and evaluate HIV/AIDS prevention and care activities
- Strengthen the capacity of community organizations to fight against stigmatization and discrimination of PLWHA
- Strengthen existing ANCS activities and expand these into new regions such as Matam and Saint Louis and Ziguinchor
- Build the capacity of community-based support groups for people living with or affected by HIV/AIDS

Sub IR. 1.4 Effective strategic approaches to behavior change implemented

V. Proposed Activities:

- Coordinate a mapping of high transmission areas and identify relevant BCC interventions
- Conduct an assessment of current behavior change approaches targeting both core transmitter and bridge groups to document lessons learned
- Develop new strategic approaches based on lessons learned which link core transmitter and bridge groups
- Expand the number of BCC Task Forces at the regional level, to facilitate coordination and lessons learned sharing among all BCC professionals and actors.

IR. 2. Increased quality prevention, care, and treatment services in targeted areas: assist to develop norms , procure as appropriate

VCT is recognized around the world as a key component to prevention strategies. By linking VCT to behavior change interventions and targeting access for high risk populations, it becomes a platform for transmission prevention and increased access for care and support. The recent introduction of ARVs and rapid tests in Senegal supports the feasibility of an accelerated and decentralized expansion of VCT and MTCT services.

USAID currently supports a full package of ante-natal care services to pregnant women living in the 15 health districts where it currently intervenes. Pilot MTCT activities indicate that 65% of pregnant women accept HIV testing. USAID will make testing available through ante-natal services it currently supports. This strategy will make testing available to all pregnant women, and will reach at risk women testing positive for syphilis. Within the framework of the Global Development Alliance, USAID will negotiate agreement(s) with pharmaceutical manufacturers to leverage drugs for the MTCT intervention.

USAID will increase the availability of STI services in the 15 integrated health districts. Biological syphilis screening will be made available in health centers and participating health posts which will be selected on the basis of their client volume. Efforts will be made to strengthen the supervision approach of STI case management. Over the next four years, USAID anticipates expanding coverage to 14 additional districts.

USAID is working the National Care and Treatment Center of the Fann Hospital to support its outreach interventions, with a focus on psycho-social support and nutrition. The U.S. Government's Food for Peace program provides an opportunity to target food distribution to this most needy sub-population. As the GOS program for care and treatment expands, USAID anticipates that it will provide the same type of psycho-social (counseling, support groups, associations, home visits) and nutritional support to future outpatient centers. With USAID assistance, the MOH HIV/AIDS Division has developed guidelines for the treatment of opportunistic infections and a training plan to roll out capacity within its health infrastructure. USAID will support the training of healthcare providers. USAID will accelerate the deployment of resources to high prevalence areas.

Sub IR 2.1 Quality VCT services expanded

Proposed Activities

- Advocate the priority opening of VCT in high prevalence zones
- Establish new VCT centers according to criteria developed with the MOH HIV/AIDS Division
- Procure and distribute equipment and supplies (including rapid tests)

- Provide technical assistance to VCT centers (laboratory technology, training of counselors, VCT center management)
- Support the National Reference Laboratory to monitor the quality of the decentralized testing operations
- Support the MOH HIV/AIDS Division to monitor the quality of counseling of decentralized VCT services

Sub IR 2.2 Quality STI services expanded

Proposed Activities

- Assist the MOH HIV/AIDS Division to review its strategy on the application of syndromic management and supervision of services
- Provide laboratory equipment and supplies to health centers and health posts
- Train laboratory technicians
- Assist the National Reference Laboratory to ensure quality of services

Sub IR 2.3 MTCT services expanded

Proposed Activities

- Develop and implement an operational plan to introduce MTCT within ante-natal care services.
- Develop counseling skills of ante-natal care personnel
- Develop national MTCT norms and guidelines
- Establish continuum of care for seropositive mothers and children
- ~~Supply Food for Peace artificial milk as breastfeeding substitute~~

Sub IR 2.4 Psycho-social and nutrition support services of PLWHA expanded

Proposed activities

- Distribute Food for Peace food through out-patient services
- Train counselors in care, support and nutrition
- Develop guidelines on nutrition
- Extend psycho-social and nutrition services to new centers
- Support PLWHA groups

Sub IR 2.5 Increased capacity to provide treatment to PLWHA

Proposed activities

- Identify and train healthcare providers in diagnosis and treatment of opportunistic infections and administration of ARV

- In collaboration with the Fann Outpatient Center, develop counseling program to support healthcare workers.

IR 3. Effective national systems in place to assure quality program

Senegal's response to the HIV/AIDS epidemic depends in large part on the leadership and management of the national program. As the largest donor in HIV/AIDS, USAID has a well established relationship with the CNLS. With technical and financial support from the CDC, USAID has been a key partner in the development of the national surveillance system. USAID will continue to support capacity building activities aimed at the central and other levels, and provide technical assistance in developing policies and guidelines to ensure quality interventions.

NGOs have been valuable partners in the national response to HIV/AIDS. Their capacities need to be strengthened to enable them to have more input into the direction of the national program, and strengthen public-private partnerships. By strengthening the nascent ICASO network, NGOs will be given a stronger voice to advocate for their constituencies, and learn to use advocacy strategies to gain greater involvement in government accountability.

Sub IR 3.1 Fully effective second generation surveillance system in place

Proposed activities

- Procure and distribute equipment and supplies to strengthen testing capacity in all 11 regions.
- Strengthen implementation of second generation surveillance.
- Review and strengthen STI surveillance
- Increase capacity in data analysis, interpretation and dissemination for prevention and care planning
- Extend biological and behavioral surveillance to include newly identified high risk and bridge groups targeted by the National Program.

Sub IR 3.2 Planning, budgeting and monitoring capacity instilled within CNLS and MOH HIV/AIDS Division

III. Proposed Activities

- Assist MOH/HIV-AIDS Division in developing refined sectoral strategy
- Provide technical assistance through Country Coordinating Mechanism
- Conduct joint reviews of programs (both programmatic and financial)
- Assist MOH in the development of technical norms as appropriate
- Assist CCM develop monitoring and evaluation system for sectoral strategy

IR 3.3 Effective distribution system for HIV/AIDS supplies and products in place in public and private sectors

Proposed Activities

- Continue to support and expand social marketing of condoms
- Expand availability of no-logo condoms
- Develop logistics for testing materials

Sub IR 3.4 Policies and norms adopted for expanded HIV/AIDS Services

Proposed activities

- Provide technical assistance to MOH HIV/AIDS Division to develop and/or update policies and norms

Sub IR 3.5 Effective participation of NGOs in implementation of National Plan

Proposed activities

- Provide institutional support, equipment and supplies to NGO network
- Provide advocacy training to NGO network members
- Provide training on key HIV/AIDS issues to NGO network members
- Provide training in information technology to NGO network members
- Provide technical assistance to NGOs in strategic planning
- Foster/encourage public-private partnerships with ministries

I. Implementation modalities and USAID Management

USAID has a variety of mechanisms in place to implement its strategy:

- 1) A Cooperative Agreement with Family Health International (FHI). The FHI CA is the largest of USAID's contractual mechanisms for HIV/AIDS support. FHI will continue to fund and provide technical oversight to NGOs in Senegal, serve as the financial conduit for CDC funds provided to USAID, and provide direct financial and material support to GOS structures.
- 2) Collaboration with the CDC to ensure an effective surveillance system, monitoring and evaluation, implementation of VCT and MTCT, and improved laboratory quality and testing.
- 3) A Cooperative Agreement with ADEMAs. ADEMAs will continue to manage the condom social marketing program and will introduce the female condom with KFW support.
- 4) A Cooperative Agreement with Management Sciences for Health (MSH) will be used to expand the MTCT intervention, in collaboration with FHI.

- 5) A Cooperative Agreement with the Center for Development and Population Activities (CEDPA) will be used to reach women and youth with HIV/AIDS prevention messages using an empowerment approach.
- 6) Specialized TA from the Division of HIV in the Global Bureau

III RESULTS AND REPORTING

A. Magnitude and nature of expected results

USAID's strategy aims to: 1) build capacity within the national program; 2) identify and reach most at risk groups with prevention and treatment interventions; 3) provide care and support to PLWHA.

The National AIDS Program is at an important juncture as it expands its response to address the epidemic on a multi-sectoral basis. The CNLS and its implementing partners are poised to launch an expanded and comprehensive response with the new levels of funding pledged by the World Bank and the Global Fund. USAID will support the strengthening of select national systems to ensure the quality of technical interventions, availability of supplies, monitoring, evaluation and surveillance.

A set menu of prevention and care interventions will target the populations covered by USAID's integrated health project in 15 districts in Louga, Thies, Kaolack and Fatick. The aggregate of the populations in the 15 districts is estimated at 3 million. It is anticipated that by 2006, 14 more districts will have been added under this component. Outside these specific sites, the geographic coverage of the strategy is driven by the locations of high-risk groups and/or high transmission areas. The strategy will also advocate decentralization and expansion of services to high prevalence areas such as the Ziguinchor, Matam and Podor. The identification of new high risk groups and the adoption of a more strategic targeted approach will greatly expand the coverage of vulnerable populations, and will also allow the development of continuum of care in high transmission areas.

The introduction of ISAARV by the GOS represents an important milestone in the national program, and opens the door for increased VCT and MTCT promotion and extension of care and support efforts. USAID, in collaboration with other donors, expects to reach at least 25% of HIV infected persons with basic care and psycho-social support by 2006.

B. Country reporting and performance indicators and targets

Proposed indicators for each of the proposed sub-IR are as follows:

IR 1. Create and support demand for quality prevention and care services and products

Sub-IR1.1 Increased safe sex practices among targeted groups

- % persons in high risk groups reporting condom use with non regular partner during the most recent sexual act in the past 12 months for HIV prevention (2 years)
- % persons (Female: 15-24 and 15-49; Male 15-24 and 15-49) reporting condom use with non regular partner during the most recent sexual act in the past 12 months for HIV prevention (2 years)
- % of persons in high-risk groups who know of condom use as a means to prevent STI/HIV/AIDS
- % persons (Female: 15-24 and 15-49; Male 15-24 and 15-49) citing condoms as a means to prevent STI/HIV/AIDS transmission
- number of men and women seeking STI treatment
- % persons in high-risk groups citing at least two accurate gender specific STI symptoms
- % women 15-49 who know of a facility for HIV testing
- % persons in high-risk groups who know of the existence of VCT
- % of persons in high-risk groups who know of at least one place where to get condoms
- median age at first sex
- % of youth (15-24) reporting abstinence as their means of prevention

Sub-IR 1.2 Enabling (political, social, legal and religious) environment strengthened for program expansion

- % of targeted companies that have adopted HIV/AIDS policy
- number of businesses that conduct prevention activities
- Number of community and religious leaders, and private companies that received an orientation on HIV/AIDS
- % of national health budget allocated for purchasing ARV drugs and reagents for HIV testing
- press coverage of public officials speaking to AIDS issues
- percent of population with accepting attitudes towards those living with HIV

Sub-IR1.3 Community response to HIV/AIDS strengthened

- Number of NGOs and/or community-based organizations working with health districts to implement IEC activities on STI/HIV/AIDS
- number of social mobilization events in each LGUs per year
- number of district HIV/AIDS committees meeting at least x times per year.
- % of population who know HIV can be transmitted from mother to child
- % of population who know that mother- to-child transmission is preventable

Sub IR. 1.4 Effective strategic approaches to behavior change implemented

- Number of interventions linking core transmitter and bridge groups
- Number of intervention sites targeting high-risk groups
- % persons in high risk groups reporting condom use with non regular partner during the most recent sexual act in the past 12 months for HIV prevention (2 years)

IR. 2. Increased quality prevention, care, and treatment services in targeted areas

Sub IR 2.1 Quality VCT services expanded

- Number of sites offering VCT
- Number of men/women using VCT services
- % of health districts that have at least one center staff by trained counselors providing specialized HIV counseling and testing services
- Number of VCT centers with minimum conditions to provide quality services

Sub IR 2.2 Quality STI services expanded

- Number of service delivery sites with at least one person trained in syndromic management
- Number of service delivery points offering syphilis testing
- % of patients with STIs who are given advice on condom use and partner notification and who are referred for HIV testing
- % of patients with STIs at selected healthcare facilities who are appropriately diagnosed and treated according to national guidelines of all STI patients at those centers

Sub IR 2.3 MTCT services expanded

- Number of health centers offering HIV testing to pregnant women
- Number of seropositive pregnant women referred for MTCT
- % of seropositive women undergoing PMTCT

Sub IR 2.4 Psycho-social and nutrition support services of PLWHA expanded

- Number of out-patient centers receiving USAID support for care and support
- Number of PLWHA receiving counseling
- Number of PLWHA enrolled in support groups
- Number of PLWHA receiving USAID food assistance

Sub IR 2.5 Increased capacity to provide treatment to PLWHA

- Number of healthcare providers trained in diagnosis and treatment of opportunistic infections
- Access to counseling for healthcare workers

IR 3. Effective national systems in place to assure quality program

Sub IR 3.1 Fully effective second generation surveillance system in place

- Behavioral data available through regular BSS
- HIV epidemiological data available through sentinel surveillance
- STI data available through continuous surveillance
- Data interpreted, analyzed and disseminated/bulletins
- Effective second generation surveillance system in place operating according to UNAIDS guidelines

Sub IR 3.2 Planning, budgeting, monitoring capacity instilled within CNLS and MOH HIV/AIDS Division

- Annual Plan and Budget approved by first quarter
- Monitoring reports available quarterly

Sub IR 3.3 Effective distribution system for HIV/AIDS supplies and products in place in public and private sectors

- Number of sites offering no-logo condoms
- Number of sales points for socially-marketed condoms
- % of SDPs who do not experience stock-outs of USAID-procured supplies or products in the course of a year

Sub IR 3.4 Policies and norms adopted for expanded HIV/AIDS Services

- Number of policies and norms developed and disseminated

Sub IR 3.5 Effective participation of NGOs in implementation of National Plan

- Number of active members in NGO network
- Number of NGOs receiving orientation on key HIV issues
- Number of advocacy activities conducted by NGOs
- NGO bulletins published, electronic forums
- Number of public-NGO MOUs developed in other ministries

According to the guidelines for intensive focus countries, USAID/
Senegal will be reporting on performance according to the following matrix:

What	Indicators	Source
Strategy Objective	National HIV/AIDS prevalence	National sero-surveillance system
Changes in sexual risk reduction behaviors in high risk groups	Number of respondents who have sex with more than one partner Condom use at last risky sex Median age at first sex among young men and women	Second generation surveillance
CSWs	HIV infection rates STI infection rates	
STIs	Number of clients provided services at STI clinics	STI surveillance
VCT	Numbers of clients seen at VCT centers Number of VCT centers w/USAID support Numbers referred for care	VCT center reports
MTCT	Number of USAID-supported facilities offering PMTCT services Number of women who attended PMTCT sites for a new pregnancy in the past 12 months % of HIV+ women attending antenatal clinics receiving a complete course of ARV therapy	MTCT center reports
Care & support	Number of individuals reached by community and home-based care programs in the last 12 months Number of USAID-assisted care and support programs Number of PLWHA in support groups	Treatment center reports
Condom use	Total condoms sold Condom distribution	Ademas reports MOH AIDS and NGO reports

C. Contribution to International and Expanded Response Goals

USAID reports on two WHO service quality indicators (PI 6 &7) in its monitoring of STI case management.

The USAID/Senegal HIV/AIDS Strategy will contribute to the following 2007 International Targets set by the United Nations General Assembly Special Session on AIDS (UNGASS):

1. Maintain prevalence below 1 percent among 15-49 year olds in low prevalence areas.
2. Provide basic care and psychological support services to at least 25% of HIV infected persons.
3. Ensure that at least 25% of HIV/AIDS-infected mothers have access to interventions to reduce HIV transmission to their infants.

D. Planned surveillance, surveys and other M&E activities

With USAID support, Senegal has developed one of the more evolved surveillance systems in Africa. The sentinel surveillance system has been in place since 1989 and behavioral surveillance was introduced in 1997. More recent efforts have targeted the development of a surveillance strategy in keeping with the principles of second generation surveillance. Combining sentinel sero-surveillance, behavioral and STI surveillance allows the system to capture the data necessary to track trends and increase understanding of the dynamics driving the epidemic. Work will continue to ensure that the system is adapted to track new target populations and expanded interventions such as VCT and MTCT.

USAID relies on the following mechanisms to gather data and information on the performance of its Program:

- The Demographic Health Survey, conducted every five years, provides data on knowledge, attitudes and practice for STIs and HIV.
- Senegal's national sentinel-surveillance system generates annual HIV prevalence data in pregnant women, TB patients, CSWs, hospitalized patients, and blood donors.
- The National STI surveillance system provides annual data on STI infection in pregnant women, CSWs, and men, as well as quality of services provided.
- Behavioral surveillance surveys, conducted every two years in 10 regions, provide data on trends in knowledge, behaviors and practice among targeted high risk groups (registered CSWs, unregistered CSWs, in-school youth, apprentices, street sellers, and merchants)
- Second generation surveillance generates data on targeted bridge groups in Dakar. This is being done on a pilot basis and the system will be strengthened and expanded.
- VCT data is collected three times a year through service statistics reports.

- Punctual surveys, mapping, and focus group discussions are used to obtain baseline data and orient strategies.
- To meet the Mission's reporting needs, the Annual Supplemental Survey generates data on select indicators relating to women of reproductive age, service delivery points, etc.
- USAID/Senegal conducts at least one data quality audit per year.

IV RESOURCES LEVELS AND ACTIVITIES

A.1 Expected levels of program funding, staff and OE

USAID anticipates an HIV/AIDS annual OYB of \$5 million in FY02, \$6million in FY03, \$6.5 in FY04 and \$6.5 millions in FY05. These funds will finance activities through the current SOAG that ends September 2006.

This level of funding, when combined with funds provided by CDC, will allow USAID to support the National AIDS Program along the lines outlined in this Strategy. This includes:

- Support to the National AIDS Council
- Strengthening of the national surveillance system
- Expanded IEC/BCC activities covering new geographic areas for current at-risk populations and implementing additional IEC/BCC activities for currently under-served groups
- The introduction of a MTCT component within the maternal health portfolio
- Expanded STI testing and VCT centers
- Care and support for PLWHA with a concentration on the psycho-social and nutritional aspects

Staffing and OE budget: USAID/Senegal believes it is adequately staffed to continue its support to the Senegal HIV/AIDS program during the planned expansion phase. The office of Health (SOT3) has maintained good relations and technical oversight of the program in the past and will continue to do so. It relies on the specific services of a highly competent FSN HIV/AIDS Project officer, supported by a Senior Technical Advisor for AIDS and Child Survival (TAACS) as well as the USDH Health Officer to manage the HIV/AIDS component of our Strategic Objective. The entire program and staff, with the exception of the USDH Health Officer is program funded. The Team works closely with CDC to identify areas of support and of comparative advantage to the USG and to seek high quality technical assistance to supplement the technical assistance being provided largely by FHI, CDC and other Field Support CAs. We believe this model has worked and will be enhanced by anticipated program support now established in the HIV Division of the Global Bureau.

B. Results with higher levels of support

Additional funding would allow USAID/Senegal to provide greater geographic coverage of the same set of interventions and activities. The challenge we foresee in this program is not so much the lack of resources but the judicious use of high quality technical assistance to ensure that a high quality and cost-effective program is developed to control the epidemic. USAID will contribute to this need in this Strategy.

What should a USAID HIV/AIDS strategy include?

A mission HIV/AIDS strategy needs to address four primary questions.

- **What is the situation?** What is the status of the epidemic? What factors are influencing its growth (or decline)? Who and where are the critical populations to reach with prevention, PMTCT, treatment, care and/or support activities? How many are affected? What are key policy, cultural, gender-based and institutional supports or constraints to progress in addressing the epidemic? What is the vulnerability to conflict? What prior assistance (nature and amount) has USAID provided? What have been the lessons learned from this or other related assistance? What have been the impact/results of prior USAID assistance? Who are USAID's main partners and what are they doing? Is there a national HIV/AIDS strategy? Is it adequate? What is the government's commitment to addressing HIV/AIDS and how is this demonstrated? Does the country have sufficient capacity to respond to the epidemic? Is there a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and/or a World Bank Multi-Country HIV/AIDS Program (MAP)? Does USAID play a role in the Global Fund country coordination mechanism? What coverage to date have USAID and its partners achieved with prevention and, where appropriate, PMTCT, treatment, care and support (including for orphans and vulnerable children)?
- **What is the mission's strategy?** What is the mission's objective? What lower-level results are essential to the achievement of this objective (results framework)? What are the major interventions that the mission intends to support? In countries with generalized epidemics, do these include the full prevention-to-care continuum of interventions? How are key policy, cultural and institutional constraints addressed? Do the interventions include activities directed at the most at-risk populations, youth, HIV-positive pregnant women and/or orphans and vulnerable children? How is stigma addressed? Are the interventions proposed based on best available evidence? Are people living with HIV/AIDS as well as the most at-risk populations involved in the design and implementation of the program? How are the different needs, perspectives and experiences of men and women addressed? How does the mission strategy respond to Agency directives and strategic directions? How do the strategy and the planned assistance relate to the stage of the epidemic, other-partner activities (including GFATM grants), the national strategy, cross-border or multi-country concerns, USAID's activities in other sectors and prior USAID experience? How does the mission plan to implement its strategy? How will the program strengthen national capacity to respond to the epidemic? Is there flexibility to respond to new information as the state-of-the-art evolves? How will essential commodity needs (condoms, test kits, drugs, etc.) be met?
- **What will be the result?** What is the nature and magnitude of the change that the mission, with its partners, expects to achieve by the end of the strategy? How will this be measured? What are the key indicators and targets? Where appropriate, are USAID standard indicators used? Are the targets consistent with prior assistance

and/or the proposed funding? Will the strategy (mission and partner assistance) achieve national-level impacts or coverage by reaching a significant proportion of the key populations? How will the mission (and its partners) contribute to the achievement of the Expanded Response international targets (in reducing/maintaining prevalence, PMTCT, access to care and support)? Are the planned investments (USAID and partner) in surveillance, behavior surveys, and monitoring and evaluation sufficient to manage, track and report adequately on the epidemic and the program? Will the mission be able to comply with new Agency HIV/AIDS reporting requirements?

Note: a few missions can reduce or maintain low national HIV prevalence. Most missions with in-country partners can achieve measurable changes in critical high-risk behaviors (number of partners, age at first sex or condom use at last risky sex) nationally or among critical at-risk populations.¹ Many in high-prevalence countries can also achieve important, measurable increases in access to PMTCT, treatment, and care and support (including for orphans and vulnerable children). Even with committed, strong partners, missions in the countries with very large affected populations may not be able to achieve results at the national level. In such cases, they may still be accomplishing a great deal if they can achieve results at a state or provincial level. Choosing the geographic and population base and the level of results requires careful consideration and needs to be clearly articulated. While it may be appropriate to target *activities* to geographic areas, particularly high-transmission areas, missions should avoid *results* that are defined in terms of “project areas.”

- **What are the resource levels?** What are the actual or planned program funding and staffing levels? Are there operating-expense (OE) constraints? Optional: if additional resources were available, how would these impact on the strategy, program coverage and the expected results?

¹ Achieving national impact or coverage does not necessitate covering every community or individual. In countries where the epidemic is still low-level or concentrated, it should be possible to achieve national-level impact in slowing or lowering prevalence by focusing on key at-risk populations such as sex workers, their clients, men who have sex with men and/or injecting drug users. These populations may be concentrated in specific cities or other limited geographic areas. In such focused, targeted strategies, missions need to describe the target population and estimate the proportion they expect to reach through the strategy.