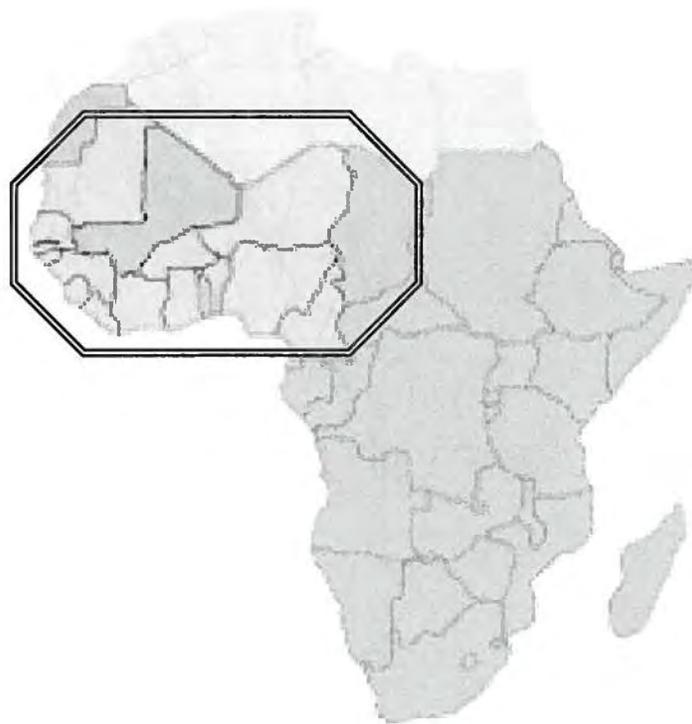


DRAFT
West Africa Regional Health Program
HIV/AIDS Strategy



November, 2002

ACRONYMS AND ABBREVIATIONS

ABC	Abstinence, Fidelity and Condom Use
USAID/AFR	USAID Africa Bureau
AFRICASO	African Council of AIDS Service Organizations
AIDS	Acquired Immune Deficiency Syndrome
AIM	AIDS Impact Model
ARV	Antiretroviral
BCC	Behavior Change Communication
BSS	Behavior Surveillance Survey
CA	Cooperating Agency
CAN	Canadian
CAFS	Center for African Family Studies
CBD	Community-based distributor/distribution
CDC	Centers for Disease Control and Prevention
CEFOREP	Centre Regional de Formation et Recherche en Santé de la Reproduction
CERPOD	Centre pour la Recherche de la Population et Développement
CI	Cote d'Ivoire
CIDA	Canadian International Development Agency
CILSS	Comité Inter-Etats de Lutte contre la Sécheresse au Sahel
COP	Chief of Party
CRS	Catholic Relief Service
CS	Child Survival
CSW	Commercial Sex Worker
DAA	Deputy Assistant Administrator
DALY	Disability adjusted live years
DFID	Department for International Department (British Bilateral Agency)
DOD	Department of Defense
DHS	Demographic and Health Survey
E.U.	European Union
ECOWAS	Economic Community of West African States
ENSEA	Ecole Nationale Supérieure de Statistiques et d'Economie Appliquées
FFP	Food for Peace
FHA	Family Health and AIDS
FP	Family Planning
FS	Field Support
FTE	Full-Time Employee
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIPA	Greater involvement of people with AIDS
GTZ	German Technical Assistance Agency
HIV	Human Immuno-deficiency Virus
ID	Infections disease
IFORD	Francophone International Demographic Center
IPPF	International Planned Parenthood Federation
IRESO	Institut de Recherche et des Etudes de Comportement
ISED	Institut de Santé et Développement
KfW	German Development Bank
LOP	Life of Program/Project
M&E	Monitoring and Evaluation

MAP	Multi country AIDS Program
MCH/FP	Maternal and Child Health/Family Planning
MH	Maternal Health
MOH	Ministry of Health
MTCT	Mother-to-Child Transmission
NAP+	Network of African People with AIDS
NGO	Non-Governmental Organization
OE	Operating Expense
OR	Operations Research
OVC	Orphans and Vulnerable Children
PABA	People Affected by HIV/AIDS
PHN	Population Health Nutrition
PLWHA	People Living with HIV and AIDS
PMP	Program Monitoring Plan
PMTCT	Prevention of MTCT
PNP	Policy Norms and Procedures
PSAMAO	Prévention du SIDA sur les Axes Migratoires de l'Afrique de l'Ouest
PSC	Personal Service Contract
PSI	Population Services International
PVO	Private voluntary organization
RAP+	Regional Association of People Living with AIDS
RAPI	Regional African Partner Institution
RAPA	Regional AIDS Program for Africa
RETRO-CI	Retrovirus-Côte d'Ivoire
RFA	Request for Applications
SO	Strategic Objective
STI	Sexually Transmitted Infections
SWAA	Society for Women and AIDS in Africa
TA	Technical Assistance
TAACS	Technical Advisors in AIDS and Child Survival
TB	Tuberculosis
UNAIDS	The Joint United Nations Program on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNGASS	United Nations General Assemblée Special Session
USDH	United States Direct Hire
USG	United States Government
VCT	Voluntary Counseling and Testing
WACASO	West Africa Council of AIDS Service Organizations
WAEN	West African Enterprise Network
WAHO	West Africa Health Organization
WARP	West Africa Regional Program
WB	World Bank
WHO	World Health Organization

TABLE OF CONTENTS

1. Regional situation	Page
1.0 Background	5
1.1 Current status of the epidemic	5
1.2 Factors affecting the spread of AIDS	7
1.3 Needs in prevention, care and support	9
1.4 Regional partners' strategies and contributions	10
1.5 Target populations	15
1.6 Current program coverage	16
1.7 Lessons learned, results of prior USAID interventions	18
2. Regional strategy	
2.1 Strategic Objective	21
2.2 Rationale	21
2.3 Key intermediate results	22
2.4 Critical assumptions	23
2.5 Special concerns	24
2.6 Planned interventions by IR	25
2.7 Implementation modalities	31
2.8 Cross-SO synergies within WARP	31
3. Results and reporting	
3.1 Magnitude and nature of expected results	34
3.2 Reporting and performance indicators and targets	34
3.3 Contribution to international and expanded response goals	35
3.4 Program monitoring and evaluation	36
4. Resources	
4.1 Expected levels of program funding, staff and OE	37
4.2 Results with higher levels of funding	37
5. Annexes	
5.1 WARP Strategic Framework	
5.2 WARP SO5 Framework	
5.3 Results from donor mapping in region	
5.4 Number of PLWHA, OVCs and deaths from HIV/AIDS in region	
5.5 Contributions to USAID's HIV/AIDS SO	
5.6 References	

Section 1.0 Background

Many of West Africa's problems are regional in scope, created by underlying factors that are common across national borders. These include poverty, unemployment, poor economic indicators, poorly maintained infrastructure and an alarming exodus of trained professionals from the public sector. Political strife and instability in one country affect its neighbors as displaced persons seek refuge in nearby countries. In addition, regional and national government funds earmarked for health or other social programs may be diverted and reprogrammed to support or combat internal conflicts or conflicts in neighboring countries. In addition, the growing HIV/AIDS epidemic in West Africa presents a huge developmental and public health challenge for countries in the region which are already overextended in addressing many problems.

In 1995, USAID authorized the Family Health and AIDS (FHA) project following the closeout of many USAID missions in West and Central Africa. FHA's mandate was to continue to provide limited support for key health and population programs in selected countries where USAID no longer had a presence. The project initially focused on four priority countries – Burkina Faso, Cameroon, Cote d'Ivoire and Togo and eventually began to develop and use regional approaches to transnational problems. In 2000, a new strategic plan was designed to promote political and economic integration among the fifteen countries which comprise the Economic Community of West African States (ECOWAS), plus Chad, Cameroon and Mauritania¹. The WARP strategy deals with four sections: economic growth and integration; food security and natural resources management; conflict prevention and resolution; and health. WARP is approved for years 2000-2008.² It is in this context that the HIV/AIDS strategy was designed.

The HIV/AIDS strategy proposes a program framework for use by USAID in collaboration with implementing agencies, other donors and regional partners.

1.1 Current status of the epidemic

Data on the HIV epidemic in West and Central Africa is generally weak and varies considerably in quality from country to country. ^{from} Five countries in the region do not have reliable estimates of national HIV prevalence (Cape Verde, Liberia, Mauritania, Niger); the others have limited surveillance systems and rely on very small samples (such as blood donors in Mauritania) to extrapolate national estimates. For example, Mali, generally thought to have a good surveillance system estimated adult prevalence at 2.5. The 2001 DHS indicated that the actual level, based on a population-based sample survey, was 1.7 percent. DHS are planned for several countries (Cameroon, Chad and Burkina in 2003; Senegal and Togo in 2004). DHS sero-prevalence modules will improve our understanding of the epidemiologic situation in the region. In the meantime, use of consecutive behavioral surveillance surveys (BSS), which focus on high risk populations, provide valuable information for program planning. In addition, surveillance systems in some countries (CI, Ghana, and Senegal) provide useful indications of levels and trends in key populations such as pregnant women, those infected with STI, and high risk groups. X

¹ ECOWAS countries are: Benin, Burkina Faso, Cameroon, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.

² The overall WARP framework is in Annex 1.

According to available data, HIV/AIDS, while less severe than in other parts of Africa, is spreading at an alarming rate in several West African countries. In 1987, only two countries in the region had prevalence rates of more than 2% (UNAIDS, 1998). By 2002, all but one country in the region is above 2% and five out of fifteen ECOWAS countries are above 5%. By 2002, the estimated HIV prevalence rates in Cameroon, Cote d'Ivoire, Burkina Faso, Togo and Nigeria are 11.8%, 9.7%, 6.5 %, 6.0% and 5.8% respectively (UNAIDS, 2002).

According to UNAIDS' recent report, there is "evidence of recent, rapid HIV spread in West and Central Africa". Recent data confirms the "folly of false assumptions" of a low, slow-growing epidemic. According to 2002 estimates, Cameroon has surpassed Cote d'Ivoire as the country with the highest prevalence in the region. In 1988, HIV prevalence in Cameroon's urban areas was at almost 2%. The 2000 round of HIV surveillance found national prevalence rates of around 11% among pregnant women. UNAIDS considers the possibility that this could be the beginning of an ongoing, steep rise, as indicated by the fact that the highest prevalence rates were found among young people- 11.5% among 15-19 year-old pregnant women and 12.2% among those aged 20-24. Also of concern is the fact that prevalence rates were almost equally high in rural and urban areas (UNAIDS, 2002).

High risk populations and geographic 'hotspots', even within countries with a generalized epidemic, have exceptionally high rates. According to UNAIDS, HIV prevalence among male STI patients in urban sites was as high as 45% in Togo, 39% in Ghana, 25% in CI and 22% in Cameroon (data collected between 1991 to 2000). The prevalence rates for female sex workers is higher with 78.9% in Togo, 50% in Ghana, 36.6% in Guinea and 36% in Cote d'Ivoire (Table 1).

Studies on STI prevalence are extremely limited in the region. Data are available only for high risk populations in selected cities of the region (Buvé et al., 2001).

Table 1: HIV Prevalence Among High Risk Urban Populations, UNAIDS, 2002

Country	High Risk Urban Populations			
	Year	Male STI patients	Year	Female Sex Workers
		Median prevalence		Median Prevalence
Benin	1999	3.9	1999	19.4
Burkina Faso	1991	17.5	1994	58.2
Cameroon	2000	22.0	1995	16.4
Chad		...	1995	13.4
Cote d'Ivoire	2000	25.0	1999	36.0
Gambia	1991	4.7	1993	13.6
Ghana	1999	39.0	1998	50.0
Guinea	1996	4.0	1994	36.6
Liberia	1993	8.0		N/A
Mali		...	2000	21.0
Mauritania	1996	1.7		...
Niger	1992	4.1	1997	23.6
Nigeria	1995	3.0	1996	30.5
Senegal	1998	3.0	1998	7.0

Sierra Leone	1992	3.3	1995	26.7
Togo	1992	45.2	1992	78.9

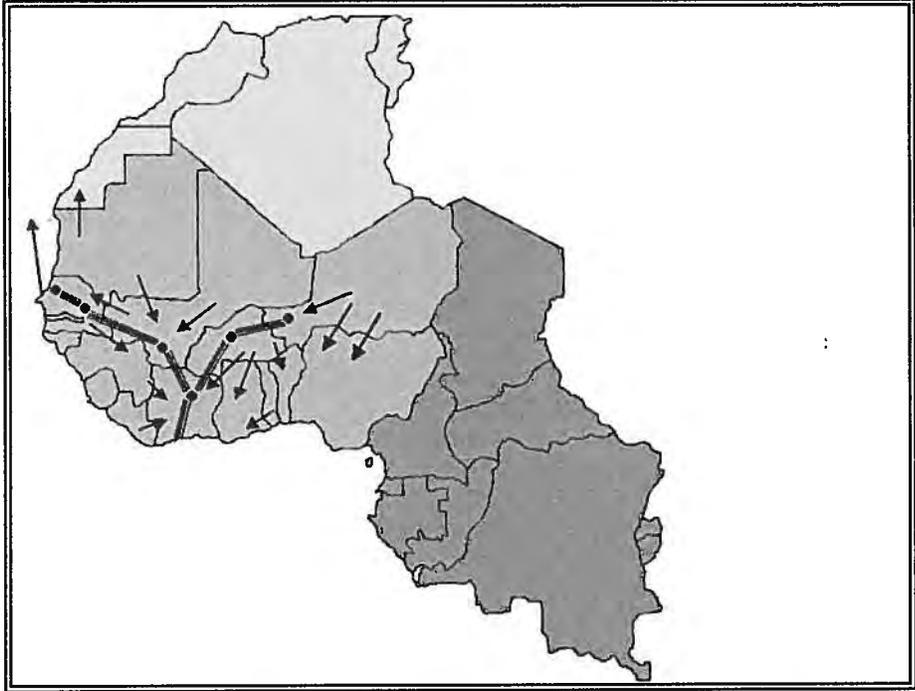
The impact of increasing HIV prevalence in the region is becoming apparent. The total number of PLWHA within the region is approximately 6 million, with approximately 2 million orphans (Annex 7). Burkina Faso alone has approximately one million PLWHA and Cote d'Ivoire almost 800,000. The increasing number of people infected and affected by HIV/AIDS has social and economic impact on families, already weak health care systems and economies. It has been projected that monthly per capita income among families living with AIDS in Cote d'Ivoire is only 32% that of families not living with AIDS (UNAIDS, 2000). Attention to care and support issues, particularly addressing stigma and discrimination will be needed for successful prevention efforts.

1.2 Factors affecting the spread of HIV/AIDS

In general, the factors in the region that make populations vulnerable to the rapid expansion of HIV/AIDS can be categorized as follows:

Migration/mobility and economic determinants- The migration of permanent and seasonal workers and individuals seeking economic opportunities along coastal areas, urban centers or along migratory routes leads to an increased vulnerability to and spread of STIs and HIV (figure 1). UNAIDS estimates that 3 million people cross the borders between Abidjan and Lagos each year (World Bank, 2002). Widespread poverty, low levels of literacy, particularly among women and limited economic opportunities exacerbate vulnerabilities. Commercial sex work within commercial hubs (such as Abidjan) and along transportation routes is common and high rates of STIs and HIV have been documented in Ivory Coast and Benin.

Figure 1: Major migratory routes and movement within West Africa, 2000 (UNAIDS)



Sexual behavior patterns- Early sexual initiation and marriage, high rates of partner change, sex work and low condom use are behaviors in the region that unnecessarily expose men and women to STIs and HIV. Furthermore, even among high risk populations, perceptions of risk of acquiring HIV is low. Findings from studies with CSWs in Benin and Cote d'Ivoire have documented successful approaches to working with high risk groups to increase condom use and improve access to treatment of STIs (Ghys, et al, 2002 and Alary et al, 2002).

Gender and social/cultural norms- Cultural practices and traditions may contribute to greater vulnerability, particularly of women and young girls. These include early sexual initiation and pregnancy, low negotiating power, polygamy, and violence against women. Socially reinforced norms fostering stigma, silence, denial and discrimination against PLWHA and people affected by HIV/AIDS (PABA) increase the impact of the epidemic and constitute a major barrier to an effective response to it.

Additional factors that are not determinants but that support or constrain an effective response in the region include:

Constraints to an effective response

Political Will- Political leaders in low-prevalence countries typically lack the will to confront the culturally sensitive topic of HIV/AIDS. Political commitment in the region is limited to participation in important declarations such as the Abuja Declaration in 2001. Action in terms of concrete measures to increase health spending (to 15% as was proposed in Abuja) or reduce barriers to HIV/AIDS prevention, care and support are limited.

Weak health care systems and institutional capacity- West Africa's weak managerial and technical expertise is frequently cited as a fundamental constraint to health policy and program development. Recent analyses indicate that there are few documented examples of good human resource practices and institutional capacity building techniques. Many health workers are ill-motivated due to poor pay, poor equipment/facilities, infrequent supervision, and limited career opportunities within the health sector. Human resource and institutional capacity weaknesses limit the region's ability to carry out the HIV interventions supported by this regional program.

Conflict and disasters- Civil conflict and disasters such as drought lead to insecure conditions, which exacerbate the spread of HIV/AIDS due to the vulnerability of people- especially women and children- to sexual abuse and violence. In addition, during these periods of conflict, HIV/AIDS prevention and care efforts are disrupted. Guinea, was recently home to 1 million refugees from Sierra Leone. It is thought that the conflict in neighboring countries contributes to slightly higher prevalence rates in the border areas (7% when compared to 5% in the capital, Conakry) (Guinea Strategy, 2002). The current conflict in Cote d'Ivoire is internally displacing thousands and the effects from disrupted prevention and treatment efforts, as well as out migration will only be known in the months and years to come.

Supports to an effective response

Male circumcision- Male circumcision (associated with lower rates of transmission) is almost universally practiced in West Africa. All countries but two in the region have high prevalence rates of male circumcision (over 80%). Burkina Faso and Cote d'Ivoire are the exceptions, falling into the medium prevalence category with 20-80% of men circumcised (Halperin et al., 1999).

Success story in the region –Senegal, the regional success story, has maintained low HIV prevalence throughout the 1990s. This is partly due to an early, integrated response. Following early reports of AIDS in 1986, there was wide, political, religious and public debate in Senegal. This facilitated prevention efforts across public health and religious divides. Another important factor in prevention efforts in Senegal has been a focus on sex workers (97% report condom use with most recent client and 60% with non client partners) (Low-Beer and Stoneburner, 2001). While there are clearly other important protective religious and behavioral factors, other countries in the region may benefit from the approaches and lessons learned in Senegal.

1.3 Needs in prevention, care and support

Needs in prevention, care and support were identified during a USAID/WARP HIV/AIDS strategic planning meeting conducted in Bamako, Mali in 2000. The issues identified by the bilateral missions, USG agency representatives and other regional stakeholders at that meeting continue to be relevant and provide a basis for the needs outlined in this section.

Surveillance systems: as was described in an earlier section, surveillance systems in the region are of varying quality and usefulness. Strengthened surveillance systems are needed to better understand regional epidemiological trends and more forcefully advocate for strategies to combat HIV/AIDS.

Behavior change communication (BCC): reflecting the generalized nature of the HIV/AIDS epidemic, programs need to pursue both selective and general BCC strategies, targeting high- and medium- risk groups along with the general population in selected sites. Additional research is required on determinants of behavior in order to develop and implement appropriate and effective strategies, channels of communication, and messages. BCC strategies will address target populations described in next section.

Condom and commodity security and improved access: there is a need for country programs (with assistance from regional entities) to identify and support the most effective condom distribution mechanisms, e.g. social marketing, community-based distributors (CBD), non-government organizations (NGO), public sector systems, and the private sector. There is a critical need for the development of effective procurement, logistics, and management systems to establish a reliable supply of condoms, HIV test kits and STI treatment kits and other commodities related to prevention/care and support.

STI case management: recognizing the important role that STI reduction plays in HIV transmission, the following are needed: new channels to reach men with STI case management services; innovative approaches such as pre-packaged therapy for men and periodic presumptive therapy for prevalent infection in high-risk groups such as commercial sex workers; syndromic therapy for women in known high-prevalence settings; and improved systems of procurement, logistics, and management for commodities.

Advocacy: the West Africa region suffers from constant comparison to East and Southern Africa. This has the effect of decreasing political will among leaders, enabling them to deny or ignore the challenges that HIV/AIDS² poses in their countries and the region. A great need remains for effective, targeted advocacy strategies to raise awareness of and mobilize key decision-makers. Successful advocacy programs require ongoing assistance to enable a process to engage “converted” decision-makers and to build a critical mass through support to coalitions and civil society.

Voluntary counseling and testing (VCT): VCT services have been demonstrated to be effective as a prevention approach. There are, however, currently very few VCT sites in this region, even in countries with the highest prevalence. There is a dire need for increased availability of quality voluntary counseling and testing services. The same need applies to MTCT, which is available only in a few urban centers in the region. NGOs play an important role in the provision of these services as well as linking individuals testing positive with care and support services.

Cross-cutting issues- other needs include strengthening of program monitoring and evaluation, improved donor coordination, leveraging resources for commodities and investment in successful prevention and care programs, the need for capacity-building of regional institutions and NGOs that could play a greater role in prevention, care and support and operations research to test approaches that seem to be effective.

1.4 Regional partners' strategies and contributions

There are currently several regional strategies by key regional organizations. USAID has worked with various donors, multilateral programs, networks and the private sector. This USAID/WARP

HIV/AIDS Strategy has been developed in consultation with these regional organizations, including USAID bilateral missions in the region. The main partners and their respective goals include:

UNAIDS Inter-Country Team for West and Central Africa

The UNAIDS regional strategy covers the countries of West and Central Africa. For FY2002, it has the following goals:

- Strengthen institutional partnerships to generate epidemiological and other strategic information;
- Mobilize and assist in channeling financial and technical resources for urgent and expanded national responses;
- Encourage regional partners to collaborate in the development of mechanisms and regional strategies to support countries in their response to HIV/AIDS;
- Develop policies, legislation and programs to address HIV/AIDS and its economic impacts, including in the workplace to protect workers' rights.

UNICEF

UNICEF's West and Central Africa regional strategy has five HIV/AIDS goals:

- Children's survival and development protected from AIDS and its impacts;
- Adolescents, especially girls, have practical knowledge and life skills to protect themselves from HIV infection;
- Women empowered to protect themselves from HIV infection, including the ability to effectively negotiate with their sexual partners;
- Communities gain competence to protect themselves from the spread of the epidemic and create the partnerships and mechanisms to reduce AIDS' impact on families and individuals.

The World Bank

The World Bank has begun planning an HIV/AIDS grant project, called the Western Africa Abidjan-Lagos Transport Corridor. The project's objective is to increase access of underserved, vulnerable groups to HIV/AIDS prevention, basic treatment, support and care services along the Abidjan-Lagos migratory route. Particular attention will be given to transport sector workers, migrant populations and local populations living in the corridor. It is expected that the project will contribute to the reduction of the spread of HIV/AIDS and to the mitigation of adverse social and economic impact of HIV/AIDS in the region. The total cost of the project will be \$16 million and is expected to be approved on January 30, 2003.

The other important World Bank initiative in the region, MAP (Multi-Country HIV/AIDS Project) included eight countries in its first round: Benin, Burkina Faso, Cameroon, Cape Verde, Gambia, Ghana, Nigeria and Sierra Leone. Senegal has been added under MAP II and Chad receives separate HIV/AIDS resources. National strategic plans provide the supporting framework for MAPI, which is designed to complement existing programs. The total planned lending to these countries, under the MAP initiative is \$250 million (with \$90 million alone to Nigeria). The World Bank is by far the largest single donor of HIV/AIDS programs in West Africa (Annex 3).

Centers for Disease Control (CDC)

USAID/WARP has collaborated with CDC and its regional project, Retro-CI, located in Abidjan. Since 1988, Retro-CI has provided HIV/AIDS epidemiologic, laboratory research and TA to the Ivoirian national HIV/AIDS program. RETRO-CI has three principal goals: 1) epidemiological and laboratory HIV/AIDS research, 2) training, and 3) technical assistance.

USAID/WARP has received up to \$2.5 million from CDC's Global AIDS Program to implement activities under the FHA project. CDC is also supporting bilateral missions (Senegal, Mali, Nigeria). WARP/CDC's future collaboration is envisaged for the following areas:

- Epidemiologic Training in the field of epidemiology particularly in HIV, STI's and Malaria, which are all focal areas of the WARP regional program;
- Laboratory Training to implement onsite quality HIV rapid testing;
- Procurement of specialized commodities including rapid diagnostics test kits;
- Training in the management of mother to child transmissions programs in the fight against HIV/AIDS.

Other bilateral donors with multi-country initiatives

GTZ – German Cooperation

Although GTZ has bilateral HIV/AIDS activities in specific countries, the West Africa region receives limited assistance from GTZ in this sector. The Regional AIDS Programme for Africa (RAPA) has a head office in Germany and an Africa regional office based in Ghana. RAPA's key activity areas include: technical advisory services for GTZ structures (staff, projects, programs, GTZ offices, sectors) on HIV/AIDS/STD issues, support for approaches involving preventive activities and alleviation of social and economic consequences of the epidemic on individuals, families and communities, and documentation and presentation of relevant lessons learned.

Canadian CIDA

Since 1995, the *Centre de coopération internationale en santé et développement* (CCISD) has been working in Côte d'Ivoire, Burkina Faso, Ghana, Mali, Guinea, Benin, and Senegal to minimize the transmission of HIV/AIDS by controlling sexually transmitted diseases. This project, now in its second phase, is reinforcing primary and community health networks by giving first priority to high-risk groups and by supporting a number of basic health services located in underprivileged urban areas and along migratory routes.

French Cooperation

Since 1985, the *Coopération Française* has been involved in HIV/AIDS prevention efforts in various countries throughout the region. Initial activities revolved around provision of HIV test kits, blood safety and IEC. More recently, the FC has 45 projects in 20 Francophone countries (including the Caribbean) with a total budget of \$40 million. Among other activities, FC supports VCT centers in several countries and ARV pilot projects in Cote d'Ivoire, Senegal and Benin.

Regional Community Network Initiatives

Several important community-based West African networks are natural strategic partners to USAID/WARP, including:

- *Society for Women and AIDS in Africa (SWAA)* – a network of community-based projects in prevention, care and support focusing on women and led by a strong cadre of women within the region;
- *Network of African People Living with AIDS (NAP+/RAP+)* – a network of associations of people living with AIDS focusing on advocacy, community-based care and support, and capacity building;
- *African Council of AIDS Service Organizations (AFRICASO)* – a network of community based NGOs working in HIV/AIDS, focusing on advocacy, information dissemination and policy development;
- *Journalists Against AIDS in Nigeria* – a network of journalists and communications specialists focusing on information dissemination, policy dialogue and capacity building for print and radio journalists.

West African institutions and their contributions

Regional and sub-regional institutions

WAHO- based in Bobo Dioulasso, Burkina Faso, WAHO was created from a merger of the Francophone regional initiative OCCGE (formed in 1960) and the Anglophone regional initiative the West African Health Community (formed in 1978). As an intergovernmental organization linking 15 nations, WAHO can potentially be an effective body to coordinate policies and norms throughout the region, particularly in the areas of essential medicines, malaria, HIV/AIDS, nutrition, and the surveillance of endemic and epidemic diseases.

WAHO recently proposed its strategic plan for FY 2003-2007 to Ministers in the region. HIV/AIDS was included as a priority area, along with several CS and ID interventions. The two main HIV/AIDS activities proposed are: to facilitate the establishment of youth-focused VCT centers, and to make high-quality drugs and other consumables available and accessible to at least 50% of PLWHA and 80% of STI patients in the sub-region (approximately 2 million people).

CERPOD- based in Bamako, Mali, USAID has supported CERPOD for several years. CERPOD conducts demographic and health studies, training in applied research, monitoring and evaluation of HIV/AIDS programs, data for decision-making, information dissemination, and advocacy.

CAFS- based in Lome, Togo, CAFS works in both Francophone and Anglophone countries in the areas of training and technical assistance in clinical practice, management, IEC, and applied research. CAFS is a partner in the Advance Africa project and has worked with FHA on several activities.

Additional African institutions

ENSEA- based in Abidjan, Côte d'Ivoire, ENSEA provides training and conducts research.

IRESCO- based in Yaoundé, Cameroon, IRESCO conducts qualitative and quantitative research, and recently completed the BSS in Cameroon.

ISED- based in Dakar, Senegal ISED provides training of public health professionals.

CESAG- based in Dakar, Senegal, CESAG provides training in health management and financing and conducts applied research.

USAID Bilateral Missions in West Africa WARP programs are intended to complement and provide added-value to bilateral mission programs, through promoting best practices, co-financing cross-border efforts, training and other efforts (see section 2.6 for examples of collaboration). Within the West Africa region, six USAID bilateral missions with HIV/AIDS programs.

USAID/Benin- In FY2001, Benin's budget for HIV/AIDS doubled from \$1.025 to \$2 million. USAID/Benin is working to increase health-seeking behaviors and reduce high-risk behaviors by promoting a supportive policy and program environment. In 1999 and 2000, USAID/Benin developed a strategy for a new national HIV/AIDS prevention program which focuses on advocacy, epidemiologic and behavioral surveillance, STI treatment, behavior change communication for vulnerable groups and continued support for condom social marketing. This strategy led to the development of a new national-level activity (four year, \$4.5 million) that was launched in July 2002.

USAID/Ghana- USAID/Ghana's HIV/AIDS strategy focuses on behavior change among vulnerable groups, youth, faith-based organization and formal and informal workplace programs. USAID has supported the development of local capacity for diagnosis and surveillance of HIV and other STIs, and social marketing of condoms. USAID provided \$4.5 million in HIV/AIDS assistance to Ghana in Fy2001, up from \$4 million the previous year. USAID/Ghana implements the only USAID-sponsored ARV treatment initiative in the region. The START Program (Support, Treatment and Anti-Retroviral Therapy) was launched in November 2001 in a high prevalence area. Services include voluntary counseling and testing; clinical management of HIV-related conditions, opportunistic infections and HIV/AIDS; prevention of mother-to-child transmission and community programs for home-based care; orphan care; and community-based prevention activities.

USAID/Guinea- In FY2001, USAID/Guinea allocated \$2.2 million to HIV/AIDS programs in Guinea, an increase from \$1.7 in FY2000. Guinea's HIV/AIDS strategy aims to contain the spread of HIV into the general population in two main ways: 1) preventive measure targeted at specific high-risk groups and high prevalence areas, and 2) activities across sectors to influence political commitment, policy, multi-sector programming and the engagement of civil society. In both cases, changes in perception of risk and sexual behavior are the primary tenets of the strategy. Interventions also extend further along the prevention-to-care continuum to include strengthening of VCT services and reestablishment of surveillance sites so that prevalence rates and program impact can be monitored.

USAID/Mali- In October 2000, USAID/Mali approved a comprehensive HIV/AIDS strategy, which targets vulnerable groups, youth and the general population through behavior change approaches, VCT services and qualitative research. The overall objective for HIV/AIDS will be to divert the emergence of a crisis HIV/AIDS epidemic by targeting high-risk groups/ high transmitters and promoting behavior change among those most at risk and the general population. In 2000, Mali, with support from CDC, successfully completed an HIV seroprevalence module as part of their DHS. In FY2001, USAID provided more than \$3 million for HIV/AIDS activities in Mali, an increase from \$2.5 million in FY2000.

USAID/Nigeria- HIV/AIDS funding for Nigeria was \$12.8 million in FY2001, up from \$6.7 million in FY2000. Prior to the election of the new civilian government in Nigeria, the entirety of

USAID's HIV/AIDS assistance was given to NGOs. In FY 1999, USAID began to examine ways to support the military HIV/AIDS program and the National Action Committee on AIDS. USAID's current program consists of 12 behavior change communication (preventative) activities, eight activities that focus on care and support of PLWHA, two activities that focus on care and support of children orphaned by HIV/AIDS, and one activity on AIDS impact modeling and advocacy. The Mission implements its HIV/AIDS activities in four states: Anambra, Lagos, Taraba and Kano.

USAID/Senegal- In FY 2001, USAID/Senegal's HIV/AIDS budget was \$4.5 million. Senegal supports efforts at the national, central and district levels. At the national level, USAID provides training and supervision in application of service delivery norms and protocols throughout the country. At the central level, the Mission supports policy dialogue, research, monitoring and evaluation, and information dissemination and communication. At the district/community level, USAID supports local health services and systems support including development, implementation, and monitoring and evaluation of local health action plans. Additional support includes: behavior change among high-risk groups, care and support, condom promotion, monitoring and evaluation, reaching in-school youth, and VCT services.

1.5 Target populations

This regional program focuses on networks and regional institutions as its⁵ target populations, with the exception of high risk groups in the areas specified below.

Select populations at cross-border sites- High risk groups include truckers and seasonal or migrant workers, commercial sex workers and selected groups in surrounding communities, e.g. school girls, traditional and political leaders.

Private sector leaders- Managers and leaders within private sector networks are an additional target group in the effort to strengthen private sector partnerships with groups such as transportation and trade unions, trading companies and networks of entrepreneurs, as well as corporations.

Immigrants- Generally overlooked within national programs are immigrants from neighboring countries who may be vulnerable or disenfranchised due to language and cultural barriers and economic hardship. It is estimated that 28% of the population of Cote d'Ivoire is non-Ivoirian (prior to the September 2002 crisis).

Policy makers and opinion leaders- Increasing leadership and commitment to improve the policies that support prevention and care and support efforts requires the involvement of policy makers at all levels- within regional organizations, media, religious groups as well as traditional leaders.

Regional institutions and networks of organizations- Whether building technical capacity or institutional capacity to implement programs, this program considers regional organizations, networks (e.g. SWAA, media networks) and institutions (e.g. CESAG or ISED) as important beneficiaries of the program.

1.6 Current program coverage

The USAID/WARP's FHA project initially focused on family planning services in four non-USAID presence countries (Burkina Faso, Cameroon, Côte d'Ivoire and Togo). At the beginning of the project, HIV/AIDS activities were limited to condom social marketing and some prevention efforts with mobile populations. Since 1998, HIV/AIDS activities have increased, commensurate with funding. Expansion began in 2000, at the same time as the project shifted from a four country focus to a regional activity (for a summary of activities by country see table on following page). The expanded HIV/AIDS program includes support for the establishment of VCT centers, STI treatment centers and HIV/AIDS informational hotlines. Also included is the promotion of dual protection and youth-focused prevention within ongoing FP programs, prevention programs with the military as well as care and support for PLWHA and OVCs. Obligated funds for HIV/AIDS activities were \$1.5 million a year in 1998 and have increased to \$10 million in 2002.

Good summary

Prevention along migratory routes

USAID/WARP's flagship HIV/AIDS activity is the inter-country prevention among mobile populations in West and Central Africa. The program combines BCC approaches through mass media as well as individualized attention to CSWs and transporters through peer educators. The other key activity is male and female condom social marketing. More recently BCC efforts have been linked with STI prevention and treatment services along the same migratory routes. These programs operate in Côte d'Ivoire, Burkina Faso, Togo, Benin, Mali, Niger, Cameroon, and Chad. Its materials and approaches are being adopted and adapted in other countries, and there is interest in using the same strategy in the Abidjan-Lagos corridor supported by the World Bank.

Youth-focused integrated prevention model

USAID/WARP has provided training, some equipment and technical assistance to 124 quality-accredited family planning sites (known as Gold Circle) within three countries (Burkina Faso, Togo and Cameroon). Within these sites several have received additional training and resources to provide risk assessment and HIV/AIDS prevention messages and materials to youth, primarily women. One-on-one counseling sessions with trained providers allow for tailored risk assessments and prevention messages.

HIV/AIDS informational telephone hotlines

Another complementary youth initiative implemented in three countries (Côte d'Ivoire, Burkina Faso and Togo) is the HIV/AIDS informational telephone hotline. Initial concerns that youth may not have adequate access to telephones or privacy have proved wrong. In Cote d'Ivoire alone, a total of 20,000 calls have been received. The project has provided training to counselors, including some youth. All hotlines are run by NGOs that also provide a range of services from VCT to care and support services. 80% of the calls registered in CI were from youth ages 15-24.

STI treatment services

USAID/WARP has supported the training and provision of STI treatment kits at 63 public service delivery points along the migratory axes. A total of 6,500 cases of male urethritis have been treated since services were made available.

Condom social marketing

Condom social marketing has been a key component of this activity since the beginning. Distribution of socially marketed condoms, within the four countries, reached a total of 68.3 million units in FY02. This figure represents an increase of 10% over FY01. The increase is partially attributed to continuous development of social marketing along the migratory routes.

VCT services

USAID/WARP has supported the development of two important documents: 1) generic policies, norms and procedures in VCT services, which have been adapted for use in Burkina Faso, Cameroon, Cote d'Ivoire, Mauritania and Togo; 2) a VCT training curriculum. The training curriculum has been used to train more than 120 VCT counselors from five countries. Furthermore, CiC-DOC in Burkina Faso, a NGO network, has received significant technical assistance and has now become itself a provider of technical assistance to other NGOs in the provision of VCT services. CiC-DOC has so far trained 50 trainers in the region.

Ambassadors' AIDS Fund

Launched in July 2001, the WARP Ambassadors' HIV/AIDS Fund provides limited resources to activities identified and developed by US Ambassadors and local partners within the twelve non-presence countries in the region. To date all twelve countries have developed proposals that have received some form of support for proposal development and/ or technical assistance design and implementation of the following activities:

- Condom social marketing activities (Sierra Leone)
- Initiation or strengthening of VCT programs (Togo, Cameroon, Mauritania)
- Condom promotion for youth (Guinea Bissau)
- STI treatment (Cape Verde)
- Strengthening associations assisting persons living with AIDS (Burkina Faso)
- Prevention among migratory populations and sex workers (Chad)
- Orphans and vulnerable children (Cote d'Ivoire)
- Support to NGOs which include youth, religious leaders and others (Liberia, Niger)
- STI treatment services (Gambia)

*Budget ?
02 \$37,000*

Implementing partners include US-based PVOs and NGOs, local NGOs and Peace Corps. A second round is being designed for FY2003 with a total budget of \$1 million.

Summary of Range of HIV/AIDS Activities by Country*

	BF	Cam	CV	Chad	CI	Gam	GB	Lib	Maur	Niger	SL	Togo
PSAMA	X	X			X					X		X
STI	X	X			X					X		X
VCT	X	X			X							X
Youth-focused	X	X			X							X
PLWA		X			X							X
Hotlines	X	X			X							X
BS Studies	X	X			X					X		X
Dual Protection	X											X
Advocacy										X		
Ambassadors Fund	X	X	X	X	X	X	X	X	X	X	X	X

* USAID Bilateral programs intentionally omitted from this list. Certain bilateral programs have benefited from cross-border activities (Benin, Nigeria and Mali) and all have participated in regional meetings and workshops related to GFATM proposal writing, the state of orphans and vulnerable children in the region and incorporating dual protection messages in FP/HIV programs.

1.7 Achievements and lessons learned

This strategy will draw upon the achievements and lessons learned during the FHA project, including those from partners, which were identified in evaluation reports of the FHA and the PSAMA cross-border projects, both completed in May 2002.

Achievements

Donor coordination and leveraging- USAID/WARP and the FHA project have been very successful at partnering with organizations, coordinating with other donors/USG organizations as well as leveraging additional resources. The FHA project has leveraged approximately \$13.5 million since FY2000. The major sources have been KfW, the World Bank and UNFPA. Resources leveraged specifically for HIV/AIDS resulted in: 1) significant resources for additional commodities, particularly condoms; 2) \$2.5 million from CDC's Global AIDS Program (via Retro-CI) and 3) \$450,000 from the US Department of Defense for HIV/AIDS prevention activities with the military in Togo. Additionally, USAID is collaborating with the World Bank in the development of a West African Transport Corridor HIV/AIDS prevention project from Abidjan to Lagos. *how?*

Building capacity of African institutions -USAID and other partners have provided important support over the years to strengthening African institutions and training African health professionals. Some of the organizations supported under FHA have grown and obtained resources outside the original project. MWANGAZA, an NGO in Burkina Faso, now works on a range of community mobilization efforts with funding from the Dutch Embassy, GTZ and USAID centrally funded projects. IRESCO, a Cameroonian NGO, involved in research and

communication activities also has a promising future. These groups were strengthened through technical assistance and support to improve institutional financial and management capacity.

Cross-border HIV/AIDS prevention - The PSAMAO project was described in an independent evaluation as, “an epidemiologically sound, technically competent, professionally managed project, which should be commended and intensified.” PSAMAO shows that a cross-border program, with regional materials can be successfully implemented in West Africa. In a six month period, the project’s BCC component (through peer educators) reached almost 100,000 truck drivers and 42,000 CSWs. Within these catchment areas 744,000 condoms were sold (690,703 male condoms and 53,605 female condoms). There were also important changes in behavior measured over a one year period. For example, the number of occasional sex partners among truck drivers decreased from 3.5 to 2.7 and the percent of individuals reporting condom use with their regular partner increased from 49% to 67% (Wilson, 2002).

Lessons learned:

Coordination and leveraging- Given the low levels of development of most of the countries of the region, poor health indicators and limited progress in recent years, USAID needs to coordinate closely with the major donors and other USG agencies to increase financial and human resources within the region. In addition, coordination is essential to increase the impact of HIV/AIDS interventions when large funds do become available (e.g. GFTAM and MAP). USAID is recognized and valued for its expertise in service delivery, provider training, institutional capacity building and work with NGOs. Partnerships with other donors (World Bank, UNAIDS, CIDA) and other USG agencies (CDC, DoD, PC) are envisioned for the future, as important international and regional initiatives progress. Finally, US Ambassadors can be important advocates both at the policy level, but may also be effective at leveraging additional resources (e.g. DOD in Togo).

Partnerships with African institutions- In addition to providing needed advocacy, NGOs and networks of NGOs in this region are increasingly providers of HIV prevention, care and support services. FHA worked with various NGO partners in provision of VCT services (Cic-Doc a Burkinabe network of NGOs), support to PLWHA (Ruban Rouge, Lumiere Action, and others in Cote d’Ivoire) and support to OVCs (MESAD). Partnerships with a range of NGOs, particularly through regional networks and in association with other regional institutions is an important way of increasing access to services and improving sustainability is an important feature of this program.

Intensify cross-border focus on sex workers - An intensified focus on high risk group, particularly sex workers, is desirable for effective behavior change. According to WB models, high risk male programs are less cost effective (\$15.42 per Disability Adjusted Life Year (DALY) saved) than sex worker programs (\$2.66 per DALY saved), because sex workers may have higher HIV infection rates and more sexual partners. The success of *Retro-CI’s Clinique de Confiance* in Abidjan underscores the importance of high quality STI and VCT services for this population. Within a decade, this project reduced HIV rates among sex workers seen at the clinic from 89% to 31% while reported condom use among the same population increased from 30% to over 90%. This model may be adopted in other areas of the region.

Further concentrate geographic and target populations within highly populated areas, not just border towns- The current cross-border approach has focused mainly on border towns. However, there are as many or more sex workers, truckers and migrants in major capital cities than in border towns. A cross-border activity should focus more on the major highway "hotspots", which may be defined as major truck stops that are also closely linked to commercial sex communities. Experience elsewhere suggests that truck stops with large commercial sex communities offer more effective and economical opportunities to address HIV through intensive, integrated services to sex workers, truckers and commercial partners. Given the limited regional resources available, USAID/WARP will work with bilaterals and non-presence countries to increase and expand cross-border activities throughout the region.

2.0 West Africa Regional HIV/AIDS Strategy

2.1 Strategic Objective

The West Africa Regional Project's Strategic Objective 5 -- **Increased Adoption of Sustainable RH, STI/HIV/AIDS, and Child Survival Policies and Approaches in West Africa** -- is an integrated SO. It is composed of elements addressing reproductive health STI/HIV/AIDS, child survival, infectious disease and health sector reform.

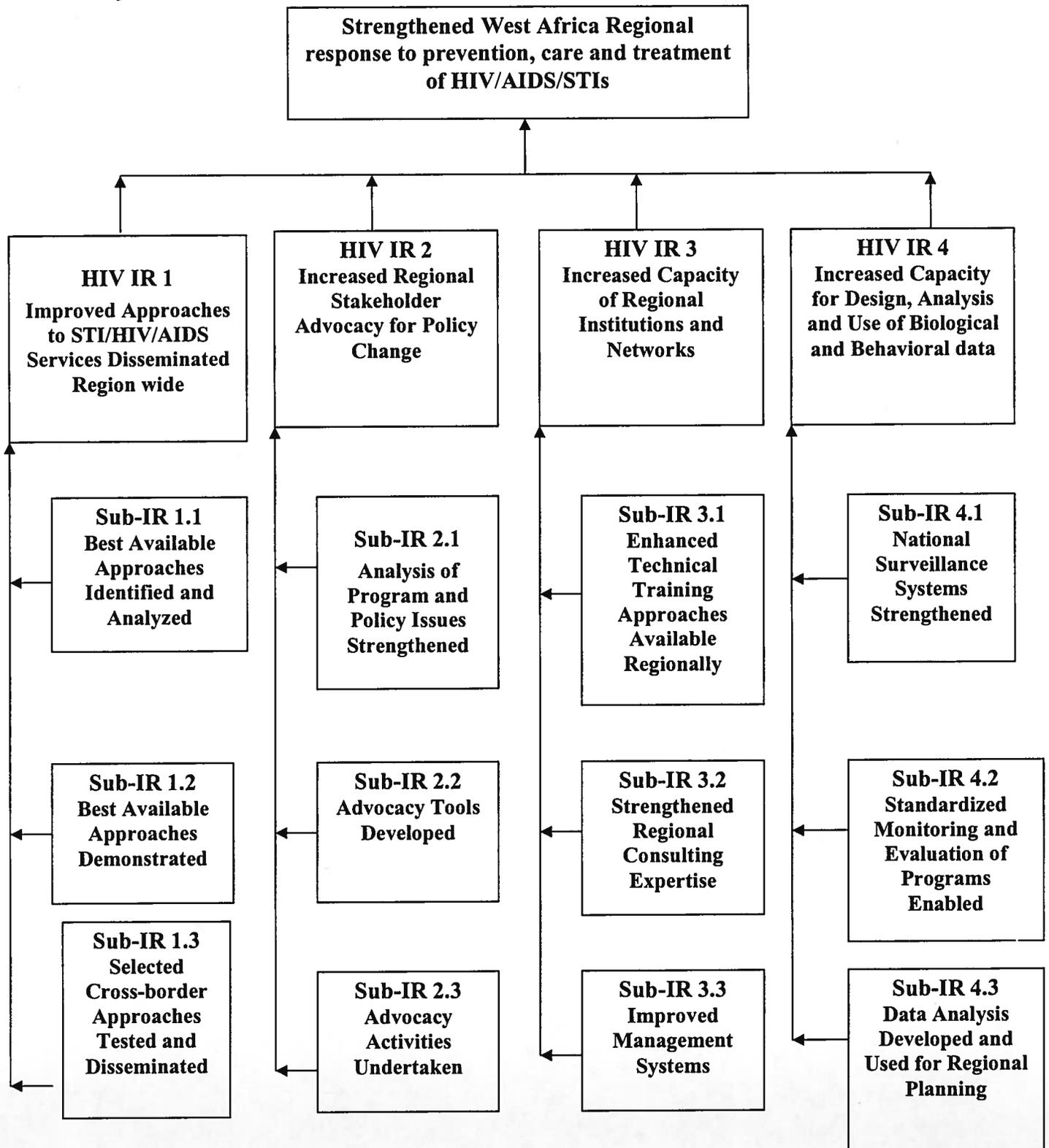
The HIV/AIDS program activities within WARP were not designed to be and have not been approved as a separate Strategic Objective. However, in an effort to clarify the results which will be expected from the HIV/AIDS activities undertaken as part of WARP, a separate results framework was derived from the WARP SO. This HIV/AIDS results framework expands upon the integrated WARP Health Strategic Objective (SO5). The four Intermediate Results mirror those in the SO5 framework. The program objective for the purposes of this HIV/AIDS Strategy is: **Strengthened West Africa Regional response to prevention, care and treatment of STI/HIV/AIDS**. The specific intermediate results and sub-intermediate results for the HIV/AIDS results framework articulate the results achievable within the WARP SO5 framework.

2.2 Rationale

The WARP program is designed to respond to some of the health (including HIV/AIDS) needs across 18 countries in West Africa. These countries are at different stages in their understanding of the epidemic and its consequences. They are also in different stages in their responses. Some are well organized, motivated, and have begun a range of activities. Others are just beginning to understand and address the epidemic. With limited resources, WARP's program will necessarily differ from those of national programs. The objectives and proposed results are intended to address two categories of countries: 1) those with no USAID presence; 2) those with USAID presence. The regional program will give added value to the latter category. Considering the different stages of countries, as well as USAID presence and non-presence, the regional program developed the following strategic approach:

- Maximize impact through targeting key high risk populations across national borders
- Standardize data collection and surveillance across the region
- Build capacity of key regional organizations and networks
- Assist stakeholders within countries advocate for appropriate policies and policy change.
- Identify and share lessons learned

2.3 Key intermediate results



HIV Program Objective: Strengthened West Africa Regional Response to Prevention, Care and Treatment of STI/HIV/AIDS

The four key intermediate results, taken together, will contribute to the overall objective of strengthening the regional response to prevention, care and treatment of HIV/AIDS/STIs.

IR1: Improved Approaches to STI/HIV/AIDS Services Disseminated Region wide focuses on identifying and disseminating best practices to improve service delivery across the region. Cross border activities will be one of the cornerstones of this IR, in which significant behavior change communication activities will be undertaken with those practicing high risk behaviors on the border areas and other hotspots where people on the move may transit or stop.

IR 2: Increased Regional Stakeholder Advocacy for Policy Change focuses on regional advocacy activities with the goal of using the regional platform to encourage political and opinion leaders to adopt policies conducive to preventive the spread of disease. It also will promote the development of norms and procedures for key intervention areas.

IR3: Increased Capacity Of Regional Institutions And Networks has the objective of increasing the capacity of regional institutions, networks and resource centers. The intention is to ensure that these organizations can eventually serve as centers of excellence capable of providing leadership and technical assistance to the region.

IR4: Increased Capacity for Design, Analysis and Use of Behavioral and Epidemiological Data is intended to ensure that countries in the region have an enhanced capacity to undertake surveillance, data collection, analysis as well as monitoring and evaluation of programs.

The desired impact of these interventions will be a reduction in high-risk behaviors, reduction of HIV transmission, and increased use of services to promote reduction in morbidity and mortality due to opportunistic infections and other HIV-related illnesses.

2.4 Critical assumptions

The success of the West Africa Regional Health Program depends on a number of factors. They include:

- USAID funding is maintained at \$12.5 million/year or more for the WARP program.
- Funding is maintained or increased in countries which have USAID bilateral HIV/AIDS programs: Benin, Ghana, Guinea, Liberia, Mali, Nigeria, and Senegal.
- Regional institutions, particularly ECOWAS institutions, will be supported by national governments in the region.
- Networks, professional associations and regionally based institutions are willing and able to play key roles as implementing partners.
- Donor cooperation and information sharing will result in increased and coordinated support for HIV/AIDS work across the region. In addition, other donors will maintain or increase their commitment to HIV/AIDS funding.
- Armed conflict will not increase across the region

2.5 Special concerns

A number of factors specific, but not unique, to West African society need to be kept in mind as HIV/AIDS prevention and mitigation activities are developed. They include:

Religious preferences for prevention Some Christian and Muslim religious leaders and groups in the region can be obstacles to dealing effectively with the HIV epidemic when they block condom use, prevent sex education, and hamper discussion of the epidemic. On the other hand, these groups can become important allies if the strategy gives attention and respect to their views and brings them into the AIDS struggle in areas where they have unique contributions to make, such as bringing the compassion and dedication needed to deal with persons living and dying of AIDS. The program will encourage a range of messages such as fidelity, abstinence, which religious groups in the region are comfortable with, as well as promoting condom use.

Women's status and gender issues West African women, particularly in rural areas, are economically and socially dependent on men and often have limited negotiation power. They have generally very low levels of education and special efforts at empowerment are needed. Gender influences leadership, national and local policies and impacts decisions about healthcare investments. Gender also shapes reproductive health broadly, by determining who has access to information, who holds power to negotiate STI/HIV prevention or to withhold sex, who decides on family size, and who controls economic resources to obtain health services. Women as caregivers of children, the elderly and the sick, are particularly vulnerable and impacted by the burden of disease. Women are more biologically prone to STI/HIV infection than men. Research shows that women are two to four times more vulnerable to HIV infection during unprotected intercourse. In sub-Saharan Africa overall, 55 percent of those living with HIV/AIDS are women. Poverty and limited employment opportunities are reasons women engage in commercial sex work. Because of stigma, women migrate and seek employment in neighboring countries, where they are disenfranchised and less likely to access needed health services. Gender will be addressed in the future program.

Youth A tendency to engage in risk-taking behavior, such as cross-generation unions, sex work, participation in multiple unions and early sexual initiation make youth vulnerable to HIV/AIDS. Further factors that contribute to vulnerability include: poverty and cultural norms, such as low social status. Women under age 25 represent the fastest growing group with AIDS in Africa, accounting for nearly 30 percent of all AIDS cases. Adolescents are a target group that provides an opportunity to promote behavior change to improve gender equity through responsible sexuality and mutual respect between the sexes.

Stigma and Discrimination In West Africa as in other parts of the world, HIV/AIDS stigma results in rejection, denial, and discrimination. These result in the violation of human rights – particularly those of women and children. Policies and programs that protect individuals from stigma and discrimination, particularly in the workplace are special concerns of this activity. People working on the “frontlines” of HIV/AIDS care and prevention have both a responsibility and a unique opportunity to overcome stigma within their professions and workplaces. USAID will work with key partners on all of its activities to continue to reduce the level of stigma associated with HIV/AIDS in West Africa.

People living with HIV/AIDS. The active involvement of persons living with or affected by HIV/AIDS is central to both the fight against stigma and the fight to create awareness. This is a

crucial lesson learned in all countries that have succeeded in countering the epidemic. However, the responsibility is not theirs alone: all individuals and all sectors of society must accept the moral obligation to fight stigma and to promote openness, acceptance, and solidarity. USAID/WARP will build on lessons learned around the world by engaging men and women living with HIV/AIDS as partners, employees, advisers, and as project recipients.

Multilingual nature of the region West Africa is rich in hundreds of languages, so communication is challenging. The colonial heritage left a major group of Francophone countries, which the FHA project focused on, and a large population in countries where English is the official language. Communications between speakers of these two languages can be problematic. Only a minority are sufficiently bilingual to function effectively in both languages. Efforts are needed to overcome this barrier. In addition, more collaboration is needed with Anglophone networks and organizations, to bring them together with their Francophone counterparts.

2.6 Planned interventions by Intermediate Result

Intermediate Result 1 : Improved approaches to STI/HIV/AIDS services disseminated region wide USAID/WARP will focus on identifying, analyzing and disseminating best practices, lessons learned and proven approaches to improving service delivery. A second key element is cross border activities at selected sites. These activities will include condom distribution and behavior change communication with groups practicing high risk behaviors along key cross-border routes.

Key interventions:

Identify and disseminate best practice models. USAID has supported a broad range of prevention, care and support activities in West Africa which merit attention and replication. Examples include HIV hotlines, STI service strengthening through quality of service provision, and behavior change campaigns targeting youth. These interventions will orient decision makers and program managers in both presence and non-presence countries to improved models of service delivery with the goal of replicating these models where feasible.

Essential Program Elements :

- Identify and disseminate successful program models within the region
- Support to replication of key interventions where possible.

Target groups:

- Decision makers and program managers.

Illustrative Outcomes :

- Project models identified, refined, and replicated by end of project

Expand and replicate cross-border HIV/AIDS initiatives targeting mobile vulnerable populations. The program will build on its previous successes in this area to target vulnerable groups along identified routes and promote behavior change interventions through peer counseling and mass media. Condom promotion, with the addition of STI treatment and strengthening of VCT sites in selected areas, will assure that vulnerable groups are reached with all possible interventions. Wherever possible, the project will also integrate RH/FP components into programs to promote family planning and maternal health.

Essential Program Elements :

- Behavior change programs in targeted areas for high risk populations (includes peer education, outreach activities, key -partnerships with leaders/decision makers)
- Production of IEC materials in English, French and local languages
- Capacity building for peer educators and key leaders in public/private sector
- Mass media campaigns
- Incorporation of FP approaches and services
- Incorporation of STI diagnosis and treatment referrals and services

Target groups:

- Truckers, seasonal or migrant workers, commercial sex workers, selected groups in surrounding communities, eg, school girls, opinion leaders, politicians.

Illustrative Outcomes:

- VCT and STI services linked to cross border programs
- Men reporting decrease in number of sexual partners
- Women reporting decrease in number of sexual partners
- Men/women using condoms during last risky sexual encounter
- Men/women seeking STI treatment

Strengthen private sector partnerships. The project will seek private sector partnerships with transport unions, trading companies and other firms which work regionally in order to leverage resources and implicate private sector groups with the health and well being of their employees and families. Within cross border programs, creative leveraging of partnerships with institutions such as transport unions, fuel and trading companies, will be targeted.

Essential Program Elements:

- Analysis of private sector to determine partnership potentials
- Maintain contact with private sector leaders, union leaders
- Provide technical capacity building for private sector initiatives

Target groups

- Managers in the private sector

Illustrative outcomes:

- Private sector entities participating in project funding and implementation

Promote HIV/AIDS prevention initiatives to immigrant groups There are numerous disadvantaged immigrant communities in major urban areas throughout West Africa. Individuals in these groups are usually socially and culturally isolated, sometimes poor, live in urban slums, and have little or no access to healthcare. They are at high risk for HIV but are often overlooked by host country HIV/AIDS programs. USAID/WARP will work closely with bilateral programs supported by USAID and other donors to develop or share activities appropriate to the special needs of these groups, including exchanging IEC materials in appropriate languages and sharing effective approaches from the home countries.

Essential Program Elements:

- IEC development for immigrant groups

- Policy discussions with leaders on immigrant health and interventions for immigrant populations

Target populations:

- Immigrant urban populations (ex. Burkinabe in Accra, Nigeriens in Lagos, or Mauritians, Burkinabe and Malians living in Abidjan, an epicenter of the epidemic).

Illustrative Outcomes:

- Country programs including services for immigrant groups
- National/Urban Policies developed and adapted to respond to immigrant health

Intermediate Result 2: Increased regional stakeholder advocacy for policy change
 USAID/WARP will focus on regional advocacy activities with the goal of using the regional platform to encourage political and opinion leaders to change policies, laws and practices within individual countries. USAID/WARP will also promote the adoption of norms and procedures for key intervention areas.

Key Interventions:

Develop a regional advocacy plan In order to promote greater advocacy for policy change throughout the region, USAID will support the development of a regional advocacy plan. The purpose will be to raise awareness of policy makers on the importance of prevention strategies in low prevalence countries; to emphasize the importance of care and support activities in countries with generalized epidemics; and to assure that appropriate laws and policies are instituted to protect the confidentiality of persons who test HIV positive or who are living with HIV/AIDS. This will be undertaken with regional partners, including regional community networks, national and regional networks of people living with HIV/AIDS (PLHIV/AIDS), professional associations, media networks, religious and traditional leaders and the West African Health Organization (WAHO).

Essential Program Elements:

- Development of regional advocacy plan in collaboration with key regional institutions, national governments and regional networks
- Incorporation of key policies into practice
- Dissemination of regional advocacy plan

Target groups:

- policy makers at all levels, regional networking organizations, media, religious and traditional leaders.

Illustrative Outcomes:

- Advocacy partners conducting HIV/AIDS advocacy and communications activities at country level
- Active members increased within key networks
- Multi-country advocacy materials developed and distributed

Establish regional policies, norms and procedures. A committee composed of technical and medical experts from the region, WHO, UNAIDS and others interested partners will be constituted to develop generic model policies, norms or procedures. The purpose of this process would be to stimulate national priority setting for a range of technical issues which some countries in the region have recently become concerned about, but they may not yet have developed technical guidelines to guide health worker or policy actions. These may include:

stigma reduction, VCT, PMTCT, ARVs, treatment protocols for care, support and treatment of PLWHA, breastfeeding, palliative care and tuberculosis. Once developed, these policies and norms could be disseminated through the advocacy partners through out the region. Specific attention is to be placed on treatment for STIs, TB and other opportunistic infections.

Essential Program Elements:

- Meetings with key technical leaders to articulate and develop technical policy documents
- Dissemination of key technical documents
- Promote adoption of key technical interventions

Target groups:

- National governments and NGOs within the region.

Illustrative Outcomes:

- Policies, norms, and procedures adopted at national level (with emphasis on care and treatment for STIs, TB and other Opportunistic Infections).
- Standard technical knowledge across the region

Small Grants Program for Ambassadors: The regional project will support an “Ambassadors’ Fund” which provides small grants for HIV/AIDS activities in non-presence countries. These grants will focus on capacity-building, incorporating elements of the USAID/WARP HIV/AIDS strategy, and responding to each Embassy’s expressed needs. In countries without significant USG HIV/AIDS funding, these grants will allow U.S. Ambassadors a “seat at the table” to better collaborate with national governments and other donors. Attention will be given to urging leveraging of funds from other donors/private sector/other USG programs.

Essential Program Elements:

- Technical support to US Embassies in development of projects
- Technical support for implementation, monitoring and evaluation of funded projects

Target populations:

- Will vary according to country and proposal.

Illustrative Outcomes:

- US assistance in national efforts across countries in the region
- Shared funding programs implemented

Intermediate Result 3: Increased capacity of regional institutions and networks

USAID/WARP will focus on increasing the capacity of regional institutions, networks, resource centers so that these organizations eventually can serve as centers of excellence capable of assuring leadership and technical assistance to the region.

Key Interventions:

Provide support to selected regional institutions. USAID will identify regional partners which will receive multi-year grants to strengthen management and financial systems; undertake strategic planning; and develop competitive costing for services. The focus will be on establishing technically and managerially sound institutions which can serve the needs of the Region through technical assistance and leadership. Where appropriate, technical capacity will

be strengthened to ensure integration of state-of-the-art approaches in key areas such as VCT, surveillance, community mobilization, policy consensus building, BCC and care and support.

Essential Program Elements:

- Technical capacity to regional institutions and networks
- Managerial capacity to regional institutions and networks
- Developmental and operational grants to regional institutions and networks
- Implementation of technical interventions in partnership with regional institutions and networks

Target groups:

- Regional organizations

Illustrative Outcomes:

- Regional institutions taking leadership roles in key technical areas and securing funding for new initiatives
- Regional institutions providing TA to programs and national governments

Promote and encourage West African technical expertise and leadership. Through support to the regional organizations, partners who can undertake key technical capacity building roles in such areas as advocacy; care and support; BCC; youth programs; M&E and operations research will be identified. A dynamic consultant database composed of regional experts will be a key result of increased capacity of regional organizations. USAID/WARP will aid in promoting and marketing the services of competent institutions and expertise to other donors and regional bodies.

Essential Program Elements:

- Build, maintain, promote a database of West African technical experts
- Support to network building for West African professional associations
- Promote internship programs for young professionals

Target groups:

- Regional organizations

Illustrative Outcomes:

- West African database of expertise used by bilateral programs, other donor partners, national governments
- Professional associations with increased activity and membership

Support to regional training activities. Training will be provided in specific technical areas and in management for the improved performance of institutions and programs. Training needs will be identified and conducted in collaboration with regional West African institutions as well as with CDC and UNAIDS. Workshops, short and medium-term courses and internships are envisioned. An internship program will target young professionals with skills in language, internet technology and professional skills to satisfy the growing manpower needs of the region. Both presence and non-presence countries are expected to provide qualified participants from government and the NGO sector for these activities.

Essential Program Elements:

- Regional training programs developed in coordination with WARP program activities

Targets:

- Health service providers, government program managers, NGO staff,

Illustrative Outcomes:

- Cadre of trained experts in the region

Improved management systems. USAID/WARP will provide management training and support for regional and national planning and programming. Identified needs in commodities procurement and security and in national coordination of resources will be key priorities. The project will respond to national level requests to work with National AIDS Control Councils, government ministries, Country Coordinating Mechanisms and other such partners in setting up fund disbursement parameters, providing capacity building in management and coordination of donor programs, and in commodity logistics management.

Essential Program Elements:

- Development of regional commodities procurement plan for key HIV-related commodities (ex. male and female condoms, STI treatment kits, HIV test kits, drugs for opportunistic and HIV antiretroviral treatment)
- Development of regional commodity security plan
- Providing management support for national AIDS programs

Targets:

- National AIDS Control Councils
- Ministries of Health
- Country Coordinating Mechanisms
- Regional and Multi-country government bodies

Illustrative Outcomes:

- Commodities security plan in place for the region
- Commodities procurement negotiated at regional level (multi-country)
- New resources for HIV/AIDS programs disbursed in countries benefiting from technical assistance

Intermediate Result 4: Increased capacity for design, analysis and use of behavioral and epidemiological data USAID/WARP will assure that countries in the region have an increased capacity to design, analyze and use behavioral and epidemiological data .

Key Interventions:

Strengthen national surveillance systems. Capacity for HIV/AIDS epidemiological and behavioral surveillance data collection and analysis varies widely across the region. USAID/WARP will provide capacity building support in partnership with CDC and other partners to improve national government and regional institution's abilities to strengthen HIV surveillance systems.

Essential Program Elements:

- support the implementation of BSS among key population groups in selected geographic areas
- Determine baseline prevalence of HIV infection in key geographic areas (primarily areas of prior military presence)
- Purchase of rapid tests to support select surveillance activities

- Development of regional surveillance standards, adaptable to each country

Target Groups :

- National AIDS Control Programs
- Regional Institutions

Illustrative Outcomes:

- National surveillance systems in place
- Technical Assistance in surveillance provided by regional institutions

Develop uniform data collection and analytical tools to be disseminated across the region.

In addition to epidemiological and behavioral surveillance, there is a need in the region for development of uniform data collection tools. USAID/WARP will build regional capacity to collect, analyze and interpret data.

Essential Program Elements:

- Support national efforts to collect data on target populations, interventions, and prevalence trends
- Capacity building support for DHS implementation
- Support to strengthen monitoring and evaluation of technical interventions

Target Groups :

- Regional policy makers

Illustrative Outcomes :

- Data analysis used for program planning and advocacy
- Data analyzed and compared across the region

2.7 Implementation Modalities--planned use of bilateral and centrally managed contracts and grants

A grant for HIV/AIDS services will be awarded in August 2003. Approximately 50 percent of WARP's yearly health budget will go to this award. 60 percent of this award (about \$7 million) is earmarked for HIV/AIDS activities.

The remaining HIV/AIDS earmarked funds (\$4 million) will go to centrally managed contracts through FS to support the following:

1. Procurement of commodities such as condoms, STI treatment kits, HIV test kits, etc.
2. TA for logistics and commodities management
3. DHS
4. TAACS position
5. Management of the Ambassadors' AIDS fund

2.8 Cross-sector collaboration and program synergies

It is expected that the activities outlined in this strategy will be planned and implemented in close coordination with other sector activities, other SOs within the West Africa Regional Program and other USAID programs, including bilateral programs.

Integration within WARP SO5 program components- The West Africa Regional Program will make maximum use of limited resources within a multi-country mandate. One way to do this is to achieve synergy between program components. In addition to HIV/AIDS, these components include FP/RH, CS and ID. The following are possible examples:

- A commodity security plan that addresses commodity needs for HIV/AIDS as well as FP/RH and CS/ID;
- Data collection and analysis that benefits all program components;
- Adaptation of quality assurance tools and other family planning program-perfected approaches to HIV/AIDS programs;
- Identification, dissemination and promotion of programs or approaches that promote cross-sectoral coordination, such as FP within VCT or MTCT services;
- Identification, dissemination and promotion of programs that promote condoms (and ABC where appropriate) within a MCH/FP context;
- Cross-cutting service delivery issues related to performance improvement, training and supervision

Synergies between other WARP SOs- The health SO within WARP is by far the largest program, representing 85% of the WARP budget. While resources from the other SOs are extremely limited, HIV/AIDS activities may coordinate with the other SOs in the following ways:

- **Economic integration-** This SO collaborates with the West African Enterprise Network (WAEN) which can be a platform for leveraging private sector resources for health and particularly HIV/AIDS activities. This network may also be an appropriate partner in workplace HIV/AIDS activities, possibly with funds from the US Department of Labor.
- **Food Security and Natural Resources Management-** Regional efforts to improve HIV/AIDS care and support programs can benefit from WARP's assistance to CILSS and other partners in the distribution of food aid. An environmental concern related to the health sector is medical waste disposal.
- **Conflict prevention-** This special SO can benefit from USAID's experience working with the military and high risk groups in planning and implementing HIV/AIDS programs. The program may provide limited services and commodities to the displaced or refugees. For example, SO5 can complement post-conflict efforts in the Manu River Basin to address health needs.

Other USAID Programs-

Food for Peace- Over \$40 million in Food for Peace Title II resources were programmed for 13 countries in West Africa during FY2002. These program support emergency needs in a few countries, but is primarily available for "development" activities programmed by U.S. based PVOs such as Africare, CRS, ADRA and World Vision. Food may be provided "in kind" or, with special approval, it may be sold or "monetized" to generate local currency resources managed by the PVOs. Eligible development activities under the FFP Title II program focus primarily on increasing food security but they also include a) Maternal Child Health and

Nutrition activities and b) HIV/AIDS activities especially targeting children affected by HIV/AIDS.

Synergies with Bilateral programs-

The following are the anticipated ways that the regional program will work with the seven bilateral missions in the region (Benin, Ghana Guinea, Liberia, Mali, Nigeria and Senegal):

- Continued and intensified cross-border joint programming and donor leveraging;
- Dissemination of successful models or approaches. Many of these are likely to come from bilateral programs, such as ARV pilot project (START) in Ghana or interventions with CSWs in Senegal. Bilaterals will also have the opportunity to learn from other programs in the region;
- Bilateral programs may recommend participation of partners or organizations for regional training courses, workshops or provide input on experts for regional consultancies;
- Improved health policy reform and improved advocacy in conjunction with key public and private sector institutions;
- Improved regional mechanisms to address commodity needs.

Section 3 Results and Reporting

3.1 Magnitude and nature of expected results (USAID and partner)

The overall program result is a strengthened West Africa regional response to prevention care and treatment for HIV/AIDS/STIs. This regional program will use process indicators, with the exception of population-based service indicators at select cross-border sites. Furthermore, the magnitude and impact of the project will vary from country to country. Key partnerships at country and regional level will also be key to the potential impact and magnitude of the projects' activities.

The cross-border programs will contribute to national level efforts to reduce HIV transmission and promote healthier behaviors. It is expected that behavior change, condom usage, STI treatment and VCT service utilization will increase within the cross-border program coverage areas. Implementing partners may proposed other appropriate indicators in their proposals.

3.2 Reporting and performance indicators and targets. The following indicators and targets are written to correspond with the overall WARP Strategic Health Objective, but correspond to the HIV Program Strategy framework as well.

WARP/SO5 Framework: Increased adoption of Sustainable STI/HIV/AIDS Policies and Approaches in West Africa

Indicators:

- Number of countries that have adopted health sector policies
- Number of countries that have adopted project-identified model approaches in FP/RH, CS and ID
- Number of countries that have adopted project-identified model approaches in HIV/AIDS
- Number of countries that have adopted cross-border integrated HIV/STI, FP/RH, CS interventions
- Number of regional institutions disseminating project-identified policies, tools, best practices and models
- Number of countries that have adopted the commodity security plans with assistance from WARP/SO5

Intermediate Result IR 5.1: Improved approaches to HIV/AIDS/STI Services Disseminated Region wide.

Indicators:

- Number of cross-border service models replicated in West Africa
- Number of best practices disseminated and replicated
- Number of health quality of care models integrated into primary health care clinics

Intermediate Result IR 5.2: Increased Regional Stakeholder Advocacy for Policy Change

Indicators:

- Number of countries abiding to international agreements initiated in West Africa
- Number of regional advocacy tools developed
- Number of model policies, norms and procedures disseminated

Intermediate Result IR 5.3: Increased Capacity of Regional Institutions and Networks

Indicators:

- Number of grant proposals written by regional institutions and networks
- Number of regional institutions managing grant awards
- Number of person weeks TA provided by regional partners and consultants
- Number of young professionals trained through bilingual (French and English) program internships
- Number of regional institutions taking leadership role in specific technical area

Intermediate Result IR 5.4: Health Sector Reform Models Developed and Disseminated Region wide

Indicators:

- Number of community financing schemes (*mutuelles*) developed
- Number of health care management systems developed
- Number of regional commodity security plans developed
- Number of national health account surveys conducted

3.3 Contribution to international and expanded response goals

The USAID/WARP HIV/AIDS Strategy will contribute to the 2007 International Targets set by the United Nations General Assembly Special Session on AIDS (UNGASS). USAID/WARP’s focus on epidemiological and behavioral surveillance strengthening in the region will improve the reliability of data in West Africa. Multi-country initiatives targeting high risk populations will contribute to these international targets as well.

While measuring the contribution to national level effort from a regional platform may be difficult, USAID/WARP will contribute the UNGASS goals in the following ways:

UNGASS Goal	West Africa Regional Health Program’s Contribution
Ensure that at least 25% of HIV/AIDS-infected mother in high prevalence areas have access to interventions to reduce HIV transmission to their infants	USAID/WARP’s main contribution will be in the identification and promotion of contextually appropriate models to donors, bilaterals and regional institutions. A second contribution will be through capacity-building to NGO networks for counseling and testing as well as referrals to community care programs.
Provide basic care and psychological support services to at least 25% of HIV infected persons and to provide community support services to at least 25% of children affected by AIDS in high prevalence areas	USAID/WARP’s technical capacity building in care and support services will emphasize development and adoption of appropriate and comprehensive services with PLWHA and their families via support to regional networks and institutions.

Provide community-support services to at least 24% of children affected by AIDS in high-prevalence countries	USAID/WARP will assist in the identification and dissemination on best practices in providing community-based support to OVCs in countries such as BF, Cameroon and CI via support to regional institutions and grants to organizations.
Maintain prevalence below 1% among 15-49 year olds in low prevalence areas	USAID/WARP will contribute to improved reliability of surveillance data and focus prevention efforts on high risk groups, in an effort to mitigate the epidemic.

3.4 Program monitoring and evaluation

Essential data to understand the HIV epidemic and its development and evolution is limited in West Africa and often non-existent. Consequently, WARP's strategy will continue to focus on providing support for surveillance, surveys and other M&E activities

WARP will continue collaboration with CDC and its Retro-CI program in the areas of surveillance, rapid testing and strengthening laboratory facilities, as well as field epidemiology, biostatistics and data analysis.

WARP will also continue to support DHS in selected countries of the region in partnership with other key donors (World Bank, UN partners, esp. UNFPA and UNICEF, bilateral) and partners such as the CDC. Surveys will include HIV/AIDS sero-prevalence modules where appropriate, as well as collecting information on attitudes, practices and behavior, particularly data useful for condom social marketing, and extension of VCT services. Five surveys will be supported by the project in non-presence countries; other will be funded by USAID missions.

Behavioral surveillance surveys (BSS) will also be supported in selected areas in key target groups such as sex workers, truckers, youth, the military, and migratory populations. Since these surveys are less costly than DHS and provide critical data on high transmission target groups, more of these can be implemented than DHS.

Section 4 Resources

4.1 Expected levels of program funding, staff and OE Although implemented in the context of an integrated reproductive health and child survival program, the HIV/AIDS/STI component of the program has steadily increased and the estimated FY03 budget is approximately \$12.5 million or 53% of the FY03 budget. Based on this threshold, WARP will probably be funded annually at this level for the next five years making an estimated LOP budget of \$62.5 million. This budget does not include potential add-ons for condoms from the central Commodity Fund. This minimal budget could conceivably be increased annually by approximately 10% to a projected budget of approximately \$76 million. Approximately 58% or \$7.3 million of the FY2003 is allocated for direct grants to implementing partners and the remaining \$5.1 million will finance the Ambassadors Fund activities, technical assistance through FS mechanisms and management costs of the program.

Staffing: One DH or program-funded senior HIV/AIDS specialist will share management responsibilities in the integrated program with one DH supervisory health officer and a reproductive health specialist. These three key senior level positions will be based at the WARP central office in Accra, Ghana. It is anticipated that HIV/AIDS and other earmarked account funds will be used to hire 2-3 FSN program assistants who will be needed to assist with program management at the central level. Because the project catchment area will steadily increase to cover regional interventions in ECOWAS countries, WARP may have to negotiate and finance additional direct management costs in non-presence countries to adequately monitor HIV/AIDS activities it sponsors in the region. Collaborative activities with the FFP program and the Ambassadors' Fund activities may require monitoring by the Accra health office staff to be supplemented by local monitoring staff. Up to 12 local-hire field level monitoring positions may be needed. In order to access specialized CDC technical assistance to support some key program activities, USAID may finance one FTE in the form of a USPSC with CDC in Abidjan.

OE budget requirements: It is planned that only one of the key health position will be OE funded. The two other positions are likely to be a USPSCs or TAACS and will be program funded. All the other positions will be program funded.

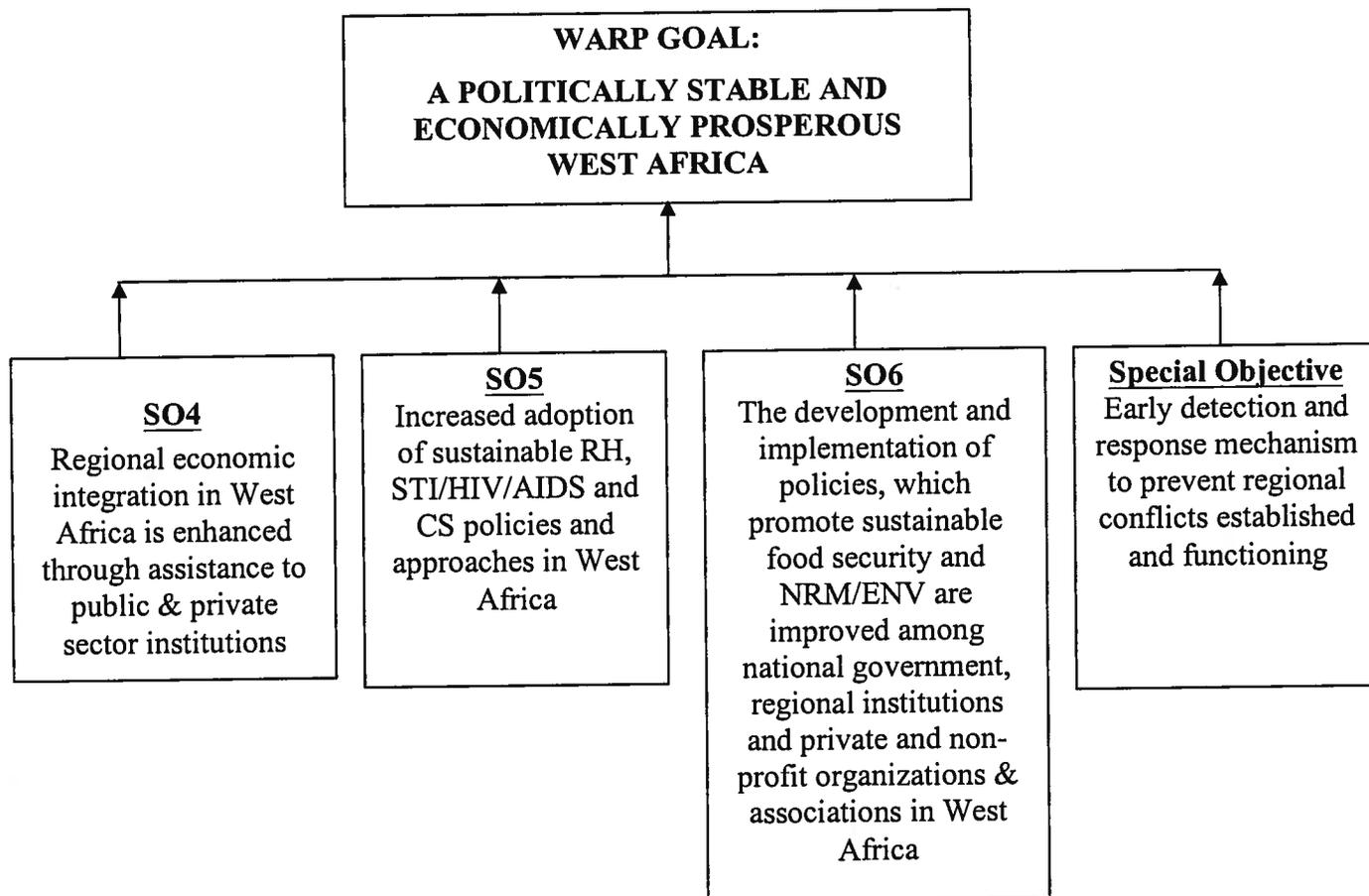
4.2 Results with higher levels of funding. This regional program is attempting to show results based on activities in 18 countries. At a level of \$12.5 million/year for HIV/AIDS, this program clearly needs additional funding. The strategy articulated in this document is broad enough to include a range of new or expanded activities. More funds would allow the project to increase activities in those areas where economies of scale can be achieved if countries work together or in new, linked areas which would contribute to the proposed results. These include:

- Bulk procurement of specific products such as condoms, test kits or drugs to treat opportunistic infections
- Increasing the number of cross-border sites to include secondary migratory routes and other hot spots. As in the current sites, activities in new sites would include VCT and STI treatment; condom promotion and BCC to selected target groups.

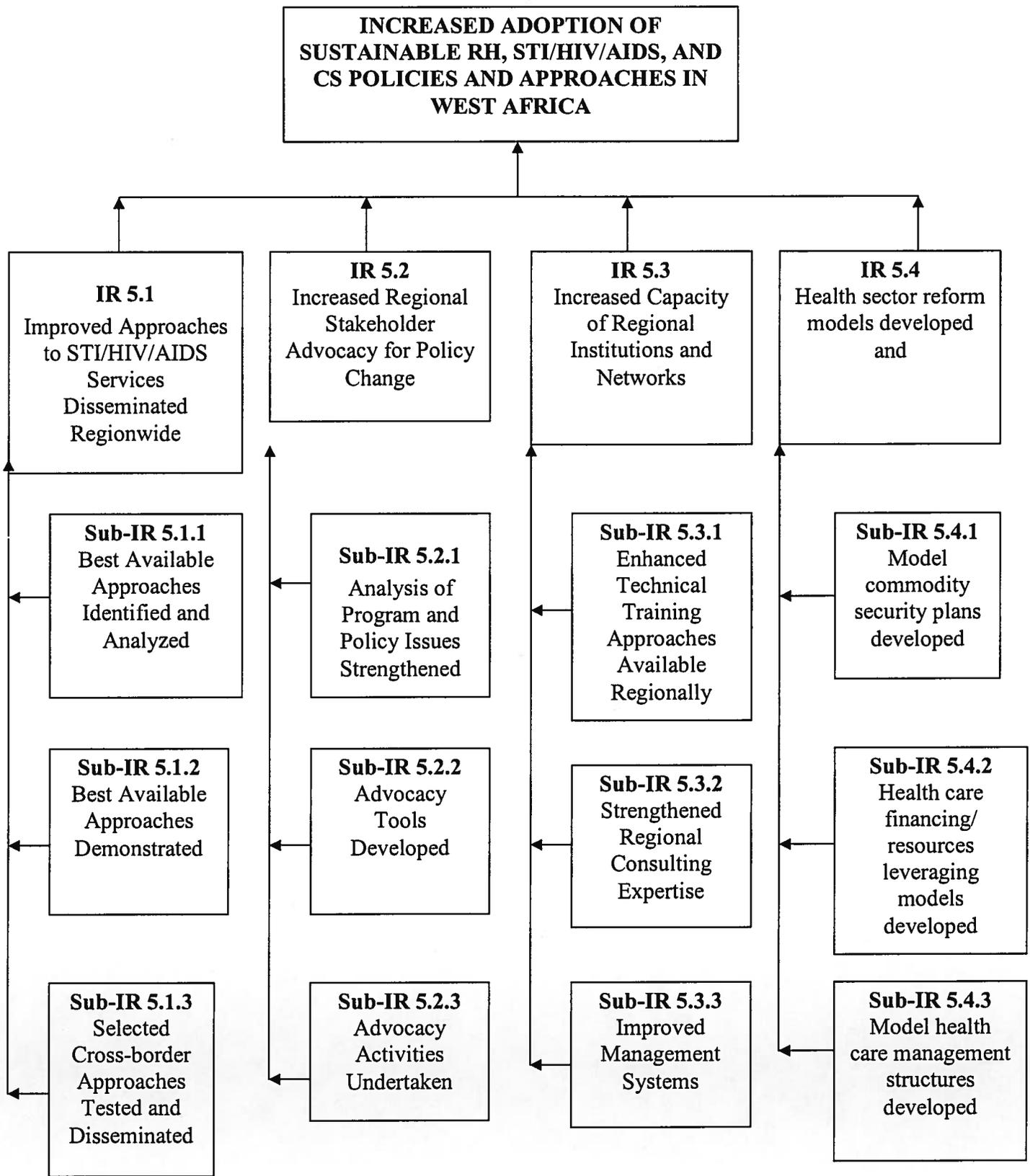
- Strengthening of regional networks of people living with HIV/AIDS to underpin programs related to stigma, advocacy, AIDS orphans, and training in a range of areas, including the basic management of opportunistic diseases and tuberculosis
- Assuring that biomedical interventions in resource poor settings related to introduction of antiretroviral and PMTCT are addressed appropriately across the region.
- Including more multisectoral programs, particularly in the education sector, where the needs are great and increased information about HIV/AIDS is clearly needed to protect the next generation of young people.

With or without additional funds from USAID, WARP will continue to seek co-financing opportunities with other donors. The probability for such multi-donor ventures is high as World Bank and Global Trust Funds are expected to be in full disbursement phase for much of the duration of the program.

Annex 1: West Africa Regional Program Goal and Strategic Objectives



Annex 2: SO5 Framework



ANNEX 3: Donor Contributions to HIV/AIDS Programs in WARP Region¹

Country	Estimated Annual Donor Contributions FY2002	USAID's Contribution FY2001 (Bilaterals)	Proportion of Donor Support Directly to the Government	Largest Single Donor in FY02 per country ²
Benin	...	\$2,000,000	...	
Burkina Faso	\$26,500,000	...	45%	World Bank (WB)
Cameroon	\$15,500,000	...	70%	WB
Cape Verde	\$6,200,000	...	...	...
Chad	\$7,100,000	...	100%	WB
Cote d'Ivoire	\$10,600,000	...	5%	CDC- Retro-CI
The Gambia	\$6,100,000	...	68%	WB
Ghana	\$16,000,000	\$4,500,000	...	WB
Guinea	...	\$2,200,000	...	...
Guinea Bissau	\$1,400,000	...	35%	WB
Liberia	...	...	...	...
Mali	...	\$3,200,000	...	...
Mauritania	\$1,000,000	...	50%	FLM (NGO)
Niger	\$3,900,000	...	74%	WB
Nigeria	...	\$12,800,000	...	...
Senegal	\$35,000,000	\$4,500,000	90%	French Cooperation ✓
Sierra Leone	\$1,600,000	...	13%	UNICEF
Togo	\$3,000,000	...	...	UNICEF
WARP	...	\$8,200,000	...	...
TOTALS	\$134,000,000	\$37,400,000		

¹ All figures are illustrative. Data was collected by UNAIDS and USAID-hired consultants. These data have not been validated at the national level, but UNAIDS hope to conduct validation meetings in the future.

² The World Bank is the largest single donor of HIV/AIDS activities in West Africa. Reports of WB funds from this donor mapping exercise totaled \$40 million. MAP funds alone for eight countries within the region total \$250 million. Discrepancy between reports is likely related to obligate versus expended funds. Most of these funds are IDA loans, not grants.

Annex 4: Number of PLWHA, Orphans and AIDS Deaths, 2002

Non-Presence Countries								
Country	Estimated number of people living with HIV/AIDS, end 2001					Orphans currently living	Estimated AIDS deaths, 2001	
	Adults & children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)	Orphans (0-14)	Adults & Children	Total (000s)
Burkina Faso	440,000	380,000	6.5	220,000	61,000	270,000	44,000	11,856
Cameroon	920,000	860,000	11.8	500,000	69,000	210,000	53,000	15,203
Chad	150,000	130,000	3.6	76,000	18,000	72,000	14,000	8,135
Côte d'Ivoire	770,000	690,000	9.7	400,000	84,000	420,000	75,000	16,349
Gambia	8,400	7,900	1.6	4,400	460	5,300	400	1,337
Guinea Bissau	17,000	16,000	2.8	9,300	1,500	4,300	1,200	1,227
Liberia	...	...	...	...	...	...	...	3,108
Mauritania	...	...	...	...	...	...	...	2,747
Niger	...	...	...	...	...	...	...	11,227
Sierra Leone	170,000	150,000	7.0	90,000	16,000	42,000	11,000	4,587
Togo	150,000	130,000	6.0	76,000	15,000	63,000	12,000	4,657
WARP Total	2,625,400	2,363,900		1,375,700	264,960	1,086,600	210,600	80,433

Source: UNAIDS 2002 (data unavailable for Cap Verde)

Countries with bilateral Missions in the region								
Country	Estimated number of people living with HIV/AIDS, end 2001					Orphans currently living	Estimated AIDS deaths, 2001	
	Adults & children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)	Orphans (0-14)	Adults & Children	Total (000s)
Benin	120,000	110,000	3.6	67,000	12,000	34,000	8,100	6,446
Ghana	360,000	330,000	3.00	170,000	34,000	200,000	28,000	19,734
Guinea	...	200,000	2.8	...	...	...	...	8,274
Mali	110,000	100,000	1.7	54,000	13,000	70,000	11,000	11,677
Nigeria	3,500,000	3,200,000	5.8	1,700,000	270,000	1,000,000	170,000	116,929
Senegal	27,000	24,000	0.4	14,000	2,900	15,000	2,500	9,662
	3,637,000	3,324,000		1,768,000	285,900	1,085,000	183,500	172,722

Source: UNAIDS 2002 (exception: Guinea estimates from their 2001 survey)

Annex 5: USAID/WARP's Contribution to Global Health Objective 4: Reducing the HIV transmission rate and the impact of HIV/AIDS pandemic in development countries

Core Indicators	Status of USAID/WARP Indicators
Condom Sales	2002 65.8 million 2003 68 million 2003-2008 N/A
Number of individuals treated in STI programs	Baseline to be developed in 2004 Targets to be developed from baseline
Is your operating unit supporting an MTCT program?	USAID/WARP is planning minimal support to MTCT programs in collaboration with national programs and donors, including CDC. USAID/WARP contributions to this effort may include support to capacity building for counseling and testing, referrals to community care programs.
Number of individuals reached by community and home-based care programs	
Number of orphans and vulnerable children reached	USAID/WARP is supporting advocacy and planning for OVC activities in the region. As the care and support activities expand, a baseline for OVC will be established.
Number of individuals reached by ARV treatment programs	USAID/WARP is not supporting an ARV program at this time. Technical assistance will be provided to national efforts as requested and as the care and support activities expand.

Annex 6: References

AIDS prevention and care in West and Central Africa: A Strategic Framework for UNICEF. UNICEF, 2002.

Alary M, Mukenge-Tshibaka L, Bernier F, Geraldo N, Lowndes CM, Meda H et al. *Decline in the prevalence of HIV and sexually transmitted diseases among female sex workers in Cotonou, Benin, 1993-1999.* AIDS 2002; 16: 463-70

A Strategic Vision of HIV/AIDS Interventions in WCA. Report to USAID. SFPS Project, 2000.

Bamako HIV/AIDS meeting report, 2001

Buvé, A., M. Caraël, R.J. Hayes, B. Auvert, B. Ferry, N.J. Robinson et al. 2001. *The multicentre study on factors determining the differential spread of HIV in four African cities: Summary and conclusions.* AIDS 15(suppl 4): S127-S131

Ghys PD, Diallo MO, Ettiegne-Traore V, Kale K, Tawil O, Carael M et al. *Increase in condom use and decline in HIV and sexually transmitted diseases among female sex workers in Abidjan, Cote d'Ivoire, 1991-1998.* AIDS 2002; 16: 251-8.

Halperin, D., and R.C. Bailey. 1999. *Male circumcision and HIV infection: 10 years and counting.* Lancet 354 (192): 1813-5.

Helfenbein, S. and DuVerlie, E. *Evaluation of the Family Health and AIDS Project.* Poptech Project for USAID. 2002

Low-Beer, D and Stoneburner, R. 2001. *In search of the magic bullet: evaluating and replicating prevention programs.* Report to the Henry J. Kaiser Family Foundation

Report on the Global HIV/AIDS Epidemic. UNAIDS, 2002

USAID/ Guinea HIV/AIDS Strategy, 2002

West Africa Abidjan-Lagos Transport Corridor Report. World Bank. Africa Regional Office, 2002

Wilson, D. *The West Africa regional migrant project (PSAMAO): Mid-term Review.* 2002

West Africa Regional Program Strategy, USAID. 2000

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.