HIV and AIDS in West and Central Africa Overview

West and Central Africa (2017)

**6.1m** people living with HIV

**1.9%** adult HIV prevalence (ages 15-49)

**370,000** new HIV infections

**280,000** AIDS-related deaths

**41%** adults on antiretroviral treatment*

**26%** children on antiretroviral treatment*

*All adults/children living with HIV

Source: UNAIDS Data 2018

**KEY POINTS**

- Despite a relatively low HIV prevalence across the region, less than half of those living with HIV in West and Central Africa are aware of their status which means that they do not access treatment services.

- Insufficient antiretroviral treatment provision means that West and Central Africa is the region most affected by AIDS-related deaths globally.

- The poor economic status of many countries in West and Central Africa has hindered the investment that is necessary for expanding HIV services.

Explore this page to read more about populations most affected, testing and counselling, prevention programmes, programmes for key populations, antiretroviral treatment, civil society’s role, HIV and tuberculosis (TB), barriers to prevention, funding, and the future of HIV and AIDS in West and Central Africa.

West and Central Africa is home to 6.1 million people living with HIV, of whom half a million are children. This is equivalent to 17% of the global population of people living with HIV, despite the region making up just 7% of the global population.1 HIV prevalence among adults is 1.9%, which is relatively low when compared to East and Southern Africa. There is wide variation between countries, ranging from 0.5% in Niger and Senegal to 4.9% in Equatorial Guinea.2

Less than half (48%) of those living with HIV were aware of their status in 2017. Of those who were aware, 83% were accessing antiretroviral treatment (ART). Of those on treatment, 73% were virally suppressed.3 The number of people accessing treatment rose significantly from 860,000 in 2010 to 2.4 million in 2017. However, because so many people are unaware of their status, this equates to just 40% of all people living with HIV being on treatment and just 29% of people living with HIV being virally suppressed.4

As a result, around 30% of all AIDS-related deaths worldwide occur in the region5 (280,000 AIDS-related deaths in 2017).6 Although AIDS-related deaths have reduced by 30% since 2006,7 they are
rising among adolescents (aged 15-19), with boys affected more than girls.8

AIDS-related deaths are also high among children (aged 0-14), with four out of every ten children who die from AIDS-related illnesses dying in the region.9 Overall, it is estimated that 5 million 0-17-year-olds in West and Central Africa have been orphaned by AIDS since the epidemic began.10

Good progress is being made on new infections among children, which decreased by around 33% between 2010 and 2017 due to the availability of more prevention of mother-to-child transmission services.11 New infection rates among adults are declining more slowly, having fallen by 8% overall over the same period (370,000 new infections in 2017), and some countries are even experiencing rising infection rates.12 13

Women are disproportionately affected by HIV in West and Central Africa, accounting for around 57% of adults living with HIV in 2017. HIV prevalence stands at 2.3% among adult women, compared to 1.6% among adult men.14 In particular, adolescent girls and young women (aged 15-24) are disproportionately more likely to acquire HIV than their male counterparts.15

West and Central Africa’s HIV epidemic is driven by heterosexual sex. Although it is generalised, meaning it affects the population as a whole, certain population groups such as sex workers, people who inject drugs and men who have sex are even worse affected. New infections among these key populations and their sexual partners accounted for 27% of all new infections in 2016, despite these groups representing a small proportion of the overall population.16 Yet programming for key populations remains insufficient, and stigma, discrimination and legal barriers prevent many people from these groups from accessing services.17

In addition, many countries are in conflict, facing post-conflict situations or dealing with the impact of other humanitarian crises which further complicate the region’s HIV response.18
Key affected populations in West and Central Africa

Young women and HIV in West and Central Africa

The annual number of new HIV infections among adolescents (aged 15–19) in the region now exceeds that of children. These new infections occur mostly through unprotected sex, and among adolescent girls, who accounted for 69% of new infections in this age group in 2016.19

The difference between young women and men is especially striking in Cameroon, Côte d'Ivoire and Guinea where adolescent girls (aged 15–19) are five times more likely to acquire HIV than boys of the same age.20

In 2016, UNAIDS named Cameroon, the Central African Republic (CAR), Côte d'Ivoire, the Democratic Republic of Congo (DRC), Gabon, Guinea-Bissau and Nigeria as countries where HIV responses for young women should be prioritised.21

The reasons why young women are disproportionately affected by HIV in the region are numerous and complex. Girls and women face high levels of gender inequality, gender-based violence and sexual violence, all of which increase vulnerability.22 For example, in Cameroon, in 2014, more than 35% of 15 to 24-year-old women had experienced spousal physical or sexual violence by their current or most recent partner in the past 12 months.23 Additionally, in conflict situations, sexual violence, particularly against women, is commonly used as a strategy of war, with younger women being especially vulnerable.

Age-disparate sexual relationships between young women and older men are common, as is adolescent marriage and pregnancy.24 The power imbalance between genders also means that many young women are not able to make decisions about their own lives. For example, more than 80% of married adolescent women in Senegal, Niger, Burkina Faso, Côte d'Ivoire and Cameroon do not have the final say on their own healthcare, according to demographic and health surveys.25

Knowledge about HIV among young people in the region is alarmingly low: with only 24% of young women and 31% of young men able to display comprehensive and correct knowledge of how to prevent HIV.26 In addition, in most countries, condom use among sexually active adolescents with multiple partners is lower among girls than boys.27

Children

Four out of five of the estimated 540,000 children now living with HIV in West and Central Africa are not accessing ART because the majority have not yet been diagnosed. Every year, an estimated 51,000 children and adolescents die of AIDS-related illnesses in the region, and more than twice that number are newly infected with HIV.28

The main route of HIV transmission to children is through birth (see later section on preventing mother-to-child transmission). However, West and Central Africa also has high levels of underage, child and forced marriage.

Across the region, 3 out of 10 girls become pregnant before the age of 18, and 4 out of 10 get married before that age. The region is home to the three countries with the highest rates of child marriage in the world: CAR (68% married before the age of 18), Chad (68%) and Niger (76%).29 However, this is not uniform across all countries in the region, for instance, in Benin, Burundi and Cameroon, the majority of girls (75% or over) are unmarried by the age of 18.30

Females who marry as minors are more likely to suffer domestic violence and rape than those who marry later; they also find it harder to negotiate safer sex.31 These factors all increase HIV risk.
Sex workers

In 2015, HIV prevalence was estimated at 16.5% among sex workers in West and Central Africa. In the 13 countries reporting data in 2016, prevalence ranged from 4% in Mauritania to 24% in Cameroon. Reported data suggests sex workers and their clients are likely to use condoms, with usage levels at 80% or more, except Burundi at 52% and Sierra Leone at 15%. However, in some cases sex workers cannot access condoms, are unaware of their importance, or have condoms confiscated by police.

Sexual violence, which often involves forced unprotected sex, has been documented among sex workers in the region, including while being arrested and in detention. A study in Benin found increasing types of violence against female sex workers to be associated with increasing HIV prevalence among this group.

A 2015 study of female sex workers in Burkina Faso and Togo explored the relationship of sexual violence with unprotected sex. Among 684 participants, one in three (33%) reported a history of forced sex. Over half of those experiencing sexual violence had experienced it on multiple occasions and almost 70% reported experiencing it before the age of 20. The study found these experiences to be associated with high-risk sexual behaviour, specifically unprotected sex with clients. Less than 5% of those who experienced sexual violence reported the event to an authority figure.

We are abused by clients, by law enforcement agents, and even at the market the police stop and harass us, asking for money and health cards. Every month we contribute 10,000 CFA so that we can practise our activities at the weekend freely.

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Debo Sow, President of Karlene (an association of sex workers living with HIV in Senegal)

Men who have sex with men (MSM)

It is estimated that 17% of men who have sex with men (sometimes referred to as MSM) who live in West and Central Africa have HIV, although prevalence differs between countries, ranging from 3.3% in DRC to 44% in Mauritania. However, data is limited, as only 12 countries in the region report on this population.

It is common for men who have sex with men to be married or in long-term relationships with women. A 2015 study of men who have sex with men in Abidjan, Côte d’Ivoire, for example, found the majority of respondents identified as bisexual.

Those countries reporting data suggest condom use among men who have sex with men is relatively high with Chad, Burkina Faso, Cameroon, Côte d’Ivoire, DRC, Mali, Niger and Senegal all reporting use above 75%.

People who inject drugs (PWID)

Burkina Faso, Chad, Côte d’Ivoire, DRC, Gabon, Ghana, Mali, Nigeria, Senegal, Sierra Leone and Togo all have populations of people who inject drugs (sometimes referred to as PWID). Overall, it is estimated that 6.5% of people who inject drugs who live in the region have HIV.
Prevalence varies between countries, ranging from 3.4% in Nigeria to 8.5% in Sierra Leone. However, Nigeria has the highest number of people who inject drugs in the region, estimated at 45,000 in 2017.

HIV prevalence among women who inject drugs is much higher than among men who inject drugs. For example, in Senegal HIV prevalence among women and men who inject drugs is 28% and 7%, respectively.

Often times, as a female you wait for your partner to inject you after he has already fixed himself. So we share needles.

-Female drug user, Nigeria

<table>
<thead>
<tr>
<th>DISTRIBUTION OF NEW HIV INFECTIONS AMONG POPULATION GROUPS</th>
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<tbody>
<tr>
<td>2017</td>
</tr>
<tr>
<td>60% Rest of population</td>
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<tr>
<td>16% Clients of sex workers and other sexual partners of key populations</td>
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<tr>
<td>12% Gay men and other men who have sex with men</td>
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<tr>
<td>10% People who inject drugs</td>
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<td>2% Sex workers</td>
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Prisoners

HIV prevalence among people who are in prison in West and Central Africa is thought to be high, with female prisoners most affected, experiencing HIV prevalence that is almost double that of men (13.1%, compared with 7.1%). High prevalence is due to a number of factors including the continued criminalisation of key population groups, limited access to healthcare, drug use, unsafe injecting practices, sexual violence, unprotected sex and tattooing.

Transgender people

Despite the lack of data, transgender people are thought to be hugely affected by HIV in West and Central Africa. Only DRC has reported on HIV among this group, estimating HIV prevalence to be 7.9%.

HIV testing and counselling (HTC) in West and Central
Africa

HIV testing and counselling (HTC) services in West and Central Africa have increased in the past decade but still remain largely inadequate. Even among groups that are usually prioritised, such as pregnant women, HTC remains low. As a result, 52% of people living with HIV were unaware of their status in 2016.

Stigma and discrimination, test kit stock-outs, staff shortages, insufficiently trained healthworkers and user fees at clinics all undermine progress.

Provider-initiated HTC at healthcare facilities, where clinical staff offer patients an HIV test, is the main testing approach in the region. However, new approaches to testing are needed and, where they are being piloted, are showing results. For example, the involvement of civil society organisations and the use of peer-led community approaches has led to relatively high testing coverage among female sex workers in many countries, with the majority reporting HTC coverage among this group of 60% or above in 2015.

As of March 2017, Chad, Burundi and DRC introduced supportive policies relating to HIV self-testing, with CAR, Nigeria and Senegal developing their own policies.

Access to HTC remains low among adolescents across the region, although girls have better access than boys. Barriers to HIV testing among adolescents include age-of-consent laws and parental consent requirements; adolescents’ low perceived risk of HIV, and negative attitudes of healthcare providers. As people age, the disparity between genders continues, as women are more likely than men to be aware of their status.

HIV prevention programmes in West and Central Africa

There were 370,000 new HIV infections in West and Central Africa in 2017, 8% less than in 2010. However, infection rates are rising in Congo, which experienced a 10% increase in infections between 2010 and 2017. In contrast, Nigeria, where 210,000 of the region’s new infections occurred in 2017, saw a 5% decline over the same period.

Countries in the region have committed to a combination approach to prevention, although certain interventions within this approach are stalling.

Condom availability and use

Condom programmes are a priority across the region. Social marketing, including through civil society organisations and in healthcare facilities, is the main strategy for distribution. However, few countries have comprehensive condom programming plans and often where they do exist they are not implemented.

Individual country progress reports show that condom distribution was particularly low in Burundi, Chad, Guinea and Mali in 2014/2015. It has also been estimated that Nigeria needs US$22 million a year to close its condom procurement gap.

Available data for 2010–2014 from 18 countries in the region indicate that condom use at last sex with a non-marital, non-cohabiting partner was higher among men than among women.
HIV education and sex education

Delivering comprehensive sexuality education (CSE) in schools in West and Central Africa is hampered by the low levels of children and young people accessing education in the first place, with gender disparities widening as children advance through the education system. In 2010, close to 17 million children aged 6–11 in the region were out of school, 52% of whom were girls.62 Enrolment to secondary education across the region stands at 37% for males and 30% for females.63

For those in school, good quality CSE is rare due to resistance from parents, teachers and decision-makers, resulting from misunderstandings about the nature, purpose and effects of sexuality education.64

MTV Shuga

MTV Shuga is a mass-media behaviour change campaign that aims to improve the sexual and reproductive health of young people, with a particular focus on young women. It is funded by a range of international and national donors and centres around an awarding-winning TV series, supported by radio, digital, social media and mobile elements. It began in 2009 in Kenya, with Series 3 (2013) and Series 4 (2015) set in Nigeria. It has been viewed in countries across the region.65

In 2016, a study conducted by the World Bank in Nigeria found a 35% increase in HIV testing among those who watched MTV Shuga for up to six months, and over half for those who watched the series for longer. The series was also found to improve viewers’ knowledge and attitudes relating to HIV, sexual and reproductive health, and risky sexual behaviour.66

Prevention of mother-to-child transmission (PMTCT)

In 2016, only 49% of pregnant women living with HIV in West and Central Africa received effective ART to prevent mother-to-child transmission of HIV (PMTCT).67

There is variation between countries with Benin, Burkina Faso, Cabo Verde and Sierra Leone all reporting PMTCT coverage of 80% or above in 2017.68 At the other end of the scale, Congo, Mauritania, Mali and Nigeria all have low coverage, at 11%, 12%, 31% and 30%, respectively.69

Just 10% of babies born to HIV-positive mothers in the region are tested for HIV within two months of their birth, compared to 50% in East and Southern Africa.70 Of the 52,000 babies born with HIV in West and Central Africa in 2016, 15,000 died from AIDS-related illnesses before their first birthday.71

The situation is particularly challenging in Nigeria, which in 2016 accounted for 62% of the 60,000 new infections among children in the region.72 There has only been a 21% decline in new infections among children in the country since 2009, compared with an average decline of 60% among other priority countries.73

Children younger than 18 months who are born to HIV-positive mothers require virological testing yet there has been limited progress on this in the region.74 However, it is increasing in Cameroon and Côte d’Ivoire,75 and Ghana is in the process of piloting programmes.76

Voluntary medical male circumcision (VMMC)

In 2007, the World Health Organization (WHO) and UNAIDS recommended voluntary medical male
circumcision (VMMC) as a key component of HIV prevention in countries with a generalised epidemic, following the discovery that it could reduce the risk of sexual transmission of HIV from females to males by 60%.

Male circumcision is common West Africa. One of the reasons for this is that circumcision is a common practice within Islam and many countries in this part of the region are predominately Muslim. A 2016 study found countries that report on both the proportion of Muslim men who were circumcised and the proportion of the population who are Muslim show a close match.

Male circumcision is less common in Central Africa. UNAIDS has identified CAR as a high priority for VMMC. However, conflict has severely disrupted HIV services there since 2013, including the implementation of VMMC.

Harm reduction

Despite the region having significant populations of people who use drugs, harm reduction interventions, which help prevent HIV transmission through injecting drug use, are scarce.

The only government-run harm reduction programme in West Africa is in Senegal. The country implements small-scale, community-based needle and syringe programmes and opioid substitution therapy. In 2014, Ghana began collecting data on people who inject drugs to establish an evidence base for future programming. In 2017, this programming was yet to be implemented.

While Nigeria’s National Strategic Plan 2010–2015 established a goal of reaching at least 80% of key affected populations, including people who inject drugs, with group-specific interventions, harm reduction interventions are not included. Despite this, 71% of people surveyed who injected drugs in Nigeria reported using sterile injecting equipment between 2005 and 2010 due to widespread availability via pharmacies.

Pre-exposure prophylaxis (PrEP)

Although pre-exposure prophylaxis (PrEP) - the use of antiretroviral drugs (ARVs) to protect HIV-negative people from HIV before potential exposure to the virus - is not available in the region, both Benin and Nigeria were investigating the uptake and impact of PrEP in 2016.

The Benin trial is looking at the effectiveness of PrEP for HIV prevention among female sex workers, while the Nigerian study is focusing on serodiscordant couples (when one person has HIV and the other doesn’t). As of 2017, PrEP remained at demonstration trial stage in both countries and was yet to get clinical approval.

Antiretroviral treatment (ART) in West and Central Africa

An estimated 40% of people living with HIV in West and Central Africa in 2017 were on ART. This means that around 4 million people living with HIV need treatment but are not receiving it.

Coverage varies between countries. More than half of the people living with HIV in Benin, Burkina Faso, Burundi, Cabo Verde, Gabon, Senegal and Togo were accessing ART in 2017. However, in Nigeria which is home to 3.1 million people living with HIV, more than half of all people living with HIV in the region, coverage stood at 33% in 2017.

The region’s coverage rate is well below that of East and Southern Africa at 40%. Conflict and other disease epidemics are partly responsible for low ART coverage, although the high number of
people who do not know their status is a key barrier. Underlying factors such as the lack of national and international political will, weak health services, and lack of support for community organisations exacerbate the situation.89

Men are less likely than women to start treatment, and those who do begin ART are more likely to have advanced HIV progression. This disparity is thought to be due, in part, to harmful gender norms that lead men to view seeking HIV testing and treatment as a sign of weakness.90

Treatment services for children also are poor, as only 26% of the 500,000 0–14-year-olds living with HIV in the region received ART in 2017. This is the lowest regional paediatric ART coverage rate of any region in the world.91 It is estimated that 77% of people accessing treatment for HIV in West and Central Africa remain in care after 12 months.92

MSF found that patients who interrupt ART do not necessarily disclose this when they re-enrol. It cites data from a 2014 study in Kinshasa, DRC which found that 70% of people with HIV who attended a health clinic due to a severe illness had previously been on ART, of whom 52% had interrupted their treatment for longer than three months. The consequence of insufficient retention data, coupled with health staff’s often-limited knowledge of how to manage treatment failure, means the need to shift to second-line treatment is often missed. This is further compounded by second- or third-line ARVs being either scarce or unavailable.93

As a result of low testing, low ART coverage and issues with care retention, in 2017 only 29% of people living with HIV in West and Central Africa had achieved the viral suppression necessary to prevent onward HIV transmission.[94 However, only 2% of people on ART had received a viral load test, bringing these statistics on viral suppression into question.95

This region reflects the fact that global prevalence of HIV drug resistance (HIVDR) is rising, mainly due to resistance to first-line antiretroviral treatment regimes. Weak health systems and low levels of adherence are the main drivers.

Civil society’s role in West and Central Africa

In West and Central Africa, many non-government organisations (NGOs) concerned with protecting the rights of people living with HIV have seen a decrease in funding since the 2008 global recession. As a result, some have had to scale down or stop activities. For instance, since the World Bank ended support to the HIV projects in CAR in 2012, civil society associations of people living with HIV have been struggling to survive.96

Additionally, the fragmentation of civil society organisations into distinct language-speaking groups (primarily English and French) leads to constraints in exchanging experiences and support between countries in the region.97

People don’t understand HIV. They have a fear of taking the test because they think that if it’s positive, they will die straight away.

Albert, 55-year-old president of an MSF peer support group in Bukavu, South Kivu, DRC
HIV and tuberculosis (TB) in West and Central Africa

In 2016, six countries (DRC, Nigeria, CAR, Congo, Liberia and Sierra Leone) were classified by WHO as being among 30 with the highest tuberculosis (TB) burdens. Overall, 77,000 people with HIV died of TB-related deaths in 2016.

Barriers to HIV prevention in West and Central Africa

Stigma and discrimination

HIV-related stigma and discrimination remains a major barrier to tackling HIV in West and Central Africa.

People Living with HIV Stigma Index surveys conducted in the region between 2011 and 2015 suggest the proportion of people living with HIV experiencing insults, harassment and threats ranged from 15% in Sierra Leone to 70% in Cameroon. People reported being denied access to health services and reproductive health services because of their HIV status, with the proportion reporting such discrimination ranging from 1% in Benin to 21% in Nigeria.

To address this, the majority (88%) of countries in the region have some training programmes for healthcare workers on human rights. Of these, 25% are on a national scale.

The region remains a difficult place for key populations such as men who have sex with men. This hostile environment often prevents people from accessing HIV services. For example, following the passage of the Same-Sex Marriage Prohibition Act in Nigeria in 2014, a greater proportion of men who have sex with men in the country reported being afraid to seek healthcare.

Legal barriers

The criminalisation of sex work, drug use, and same sex practices, as well as the lack of legal recognition of gender identity, compounds key affected populations’ inability to access HIV services.

In Mauritania and Northern Nigeria, the death penalty exists for men who have sex with men. Homosexuality is also illegal in Cameroon, Gambia, Ghana, Guinea, Senegal, Sierra Leone and Togo.

Sex work is illegal in most countries in the region. However, in Senegal, women over the age of 21 may register and work legally as sex workers if they submit to periodic medical examinations. Male and transgender sex workers are not allowed to register. In addition to heavy regulations on legal sex work, Senegal retains criminal penalties for solicitation, brothel ownership, and procuring sex work. However, when sex workers register their files are sent to the police, which sex workers say facilitates harassment, abuse, and extortion at the hands of authorities.

Sex work is also legal in Burkina Faso, although profiting from others engaging in sex work is illegal.

In many countries in the region there are laws criminalising people who expose others to HIV or transmit the virus sexually. This fuels HIV-related stigma, which can cause significant barriers to accessing HIV prevention, treatment and care services.
Data issues

Monitoring of HIV-related information is weak in West and Central Africa. As a result, there are data gaps, questions about the validity of existing data, and a lack of quality available data, all of which hamper adequate programming.108

Data on key populations is also lacking, as many countries do not record consistent, national level data on these groups.

Weak healthcare systems

In 2016, 20 out of 25 countries in the region were classified as ‘fragile states’ by the Organisation for Economic Co-operation and Development, while eight were classified as ‘challenging operating environments’ by the Global Fund to Fight AIDS, Malaria and Tuberculosis, situations that greatly compromise health systems.109

Humanitarian crises such as the 2014-2016 Ebola epidemic in West Africa put yet more strain on already weak healthcare systems, with patients suffering as a result.110

The over-medicalisation of HIV service delivery, and inadequate decentralisation of healthcare services with little focus on community participation and community service delivery, pose further significant barriers to accessing HIV services and the quality of care.111

Weak supply systems in the region often result in stock-outs of ARVs, equipment and other commodities such as HIV testing kits. Up to 77% of healthcare facilities in Kinshasa, DRC reported stock-outs of at least one ARV during the previous three months in 2014. In addition, stock-outs of test kits over a three-month period resulted in an estimated 4,000 patients not being tested at their request. Although most of the commodities were available at central level, these stock-outs resulted in 68% of people living with HIV being sent away without the necessary medication.112

Funding the HIV response in West and Central Africa

Resources available in West and Central Africa to respond to HIV increased by 65% between 2006 and 2016, reaching an estimated US$2.1 billion. However, investment is lower than what is needed to achieve UNAIDS’ Fast-Track Targets by 2020.

Domestic funding for HIV reached its highest level in 2016. Côte d’Ivoire has been particularly active in increasing domestic funding, with Nigeria and Senegal due to increase domestic HIV funding in 2018.113

However, domestic funding accounted for just 35% of the total resources available for the region’s HIV response in 2016. Most of the countries remain highly donor dependent, although international funding is declining.114

The Global Fund to Fight AIDS, Malaria and Tuberculosis tends to be the major donor in the region, particularly for the provision of ARVs. For example, in 2016 a total of US$20 million was reprogrammed in existing Global Fund grants to cover essential treatment needs such as ARVs and test kits. This reliance creates a potentially precarious situation.115

There is concern that pressure to increase domestic funding could lead to policies that increase out-of-pocket expenses for people in the region through the introduction or expansion of user fees. Patient fees already represent one of the main barriers to care in West and Central Africa. For example, in DRC in 2012 households contributed 38% of all HIV spending. In Nigeria this figure stood at 31%, with 14.5% of annual household budgets spent on HIV services.116
The future of HIV in West and Central Africa

Tackling the HIV epidemic in West and Central Africa is a long-term task that requires sustained effort and planning from both domestic governments and the international community.

In 2016, the African Union and political leaders in the region endorsed the West and Central Africa ‘catch-up’ plan, which aims to drastically improve HIV treatment for adults and children by 2018 in order to meet UNAIDS 2020 Fast Track targets.117

Among the key strategies of the catch-up plan are increasing community involvement in care delivery; improving country ownership and political leadership for domestic HIV responses; task shifting; and investment in strengthening supply chains for commodities such as test kits, ARVs, early infant diagnosis kits and viral load kits.118

The plan has seen 10 countries (Benin, Cameroon, CAR, Côte d’Ivoire, DRC, Guinea, Liberia, Nigeria, Senegal and Sierra Leone) implement country operational plans to implement these strategies.119 Results from 2017 and 2018 will show whether these accelerated efforts have been effective.

However, without addressing fundamental barriers to treatment, particularly HIV-related stigma and discrimination and HIV-specific criminal legislation, the number of people getting tested for HIV and seeking treatment will remain compromised.

Girls and young women must also be placed at the centre of the response if the region is to reduce HIV. This involves meaningfully addressing gender inequality, tackling harmful traditional practices such as child marriage, and increasing educational opportunities.120

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115. MSF (2016) ‘Out of focus: How millions of people in West and Central Africa are being left out of the global HIV response’[pdf]
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