WESTERN AFRICA ASSESSMENT ON SEXUAL HEALTH AND RIGHTS

REPORT

OPEN SOCIETY INSTITUTE
Network Public Health Program
Sexual Health and Rights Program

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TABLE OF CONTENTS

Programmatic landscape

C- Health care systems
D- Policy or programmatic priorities

Funding landscape

D- Key players/donors
E- Collaboration between donors and government
F- Funding gaps

III- RECOMMENDATIONS

Pertinent issues and approaches

Possible funding strategies and partners

LIST OF ANNEXES

- Sexual health and legal environment for vulnerable populations: Senegal
- Sexual health and legal environment for vulnerable populations: Cote d'Ivoire
- SOW
- Work Schedule
- List of persons interviewed
- List of documents

LIST OF ABBREVIATIONS

OSI	Open Society Institute
NPHP	Network Public Health Programs
SHARP	Sexual Health and Rights Program
HIV	Human Immunodeficiency Virus
AIDS	Acquire Immune Deficiency Syndrome
LGBT	Lesbian, Gay, Bisexual and Transsexuals
MSM	Men Having Sex with Men
SW	Sex Workers
SHR	Sexual Health and Rights
CNLS	National AIDS Council
DLS	National AIDS Division
NGO	Non- Governmental Organisation
STI	Sexually Transmitted Infection
ARV	Antiretroviral
ACI	Africa Consultant International
ANCS	National Alliance against AIDS
CTA	Ambulatory Treatment Center
UCAD	Cheich Anta Diop University
RADHO	Human Rights African Network
PLWHA	People Living with HIV/AIDS

EXECUTIVE SUMMARY

Background

In April, the Network Public Health Program (NPHP) of the Open Society Institute officially launched the Sexual Health and Rights Program (SHARP) in order to develop and implement a global strategy to improve the sexual health and rights of socially marginalized populations. Existing HIV/AIDS epidemics linked to high-risk sexual practices or the violation of sexual rights and the potential emergence of new HIV/AIDS epidemics among socially marginalized populations are of particular concern. As a new program, SHARP will create a strategic framework for its activities, to ensure that it complements existing (internal and external) efforts, makes a valuable contribution to the field, and executes a well thought-out approach.

This study, undertaken by OSI/SHARP in Senegal and Cote d'Ivoire, is to provide useful information for the development of a regional strategy related to the sexual health and rights of marginalized populations. The goal of this assessment is to answer outlined strategy questions in order to inform strategy dialogue and discussions.

The assessment was conducted between August 15 and September 23 in Senegal and Cote d'Ivoire. The study methodology was organized around information gathering through document review, interviews and focus group discussions, and incorporated data collection and analysis.

Results

In the two countries, the political, social and cultural environment is unfavourable for the open development and expression of sexual health and rights for vulnerable groups. Strong cultural and religious rejection of same sex sexual behavior has negatively shaped societal opinion as well as health program planners and law makers. Though they recognize the impact of high risk sexual practices and the violation of sexual rights on HIV infection, government health program managers are reluctant to advocate for this issue at higher political levels.

National policies developed to respond to the HIV/AIDS epidemic mainly target youth, women, female sex workers, people living with AIDS, orphans and vulnerable children as society's vulnerable groups. With the exception of HIV prevention for female sex workers care and support programs, the issues of sexual health and rights for these groups are not sufficiently addressed. Existing policies do not address the sexual health and rights of populations like MSM, lesbians, bisexuals, transsexuals, handicapped persons, drug users and prisoners.

The lack of recognition of the sexual health needs and rights for specific populations, the high vulnerability of these populations to HIV infection, and the subsequent lack of interventions targeting these groups are important barriers to the HIV/AIDS response.

The objective of reducing HIV transmission among male and female sex workers does not clearly differentiate strategies targeting MSM. Therefore, this lack of clarity is a barrier to the implementation of interventions targeting this population.

There is no official recognition of same sex sexual behavior in prisons creating is a barrier to behavior change communication and condom availability in prisons. While equal access to antiretroviral treatment is one of the policy's strongest principles, prisoners' access to treatment is hindered by constraints related to observance, psychological support and social support. Another barrier in the advancement of sexual health and rights is the lack of data and prospective studies targeting vulnerable and marginalized populations.

With an environment characterized by the rise of poverty, increase of illiteracy, and unemployment, the list of populations most exposed to either a lack of sexual health care services or a violation of sexual rights is quite exhaustive. These populations are particularly vulnerable to HIV infection. Anecdotal evidence indicates that youth, particularly young unmarried mothers, house maids, barmaids, displaced persons, young girls, ambulatory vendors, handicapped persons, street children and drug users adopt risky behavior exposing them to the HIV infection in order to survive. No specific studies have been done to assess their vulnerability to HIV infection but their level of exposure to the infection is obvious.

Health care systems set-up to deal with the health care needs of and access to HIV/AIDS services for marginalized populations mainly offer services to female sex workers. Meanwhile, for a growing number of female sex workers, access to needed STI services is influenced by the limited distribution of structures inside the countries (15 sites in Senegal and 3 sites in Cote d'Ivoire) and financial capacity to pay for some services due to rising poverty among this population.

In Senegal, interest created among stakeholders since the dissemination of the Population Council's study on MSM led to the implementation of a discrete and non-stigmatizing MSM intervention in 2003. The intervention was launched by CNLS, the Division of AIDS and a task force of NGOs (Enda, ANCS, CTA/OPALS) with assistance from USAID. Main activities focused on behavior change communication, capacity building of MSM leaders, training of peer educators, the distribution of condoms and lubricants, STI treatment, HIV voluntary testing, antiretroviral treatment and socio-psychological support for MSM/PLWHA. STI services are offered in three sites within the country.

Access to health services for the MSM population is, for the moment, limited to a free consultation at a clinic, Clinic Confiance, every Tuesday afternoon. There is no other service in the public or private sector. Condoms and lubricants are also available and are redistributed by MSM leaders to their pairs at the level of five MSM clubs. Attitudes of stigmatization, neglect and rejection which confront MSM who seek care at public services are obvious. Many of the MSM living with AIDS self-medicate, using street drugs or traditional medicine.

In Senegal, HIV prevention programs in prisons are limited to IEC messages by some NGOs. In Cote d'Ivoire, access to preventive STI and HIV/AIDS services is not available for prisoners. The lack of messages targeting this particular population, unavailability of condoms, and poor access to care for AIDS sufferers are serious factors affecting prisoners' sexual health and rights.

The policy and programmatic priorities required to advance the sexual health and rights of marginalized/vulnerable populations vis-à-vis the AIDS pandemic can be seen at two levels.

Country Level Interventions:

The development of strategic approaches for sexual health and rights for vulnerable groups is dependant on the existing social environment. Currently, in Senegal, the development of a core program for MSM is very encouraging and indicates the feasibility of such interventions despite the fact that society and policy makers are unprepared to face such issues upfront. Developing sexual health and rights for vulnerable groups will require a long term commitment and simultaneous development of programs including advocacy, prevention, care and support, NGO capacity building, and ethics and law development around vulnerable populations' sexual health and rights. In Senegal, advocating at the level of religious leaders will be essential because of their strong influence in policy making around social and cultural issues. The advocacy program will require a special approach focusing on the impact of the sexual health and rights of vulnerable populations on HIV/AIDS

The policy and programmatic priorities are:

- Recognition of social, cultural, legal and service delivery factors affecting sexual health and rights of all vulnerable populations. Needs assessments will be essential to informing policy development.
- Recognition of sexual health and rights of all vulnerable populations and their impact on the spread of HIV/AIDS. This will require advocacy through the dissemination of the results of anthropological studies at all levels of decision making and service provision. Training researchers on dissemination strategies will help in conveying the message and avoiding the adverse effects that could be created by the moral attitudes of decision makers toward the issue of sexual orientation.
- Development of a policy dialogue involving all actors for the adoption of a global strategy targeting the sexual health and rights of all vulnerable groups, and putting the vulnerable groups at the center of the dialogue and the interventions. This will lead to the inclusion of vulnerable groups' sexual health and rights in countries' strategic plans.

- Development of a policy and legal environment promoting sexual health and rights for all vulnerable groups. This activity is being implemented at the level of 10 African countries with the assistance of the USAID funded regional AWARE project.

- In Senegal, the broad interest in modifying the existing law related to sex work can be adapted to the HIV/AIDS context and used to further explore legislation for other vulnerable groups. In both countries, extending the law being prepared for the protection of PLWHA to all vulnerable populations will help resolve current legal weaknesses described later in this report. This will need the extensive consultation and participation of all structures involved in the development of sexual health and rights for vulnerable groups.

- Advocacy at national, multisectoral, and community levels, and among jurists, human rights advocates, civil society and the donor community to raise awareness of the importance of the sexual health and rights of vulnerable groups in the HIV/AIDS response. The role of the press and civil society at the population level must also be strengthened.

- Strengthening and decentralizing the ongoing programs targeting MSM and improving coordination between actors involved in program implementation. Adequate coordination conducted by the HIV/AIDS Division will lead to more efficiency and will serve as a catalyst for other partners wanting to support the program.

- Strengthening ongoing programs targeting women, youth, sex workers, orphans and other vulnerable children and increase availability of services targeting MSM, prisoners, lesbians, etc. Decentralization of these programs will bring more equity in terms of access to services between urban and rural areas.

- Training all decision makers, program managers, jurists, service delivery staff, NGO leaders, women leaders, religious leaders and communicators on issues such as the legal, social, cultural, and economic aspects of sexual orientations and their impact on health and human rights. The BCC capacity already developed in Cote d'Ivoire is a good asset for developing programs targeting vulnerable groups.

- Extending HIV testing and the availability of condoms and lubricants to prisoners and other vulnerable groups.

- Reinforcing the financial and technical capacities of NGOs in charge of social rehabilitation. These NGOs will work to reinforce the personal growth of vulnerable populations through education, economic activities, psychosocial and religious support.

Regional Level Interventions:

Consider a regional focus strategy for programs targeting vulnerable groups, particularly sex workers, MSM, prisoners, street children and maids. Strategies will mainly focus on organizing and reinforcing networks for the development of a legal environment,

advocacy, prevention, care and support and NGO capacity building. Exchange of experiences, lessons learned and collaboration between researchers, law makers, health program managers and associations of vulnerable groups will constitute an important part of the regional strategy. Côte d'Ivoire could be considered as an entry point for a regional program because of its position between western and central Africa, the importance of its migrant population and the existence of sex work as sex trade or slavery with actors coming from neighboring countries.

The available anthropological data and proposed interventions for MSM in Senegal, the Gambia, and Burkina Faso are a good starting point for future interventions targeting this group in the region.[1] Countries like Mauritania, Mali, Guinea, and Guinea Bissau could be reached through a regional program. Building on existing sex workers and MSM networks would be beneficial for regional strategy development and implementation.

In both countries key donors in the field of Sexual Health and Rights as related to the AIDS pandemic are the UNAIDS member organizations, the World Bank, bilateral donors, the Global Fund and international NGOs. Innovative partnerships between donors, the public sector, national NGOs, and associations of vulnerable groups are working positively for existing programs.

Funding gaps related to SHR and HIV/AIDS have been seriously affected in Cote d'Ivoire by the closing of programs funded by major bilateral donors and by the postponement of MAP/World Bank funding since the beginning of the political and military crisis.

Issues which are particularly timely to move on in order to best promote SHR are the development of a policy and legal environment promoting sexual health and rights for all vulnerable groups. The actual development of law aiming at the protection of PLWHA is a great opportunity to extend sexual health and rights to all vulnerable populations. Advocacy at regional, national, multisectoral and community levels, reaching jurists, human rights advocates, civil society and donor community actors, is critical in raising awareness of the impact of the sexual health and rights of vulnerable groups in the HIV/AIDS response. Vulnerable groups' leaders should be placed at the center of decision making and program execution.

Recommendations

Approaches for possible funding strategies need to take into account the existing in-country funding environment and programs.

- In Senegal and Cote d'Ivoire, the best funding strategy would be leveraging with existing funding to cover aspects that were not fully funded in on-going programs such as advocacy for policy and law development as well as service delivery

[1] Targeting Vulnerable Groups in the Multi-Country HIV/AIDS Program (MAP) for the Africa Region: The Case of Men Having Sex with Men, Senegal, Burkina Faso, The Gambia, January, 2004.

strengthening and extension, capacity strengthening of NGOs and associations of vulnerable groups, and the development of a legal environment promoting sexual health and rights.

- In a regional approach, a fully funded program will be implemented through two possible channels: 1) consortiums of NGO networks specializing in advocacy, capacity building, behavior change communication, human rights development and the press, and 2) partnerships with other regional donors like the World Bank, the Global Fund, UNAIDS and bilateral and international NGOs.

I- METHODOLOGY

The assessment was conducted between August 15 and September 23 in Senegal and Cote d'Ivoire. The study methodology was organized around information gathering through document review, interviews and focus group discussions, and incorporated data collection and analysis.

1- Information gathering in the two countries through three channels:

- Review of documents

  During the first week in Senegal and the first two days in Cote d'Ivoire, a list of documents provided by key informants and researchers were reviewed to explore the broad picture of sexual health and rights for vulnerable groups.

- Interviews of researchers, policy makers, health care programs managers, NGO leaders, jurists, human rights advocates, service delivery staff, legal advisors, etc.

- Focus group discussions with the leaders of vulnerable groups and vulnerable group associations.

2- Policy and Law specific review through contracting with legal advisors in the two countries. Information gathered in their reports is included in this report. The two reports on law and policy issues are translated into English and included in the annexes.

An interview guide was developed with the following questions:

- What are the specific national context issues with the most impact on the sexual health and rights of vulnerable or marginalized populations?

- What are the relevant national policies and/or laws promoting or working as barriers for the sexual health and rights of vulnerable or marginalized populations?

- How are health care systems set-up to deal with the health care needs and access to HIV/AIDS services for marginalized populations?

- What are the populations most exposed to either a lack of sexual health care services or a violation of sexual rights that make them particularly vulnerable to HIV infection?

- What policy or programmatic priorities are required to advance the sexual health and rights of marginalized/vulnerable populations vis-à-vis the AIDS pandemic?

- Who are the key players/donors in the field of sexual health and rights as related to or impacting on the AIDS pandemic?

- Is there collaboration between donors and government? What kind?

- Where are the funding gaps related to SHR and HIV/AIDS?

- What issues which are particularly timely to move on in order to best promote SHR?

II- RESULTS

1-The Case of Senegal

1-1 Policy landscape

Senegal is situated on the North Atlantic side of West Africa with a population of 11,126,832 million (July 2005 estimate), a population growth rate of 2.48% and a life expectancy at birth of 56.75 years. This population is young, with 42.8% below the age of 15. The overall literacy rate is 40.2%, with 50% for men and 30.7% for women[2].

The HIV epidemic is concentrated at a high rate in populations with high risk behavior (11-30%) and a low rate among the general population (1.5%). According to sentinel site surveillance data, the HIV prevalence rate in pregnant women was estimated at 1.5% in 2003 with some significant regional variations (0.5 to 2.8%). The number of People

[2] The World Bank Fact Book: Senegal 2004

Living with HIV/AIDS (PLWHA) was estimated at 77,710. The orphan population was estimated at 20,000 with an estimated 3000 orphans infected by HIV.

In 2004, women represented 54% of those infected and children under the age of 15 represented 7%. According to a study by the National Service of Infectious Diseases, 25% of women infected by HIV are between 20-30 years old and 72% are between 30 and 40. (Sow, N.K 1997)[3].

Other significant facts about the epidemic in Senegal are the high prevalence rate among vulnerable populations. The HIV prevalence rate among sex workers is 20.9% in Dakar, 10.9% in Thies and 30.3% in Zinguinchor. The MSM HIV prevalence rate is 21.5%.

Senegal is one of the countries cited as an example in terms of prevention and control of the HIV epidemic. Factors explaining the relatively low and stable HIV/AIDS prevalence rate include beneficial social behavioral factors. These include relatively low alcohol consumption, a somewhat lower incidence of premarital sex than in surrounding countries, early intervention by the Senegalese government, the assistance of international organizations, and finally, the existence of a legal framework and health controls for commercial sex work.

A -Political environment

1- Specific national context issues impacting the sexual health and rights of vulnerable or marginalized populations

Senegal is characterized by its social and political stability since its independence in 1960. Politically, it is characterized by an open, multiparty democracy. The media environment is very open and is made up of many independent newspapers and radios.

Senegal is a fairly poor country ranking 157 in the UNDP human development index (HDI) out of a total of 177 countries (UNDP, 2005). Economic reforms were implemented with the World Bank in the mid-eighty's and some progress has been made in terms of macro economic growth, with GDP averaging 5% annually from 1995-2003. The unemployment rate is high with 40% of youth unemployed. Fifty-four percent of the population lives below the poverty line[4]. The average per capita income was $550 in 2003 with about 26% of the population earning less than $1 per day.

The high mobility of the population coming from rural areas to work in urban cities (mainly Dakar) also has an impact on sexual health. Most of these migrants are illiterate young men and women with no professional qualifications, who live in suburbs and are very vulnerable to HIV infection because of separation from their families and crowded living conditions. It is among these groups that clandestine prostitution flourishes.

[3] Source : Plan National d'Action du Sénégal pour la prise en charge des orphelins et enfants rendus vulnérables par le VIH/Sida élaboré par le GTMS OEV, janvier 2005.
[4] The World Bank Fact Book: Senegal 2004

The high presence of migrant populations coming from neighboring countries, mainly Mauritania, Nigeria, Ghana, Liberia, Sierra Leone, Mali, Guinea, etc., is another contributing factor**.** The current migrant population in Senegal is made of university or professional school students, employees of international agencies, and some refugees.

2- Socio cultural environment: societal attitudes towards vulnerable or marginalized populations

Commercial sex work is judged by society to be immoral. Those who practice it are often punished by the family and the community through rejection and physical and verbal violence. This moral attitude of the population has a strong source in religious sermons and beliefs. The daily, sensational press articles showing the negative character of the business of sex work also contribute to the marginalization of this population. In some cases films shot during raids on sex workers by the police have been broadcast by journalists on national television. These broadcasts focus only on sex workers and not on the men working in the brothels or bars that constitute the environment for sex work. More recently, during this study, a radio journalist interviewed sex workers who had been arrested at a police station. The journalist's main objective was to morally educate the population, not to better understand the issues. The great majority of sex workers have to hide their activities in order to maintain their relationship with their families and communities.

The regulation of prostitution since the 1960's has not had a significant influence in changing society's attitude toward sex work. Nevertheless, it recognized that sex work is encouraged by factors such as the disintegration of traditional families and communities due to urbanization, and exposure to other types of social behavior and attitudes through media. Poverty, lack of education and professional skills, and lack of economic support are factors attracting sex workers to pools of industrial development and tourism.

Female sex workers

Profile: In Senegal sex workers are classified into two categories: official sex workers who are registered in the STI health center sanitary control file and clandestine sex workers who are not registered. Meanwhile the classification between registered and non-registered is more complex if other forms of clandestine prostitution like full-time, part-time and occasional workers are taken into account.

Sixty percent of official sex workers are Senegalese and Nigerian, and Ghanaians represent 60% of the expatriate sex workers. Ninety-one percent of the official sex worker population is fairly young with a median age of 22.5. The median age of clandestine sex workers in Dakar is 26. The mean duration of working in sex work is 12.5 years. The level of education among sex workers is low with 52% illiterate and 32% with a few years in primary school. Only16% have a high school level education.

Most sex workers are unmarried and 82% of official sex workers are divorced or widows who support children and sometimes relatives as well. Seventy-three percent of clandestine sex workers support at least two children. Ninety-two percent live outside of their original community or town.

Main prostitution sites are brothels, hotels, tourist sites, night clubs and bars, restaurants, markets, bus and train stations, military camps, university housing and the homes of sex workers. In 2003, 170 clandestine sex worker prostitution sites were identified in Dakar and MBour by the organization Enda.

Condom use, health seeking behavior for STI care, and HIV testing are all well practiced by official sex workers because of their early exposure to behavior change communication. Conversely, 78% of clandestine sex workers do not seek care at health centers.

Data from the third behavioral surveillance survey, which included clandestine sex workers for the first time in 2001, showed minor differences between the two groups in terms of knowledge and behavior towards HIV prevention (CNLS, Senegal)[5]. The main difference between the two groups is related to health-seeking behavior. The HIV testing acceptance rate was 73% for official sex workers compared to 48% for clandestine sex workers. Condom use during last sexual intercourse was 86.6% for official sex workers. The HIV prevalence rate has been stable for several years, at 27.5%. The HIV prevalence rate is higher among official sex workers (33.9%) than clandestine sex workers (10.1%). According to researchers, this is due to shorter exposure times and reduced numbers of clients for clandestine workers as compared to registered sex workers.

Despite the regulation of prostitution, sex workers' lives are dominated by rackets, sexual harassment, exploitation, rape and other forms of violence from their clients, barmen, pimps and particularly the police. Sex workers are forced to pay a daily fee to the policemen of $10 on week days and $20 during weekends in order to be allowed to work in official sites. The worst and most embarrassing form of harassment is the verbal violence they are subjected to on the street when they are accompanied by their children or relatives. Today, because of the intensity of police harassment, many official sex workers are turning down the benefits of registration by returning their health file and withdrawing themselves from STI control. As a result, the number of official sex workers is decreasing while the number of clandestine sex workers is increasing.

> “My deepest fear is to meet a policeman in the street when I am with my children or my relatives. They always take the occasion to verbally humiliate you before your children unless you pay the price very quickly before they talk."
>
> *Sex workers focus group participants in Dakar*

[5] Social Profiles and geographic distribution of sex workers and clients in Senegal; Mapping as a basis for intervention planning: Hans J. ebbing, M.D, MPH Capstone Project, CNLS, Senegal, April 2005

"The worst situation is when you are illegally arrested on Friday night, and kept at the police station over the week end. Imagine the psychological situation of a mother leaving her children alone for three days…"

Official Sex worker, Dakar

The economic status of sex workers is generally poor. A great majority are jobless, some are in school and some perform commercial activities or are involved in restaurant or hairdressing businesses. The fact of being a registered sex worker and being often exposed to arrest and accusation of misdemeanors by the police constitutes a serious limit to accessing a formal job because of the impossibility of obtaining a clean legal file *("casier judiciaire")* when competing for a job. The majority of official sex workers are impoverished by the continual police harassment and the serious competition imposed by younger clandestine sex workers and young men. There is a strong need for socio-economic reintegration. Some income generating activities conducted by the NGO AWA have been successful but more resources are needed to strengthen this experience.

One of the worst consequences for sex work is the refusal of men to acknowledge their children in case of pregnancy. As a result, many of the sex workers' children are not registered at birth. Later in life, this will constitute a heavy burden on the relationship between the sex worker and her child. The fact of hiding their sex work activities while raising children is also a big challenge for older sex workers.

Men having sex with men[6]

Profile: Young Senegalese population with a median age of 26.13, fairly educated (88% with secondary school level and 30.5% with a professional diploma or university degree). High school and university students represent 10% of the MSM and 15.6% are unemployed. Ninety-eight percent are Moslem. Eighty-two percent are single and 15% reported being married, some in polygamous marriages. About 25% of the men had children.

The first sexual encounter with a man occurred on average at age 15. The sexual experience was often with an adult and 30% of MSM reported that the adult was part of their direct extended family. In terms of sexual identity, MSM are characterized by two major categories, the "Ibbis" and the "Yoos", but there are many other identities based on age, status and type of relationship. The "Ibbis" often adopt feminine mannerisms and have close relationships with women who have political or economic power. The "Yoos" are generally the insertive partners and do not consider themselves as homosexuals.

[6] From “Meeting the Sexual Health Needs of Men Having Sex With Men in Senegal”. Institute of Environmental Sciences, UCAD, Senegal National AIDS Control Council, Population Council Horizon Program/USAID, September 2002.

The vast majority of MSM have had sex with women with 88% reporting vaginal sex and nearly 20% reporting anal sex with women. While exchanging sex for money is a practice in the MSM's interactions, receiving money from a partner is more frequent.

High rates of STI and HIV infections, bisexuality, and unprotected sex are serious factors increasing the exposure of MSM to HIV infection. Despite a high level of knowledge of HIV transmission, practices to prevent STI and HIV infections are very poor. Condom use during last sexual intercourse is very low (23%) with a much lower figure for receptive anal sex (14%). Condom use is higher with women (37%). Reported STI symptoms were burning or penile discharge (42%) and anal lesions (22%). Voluntary HIV testing was done by only 19.3% of MSM.

A recent study done at the Division of the AIDS Clinic in Dakar reports an HIV prevalence rate of 21.5% in MSM and demonstrates high risk behavior among MSM. Thirty-five percent have had STI symptoms during the past year. Unprotected active anal sex was practiced by 24% of the MSM participants in this study. Unprotected passive sex was practiced by 20% of these study participants, and unprotected vaginal sex was practiced by 18%. The majority of MSM in the study had had sex with women (94.1)[7].

In traditional Wolof society, an attitude of tolerance towards some MSM is explained by the vision of their being "goor jiggen" or "men-women". They are seen as men who penetrate the world of women to the point of identifying with them. The attitude of tolerance can be explained by a perception of gender transgression that is accepted by society based on some mystical interpretations such as the responsibility of the "men-women" for carrying the load of the society's defects. A social mechanism of protection exists through the role assigned to "men-women" in some cultural ceremonies to allow them to express their identity. The acceptance of a sexual relationship between men is not demonstrated through this mechanism but there seems to be tacit social acceptance as long as moral norms are not broken by MSM attitudes. It is estimated that the denial of the sexual dimension is a form of protection[8].

Actually same sex sexual behavior is not denied but social rejection and stigma are expressed when MSM openly exhibit their sexual orientation. Recent studies have reported verbal and physical abuse at the level of the family, the community and the police. Forty-three percent of MSM had been raped at least once outside the family home and 13% reported being raped by a policeman. Rackets, blackmail and raids from the police are frequent facts affecting the MSM population in the bars, gay clubs, and houses. MSM are often forced to move from their families or houses when their homosexual status becomes known (25% reported being forced to move in the last 12 months preceding the study).

[7] Epidemiology of STI and risk factors in the MSM population: Dr Abdoulaye Wade, HIV/AIDS Division and ANRS, August 2005.
[8] Interview with Pr Cheikh Ibrahima Niang, Institute of Environmental studies, UCAD, Dakar, August 2005.

The "Ibbis", MSM exhibiting feminine mannerisms, are most exposed to violence, ostracism and stigmatization. The fact of being forced to live a “double life” is psychologically very difficult for MSM who have to develop ingenious survival strategies. Sometimes this leads the MSM to break the status quo and to take the risk of expressing themselves, thus reinforcing the community’s attitude of rejection.

Self stigmatization among the MSM and recurrent blackmailing in the MSM community constitute a serious limitation to the development of the MSM community. The attitudes of journalists reporting on questions related to MSM are also influenced by ignorance and the community’s attitudes. Interventions targeting journalists in Senegal have helped reshape their traditional vision on the MSM issue and awareness is slowly being raised in the media.

As a result of the Population Council 2001 MSM Study, the HIV/AIDS multisectoral response managers, financial and technical partners and the NGO community formed a partnership to develop a non-stigmatizing intervention for MSM. One of the study outcomes was the awareness of MSM themselves of the challenges facing their community and the necessity to form associations with the objectives of participating in their own capacity development and problem solving. Discrimination is often present in the service delivery environment creating attitudes of refusal of care for MSM.

Prisoners

Total rejection used to be the conventional attitude of families and communities towards prisoners. In the past, being arrested and put in jail was associated with shame for the prisoners, for the extended family and for the community. This is why prisoners used to leave their communities or the country once liberated from jail. Today, societal attitudes towards prisoners are more flexible because of the increase in the number of prisoners and a certain level of demystification of prisons, but prisoners continue to be rejected by their families and are affected by a lack of adequate nutrition, hygiene, health care and security. While prison managers accept that same sex sexual behavior is a reality, there are no services to protect prisoners against HIV infection.

The 2000-2004 National HIV/AIDS Response Strategic Plan does not include any strategy for the protection of prisoners from HIV/AIDS**,** but thanks to the ISE/Population Council Study, awareness of the problem is growing in HIV/AIDS decision-making circles.

Other vulnerable populations

Youth, particularly young unmarried mothers, house maids, handicapped persons, orphans, sex workers children, street children and drug users often adopt risky behavior exposing them to the HIV infection. Very few studies have been done to assess their vulnerability to HIV infection and there are very few specific programs addressing these groups.

B- Law and policy environment

1- Relevant national laws that work to promote the sexual health and rights of vulnerable or marginalized populations: (See annex # 1 for details)

Ratification of international laws and conventions: Senegal has ratified the following international laws and conventions, marking its adhesion to human rights protection regardless of age, sex, education, economic status, and religion or socio cultural group:

- The WHO Constitution prescribing total access to health rights;
- The Universal Declaration of Human Rights promulgated on December 10, 1948;
- The International Pact relative to Economic, Social and Cultural Rights of December 16, 1966;
- The Convention on the elimination of discrimination for women;
- The African Charter of Human Rights and People promulgated on October 21, 1986.
- The Convention on Torture and Other Penalties and Cruel, Inhuman and Degrading Treatment, promulgated in December 1984; and
- The Convention relative to children's rights promulgated on November 20, 1989.

Internal laws: According to the country's constitution (revised in January 2001), all citizens are equal before the law without any distinction or discrimination related to race, sex or religion. The constitution protects the right of every person to life, freedom, and respect of their dignity and integrity. The Title II entitled "Public freedom and people's freedom and economic, social and collective rights" illustrates Senegal's commitment to respect the rights and freedom of human beings. The State has the obligation to protect the individual's right to life, freedom, security, free development of his personality and his moral and physical integrity.

Under the Penal Code article # 49**,** legislation protects the rights of all people, including vulnerable groups, to be assisted in case of danger. Health professionals who refuse to provide needed health assistance to members of vulnerable groups can be sued under this law.

The decree # 67-147 of February 1967 establishing the Medical Code of Deontology prescribes the obligation of all health care providers to provide health care with the same attention to all people regardless of their opinions, social conditions, nationality, religion, reputation or feelings inspired by them.

Senegal was one of the first countries in West Africa to regulate prostitution in the 1960's. A legal framework for commercial sex work was established through law # 66-21

of February 1966 and its application decree # 69-616 was issued on May 1969. These legal dispositions had a positive influence on STI infections and HIV prevention and control. This regulation of commercial sex work was quite unique in the sub-region in the 1960's and to date, Senegal is one of the few countries in the region where sex workers are officially recognized (UNAIDS, 2003). Damage to physical morality like pimping is severely punished. Women, children and handicapped persons are protected against all types of abuse and sexual violence. Rape is severely suppressed by law. (See Annex 1 for details)

Some of the positive results of the above legislation were free access to health care and STI control as well as free access to condoms and information. Another important benefit was the early control of STIs among female sex workers prior to the beginning of the HIV epidemic. However, with the expansion of sex work and the development of other forms of prostitution, in the new context of the HIV/AIDS response this legislation became ambiguous, obsolete and inappropriate.

Other facts in the legal environment concurring to the promotion of sexual health and rights of vulnerable populations are:

1) The creation of the national committee of human rights that is offering assistance to all citizen or resident victims of right violations.
2) The provisions of the law relative to the family code recognizing equal rights to men and women for divorce, separation, sharing of goods, the custody of children and mutual assistance in case of illness or disability, which are also promoting the protection of women and children's rights.

With assistance from UNDP and the USAID regional project AWARE, the National Assembly is preparing a draft law protecting the rights of PLWHA. The draft is to be submitted to the Parliament by the end of November 2005. The proposed draft law will serve as the starting point for further improvement and adaptation in Senegal. For example, the model law does not yet take into account the aspects of sexual health and rights of vulnerable populations. This is most probably due to the lack of perception of decision makers and lawyers on the importance of these issues and their relation to the spread of HIV infection. Our participation in a two-day workshop organized by congressmen to launch the process of consultation to improve the law helped to raise awareness of the issue of sexual health and rights for vulnerable populations. All stakeholders will be involved in the effort to improve the model law: human rights advocates, AIDS/NGOs, journalists, PLWHA associations, service delivery NGOs, associations of women jurists and other partners.

2- Relevant national laws that work as a barrier to advancing the sexual health and rights of vulnerable or marginalized populations

Despite the encouraging legal framework for the protection of human rights, the regulations on social morals are very restrictive. The limits for the law legalizing prostitution are set by article # 318 of the penal code which can be used to accuse sex workers of public indecency.

The conditions set for controlling sex work are working against the good application of the law which is no longer efficient in the context of the HIV/AIDS response for the following reasons:

1) The required bimonthly visits at the STI health center is too short an interval to be followed regularly;
2) The obligation to present health records during routine police controls.

Because of these restrictive criteria sex workers can be prosecuted for soliciting, non presentation of the health records, and non respect of medical visits. Non registration of sex worker is a misdemeanor punishable by law.

One of the strongest limits of the law is the ambiguity surrounding the conditions of exercising sex work. Doing sex work in hotels and brothels is quite impossible according to the penal code articles 323 and 325 repressing pimping and all persons owning, managing or financing these facilities for the use of sex work. The second important limit is the ambiguity on defining the action of soliciting. The definition of soliciting by the article 9 alinea 3 of the penal code is an open door for the police who are free to interpret it in an abusive way.

MSM harassment by the police is mainly due to the abusive use of the notion of public indecency and soliciting.

Today, because of police abuse created by this ambiguity, sex workers are no longer motivated to be registered and prefer to exercise their trade clandestinely. Therefore the law needs to be reviewed and to be readapted to the context of the current response to the HIV/AIDS epidemic response. Legal questions to be resolved are:

- Conditions for exercising sex work, in particular, improved definitions of soliciting and pimping;
- The appropriate legal age for registration as sex workers and legal protections;
- The legal treatment of pedophilia as distinct from consensual sex between adult same sex partners;
- Legal vacuum regarding the sex worker's clients;
- The lack of declaration of sex worker's children for birth certificates;
- The protection of sex workers against exposure by press;
- The application of the law legalizing the prevention and treatment of STI diseases to all other categories of vulnerable groups, regardless of their sexual orientations;

The fact of not allowing condom provision because of a lack of recognition of same sex sexual behavior in prisons is a serious barrier to prisoners’ rights to protection as recommended by the WHO directives on prisoners' HIV protection, published in 1993.

3- Relevant national policies that work to promote the sexual health and rights of vulnerable or marginalized populations

Senegal's efforts to control the HIV epidemic are well known. Early political commitment, STI prevention and control, civil society involvement, and donor assistance explain the stability of the HIV epidemic in Senegal. Over the years, the response framework has evolved from the 1986 AIDS Committee to the National AIDS Control Program managed by the Ministry of Health. Within the international evolution of the response to HIV/AIDS, Senegal has now decided to respond to the AIDS epidemic through a stronger and more structured multisectoral response involving all government sectors, the private sector, and civil society organizations. This is coordinated by the National AIDS Council under the Office of the Prime Minister.

The National Strategic Plan 2002-2006 is being implemented with the objective of maintaining the HIV prevalence rate under 3%, improving management and decentralization, coordination structures, and resource mobilization, as well as rationalizing national monitoring and evaluation systems. The Ministry of Health is specifically in charge of the National Service Delivery Program ("Programme National de Prise en Charge": IST, Mother to Child Transmission, Voluntary testing and Anti retroviral Therapy).

The National Strategic Plan's five priority strategies are prevention, care and support, epidemiological surveillance, research and ethics, and coordination, management and advocacy. Out of the 12 components of the prevention strategies, vulnerable populations targeted include youth, women, military and paramilitary corps, and migrants. The main interventions of the strategy are communication, STI prevention, condom availability and use, social, psychological and economic support, gender awareness, and protection of young girls against harmful practices. Under the care and support strategy, a specific focus is made on STI treatment for sex workers and equal access to antiretroviral therapy. Revision of the law regulating prostitution is planned under the research and ethics strategy.

To correct the weaknesses in the strategic plan regarding orphans, vulnerable children and MSM, the National AIDS Council decided to design a specific plan addressing the needs of orphans and vulnerable groups in 2004. The council is launching a special intervention providing prevention, care and support for MSM in collaboration with Population Council, NGOs and USAID.

Other significant policy efforts targeting the sexual health of vulnerable populations are the creation of the HIV/AIDS advisory committee on ethical and legal aspects and the Health and Social Development Plan. The latter mentions the reproductive health of youth as a major concern because of early sexual activity, the exposure of young people to STIs, drug addiction, and early pregnancy.

4- Relevant national policies that work as a barrier to advancing the sexual health and rights of vulnerable or marginalized populations

The lack of an exhaustive listing of vulnerable and marginalized populations in policy documents constitutes a first limitation in terms of policy development for these populations. This can be explained by a lack of awareness of the issues of the sexual health and rights of vulnerable populations at the time of the design of the program. Some policy makers express a moral position and are still reluctant to bring the issue of other sexual orientations to public awareness. The lack of recognition of the sexual health needs and rights of specific populations, their high vulnerability to HIV infection, and the subsequent lack of interventions targeting these groups are important barriers to the HIV/AIDS response.

The objective of reducing HIV transmission among male and female sex workers does not clearly differentiate strategies targeting MSM. This lack of clarity is a barrier to the implementation of interventions targeting this population.

The interventions in the 2002-2006 National HIV/AIDS Strategic Plan do not adequately target vulnerable populations because there is no mention of sexual health and rights violations. There is no specific intervention targeting MSM, prisoners or other vulnerable populations. Clear interventions for stigma reduction and plans to improve the legal environment for PLWHA are missing.

The Strategic Plan does not include any intervention for the protection of prisoners against HIV/AIDS. The lack of policy for HIVAIDS interventions in prisons is a barrier to the promotion of the sexual health and rights of prisoners. Very little research has been done on the HIV status of prisoners.

The fact of not officially recognizing same sex sexual behavior in prisons is a barrier to behavior change communication and condom availability in prisons. While equal access to antiretroviral treatment is one of the policy's strongest principles, the access of prisoners to treatment is hindered by constraints related to observance, psychological support and social support.

Another barrier in the advancement of sexual health and rights is the lack of data and prospective studies targeting other sexual orientations like lesbians, transsexuals, and other vulnerable populations like prisoners, handicapped persons, drug users, etc.

1-2 Programmatic landscape

A- Health care systems or structures set-up to deal with the health care needs and access to HIV/AIDS services for marginalized populations (sex workers, MSM, prisoners, etc.)

Sex workers' access to health care and STI prevention has been organized under the prescriptions of the law regulating prostitution. A main reference health center was equipped in Dakar to serve as a reference health center for STI care and support to female sex workers. Fourteen other health centers have been progressively equipped throughout

the country to provide STI care and support to sex workers. The government plans to reach a total number of thirty centers in the near future in order to meet the needs of sex workers in vulnerable zones. HIV/AIDS information, BCC activities and free male and female condoms are available in sex worker programs, along with voluntary testing and antiretroviral treatment. Outreach activities are being supported by the Canadian NGO Sida 3 and Enda with special focus on clandestine sex workers. The NGO AWA is mainly focusing on capacity building in sex workers' associations, as well as providing psychological, social and economic assistance to sex workers and their children.

Since 1999, small scale prevention efforts have been implemented by some NGOs. Activities were limited to organizing MSM into associations, raising awareness of HIV/AIDS and providing condoms and lubricants. The dissemination of the Population Council study in 2001 created interest among stakeholders who decided to participate in the implementation of a discrete and non-stigmatizing MSM intervention. In 2003, the intervention was launched by CNLS, the Division of AIDS, and a task force of NGOs (Enda, ANCS, CTA/OPALS) with assistance from USAID. Main activities focused on behavior change communication, capacity building of MSM leaders, training of peer educators, the distribution of condoms and lubricants, STI treatment, HIV voluntary testing, antiretroviral treatment and socio-psychological support for MSM/PLWHA.

One of the challenges is the recruitment of health providers who are motivated to provide care and support to MSM.

HIV prevention programs in prison are implemented by NGOs such as Enda and Sida Service but activities are only focusing on HIV/AIDS messages. Condoms are not available in prisons but prisoners living with AIDS are being medically treated with antiretroviral drugs and being provided psychosocial assistance at the ambulatory treatment center under the discrete surveillance of their guards.

B- Policy and programmatic priorities required to advance sexual health and rights of vulnerable or marginalized populations vis-à-vis the AIDS pandemic

The development of strategic approaches for sexual health and rights for vulnerable groups is dependant on the existing social environment. Currently, in Senegal, the development of a core program for MSM is very encouraging and indicates the feasibility of such interventions despite the fact that society and policy makers are unprepared to face such issues. Developing sexual health and rights for vulnerable groups will require a long term commitment and simultaneous development of advocacy, prevention, care and support, NGO capacity building, and programs for the development of ethics and laws. Advocating at the level of religious leaders will be essential because of their strong influence in policy making around social and cultural issues. This advocacy will require a special approach focusing on the impact of the sexual health and rights of populations vulnerable to HIV/AIDS.

Programmatic priorities are:

- Recognition of the sexual health and rights of all vulnerable populations and their impact on the spread of HIV/AIDS. This will require advocacy through the dissemination of the results of anthropological studies at all levels of decision making and service provision. Training researchers on dissemination strategies will help in conveying the message and avoiding the adverse effects that could be created by the moral attitudes of decision makers toward the issue of sexual orientation.

- Recognition of social, cultural, legal and service delivery factors affecting sexual health and rights of all vulnerable populations.

- Including the sexual health needs and rights of vulnerable groups in the next strategic plan, 2007-2010, based on needs assessments to inform policy development. Particularly, assess the sexual health of prisoners and the HIV prevalence situation in prisons and assess the sexual health needs of all vulnerable groups.

- Development of a policy and legal environment promoting sexual health and rights for all vulnerable groups. The open door on sex work legislation can be used to further explore legislation for other vulnerable groups. The extension of the law being prepared for the protection of PLWHA to all vulnerable populations will help resolve current legal weaknesses described above. This will need an extensive consultation and participation of all structures involved in the development of sexual health and rights for vulnerable groups.

- Develop a policy dialogue involving all actors for the adoption of a global strategy targeting the sexual health and rights of all vulnerable groups, and put the vulnerable groups at the center of the dialogue and the interventions.

- Strengthen and decentralize the ongoing MSM program and improve coordination between actors involved in program implementation. Adequate coordination conducted by the HIV/AIDS Division will lead to more efficiency and will serve as a catalyst for other partners wanting to support the program.

- Strengthen ongoing programs targeting women, youth, sex workers, orphans and other vulnerable children and increase availability of services targeting MSM, prisoners, lesbians, etc. Decentralization of these programs will bring more equity in terms of access to services between urban and rural areas.

- Training all decision makers, program managers, jurists, service delivery staff, NGO leaders, female leaders, religious leaders and communicators on issues such as legal, social, cultural, and economic aspects of sexual orientations and their impact on health and human rights. The BCC capacity already developed in the country is a good asset for developing programs targeting vulnerable groups.

- Advocacy at national, multisectoral, and community levels, and among jurists, human rights advocates, civil society and the donor community to raise awareness of the importance of the sexual health and rights of vulnerable groups in the HIV/AIDS response. The role of the press and civil society in raising awareness at the level of the population must also be strengthened.

- Extend HIV testing and the availability of condoms and lubricants to prisoners and other vulnerable groups.
- Reinforce the financial and technical capacities of NGOs in charge of social rehabilitation. These NGOs will work to reinforce the personal growth of vulnerable populations through education, economic activities, psychosocial and religious support.

1-3 Funding landscape

A- Key players/donors

The funding level has been constant and even increasing since the beginning of HIV/AIDS program implementation in Senegal. Main partners are:

- UNAIDS member organizations such as UNPD supporting legislation development and policy dialogue, UNICEF supporting orphans and vulnerable children, WHO supporting STI and ARV treatment, UNFPA supporting voluntary counseling and testing, UNESCO and WFP supporting orphans, vulnerable children and PLWHA nutrition, the ILO and FAO;
- The World Bank supporting a multisectoral response, decentralization, donor coordination, resource mobilization and monitoring (funding $30 million);
- Bilateral cooperation between France, Canada, Belgium , America, Germany, Luxembourg, and Japan, mainly focusing on voluntary testing, care and treatment, psychological and economic support;
- The Global Fund ($6 million);
- National Funds for HIV/AIDS for ARV treatment ($3 million annually);
- Many partnership schemes organized between multilateral and bilateral donors, and international and national NGOs for the development of voluntary counseling and testing centers, MSM core programs, and sex workers prevention and treatment programs;
- International NGOs like Alliance against AIDS, ACI supporting the development of PLWHA associations; HACI, World Vision, Catholic Relief Services, Plan International, Counterpart, and SWAA supporting orphans and vulnerable children; Enda Tiers Monde, French Red Cross, and CCISD/Sida 3 supporting female sex workers; OPALS supporting ambulatory treatment for PLWHA; the Barcelona 2000 Foundation supporting voluntary testing and care for PLWHA; and

- National NGOs like AWA, ASBEF, SIDA Service, Synergie pour l'Enfance, Survie SIDA, AFDS, APAPS, ADEMAS supporting sex workers, social marketing, orphans and vulnerable children, and PLWHA;

B- Collaboration between donors and government

Since the implementation of the HIV/AIDS multisectoral response, coordination is the main challenge for the National AIDS Council.

Collaboration mechanisms are diverse and complex, depending on the strategic position of the partner and its dynamism. Meetings with the World Bank and the Global Fund are very regular; once a month with USAID; every two months with the French Cooperation. The more formal coordination mechanism is with the CCM quarterly meetings.

Internal collaboration between international and national NGOs is more active as well as the UNAIDS collaboration mechanism. One of the cornerstones of the national strategic plan is public and private sector involvement in the response, but collaboration has been weak between these sectors and the National AIDS Council.

Collaboration has been more effective between technical and financial partners and civil society organizations.

C- Funding gaps

The HIV/AIDS response funding has been increasing during this past few years. The six main donors (the World Bank, the Global Fund, USAID, France, Germany, the European Union) provide total funding for the 2002-2006 strategic plan amounting to $74 million.

Within the multisectoral response to HIV/AIDS most of the ministry departments have already organized an HIV/AIDS Committee and designed a sectoral plan which is funded through the National Council of AIDS.

A general gap is a lack of funds allocation for programs targeting vulnerable groups like MSM, sex workers social reintegration, lesbians, prisoners, and others.

2-Cote d'Ivoire Case

Cote d'Ivoire is situated in West Africa with a population of 16 million. The population growth rate is 3.3% and life expectancy at birth is 50.9 years. This population is young and urbanized: 43% are children under 15 and 47% live in cities. The literacy rate is 51% among men and 49% among women[9].

In the context of the HIV/AIDS epidemic, since the mid-nineties Cote d'Ivoire has been recognized as being the country with the highest HIV prevalence rate in West Africa. In 2002, the HIV prevalence rate was 9.7%, and the number of people living with AIDS was estimated at 770,000, the orphan population at 420,000, and total number of deaths caused by HIV/AIDS, 75,000[10]. Both the HIV-1 and HIV-2 viruses are found in Cote d'Ivoire.

Another significant fact about the epidemic in Cote d'Ivoire is the high HIV prevalence rate among vulnerable populations. For pregnant women the rate is 9.5% in urban areas and 5.6% in rural areas, while among sex workers it is 27%. AIDS is the first cause of death. In 1996, the HIV prevalence rate in the youth population was 18% and the prevalence rate among the migrant population was 26.36%.

2-1 Policy landscape

Specific national context issues impact the sexual health and rights of vulnerable or marginalized populations:

A - Political environment

The country has been undergoing a politico-military crisis since September 2002. The permanent threat of civil war has had numerous destabilizing effects on West Africa and the UEMOA organization. As a result of the military rebellion, the country is split into Northern and Southern zones, with a climate of institutional disorder and political uncertainty, and destabilization of the population with large numbers of refugees in Abidjan, and other southern cities.

The crisis has had a negative economic impact with a fall in national production, decreases in financial resources flowing into the country, and an increase in poverty in the general population. The lack of access to basic services offered by national programs is particularly serious in the North. Life expectancy at birth has declined from 53 years in 1985 to 50.9 years in 2000.

The presence of large numbers of national, African and UN military forces in the country (ONUCI, Forces Licorn, FANCI) encourages sex work and the accompanying increases in the risk of HIV infection both within the country and across the West African region.

[9] DHS II. 1998-1999
[10] UNAIDS 2002 Annual Report

Because of its past economic strength and stability, Cote d'Ivoire has traditionally had the largest migrant population in West Africa. Large numbers of migrant populations from neighboring countries, mainly Nigeria, Ghana, Liberia, Sierra Leone, Mali, Guinea, Senegal, Niger, Benin, and Togo, can be found in the country**.** Many have returned to their countries of origin or to other neighboring countries to escape the conflict.

The immediate effect of the politico-military crisis in Cote d'Ivoire is the dramatic increase of factors which make people vulnerable to HIV infection, particularly women and youth. Women in particular are affected by the high poverty level, illiteracy, ignorance, destructruration of families, mobility and lack of adequate health services.

As a consequence of the military and political crisis, there has been a dramatic increase observed in the number of professional and occasional women and male sex workers in Abidjan and all cities surrounded by a military presence. The massive displacement of the population from the occupied zones to the south has aggravated the factors exposing people to the HIV/AIDS infection, as has the lack of adequate services. The classic female sex worker used to be a woman from a neighboring country and her clients were the migrants. This is the reason why people with HIV/AIDS returning to their countries were described socially as having the "Cote d'Ivoire illness''. Today, more and more Ivoirian citizens have resorted to sex work because of the economic crisis. Men and female sex workers are increasingly young, poor and uneducated, coming from broken families and disrupted communities. The number of men having sex with men is also dramatically increasing despite the hostile environment towards this practice.

1- Socio cultural environment: societal attitudes towards vulnerable or marginalized populations

While female sex work and men having sex with men are considered to be negative and punishable social deviances, female sex work is more tolerated than men having sex with men. Due to the political and military crisis and its consequences among the population, there are growing concerns about sexual violence.

Female Sex workers

Profile: A fairly young Ivoirian (48.15%) and West African population with a median age of 14 among those under-18 and 28.5 among adult sex workers. The average duration of working in sex work is 12 years. The level of education is low with 30% of sex workers illiterate and 60% with only a few years in primary school. The great majority of those under-18 come from destructured families and most of the adults are unmarried or divorced, widows or temporarily separated from their husbands. Fifty-three percent are from very poor families with an average number of 7 children. The majority are unemployed and live far from their families, in Abidjan's suburbs, particularly in Youpougon (64.81%).

Occasional prostitution is practiced by a majority of Ivoirian sex workers (53.38%); semi-professional prostitution is mostly practiced by Ivorian sex workers working as barmaids (17%) and professional prostitution is mostly practiced by Ghanaians and Nigerians (29.62%)[11].

Condom use, health seeking behavior for STI care and HIV testing is well practiced in the sex worker community due to very dynamic behavior change communication delivered through relays and using visual and audio-visual materials. From 1992 to 2002, STI prevalence rates among sex workers dropped from 34% to 10%. In 2002, HIV testing acceptance rates among sex workers was more than 60% and total condom use during last sexual intercourse was 85%. The HIV prevalence rate dropped from 89% in 1992 to 27% in 2003[12].

While prostitution is not legalized, it is "tolerated". However, the majority of sex workers' daily lives are made up of rejection, ostracism, rackets, exploitation, stigma, rape and violence from men, including the police (i.e. clients, barmen, pimps, policemen, young boys enrolled in the political militia, etc.) Leaving families and communities to live in brothels and other informal sites increases women's social and economic vulnerability. Originally enrolled in prostitution to resolve their basic financial needs, most female sex workers are now faced with the urgent need to survive because of the rampant poverty imposed on them by the multiple forms of exploitation they face on a daily basis.

"We earn our living on a daily basis. When we are ***racketed*** by these men, we end up not being able to pay for our meals. Thanks to solidarity among us, we can organize group meals"

Sex workers focus group participants

"The situation is worse for me because I have been sick for weeks. I couldn't buy my drugs and right now, I am just having one meal a day thanks to my friend's help."

Ivorian sex worker, age 16

The high level of self stigmatization among female sex workers is rooted in their low economic status, high illiteracy rate**,** and the number of cases and diverse forms of violence they are subjected to from the police and other men in their work environment. These facts constitute major constraints to their ability to speak out and to look for help when their rights are violated. When they are asked why they do not report cases of violence to the police or look for help, female sex workers have a very straight forward

[11] ***Studies on the phenomenon of prostitution in Abidjan: Mouvemenet du Nid, Abidjan……***
[12] RETROCI Project annual report 2003

response: ***"If the people who are supposed to protect your rights are the ones who torture you in your room or on the street, how can you rely on them to provide any protection?"***

One of the most serious threats to human rights and access to health care is the "sex slavery/sex trade" practiced by migrant pimps from neighboring countries, mainly Nigeria. Groups of young women are brought into Cote d'Ivoire by male or female pimps, locked in brothels, deprived of their travel documents and forced to do sex work for a period determined by the pimps. They are exposed to sex without protection on the client's demand and, in case of pregnancy, are forced to have an abortion. In the case of STIs, their access to the clinics is highly controlled. When clinic workers try to gain access to these facilities, they face the visible hostility of the pimps or are simply refused access to the sex workers for BCC activities.

The situation of women trafficked into sex work is characterized by high levels of coercion by pimps who see access of these sex workers to information and care as a threat for their trade. Pimps fear that the trafficked sex workers may escape on their way to the clinic. This seems quite unlikely given the strict control imposed on the women. Once they pay the amount requested by the pimp, the trafficked women can be freed, although many will stay in Cote d'Ivoire and continue sex work. Until now STI clinic managers have not reported these violations to the authorities because they fear reprisals that will worsen the case of these sex workers and completely block their access to the clinic. This very lucrative trade is now being replicated by migrant pimps from Guinea and Mali.

> *"They are always* accompanied *by a brothel employee who keeps an eye on them and who often wants to be present during the medical examination. We are often asked to reveal our case assessment and exam results but we refuse to provide them. We often notice that the sex workers write down the clinic's address and phone number, wrap it into a plastic sheet and* furtively *introduce it to the vagina. This is to make sure they can call us secretly when they are in need.*
>
> **STI Clinic staff**

Men having sex with men

Profile: Young Ivoirian population with an average age of 27, fairly educated (52.4% having attained a secondary school level and 30.5% with a professional diploma or university degree). Many are students, artists or working in the informal sector, while 26.7% are unemployed. The great majority are unmarried (90.4%); half of the MSM population lives with family where no one is in charge. In terms of sexual identity, 47.1% are homosexual, 46.2% are bisexual, and 6.75% are heterosexual.

While the majority consider themselves to be in good health, 30.9% have had an STI during the six months preceding the study and 59% of the MSM tested at Clinic

Confiance are HIV positive (16 out of 27 MSM). Condom use with men is 54.9% and 55.7% with women. Voluntary HIV testing is already done by 42% of the study participants[13].

The reality of homosexuality for MSM populations is social rejection and stigma illustrated by verbal (65.7%), physical (23.5%) and sexual (15.3%) violence, separation with families, rackets, torture, blackmail, and raids from the police or other homophobic youth in bars, gay clubs, and houses. Some cases of severe rights violations, such as MSM who are beaten to death, were reported to the court by the MSM Association without any response. The Ibbis, MSM exhibiting feminine mannerisms, and expatriate MSM are most exposed to violence. Furthermore, MSM self stigmatization and recurrent blackmailing in the MSM community constitute a serious limitation to MSM community development. The attitudes of journalists and their reporting on questions related to MSM are also influenced by ignorance and community attitudes. The large majority of the press adopts the line of sensational scoops when reporting on MSMs.

Denial from HIV/AIDS multisectoral response managers and from other political and legal authorities is prevalent, but the advocacy activities of the recently created MSM Association are creating awareness at the ministerial level where the HIV/AIDS response is coordinated.

Strong discrimination in the service delivery environment creates attitudes that lead to the refusal of care for MSM. In the past, many of the MSM living with AIDS died in their houses in miserable conditions without any social or medical assistance.

The first support of the MSM and Lesbian associations is the Raelian Movement with 1500 members in Côte d'Ivoire. This organization provides social, psychological and financial support to the organizations, mainly in their actions to fight discrimination.

Lesbians

The Lesbian Association is composed of about 200 members. The president of the association is the Committee of Sexual Minorities, established in Côte d'Ivoire in January 2005. The lesbian community is less stigmatized by the population and service delivery staff because their sexual orientation is well disguised by their adoption of social norms such as marriage or false love relationships with men**,** particularly MSM. This, however, makes them vulnerable to the HIV epidemic.

Prisoners

The case of discrimination against prisoners is worse because they are not only deprived of freedom but also totally excluded from their families and rejected by their communities. Prisons in West Africa are often considered to be "***living cemeteries*"**.

[13] Pilot participatory study for the identification of IST and HIV/AIDS prevention and service delivery needs in the Cote d'Ivoire MSM population: Pr Vinh-kim N'Guyen, Mc Gill University Montreal; Ako Cyriaque Yapo, advisor Arc en Ciel + NGO.

Access to the basic rights of prisoners is strongly affected by problems which are typical of African prisons: overcrowding, lack of adequate staffing and lack of funding. Prisoners are affected by a lack of adequate nutrition, hygiene, health care and security. While prison managers accept that homosexuality is a reality, no decision is made to protect prisoners against HIV infection. There is no HIV prevention program in prison. HIV/AIDS messages and condoms are not available. There is an informal and irregular sale of condoms through the prison's internal, hidden trade.

Prisoners are involved in unsafe sex, including sex between men without condoms, drug dealing and illegal trade.

Other vulnerable populations

The list of vulnerable populations can be quite exhaustive in an environment characterized by the rise of poverty, illiteracy, unemployment, family rejection and exploitation, aggravated by the military and political crisis in Cote d'Ivoire. Anecdotal evidence indicates that youth, particularly young unmarried mothers, house maids, barmaids, displaced persons, young girls, ambulatory vendors, handicapped persons, street children and drug users adopt risky behavior exposing them to the HIV infection in order to survive. No specific studies have been done to assess their vulnerability to HIV infection but their level of exposure to the infection is obvious.

B- Law and policy environment

1- Relevant national laws that work to promote sexual health and rights of vulnerable or marginalized populations

Ratification of international laws and conventions: Côte d'Ivoire has ratified the following international laws and conventions, marking its adhesion to human rights protection regardless of age, sex, education, economic status, religion or socio cultural group:

- The Universal Declaration of Human Rights promulgated on December 10, 1948;
- The International Pact relative to Economic, Social and Cultural Rights of December 16, 1966;
- The African Charter of Human Rights and People promulgated on October 21, 1986;
- The Convention on Torture and Other Penalty and Cruel Treatment, Inhumane and Degrading promulgated in December 1984;
- The Conventions relative to children's rights promulgated on November 20, 1989; and
- The African Charter of Rights and Child Wellbeing promulgated in 1990.

Internal laws: According to the country's constitution (article 2 and 3), all citizens enjoy their rights to life, freedom, and respect of their dignity and integrity. Under the ***Penal Code,*** legislation protects children and all other people who are not able to protect themselves because of their physical and mental status. Damage to physical morality such as pimping is severely punished. Women, children and handicapped persons are protected against all types of abuse and sexual violence. Rape is severely suppressed by law. (See Annex 2 for details.)

In December 1998, the promulgation of the law suppressing certain forms of violence against women such as excision and genital mutilation represented significant progress in the promotion and protection of the sexual health and rights of women and young girls. In November 1998, the protection of the law was extended to persons whose physical and mental integrity are temporarily or definitively diminished. This law promotes the economic status of handicapped persons through education and professional training.

There is no particular legal provision condemning or repressing sex work, homosexuality and other sexual orientations. A newly prescribed article in the penal code (378) represses incitement to homosexuality. This situation is beneficial to the promotion of sexual health and rights for MSM, sex workers and others. Furthermore, the provisions of the law authorizing the creation of associations to all citizens are an open door for the legal gathering of vulnerable populations. As a result, the MSM group has created the Arc En Ciel + association in *2004*

The abolition of the death penalty in 2000 provides prisoners the right to life and consequently the right to enjoy the protection of their health status. The decree organizing jail management and procedures for executing restricted penalties for prisoners promotes the prevention of promiscuity. In principle, this disposition promotes the sexual health of prisoners.

Other factors in the legal environment that contribute to the promotion of sexual health and the rights of vulnerable populations are:

1) The creation of the national committee of human rights that offers assistance to all citizens or resident victims of rights violation.

2) All vulnerable populations enjoying their civil rights are eligible to request compensation for damages caused by individuals or the state if its obligations to insure public service are not met.

3) The provisions of the law relative to marriage, recognizing the equal rights of men and women to divorce, separation, goods sharing, child custody and mutual assistance in case of illness or disability, also promote the protection of women and children's rights.

The legal environment is now ripe for introducing legislation supporting PLWHA, and sexual health and rights of vulnerable groups. The Ministry of Human Rights is preparing

a draft proposal for a law protecting the rights of PLWHA to be submitted to the Parliament by the end of October 2005. This result is the effect of 10 years of advocacy strongly conducted by PLWHA associations, women's associations, and particularly, congressmen and jurists, journalists' networks and the technical and financial partners in Côte d'Ivoire. This environment is also influenced by regional donor orientations supporting the reactivation of the country's HIV/AIDS law and ethics responses. The main partners are UNDP, and the USAID-funded regional project, AWARE. A regional workshop sponsored by UNDP was organized in Dakar in June 2004, with the objective of designing a model AIDS law protecting the rights of PLWHA. Likewise, another workshop was sponsored by the AWARE regional project in November 2004 for the same objective. This model AIDS law is serving as a basis for further investigations and adaptation in Côte d'Ivoire. However, this model law does not take into account the aspects of sexual health and rights for vulnerable populations because of a lack of perception of decision makers and lawyers of the importance of these issues on the spread of the HIV infection.

Our feed back to the Ministry of Human Rights on the findings of this study has called the attention of senior decision makers to the status of the sexual health and rights of vulnerable groups in Côte d'Ivoire. A decision was made to set up a committee composed of the Ministry of Human Rights, the Ministry of Justice, the AIDS/NGOs network COSCI, the journalists and artists NGO network REPMACI, the PLWHA NGO network RIP, service delivery NGOs, and NGOs working with vulnerable groups and other stakeholders and partners. This committee would further assess the status of sexual health and rights for vulnerable groups and include this issue in the design of the new draft law project.

2 - Relevant national laws that work as a barrier to advancing the sexual health and rights of vulnerable or marginalized populations

Ethical and legal policies are the weakest side of the HIV/AIDS response in Côte d'Ivoire. For the time being there are no specific legal tools for the HIV/AIDS response, including sexual health and rights for vulnerable populations. This legal loophole creates misinterpretation of existing laws when facing legal problems involving HIV/AIDS. In the case of prostitution and homosexuality, the ambiguity of current laws is beneficial to the police, military and paramilitary corps who are not punished for the violation of the rights of these populations.

The lack of provision for legal protection for women living in cohabitation with men and their children increases the social and economic vulnerability of women and children in the case of separation from or death of the man. As an example, many of the young sex workers come from families with this type of union.

3- Relevant national policies that work to promote the sexual health and rights of vulnerable or marginalized populations

The HIV/AIDS Response: In the mid 1990's, Cote d'Ivoire political leaders demonstrated strong leadership in the response to HIV/AIDS. A dynamic multisectoral program was implemented with the aim of responding to the dramatic increase of the HIV epidemic affecting all segments of its population and its economy. In 2003, this proven political leadership evolved into the creation of a Ministry of AIDS and the development of a stronger and a more structured multisectoral response. The response is characterized by the distribution of roles to ministries according to their specific capacities; improved management and decentralization; improved coordination structures, and improved resource mobilization; and a rationalized national monitoring and evaluation system. The Ministry of Health is specifically in charge of the National Service Delivery Program created in 2001 (Programme National de Prise en Charge: STI, mother to child transmission, voluntary testing, antiretroviral treatment).

HIV/AIDS policy and strategies are described in the National Strategic Plan 2000-2004, extended to an interim plan 2004-2005. The next strategic plan will run from 2006 to 2010.

Out of the 2000-2004 National Strategic Plan's 11 priority strategies, 5 target vulnerable populations such as educated and uneducated youth, women, sex workers and their clients, PLWHA, children in difficult situations and mobile populations. The main interventions are communication, STI reduction and care, condom availability and use, fight against stigma, reduction of harmful traditional practices, promotion of economic activities, and equal access to antiretroviral therapy. Some of the needs for vulnerable groups are targeted by these interventions but there is no mention of rights violations and other social and cultural factors affecting sexual health. There is no intervention targeting MSM, prisoners or other vulnerable populations. While the intervention on stigma plans to improve the legal environment for PLWHA, there is no mention of rights protection for other vulnerable populations

The interim plan 2004-2005 conducts the above mentioned interventions and puts more emphasis on pregnant women, military and paramilitary corps and vulnerable children.

4- Relevant national policies that work as a barrier to advancing the sexual health and rights of vulnerable or marginalized populations

The lack of recognition of the sexual health needs and rights for specific populations, their high vulnerability to HIV infection, and the subsequent lack of interventions targeting these groups are important barriers to the HIV/AIDS response.

The objective of reducing HIV transmission among male and female sex workers does not clearly differentiate strategies targeting MSM. Therefore, this lack of clarity is a barrier to the implementation of interventions targeting this population.

Neither the 2000-2004 National HIV/AIDS Response Strategic Plan, nor the 2005-2006 Interim Plan, include any strategies for the protection of prisoners from HIV/AIDS. The lack of policy for HIVAIDS interventions in prisons is a barrier to the promotion of prisoners' sexual health and rights. The single reference document which mentions prisoners' HIV status is from 1986, and the prevalence rate was 9.1% at that time.

The fact that same sex sexual behavior is not officially recognized in prisons is a barrier to behavior change communication and condom availability in prisons. While equal access to antiretroviral treatment is one of the policy's strongest principles, prisoners' access to treatment is hindered by constraints related to observance, psychological support and social support. Prisoners who are eligible for treatment stay in prisons with no access to the whole package and no continuity. There is no mention of prisoners' antiretroviral treatment in the policy. Due to the absence of statistics on HIV/AIDS infection in prisons, this constitutes a nebulous question in Cote d'Ivoire.

Another barrier in the advancement of sexual health and rights is the lack of data and prospective studies targeting other sexual orientations like lesbians and transsexuals, and other vulnerable populations like prisoners, handicapped persons, drug users, etc.

2-2 Programmatic landscape

A- Programs addressing the needs of vulnerable populations

Considering the high rates of HIV among sex workers at the beginning of the epidemic in Côte d'Ivoire, the National AIDS Program decided to implement the Sex Workers, their Clients and Children Prevention Program (PPP) funded by the Global Program on AIDS (GPA). Since then, this program has served as a mainstream for all technical and financial partners involved in STI prevention in Côte d'Ivoire, including Belgian, Canadian, French and American (PSI, FHI, CDC) bilateral cooperation, and UNFPA. The main strategies of the PPP involved providing sex workers with access to behavior change communication through trained community relays, and giving them access to condoms and referral to STI clinics. Implementation was made easier with the mapping of all prostitution sites.

Due to the closing of the offices of the main bilateral partners since the beginning of the military and political crisis in Cote d'Ivoire, the PPP has been shut down. Efforts to maintain access to STI services and quality of care are being sustained by service delivery NGOs technically supported by FHI and the Tropical Medicine Institute and funded by the PEPFAR project. The project objectives are service delivery, NGO capacity building and integration of services (BCC, STI care, HIV counseling and testing, condom distribution, RH services and referral to hospitals for antiretroviral treatment). The emergence of NGOs doing communication and service delivery work for sex workers, particularly with Clinic Confiance as a model, contributed to a decrease of the marginalization of sex workers by health workers.

Sex workers: For more than ten years, Côte d'Ivoire has benefited from the CDC RETROCI research project to implement quality STI case management. In addition to STI clinics run by the project in Abidjan and San Pedro, RETROCI is serving as a center for research, training and capacity building for NGOs, public and private health centers in Cote d'Ivoire and West Africa. Currently, three STI care clinics are functioning in Côte d'Ivoire: Clinique Confiance and CIP in Abidjan and APROSAM in San Pedro. Two other service delivery NGOs will be selected in the country and will benefit from the same assistance.

Very few social rehabilitation programs are available in Abidjan. The NGO "Mouvement du Nid" is having some success in this area as well as the NGO Côte d'Ivoire Prosperite (CIP).

Access to health services for the MSM population is, for the moment, limited to a consultation free of charge at the Clinic Confiance every Tuesday afternoon. There is no other service in the public or private sector. Condoms and lubricants are also available and are redistributed by MSM leaders to their pairs at the level of five MSM clubs.

Attitudes of stigmatization, neglect and rejection of MSM seeking care at public services are obvious. Many of the MSM living with AIDS self-medicate at home, using street drugs or traditional medicine.

Access of preventive STI and HIV/AIDS services is not available for prisoners. The lack of messages targeting this particular population, unavailability of condoms and lack of access to care when suffering from AIDS are serious factors affecting prisoners' sexual health and rights.

A quite similar situation is observed for other marginalized populations like drug users, handicapped persons, street children, young unmarried mothers and house maids who are left out from public health services mainly because of their ignorance, low economic status and lack of support. Lack of physical and financial access to health services is the main factor affecting their vulnerability to health problems in general and the HIV infection in particular. Only one NGO is known for taking care of drug users in Abidjan and there are very few actors providing health care assistance to prisoners.

B- Policy and programmatic priorities required to advance sexual health and rights of vulnerable or marginalized populations vis-á-vis the AIDS pandemic

Considering the multisectoral response to the epidemic and the capacity for reducing STI and HIV prevalence among sex workers, strengthening weaknesses within existing programs for other vulnerable groups requires the development of a vision for the following programmatic priorities:

- Recognition of the sexual health and rights of all vulnerable populations and their impact on the spread of HIV/AIDS.

- Recognition of social, cultural, legal and service delivery factors affecting the sexual health and rights of all vulnerable populations.
- Needs assessment to inform policy development. Extend the MSM study by including other MSM groups outside Abidjan. Particularly, assess the sexual health of prisoners and the HIV prevalence situation in prisons.
- Development of a policy and legal environment promoting sexual health and rights for all vulnerable groups. Extending the law being prepared for the protection of PLWHA to all vulnerable populations will help resolve the current legal weaknesses described above.
- Strengthen ongoing programs targeting women, youth, sex workers, orphans and other vulnerable children and increase availability of services targeting MSM, prisoners, lesbians, etc. Decentralization of these programs will bring more equity in terms of access to services between urban and rural areas.
- Training all decision makers, program managers, jurists, service delivery staff, NGO leaders, religious leaders and communicators on issues such as legal, social, cultural, and economic aspects of sexual orientations and their impact on health and human rights. The BCC capacity already developed in the country is a good asset for developing programs targeting vulnerable groups.
- Advocacy at national, multisectoral and community levels, and among jurists, human rights advocates, civil society and the donor community to raise awareness of the importance of the sexual health and rights of vulnerable groups in the HIV/AIDS response. The role of the press and civil society will be a determinant in raising awareness for all segments of the population.
- Extend HIV testing and condom social marketing and lubricants for MSM, prisoners and occasional sex workers.
- Reinforce the financial and technical capacities of NGOs in charge of social rehabilitation. These NGOs will work to reinforce the personal growth of vulnerable populations through education, economic activities, psychosocial and religious support.
- Consider a regional focus for programs targeting vulnerable groups, particularly sex workers and MSM. Côte d'Ivoire could be considered as an entry point for a regional program because of the importance of its migrant population and the large trafficked population from neighboring countries.

2-3 Funding landscape

A- Key players/donors

Before the political and military crisis, the HIV/AIDS response in Côte d'Ivoire benefited from financial and technical assistance from:

- UNAIDS member organizations like UNPD supporting decentralization, UNFPA supporting women's programs, UNESCO supporting education, particularly of young girls and teachers;

- The World Bank supporting the multisectoral response, decentralization, donor coordination, resource mobilization and monitoring;

- Bilateral cooperation: French, Italian, Canadian, Belgian, American, and German mainly focusing on service delivery, care and treatment, psychological and economic support;

Unfortunately, due to the crisis, most of the bilateral cooperation (Belgian, Canadian, Italian, French) and UNFPA assistance are being postponed and the World Bank has already postponed its $27 million funding package. The current partners are:

- The Global Fund ($17 million);

- The Bush Administration's PEPFAR ($15 million);

- The German KFW cooperation funding the national social marketing agency for condom social marketing and development of BCC materials targeting vulnerable groups;

- National Funds for HIV/AIDS funding ministries ($54,000) and ARV treatment ($1,700 000);

- Partnership between UNICEF, UNFPA and ONUCI funding a program supporting the legal, psychological, and medical aspects of sexual violence in two zones (Djokoue and Yamoussokoro) in collaboration with the Ministry of Women, the Women Parliamentarian and Ministers Network (REFAM) and the Women's Jurist Association;

- International NGOs like Alliance against AIDS supporting NGOs, press, PLWHA networks and MSM associations; the Nest Movement (France) supporting socio-economic reintegration for sex workers; the Raelian Movement supporting MSM and lesbian associations; the Catholic International Bureau for Children (BICE) and UNICEF supporting prisoners under age 18; the International Red Cross and MSF supporting prisoner care and support;

- National NGOs like Djigui Foundation supporting prisoners' spiritual development. (Implementing NGO networks are COSCI, REPMACI, RIP and service delivery NGOs include Espace Confiance, Aprosam, CIP, Renaissance Sante Bouake, ect.)

B- Collaboration between donors and government

Collaboration is well established between:

1) Government sectors, private sectors and donors through the various coordinating mechanisms of the Ministry of AIDS;
2) Donors, government and civil society through partnerships such as UNICEF/UNFPA/ONUCI;
3) Technical partners and civil society such as FHI/the Belgian Tropical Institute and service delivery NGOs; and NGOs such as the partnership between Alliance and the NGO networks.

C- Funding gaps

Analysis of the 2004 response by the Ministry of AIDS reveals that the funding gap is mainly due to the postponement of expected funding from the World Bank. Within the multisectoral response to HIV/AIDS most of the ministry departments have already organized an HIV/AIDS Committee and designed a sectoral plan but few of them have started activities due the lack of funding from the World Bank Project. There is not enough funding for programs addressing youth, women, orphans and migrants throughout the country.

The ending of most of the bilateral assistance support programs aimed at reducing STI among sex workers is of big concern in a period where all factors of vulnerability to infection are increasing due to the political and military instability.

A general gap is a lack of funds supporting vulnerable groups like MSM, sex workers' social reintegration, lesbians, prisoners, and other vulnerable groups.

III- RECOMMENDATIONS

Approaches for possible funding strategies need to take into account the existing in-country funding environment and programs.

- In Senegal and Cote d'Ivoire, the best funding strategy would be one that leverages existing funding to cover aspects that were not fully funded in on-going programs such as advocacy for policy and law development as well as service delivery strengthening and extension, capacity strengthening of NGOs and associations of vulnerable groups, and the development of a legal environment promoting sexual health and rights.

- In a regional program a fully funded strategy will be implemented through two possible channels: 1) consortiums of NGO networks specializing in advocacy, capacity building, behavior change communication, human rights development and the press, and 2) partnerships with other regional donors like the World Bank, the Global Fund, USAID and international NGOs.

ANNEXES 1

Scope of Work

Terms of Reference: Assessment in Western Africa on Sexual Health and Rights

Duration:
To be confirmed

Time Period:
August 15- September 23

Background:
In April, the Network Public Health Program (NPHP) of the Open Society Institute officially launched the Sexual Health and Rights Program (SHARP) in order to develop and implement a global strategy to improve the sexual health and rights of socially marginalized populations. Existing HIV/AIDS epidemics linked to high-risk sexual practices or the violation of sexual rights and the potential emergence of new HIV/AIDS epidemics among socially marginalized populations are of particular concern. As a new program, SHARP will create a strategic framework for its activities, to ensure that it complements existing (internal and external) efforts, makes a valuable contribution to the field, and executes a well thought-out approach. Please see attached program description.

In initial strategy discussions, Western Africa was identified as a possible priority region for SHARP funding. The basis of regional prioritization included first and foremost the intention of the foundation to work in this area and the possibility for collaboration with the Open Society Institute's Western African Initiative (OSIWA). Other considerations include the epidemiological profile of the AIDS pandemic, other funders (or lack thereof), and ability for impact with limited resources.

To inform the development of a strategic plan, SHARP and OSIWA are interested to commission an assessment of 2 countries: Senegal and another to be determined (Mali, Burkina Faso, and Guinea are considerations).

OSI Background, Experience and Potential:
The Open Society Institute (OSI), a private operating and grantmaking foundation, aims to shape public policy to promote democratic governance, human rights, and economic, legal, and social reform. On a local level, OSI implements a range of initiatives to support the rule of law, education, public health, and independent media. At the same time, OSI works to build alliances across borders and continents on issues such as combating corruption and rights abuses.

OSI was created in 1993 by investor and philanthropist George Soros to support his foundations in Central and Eastern Europe and the former Soviet Union. Those foundations were established, starting in 1984, to help countries make the transition from communism. OSI has expanded the activities of the Soros foundations network to other

areas of the world where the transition to democracy is of particular concern. The Soros foundations network encompasses more than 60 countries, including the United States.

Historically, OSI has prioritized protecting the health and human rights of socially marginalized populations, including sexual and reproductive health and rights. Since 1995, OSI has undertaken a range of domestic, international, and global activities, from increasing the diversity of safe abortion methods to funding grassroots women's NGOs in the Middle East and North Africa. Various OSI programs have supported activities that include: capacity building for NGOs, lawyers, and health providers in policy advocacy and litigation; advocacy and model service delivery efforts; public education and training/sensitization of health providers; and research and data analysis codifying the sexual health and rights experiences of vulnerable populations.

Objective:
This evaluation will provide useful information for development of a regional strategy related to sexual health and rights of marginalized populations. An initial strategy overview of SHARP is attached. The goal of this assessment is to answer outlined strategy questions in order to inform strategy dialogue and discussions. Recommendations should be based on the assessment as well as the consultant's knowledge of the field of Sexual Health and Rights in Western Africa.

The evaluation will cover at least three countries including Senegal and another to be determined in collaboration with OSIWA.

The consultant should submit to OSI a proposal which includes the methodology of the assessment (methods, tools, timeline, key stake holders) and a budget. This needs to be approved by the HIV/AIDS Program Officer in OSIWA and the Director of SHARP in Network Public Health Programs, New York before the field work commences.

Tasks of the Consultant:

2- Propose an assessment methodology and report outline. The study methodology should include time line, methods, study tools and target individuals/communities/organizations. OSIWA will assist with logistical arrangements when possible. Included in the methodology should also be a list of the pertinent questions that are expected to be answered through the evaluation. These include but aren't limited to:

- **a.** What are the specific national context issues that most impact on the sexual health and rights of vulnerable or marginalized populations? Please include information about the societal attitudes towards marginalized populations (MSM, sex workers, Lesbian-Gay-Bisexual-Transgender (LGBT) individuals).
- **b.** What are the relevant national policies and/or laws that work as a barrier to advancing sexual health and rights of vulnerable or marginalized populations? And those that work to promote them?

c. What health care systems/structures are set-up to deal with the health care needs and access to HIV/AIDS services for marginalized populations (sex workers, MSM, prisoners, etc.)?
d. What populations are most exposed to either a lack of sexual health care services or a violation of sexual rights that make them particularly vulnerable to HIV infection?
e. What are the policy or programmatic priorities required to advance sexual health and rights of marginalized/vulnerable populations vis-à-vis the AIDS pandemic?
f. Who are the key players/donors in the field of Sexual Health and Rights as related to or impacting on the AIDS pandemic? Has there been positive or negative impact related to the influx of donors funds in recent years?
g. What is the collaboration between donors and government? Is this seen as successful and what are the areas that need to be improved?
h. What are the funding gaps related to SHR and HIV/AIDS?
i. What issues are particularly timely to move on in order to best promote SHR?

3- Meet/discuss with OSI staff to finalize study objective and methodology.
4- Conduct assessment in two countries.
5- Prepare and submit first draft report for comments to OSI staff.
6- Integrate comments into final report.
7- Present report at a strategy meeting of OSI staff and SHR health experts. The meeting is scheduled for October 4th in New York, New York.

Output:
A final assessment report on the policy, programmatic and funding landscape around Sexual Health and Rights and HIV/AIDS in two countries in Western Africa. The report should include recommendations aimed at OSI staff on possible funding strategies, partners and pertinent issues.

Attending a strategy meeting by SHARP/OSIWA to take place on October 4th in New York to present the assessment.

Working relationship:
The consultant will work with Soros Foundation staff at the Open Society Initiative for West Africa (OSIWA) and the SHARP/Network Public Health Staff in New York. The OSI contact information is as follows:

Heather Doyle/ Program Officer, Network Public Health Programs
(1) 212 548 0659
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Hortense G. Niamke/ HIV/AIDS Program Officer, OSIWA
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ANNEXE 2

Revised Work Schedule

Time period	Activities	Country	Observations
August 15-20	Document review Study tools finalized	Senegal	Needs assistance from Dakar/OSIWA Office
August 22-27	- Interviews of key stakeholders and partners - Focus group discussions with vulnerable groups	Senegal	Needs facilitation from NGOs or service providers in charge of vulnerable groups
August 29-31	- Interviews - Clinic site visits - Policies and laws review - Participate in MSM final program evaluation workshop - Contact with legal advisor	Senegal	Contract with legal advisor
September 1-3	- Travel to Cote d'Ivoire - Document review - Contacts with facilitator and legal advisor - Work schedule finalized	Cote d'Ivoire	Contract with facilitator and legal advisor
September 5-11	- Interviews with key informants - Focus group discussions with vulnerable groups - Policies and laws draft report review - Return to Senegal	Cote d'Ivoire	

September 12-13	-Finalize interviews -Policies and laws draft report review	Senegal	
September 14-18	- Draft report writing and submitted to OSI/SHARP staff	Senegal	Needs working space at the Dakar/OSIWA Office if possible
September 19-20	Draft report review by OSI/SHARP and OSIWA staff and feed back	Senegal	
September 21-23	Finalize report and submission to OSI/SHARP	Senegal	
September 26-28	Preparation of presentation of the assessment	Senegal	In collaboration with OSI/ SHARP and OSIWA staff
October 1, 2005	Travel to New York		
October 3, 2005	Finalize presentation	New York	In collaboration with OSI/SHARP staff
October 4, 2005	Presentation of the assessment		Idem

ANNEXE 3

List of persons interviewed

1- In Senegal

Dr Abdoulaye Wade	Chief, Division of AIDS/ MOH
Gary Engelberg	Director, Africa Consultant Inc,
Amadou Mody Moreau	Research …Population Council
Ababacar Thiam	Research assistant, Pop council
Dr Abdou Khoudia Diop	Responsible of MSM Health Service, Division of AIDS
Pr Cheikh Ibrahima Niang	Anthropologist, Researcher UCAD
Dr Kader Bacha	Program Director, AFRICASO
Dr N'Deye Fatou N'Gom N'Diaye	Service Chief, CTA
Jerome Bougazeli	Juriste
Marieme Soumare	Coordinatrice ONG AWA
Mintou Fall Sidibe	**Juriste**, Law Consultant
Barbara Sow	Team Leader, FHI, Senegal
Kathy Cisse Wone	Responsible Civil Society and Private Sector at the AIDS National Council
Pr Babacar Kante	Professor Law School University of St Louis
Assane Sada	Journalist, le Journal
Tidiane Kasse	Journalist, Wal Fadjri Radio
Aboubakry M'Bodji	…….Raddho
Alioune Fall	

Alioune Badara Sow	Program ……ANCS
Daouda Diouf	HIV/AIDS Program manager, ENDA
Gnilane N'Diaye	……UNDP
Charles Becker	Researcher,…….
…….	Police Inspector, **Brigade des mœurs**
13 members	AWA sex workers association
….. members	MSM association

2- In Cote d'Ivoire

ANNEXE 4

List of documents