



Baseline Assessment – Cameroon

Scaling up Programs to Reduce Human Rights- Related Barriers to HIV and TB Services

2018
Geneva, Switzerland

Disclaimer

Toward the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics, 2017-2022*, this baseline assessment was commissioned by the Global Fund to Fight AIDS, TB and Malaria. It presents, as a working draft for reflection and discussion with country stakeholders and technical partners, findings of research relevant to reducing human rights-related barriers to HIV and TB services and implementing a comprehensive programmatic response to such barriers. The views expressed in this paper do not necessarily reflect the views of the Global Fund.

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Acronym List

ACAFEJ	Association Camerounaise des Femmes Juristes
ACHPR	African Commission on Human and Peoples' Rights
ACMS	Association Camerounaise pour le Marketing Social
AFASO	Association des Femmes Actives et Solidaires
AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral treatment
CAF	Central African Franc
CAMFAIDS	Cameroonian Foundation for AIDS
CAMNAFAW	Cameroon National Planning Association for Family Welfare
CHAMP	Continuum for Prevention, Care and Treatment of HIV/AIDS with Most at-risk Populations
CEDAW	Convention on the Eradication of Discrimination Against Women
CDT	Centre de diagnostique et de traitement
CNLD	Comité National de Lutte contre les Drogues
CNLS	Conseil National de Lutte contre le VIH/SIDA
CRS	Catholic Relief Services
CSO	Civil society organisations
DIC	Drop-In centres
DSF	Division de la Santé Familiale
FESADE	Femmes Santé et Développement
FGC	Female genital cutting
FGD	Focus group discussion
FIS	For Impacts in Social Health
FSW	Female sex workers
GBV	Gender-based violence
GFBC	Groupement de la Filière Bois au Cameroun
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GNP+	Global Network of People Living with HIV
HEARD	Health Economics and HIV/AIDS Research Division
HIV	Human immunodeficiency virus
HR	Human rights
IBBS	Integrated Biological and Behavioural Surveillance
ICN	Instance de Coordination Nationale
IGLHRC	International Gay and Lesbian Human Rights Commission
ILO	International Labour Organisation
INS	Institut National de la Statistique
IPPF	International Planned Parenthood Federation

JAPSSO	Jeunesse Active pour la lutte contre la Pauvreté, le VIH/SIDA et ses Souffrances
KII	Key informant interview
LGBT	Lesbian, gay, bisexual, transgender
LINKAGES	Linkages across the Continuum of HIV Services for Key Populations Affected by HIV
MINAS	Ministère des Affaires Sociales
MINDEFENSE	Ministère de la Défense
MINJEC	Ministère de la Jeunesse et de l'Éducation Civique
MINJUSTICE	Ministère de la Justice
MINPROFF	Ministère de la Promotion de la Femme et de la Famille
MINSANTE	Ministère de la Santé Publique
MOJ	Ministry of Justice
MOT	Modes of transmission
MPS	Minimum package of services
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
MSW	Male sex workers
NCHRF	National Commission on Human Rights and Freedoms
NSP	National Strategic Plan
OHCHR	Office of the High Commissioner for Human Rights
OVC	Orphans and other vulnerable children
PEPFAR	United States President's Emergency Plan For AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PNLT	Programme nationale de lutte contre la tuberculose
RéCAP+	Cameroonian Network of PLHIV Associations
TB	Tuberculosis
TWG	Technical working group
UKZN	University of KwaZulu Natal
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
US	United States
USD	United States dollar
USAID	United States Agency for International Development
WHO	World Health Organization

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I. Executive Summary

Introduction

This report comprises the baseline assessment regarding human rights-related barriers to access, uptake and retention in HIV and TB services in Cameroon. This assessment is one component of intensive support being provided by the Global Fund to Fight AIDS, TB and Malaria (Global Fund) to strengthen Cameroon's efforts to identify and remove such barriers for people living with HIV and other key and vulnerable populations who have insufficient access to HIV or TB services in the country.

Since the adoption of its strategy, *Investing to End Epidemics, 2017-2022*¹, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human-rights related barriers in national responses to HIV, TB and malaria. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants. The programs increase uptake of and retention in health services and help to ensure that health services reach those most affected by the three diseases.

In addition to the Global Fund, governments, technical partners and other experts have recognized the following program areas as key components and critical enablers of the HIV and TB response: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV; (e) legal literacy ("know your rights"); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV and TB.² Additional program areas for TB include (a) ensuring confidentiality and privacy related to TB diagnosis and treatment, (b) mobilizing and empowering TB patient and community groups, (c) addressing overly-broad policies regarding involuntary isolation or detention for failure to adhere to TB treatment, and (d) making efforts to remove barriers to TB services in prisons.

Though the Global Fund will support all countries to increase investment in these programs so as to remove human rights-related barriers to services, the Global Fund is providing intensive support to 20 countries to enable them to put in place comprehensive programs aimed at significantly reducing these barriers.³ Based on criteria involving needs, opportunities, capacities and partnerships in country, Cameroon has been selected as one of the countries to receive intensive support.

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in the *right combination* at the *right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.⁴

This assessment: (a) establishes a baseline of human rights-related barriers to HIV services and existing programs to remove them; (b) sets out a costed comprehensive program aimed at reducing these barriers; and (c) identifies next steps in putting this comprehensive program in place.

The assessment was conducted between May and June, 2017. In addition to a comprehensive desk review, it involved in-country interviews and round-table discussions with 41 entities

¹ *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

² See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also *Global Fund Technical Brief HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017)

³ *Ibid*, Key Performance Indicator 9.

⁴ This definition of "comprehensiveness" for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

representing 186 key informants. A series of focus groups discussions were also convened in country with representatives from key and vulnerable populations, including people living with HIV; gay, bisexual and other men who have sex with men; female sex workers; people who inject drugs; transgender men and women; members of the military; and young people.

Summary of baseline assessment findings – HIV

Key and vulnerable populations

The population groups included in the HIV component of the assessment were identified on the basis of epidemiological evidence, Global Fund criteria, the categories of ‘populations prioritaires’ in Cameroon's *Plan Stratégique National de Lutte contre le VIH, le Sida et les IST 2018-2022* (PSN HIV) (Conseil National de Lutte contre le VIH/SIDA [CNLS], 2017) and the findings of the desk review and in-country research of this assessment.

Table A, below, shows the key and vulnerable populations that the assessment addressed.

Table A: Key and vulnerable populations for HIV

Key populations HIV	Vulnerable populations HIV
<ul style="list-style-type: none"> ▪ People living with HIV ▪ Sex workers (male and female) ▪ Men who have sex with men ▪ People who inject drugs ▪ Prisoners ▪ Transgender people 	<ul style="list-style-type: none"> ▪ Adolescent girls and young women ▪ Uniformed services ▪ People with disabilities

Although issues for transgender people and male sex workers, to the extent that data was available, were included in the assessment, they are not yet recognised as key populations in the national HIV response, a situation that may itself be a human rights barrier (Nemanda, 2013).

Human rights-related barriers to HIV services

The assessment identified the following barriers to access, uptake and retention in HIV services for people living with HIV and other key and vulnerable populations:

- High levels of HIV-related stigma across the population and on-going instances of stigma and discrimination against people living with HIV, including in housing, employment and in their personal and social environments (though less so in health services).
- A legal and socio-cultural context that continues to be punitive, particularly for men who have sex with men, female and male sex workers, transgender people and people who inject drugs, limiting both these people’s willingness to access HIV services, and the effectiveness of current efforts to reach them, as, among other things, they do not wish to enter situations where personal information about them will become known without their consent.
- Gender-related socio-cultural attitudes and beliefs regarding adolescents and young people, particularly adolescent girls and young women, that deny that they are sexually active and that limit their ability to access HIV and other sexual and reproductive health information and services. Similar attitudes and beliefs regarding people with disabilities also affect their access to HIV services.

- Rigid gender norms that, in addition to fuelling gender-based violence against women and girls, also drive sexual and physical violence and abuse against key populations, particularly men who have sex with men, female sex workers and transgender people. Comprehensive responses to this gender-based violence remain inadequate, including those that seek to link survivors of such violence to HIV services.

Programs to address barriers to HIV services – from existing programs to comprehensive programs

In response to these challenges, a range of stakeholders is engaged in interventions to address and remove human rights and gender-related barriers to HIV services. These efforts include work by key-population-led organisations to reduce stigma and discrimination, including self-stigma; training of health care workers on HIV and other health needs for key populations; legal literacy interventions and provision of legal services; work to engage the police, judiciary and local leadership to understand and support the importance of access to HIV services for key populations; and, improved responses to gender-based violence.

Despite these interventions, a number of challenges and gaps remain:

- There are no specific, HIV-related services for people who inject drugs or for transgender people
- Interventions to address and remove barriers are almost exclusively dependent on external funding. Other than supportive policy commitments, there is little active engagement on the part of government stakeholders, including the National Commission on Human Rights and Freedoms, to ensure that such commitments are implemented.
- Due in part to inadequate funding and other factors, a number of efforts by key-population-led organisations have not been implemented at sufficient scale or continued over sufficient periods of time to bring about sustained, positive improvement for their constituencies to remove barriers to HIV services.
- Coordination and collaboration remain challenging, with a number of entities implementing similar programs that, in some cases, overlap geographically or within target populations.
- There is almost no evaluation of interventions that address human rights and gender-related barriers to HIV services, particularly with regards to how this work affects access and uptake of HIV services for the target populations.

Based on the assessment findings, the report outlines a 5-year comprehensive approach that includes in summary the following efforts to address human rights-related barriers to HIV services:

- Addressing critical evidence gaps relevant to human rights-related barriers experienced by specific key populations (transgender people, people who inject drugs) and impacting trends in uptake and retention in HIV services for all key population groups;
- Scaling up multi-sectoral interventions to address stigma and discrimination for people living with HIV;
- Improving and expanding efforts to address HIV-related stigma within and amongst other key populations;
- Addressing challenges of self-stigma amongst key populations through interventions to strengthen personal and collective resilience;
- Strengthening the accountability of the CNLS to facilitate and ensure inter-ministerial and multi-sectoral collaboration and commitment to a human rights-based approach to the provision of HIV services for key populations as provided for in the new PSN HIV;

- Support to collaboration, coordination and coordination mechanisms among key and vulnerable populations with regard to their human rights-related programming for greater coverage and accessibility, and for greater effectiveness to remove barriers;
- Support to evaluation, learning and continuous improvement for the design and delivery of interventions to remove barriers; and
- Making the case for sustained investment of needed technical and financial resources to ensure that the approach can be fully implemented.

What a comprehensive program will cost – HIV

The assessment describes these comprehensive approaches in more programmatic detail in **Annex A** as well as a monitoring framework for follow-up assessments to measure progress (**Annex C**). Finally, the assessment calculated a prospective cost to implement the comprehensive approach. This is shown in **Table B** below:

Table B: Estimated funding needs for comprehensive programming to address human rights-related barriers to HIV services (US\$)

Programme Area	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Stigma and discrimination reduction	1,105,987	509,678	844,233	418,535	906,706	3,785,140
Training of health care workers on human rights and medical ethics	223,930	337,335	146,148	97,623	271,217	1,076,252
Sensitisation of law-makers and law enforcement agents	300,328	134,590	263,240	131,130	263,240	1,092,528
Legal literacy	70,389	36,661	51,008	52,466	51,008	261,533
HIV-related legal services	294,639	197,105	197,105	276,566	180,737	1,146,152
Monitoring and reforming laws and policies	349,004	247,886	185,038	189,278	151,897	1,123,104
Reducing HIV-related discrimination against women	571,946	490,207	431,123	402,452	490,207	2,385,935
Other activities	8,820	379,774	507,199	379,774	507,199	1,782,766
TOTAL	2,925,043	2,333,236	2,625,094	1,947,825	2,822,211	12,653,408

The limited financial data captured by the assessment suggested that, between 2015 and 2016, the level of funding for interventions to address human rights-related barriers to HIV was between US\$400,000 and US\$600,000 annually, including from the Global Fund and other sources. This does not include PEPFAR investments for such interventions as these could not be disaggregated from the main funding amounts for key population-focussed programming. Sustained over 5 years, this would amount to a total of US\$3 million which is significantly lower than the projected US\$12.6 million needed to fully implement a comprehensive approach to human rights-related barriers to HIV services. During the 2018-2020 period, the country will allocate approximately US\$3.5 million in Global Fund resources to support expanded efforts to remove human rights barriers to HIV services. Thus, additional investments will be needed from the country and donors to reach the estimated cost of the comprehensive approach

Summary of baseline assessment findings - TB

The assessment found that the population groups that experience human rights-related barriers to TB services include people living with HIV, health care workers, prisoners and other detainees, prison workers, and people who inject drugs. These were identified on the basis of epidemiological evidence, Global Fund criteria, and the categories of '*populations prioritaires*' in Cameroon's *Plan stratégique de lutte contre la tuberculose au Cameroun 2015-2019* (PSN TB) (Programme nationale de lutte contre la tuberculose [PNLT], 2014).

In relation to these groups, the assessment identified the following human rights-related barriers to access, uptake and retention in TB services:

- Overall, across the national TB response, the concepts of human rights and gender-related barriers to TB services were not well understood. TB was largely considered a medical issue, and barriers were conceived of as those related to health-system weaknesses and the limited capacity of the PNLT to screen, diagnose and treat individuals with TB.
- People who inject drugs are not recognized as a key population within the national TB response, and therefore there are no specific services or approaches to address their needs.
- TB-related stigma, including self-stigma, inhibits individuals who may be living with TB from acknowledging the signs and symptoms of the disease and delays their seeking diagnosis and treatment at health facilities.
- Efforts to address TB-related stigma in prisons do not cover all facilities and access to needed health services is not consistent, particularly for the high proportion of transient, pre-trial detainees.
- Poverty remains a barrier to TB services, largely because there are user fees.

Programs to address barriers to TB services – from existing programs to comprehensive programs

There are some current interventions underway to address human rights-related barriers to TB services, including work within prisons, and the training and sensitisation of health care workers on stigma reduction and human rights. However, the community component of the national TB response, which is *inter alia* meant to address stigma and discrimination, is not fully operational. TB issues are not well addressed within efforts to deal with human rights-related barriers to HIV services despite a sizeable level of co-infection. Finally, addressing poverty-related barriers requires a comprehensive, multi-sectoral effort that appears to be well beyond the scope of what TB stakeholders are currently able to undertake.

A comprehensive approach to addressing human rights-related barriers in the context of TB should include:

- Sensitization of TB stakeholder towards a stronger technical grasp of the human rights and gender-related dimensions of TB;
- Full operationalisation of the human rights-related interventions of the community component of the national TB response, with the National TB Coalition as the entry point;
- Support to coordination/collaboration mechanisms across efforts to address TB-related stigma and discrimination;
- Support to human rights literacy and advocacy towards stronger ownership and accountability on the part of the Ministry of Justice to address TB in prisons, including the investment of more of its own resources in this effort;
- Human rights literacy and advocacy regarding the need for stronger workplace protections for prison staff and health care workers
- Human rights literacy and advocacy regarding the removal of user fees for TB diagnosis and treatment; and,

- Support to integration of efforts to address human rights-related barriers to HIV and TB services where relevant and possible.

Needed investments to support the comprehensive approach

The assessment describes in a more programmatic manner these comprehensive interventions to address human rights-related barriers to TB services in **Annex B**, as well as a monitoring framework for follow-up assessments to measure progress (**Annex C**). Finally, the assessment calculated a prospective cost to implement the 5-year comprehensive approach. This is shown in **Table C**, below:

Table C: Estimated funding needs for comprehensive programming to address human rights-related barriers to TB services (US\$)

Programme Area	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Stigma and discrimination reduction	392,774	267,705	186,000	267,705	392,774	1,506,957
Training of health care workers on human rights and ethics	29,910			29,910		59,821
Sensitisation of law-makers and law enforcement agents	71,874	-		71,874	-	143,748
Legal literacy	106,584	88,040	-	106,584	-	301,209
TB-related legal services	146,320	146,320	146,320	146,320	146,320	731,600
Monitoring and reforming laws and policies	8,820	8,820	8,820	8,820	8,820	44,100
Reducing discrimination against women in the context of TB	96,115		-	96,115	-	192,230
Improving confidentiality and privacy	-	90,386	-	-	-	90,386
Community mobilisation for people living with TB	54,699	54,699	54,699	54,699	54,699	273,494
Improving TB services in prisons	48,767	132,206	-	-	33,077	214,050
Other activities	-	370,954	-	243,529	-	614,483
TOTAL	955,863	1,159,130	395,839	1,025,557	635,690	4,172,078

The assessment was not able to capture all data on current investments to address human rights-related barriers to TB services. Available data suggest that this funding reached a level of US\$150,000 in 2016, included what was available through the Global Fund. There is some distance to go, then, for all stakeholders to mobilise the approximately US\$200,000-US\$500,000 per year that will be needed to fully implement a comprehensive approach to these barriers.

II. Introduction

This report comprises the baseline assessment carried out in Cameroon as part of efforts by the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) to support Cameroon to scale-up programmes to reduce human rights-related barriers to HIV and TB services. Since the adoption of the Global Fund *Strategy 2017-2022: Investing to End Epidemics*, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investments in programmes (described below) to remove such barriers in national responses to HIV, TB and malaria (Global Fund, 2016a). This effort is grounded in Strategic Objective 3 which commits the Global Fund to: “*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria services*”; and, to “*scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities*.” The Global Fund has recognized that programmes to remove human rights barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

Though the Global Fund will support all countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of its corporate Key Performance Indicator (KPI) 9: “*Reduce human rights barriers to services: # countries with comprehensive programs aimed at reducing human rights barriers to services in operation (Global Fund, 2016b)*.” This KPI measures, “*the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries*.” Based on criteria that included needs, opportunities, capacities and partnerships in the country, the Global Fund selected Cameroon, with 19 other countries, for intensive support to scale up programs to reduce barriers to services. This baseline assessment for Cameroon, focusing on HIV and TB, is a component of that support.

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in the *right combination* at the *right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.⁵

Objectives and Expected Results

The objectives of the baseline assessment were to:

- Identify the key human rights and gender-related barriers to HIV and TB services in Cameroon;
- Describe existing programs to reduce such barriers;
- Based on data concerning country realities, describe a comprehensive response to existing barriers in terms of the types of programs, their coverage and costs; and,
- Identify the opportunities to bring these to scale over the 5-year period of the Global Fund’s 2017-2022 strategy.

Overall, the results of the assessment are meant to provide a baseline of the situation as of 2017 in Cameroon. This effort will be followed up by similar assessments at mid- (2019) and end-points (2022) of the Global Fund’s strategy in order to capture the impact of the scale up of programs to remove barriers in Cameroon and in those other countries included in the initiative.

⁵ This definition of “comprehensiveness » for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

III. Methodology

The baseline assessment for Cameroon was conducted between May and June 2017 according to the methodology described below.

Conceptual framework

The conceptual framework that guided the assessment was as follows:

- In Cameroon, as in other countries regionally and globally, there exist human rights and gender-related barriers to full access to, uptake of and retention in HIV and TB services.
- These barriers are experienced by certain key and vulnerable populations who are more vulnerable to and affected by HIV and TB than other groups in the general population.
- There are human rights programme areas comprising several interventions and activities that are effective in removing these barriers.
- If these interventions and activities are funded, implemented and taken to sufficient scale in the country, they will remove, or at least significantly reduce, these barriers.
- The removal of these barriers will increase access to, uptake of and retention in HIV and TB services and thereby accelerate country progress towards national, regional and global targets to significantly reduce or to bring an end to the HIV and TB epidemics.
- These efforts to remove barriers will also protect and enhance Global Fund investments and will strengthen health and community systems.

The main categories of human rights and gender-related barriers to HIV and TB services that the assessment addressed were (Global Fund, 2017a, b; Timberlake, 2017):

- Stigma and discrimination, including within the provision of health services;
- Punitive laws, policies, and practices;
- Gender inequality and gender-based violence;
- Poverty and socio-economic inequality; and,
- Harmful working conditions and exploitation (mainly for TB).

Governments, UNAIDS, the Global Fund, and the Stop TB Partnership have identified the following main program areas by which to address and remove human rights-related barriers to HIV and TB (UNAIDS, 2012; Global Fund, 2017a,b; *Political Declarations on HIV/AIDS*, 2011, 2016):

- Stigma and discrimination reduction
- Training for health care workers on human rights and medical ethics
- Sensitization of law-makers and law enforcement agents
- Legal literacy (“know your rights”)
- HIV- or TB-related legal services
- Monitoring and reforming laws, regulations and policies relating to HIV and TB, and
- Reducing discrimination against women in the context of HIV and TB.

In addition for TB, program areas include:

- Ensuring confidentiality and privacy related to TB diagnosis and treatment
- Mobilizing and empowering TB patient and community groups
- Addressing overly-broad policies regarding involuntary isolation or detention for failure to adhere to TB treatment, and

- Making efforts to remove barriers to TB services in prisons.

Activities under these program areas should be integrated into ongoing HIV and TB prevention and treatment programs where possible, or can be implemented as stand-alone programs, so as to support the national response and increase access to HIV and TB health services.

Key and vulnerable populations included in the assessment

The specific populations included in the assessment as most affected by human rights-related barriers were identified by taking into account the following:

- Global Fund and Stop TB Partnership criteria for identifying key and vulnerable populations for HIV and TB (Global Fund, 2013; Global Fund, 2017b)
- Epidemiology of HIV and TB
- Key and vulnerable populations as identified in national strategic documents, particularly the *Plan Stratégique National de Lutte contre le VIH, le Sida et les IST 2018-2022* (PSN HIV) and the *Plan stratégique de lutte contre la tuberculose au Cameroun 2015-2019* (PSN TB) (Conseil National de Lutte contre le VIH/SIDA [CNLS], 2017; Programme nationale de lutte contre la tuberculose [PNLT], 2014a); and the
- Data compiled from the desk review and in-country research during this assessment.

Based on these criteria, the population groups considered as experiencing human rights-based barriers to HIV and TB services are shown in **Table 1**, below:

Table 1: Key and vulnerable populations for HIV and TB included in the assessment

Key populations HIV	Vulnerable Populations HIV	Key populations TB
<ul style="list-style-type: none"> ▪ People living with HIV ▪ Male and female sex workers ▪ Men who having sex with men ▪ People who inject drugs ▪ Prisoners ▪ Transgender people 	<ul style="list-style-type: none"> ▪ Adolescent girls and young women ▪ Uniformed services ▪ People with disabilities, including women and girls with disabilities 	<ul style="list-style-type: none"> ▪ People living with HIV ▪ Health care workers ▪ Prison workers ▪ Prisoners and other detainees ▪ People who inject drugs

Although issues for transgender people and male sex workers, to the extent that data were available, were included in the assessment, these groups are not yet recognised as key populations in the national HIV response. Similarly, the assessment also considered people who inject drugs as a key population for TB although this group is not included as such in the national TB response. While the populations included in the assessment are not the only population groups that are prioritised under the national HIV and TB responses, they are, nevertheless, those groups whose access to HIV or TB services is most affected by human rights or gender-related barriers.

Data collection and analysis

Data collection and analysis involved the following steps:

- **Desk review**--A comprehensive desk review was conducted of sources in English and French describing the context for HIV and TB in Cameroon; sub-populations and groups most affected by the two diseases; human rights and gender-related barriers to HIV and

TB services for these groups; and, the country's efforts to address and remove these barriers. Sources used for the desk review ranged from peer-reviewed publications, to national documents (plans, policies, strategies and progress reports), to reports produced by the many different stakeholders involved in efforts to address and remove barriers. A national consultant assisted the technical team at HEARD to compile the desk review and to ensure that all available documentation was included. A desk review report was prepared, including a bilingual Executive Summary that was shared with key stakeholders as part of the planning for the fieldwork phase.

- **Development of fieldwork priorities and the fieldwork plan**--Based on the results of the desk review, specific priorities for in-country data collection were defined. These then informed the development of a fieldwork plan in consultation with the national consultant and the Country Coordinating Mechanism (Instance de Coordination Nationale (CCM or ICN)) and the Comité nationale de lutte contre le VIH/SIDA (CNLS). The fieldwork plan included key informant interviews (KII), round-table discussions, and focus group discussions (FGD) convened by local partners with members or representatives of key or vulnerable populations.
- **In-country data collection**--In-country data collection took place between 22 May and 16 June 2017. Data collection was conducted in both English and French depending on the preferences of the participants. The Cameroon National Association for Family Welfare (CAMNAFAW) and the CNLS provided logistical support for data collection. Preliminary meetings were held with the ICN and CNLS prior to data collection. In addition, an Inception Meeting was convened to present the objectives of the baseline assessment and the data collection plan to key stakeholders for their input and participation.

Overall, 41 entities (19 CBOs, 5 NGOs, 10 ministries and government agencies, including CNLS), 6 multi-lateral and bilateral agencies, and selected members of the ICN participated in the data collection, representing a total of 186 key informants (87 from CBOs, 17 from NGOs, 53 from ministries and government agencies, 9 from multi-lateral and bilateral agencies, and 20 members of the ICN). In addition, seven FGDs were convened with representatives from key or vulnerable populations, including people living with HIV, men who have sex with men, female sex workers, people who inject drugs, transgender people, members of the military and young people.

As a final step, during the last week of in-country data collection, high-level preliminary observations were shared in two sessions. The first was a meeting of the ICN where, amongst other agenda items, a first set of priorities for inclusion in the next Global Fund funding request was considered. The second was a meeting convened by the assessment team with stakeholders who had participated in the data collection in order to share high-level, preliminary findings and tentative recommendations for further review and discussion with them.

- **Collection of financial data.** The assessment identified investments in recent or current programmes to reduce human rights and gender-related barriers for HIV or TB. This data was then used to inform the costing of the comprehensive approach. Collection of financial data involved administering a resource-tracking tool which was either self-administered or done as part of a site visit. Challenges regarding data collection are described in **Section 8**, below.
- **Data analysis** involved mainly thematic analysis of documents and interview notes according to the key themes and concepts set out in the conceptual framework.

The assessment was conducted by a consultancy team comprised of a lead researcher from the Health Economics and AIDS Research Division (HEARD) of the University of KwaZulu Natal (UKZN) and five national consultants. Overall ethics clearance (for the five assessments HEARD is conducting) was provided by UKZN. During the fieldwork-planning phase, the ICN advised that this type of assessment did not require country-level ethics clearance.

IV. Baseline Findings: HIV

The findings for HIV are presented below in the following sequence: an overview of the HIV epidemic in Cameroon, with specific attention to the key and vulnerable populations included in the assessment; information on trends in access and uptake of HIV services to illustrate the extent of current gaps; an overview of the general context for the HIV response with a particular focus on the components addressing human rights and gender; an analysis of human rights-related barriers to HIV services; an analysis of current programmatic efforts to address barriers, including gaps, challenges, and a description of a comprehensive approach; and, finally, an analysis of opportunities for scaling up current efforts towards the comprehensive approach over a 5-year period.

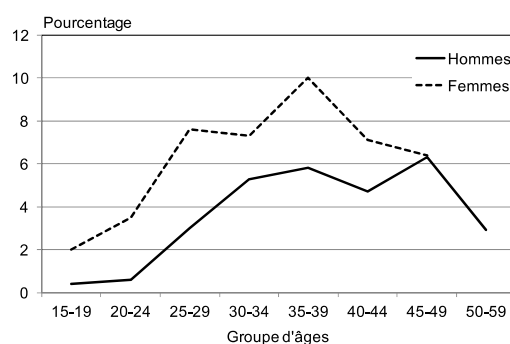
The findings show that, even though the general context for the HIV response in Cameroon is slowly becoming more enabling, key and vulnerable populations who carry the highest burdens of HIV disease continue to experience human rights and gender-related barriers to HIV services. The main barrier is the punitive legal context experienced by female sex workers, men who have sex with men and people who inject drugs which continues to fuel stigma, discrimination and violence, including abusive practices by the police and others. This in turn drives individuals away from HIV and other services, including those provided through key-population-led entities. Although there is growing commitment on the part of the government and others to improve access to HIV services for these groups, without changes in the legal and socio-cultural context, many individuals will still not come forward to use them. While there are current interventions in the country to address these barriers, they are not yet implemented at sufficient scale and scope to sustain positive change.

Overview of epidemiological context and key and vulnerable populations

Cameroon continues to experience a mixed HIV epidemic with significant epidemiological dynamics in both the general population, and amongst key and vulnerable populations. In 2016, across a population of 23.4 million, there were approximately 32,000 new HIV infections and 29,000 AIDS-related deaths (UNAIDS, 2017). For new HIV infections, 53% occurred amongst adult females (15-65 years) and 12.5% amongst children of both genders (0-14 years). Also in 2016, there were an estimated 560,000 people living with HIV, 59% of which were adult females and 14% children.

In the same year, the adult HIV prevalence was estimated at 3.8% - 2.5% for males and 5.1% for females (UNAIDS, 2017). More specific disaggregated data by age and sex come from 2011. **Figure 1**, below, shows the differences in HIV prevalence by age and gender from that year.

Figure 1: HIV prevalence by age and gender (2011)

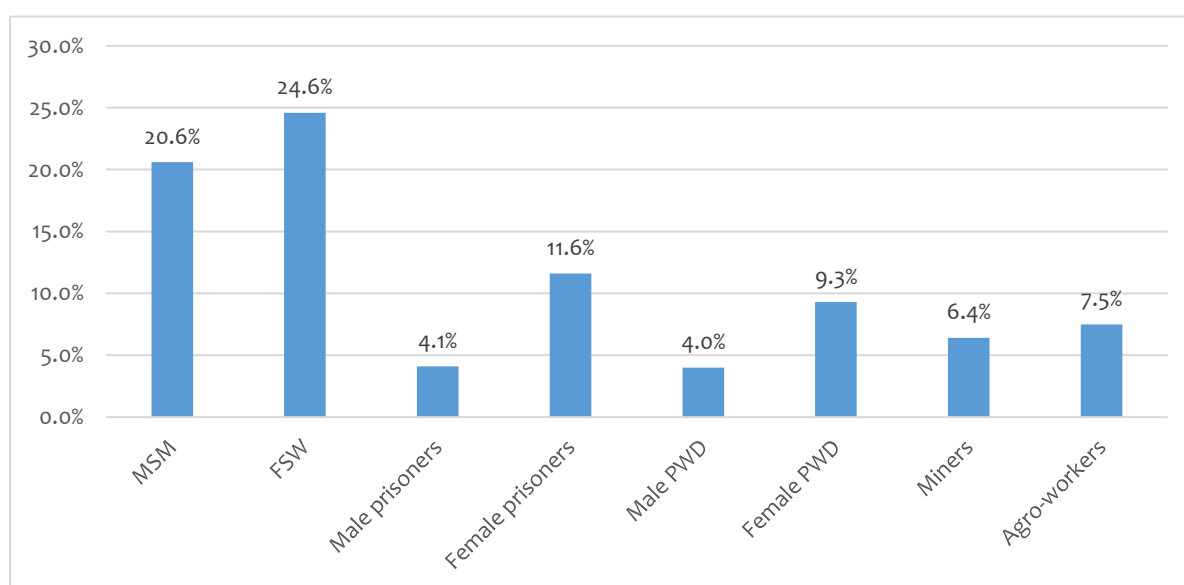


Source: Institut National de la Statistique (INS) et ICF International (2012)

HIV prevalence was significantly higher for females than for males in all age groups. The data showed that amongst adolescents and young people aged 15-24, it was 1.7% overall but as high as 5% amongst females. In the 15-19 and 20-24 age categories, there were between five and six times as many girls and women as there were boys and men who were infected (2.2% versus 0.4%, and 3.5% versus 0.6%, respectively) (INS and ICF, 2012). Similar differences were found across geographic regions where, for example, HIV prevalence reached 8.5% and 6.5% for adolescent girls and young women in the South and East regions, respectively, as compared to only 1.3% for their male counterparts in both regions.

HIV prevalence data for other key populations comes from different time periods and different sources. **Figure 2**, below, summarizes information from studies, national documents and programme reports to give a very general indication of prevalence trends.

Figure 2: Comparative data on HIV prevalence for key and vulnerable populations



Sources.⁶ PWD=people with disabilities.

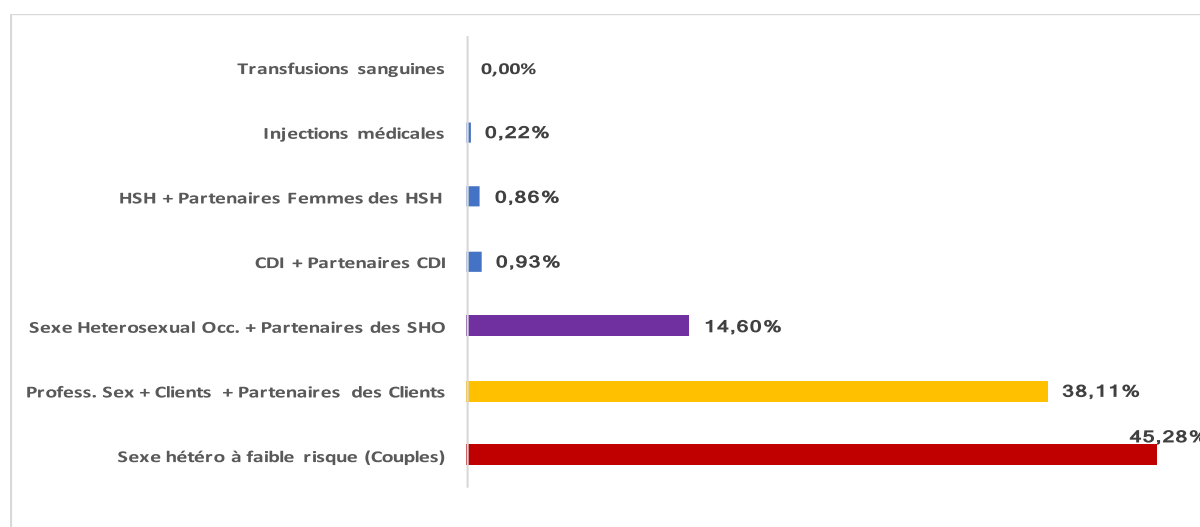
Amongst all groups, HIV prevalence was highest amongst female sex workers (there is no specific prevalence estimate for male sex workers), followed by men who have sex with men. In 2016, national HIV prevalence was 24.3% for female sex workers and 20.6% for men who have sex with men; however, as with general population prevalence trends, there were significant geographic variations ranging from 33% in Bamenda and 30% in Douala to 15% in Kribi for female sex workers; and, from 45% in Yaoundé and 25% in Douala to 3.8% in Bamenda for men who have sex with men. Country stakeholders are continuing to work to understand these variations. Most notably for men who have sex with men, HIV prevalence did not change significantly between 2011 and 2016 in Douala and Yaoundé (24.2% versus 25.7% in Douala, and 43.3% versus 45.1% in Yaoundé) (Johns Hopkins University et al., 2017).

⁶ Sources: MSM and FSW (Johns Hopkins University et al., 2017); male/female people with disabilities (PWD) (Beaudrap et al., 2017); male/female prisoners (GIZ 2013); miners/agro-workers (Noeske et al., 2014).

HIV prevalence is also higher than the general population amongst some other key or vulnerable populations, especially female prisoners,⁷ female people with disabilities, miners, and agro-workers (Noeske et al., 2014; GIZ, 2013). Recent data on HIV prevalence and behaviour amongst people with disabilities have shown that increased vulnerability to violence, including sexual violence; high rates of transactional sex driven by poverty; and low levels of knowledge about HIV and HIV risks are factors in higher HIV prevalence amongst disabled females (De Beudrap et al., 2017).

A Modes of Transmission (MOT) analysis was conducted in 2013. **Figure 4**, below, summarizes the results:

Figure 4: MOT results for 2013 (CNLS, 2014)



HSH=hommes ayant des relations sexuelles avec hommes (MSM); CDI=consommateurs de drogues injectables (PWID); SHO=sexe hétérosexuel occasionnel [casual sex].

Approximately 40% of all new infections in 2013 were estimated to have come from key populations, the majority from female sex workers and their clients and partners. The highest proportion, 45%, occurred amongst stable heterosexual partnerships. Estimates of new HIV infections use population size estimates as one parameter. According to key informants, the population size estimate for men who have sex with men in 2013 was extremely low, at 7,000 countrywide. This would underestimate the number of new infections occurring within this group. In addition, the MOT methodology does not account for overlaps between groups such as how many men in stable heterosexual unions would also be clients of female sex workers, or occasional partners of men who have sex with men.

Finally, there is no HIV prevalence data for transgender people or people who inject drugs. With regards to drug use, it is important to note that in the recent IBBS surveys of men who have sex with men and female sex workers, 9% of men who have sex with men participants had used an injectable substance of which 45.8% reported sharing needles. Amongst female sex workers, 2% had used an injectable substance (not defined in the study results) of which 16% reported sharing needles. The lifetime use of 'illicit' drugs (not defined in the study results) in Cameroon reached 31.9% of men who have sex with men and 59.6% of female sex

⁷ The prevalence estimate for female prisoners was derived through programme data for HIV testing in 10 prisons (8 of 69 female prisoners accepting to be tested were found to be HIV-positive). It should therefore be interpreted with caution. There was no analysis in the report as to why the prevalence was higher (GIZ 2013).

worker participants. Finally, 16.8% of female sex workers and 5.7% of men who have sex with men participants reported that they had sexual partners who injected drugs (Johns Hopkins University et al., 2017). Amongst key informants working with men who have sex with men, female sex workers and people who inject drugs, injection drug use was perceived to be increasing in these groups (KIIs with MSM, FSW and PWID CSO leaders, May-June, 2017).

Overall, where data is available, HIV prevalence is substantially higher in key population groups, especially men who have sex with men and female sex workers, compared to general population trends. Coupled with low access and uptake of HIV services, as discussed below, the situation in Cameroon for key populations with regards to HIV continues to be serious.

Current trends in access and uptake of HIV services

Coverage and uptake of core HIV services are low overall in Cameroon. In 2014, for example, the latest year for which data is available, although 88% of adult males and 83% of females knew where to obtain an HIV test, only 22% and 25%, respectively, had done so in the previous 12 months. For adolescents and young people, 30,7% of sexually active females and 22,5% of males had obtained an HIV test in the same time period.

In 2016, it was estimated that 58% of all adults and children living with HIV knew their status (UNAIDS, 2017). ART coverage reached 37% of all people living with HIV, which was 38% of all adults and 18% of all children. Treatment coverage was higher for adult females at 42% versus 32% for males (ibid.) Of all people on ART, 52% were virally suppressed based on a 14% coverage rate for viral load testing (ibid.). Coverage of the prevention of mother-to-child transmission of HIV (PMTCT) programme reached 74% in the same year (UNAIDS Spectrum Estimates, 2017). The latest cohort analysis results were from 2015 and indicated a retention rate of only 60% after 12-months on ART (CNLS, 2016).

With regard to men who have sex with men and female sex workers, data is more limited. In 2016, for men who have sex with men, 72,5% had ever received an HIV test with 93% knowing their results; 55% had done so in the past 12 months. Of the 13% of study participants that self-disclosed as people living with HIV, 97% were currently on ART. However, it is very important to note that 60% of participants with HIV-positive test results (through anonymous linked HIV testing) had indicated in their questionnaires they believed themselves to be HIV-negative, a finding that shows the significant gap in uptake of HIV testing for this population.

Amongst female sex workers, the findings for 2016 were generally similar with higher uptake of HIV testing. Amongst study participants, 92% had ever received an HIV test with almost all (97%) knowing their results; 60% had received an HIV in the past 12 months. Of the 15% who self-disclosed as living with HIV, 81% reported ever initiating ART of which all were still on treatment. However, 48% of participants with HIV-positive test results had indicated they believed themselves to be HIV-negative, a finding that appears to contradict what participants recorded as high rates of HIV-testing and knowledge about their status.

There is no other current data on access and uptake of services for key and vulnerable populations, a situation that should be addressed in order to more accurately determine the extent of service gaps and what progress can be made to resolve them by removing human rights or gender-related barriers.

Overview of country context relevant to human rights -related barriers to HIV services

The findings under this section describe the country context for Cameroon with regard to human rights-related barriers to HIV services. They address law, policy and strategy issues as well as more general considerations regarding the political and socio-cultural context for HIV and key populations. While key population groups and their human rights and gender-related concerns are recognised in a number of key policy documents for HIV, the broader legal and socio-cultural context remains largely punitive for these groups and continues to impede the growing number of efforts to improve access and uptake of HIV services for them.

Legal Framework for HIV-related Human Rights

The rights and entitlements of Cameroonian citizens are set out in the Constitution (République du Cameroun, 1996). Although the right to health is not specifically addressed in the Constitution, the Government of Cameroon routinely affirms its commitment to this right and reports on efforts aimed at fulfilling it for its citizens (Ministry of Justice (MOJ), 2016).

The Government of Cameroon has signed, ratified, or acceded to 42 international treaties or conventions. These included all the major United Nations human rights instruments as well as those governing African States under the African Union (MOJ, 2016). According to reports submitted to the United Nations (UN) Human Rights Council and the African Commission on Human and People's Rights (ACHPR), the country has made slow but steady progress to domesticate its regional and international commitments into laws, policies and practices (ACHPR, 2013; UN Human Rights Council, 2013). Currently, the Ministry of Justice is implementing a *National Plan of Action for the Promotion and Protection of Human Rights in Cameroon (2015 - 2019)* to accelerate this progress and to address some of the concerns these bodies have raised (MOJ, 2015). However, nothing in the plan specifically addresses populations key to the HIV epidemic.

There are specific laws governing the provision of health services, including the obligation of health care workers to provide services to those in need (Article 2 of the *Décret N°83-166 du 12 Avril 1983 portant code de déontologie des médecins*) and the imposition of penalties for those who refuse to do so (Article 140 of the *Penal Code*). However, the assessment found no specific instances where legal action had been brought under these provisions, and there has been no interpretation of them in the context of refusing to provide medical services to key population groups.

Other than a general framework law regarding the health system (*Loi n°96/03 du 4 janvier 1996 portant loi cadre dans le domaine de la santé*) which, under Article 4, envisions the creation of programs to address "*les grandes épidémies*", including HIV, TB and malaria, and the Cabinet decision in 2002 to create national coordinating mechanisms for the three diseases, including the CNLS, there are no other HIV-specific legal instruments in Cameroon. There were mixed views expressed by key informants in this regard. Some were of the view that HIV-specific legal instruments were not necessary (KII with human rights lawyers, June 2017). Others continued to stress the need for a more specific law or legal framework protecting the rights of people living with HIV (KIIs with UNAIDS, and PLHIV networks, May-June, 2017).

With regard to population-specific provisions that can directly or indirectly enable access to HIV services, the assessment found the following:

- **Prison inmates**--Legal and regulatory provisions governing the administration of prisons, as well as the treatment of individuals in temporary detention, stipulate that it is the responsibility of the Ministry of Justice to provide access to health services for detainees, either within prison facilities or in adjacent public facilities (Articles 32 and 33 of the *Décret n°92-052 du 27 mars 1992 portant régime pénitentiaire au Cameroun*; and, Articles 122 and 123 of the *Code de procédure pénale*).
- **People who inject drugs** --Although the legal context regarding drug use is very proscriptive and largely punitive, there does exist a provision, Article 113 of the *Loi n°97-019 du 7 août 1997 Code des drogues*, regarding sentencing for criminal conviction that allows an accused to opt for enrolment in a drug treatment programme to either replace or reduce the proposed sentence (according to key informants, however, such opportunities are limited to one centre in Yaoundé).
- **People with disabilities**--The rights and entitlements of people with disabilities in Cameroon are articulated in the *Loi n°2010/002 du 13 Avril 2010*. Among the numerous provisions, the law guarantees access for them to all public spaces and services, including health services. Article 7 further specifies that the state must take measures to protect this group from epidemic diseases; however, there is no specific mention of HIV or TB. Article 46 makes it an offence to refuse services to a person with a disability.
- **Refugees and asylum seekers**--Cameroon, in its own laws, and as part of its participation in international and regional frameworks for the protection of refugees and asylum seekers, provides for access to health services for these groups, both while they await status determination and once they have received asylum (Article 8 of the *Loi n°2005/006 du 27 juillet 2005 portant statut des réfugiés au Cameroun*). How these provisions apply in the context of access to HIV or TB services could not be determined through the assessment.
- **Orphans and other vulnerable children**--Cameroon has a number of laws aimed at protecting children, including vulnerable children (a child is defined as someone below the age of 18). These include compulsory schooling up to the age of 14; prevention of child labour; prevention of child trafficking; special treatment of children in conflict with the law; and, provisions for state protection of orphaned children and for state support for health and social services. The state's ability to effectively apply these laws, however, remains challenging, according to key informants.
- **Adolescents and young people, including adolescent girls and young women**--The legal framework for their protection is both extensive and contradictory. On the protective side, in addition to the provisions protecting children noted above, the age of legal capacity remains 21 in the country and, within the *Penal Code*, there are provisions against sexual relations with minors, particularly those between the ages of 16 to 21. In the most recent amendment to the *Penal Code*, forced marriage (including for children), female genital mutilation, and breast ironing were criminalised. The extent to which these provisions can be effectively implemented country-wide remains limited.

HIV-related Policies, Strategies and Guidelines

Starting in 2011, the national strategic plans (NSPs) on HIV began to explicitly address the needs of key and vulnerable populations, including men who have sex with men, female sex workers, people who inject drugs and prisoners, with a call for targeted interventions governed by principles of gender equality, respect for human rights and barrier-free access to health

services (CNLS, 2010; Mossus-Etounou et al., 2016). This focus was intensified in the 2014-2017 NSP (CNLS, 2013).⁸ Factors that drove these changes included, first and foremost, sustained advocacy by key population constituencies; results of the first IBBS surveys amongst female sex workers and men who have sex with men conducted in 2010-11; and the influence of Global Fund, PEPFAR, and development partners (KIIs with CSOs, May-June 2017).

In the 2014-2017 NSP, there was more emphasis on the human rights dimensions affecting the HIV response for these groups. The following are examples of what were included as strategic priorities:

- Developing the capacity of health care institutions (public, private and faith-based) to respect the human rights of people living with HIV;
- Reducing stigma and discrimination amongst health care providers against people living with HIV and other key populations;
- Building the capacity of law and justice sectors and the media on national and international instruments that protect the right of key populations to access health services;
- Improving the capacity of the National Commission on Human Rights and Freedoms (NCHRF) and other legal bodies to protect and promote the rights of key populations to access health services; and
- Improving the capacity of key populations themselves as well as civil society organisations (CSOs) to advocate for and protect their rights to health services.

These statements and commitments represented important advances over the previous NSP in terms of the recognition by the government of human rights issues for key populations in the provision of HIV services. However, the movement from commitment to action remains challenging. Although progress was initially very limited, by 2016 momentum had begun to increase for some components, particularly the expansion of HIV services and the reduction of stigma and discrimination in these settings for men who have sex with men and female sex workers (USAID and others, 2016; Nemande, 2017; see also **Section 4.4**, below). In the recently concluded evaluation of the 2014-2017 NSP, the finding was made that most progress was due to support from external partners, however, and not from the government itself (MINSANTE, 2017).

As already noted, even though people who inject drugs are included as a key population in the NSP, no interventions to either provide specific services or to include this group within broader efforts to improve human rights protections were in the document. During the fieldwork component of the assessment, the Comité National de Lutte contre les Drogues (CNLD) shared a regulation approved in 2015 for the creation of *Centres de soins, d'accompagnement et de prévention en addictologie* in designated referral hospitals.⁹ Amongst other provisions, the regulation outlines a multi-disciplinary approach to treatment for drug dependency. It also, under Article 10, allows for the creation of other *unités*

⁸ As the assessment was being completed, the country was in the process of developing a new NSP for the 2018-2022. The items relating to addressing human rights and gender-related barriers are discussed in **Section 4.4.1**, below.

⁹ The specific components of 'soins' or care and treatment were not defined. The current approach is primarily detoxification.

spécialisées at the discretion of the Minister of Health. In the view of the CNLD this could, at some future point, allow for the introduction of harm reduction approaches, but no specific plans have been articulated or adopted. At the time of the assessment, however, other than in Yaoundé, no centres had been established in the country as envisioned by the regulation, largely due to lack of funds, according to the CNLD.

There are a number of policies and strategies to address access to services for adolescents and young people, including adolescent girls and young women. In addition to what is provided for in the NSP (targeted prevention interventions, PMTCT and adolescent-friendly services, for example), there are policies and guidelines addressing provision of adolescent-friendly health services and school health, although the latter is restrictive on condoms, for example. Condoms cannot be distributed in schools, and discussion of condoms is not allowed in school health programmes for students under the age of 16 (KIIs with MINSANTE Division de la Santé Familiale (DSF) and UNFPA, May-June 2017).

Political and social context for the national HIV response

The national HIV response in Cameroon is led by the CNLS. There were very mixed views across key informants on the effectiveness of the CNLS with the majority expressing a concern that the entity was becoming less able to lead and coordinate an effective national and regional level response to HIV. Using financing for the HIV response as an indicator of government leadership and commitment, it is important to note that, in 2013, the latest year that comprehensive data are available, on an expenditure of US\$60 million, 70% was funded through external sources, including Global Fund (22%), PEPFAR (23%), and other bilateral and multi-lateral partners (26%) (CNLS, 2014).

The wider socio-political context for the national HIV response, and for the promotion and protection of human rights more generally, continues to be challenging in Cameroon. Across a population of 23 million, 42% is under the age of 15 years and 60% under the age of 25 years (UNDP, 2016). Fifty-five percent live in urban areas. Ethnic and linguistic tensions between Anglophone and Francophone groups and regions continue to plague the country causing, amongst other effects, interruptions in the provision of public services, including health care in some regions. User-fees are the primary mode of funding health services in Cameroon. Despite Ministry of Health policies regarding standard prices for all services, these policies are not always followed by health care workers, and there is a practice of either demanding (by health care workers) or offering (by health system users) additional payments for provision of services. This operates as a deterrent for a significant proportion of individuals and families from seeking timely access to health care services, including those related to HIV (KII with Technical Partners, May, 2017).

The extent to which Cameroon consistently upholds and applies its domestic, regional and international commitments to human rights standards within its domestic affairs is not consistent and is sometimes controversial (Africa Commission on Human and People's Rights (ACHPR) 2016; Amnesty International 2016; US Department of State 2016). According to the findings of the desk review, and amongst key informants themselves, including those from key populations and from women's organisations, human rights challenges in a wide variety of forms continue to occur across Cameroonian society, largely as a result of government actions. These include: arbitrary arrest and detention; detention without trial; physical and sexual violence perpetrated by uniformed services; inhumane conditions for detention; failure to protect children from physical and sexual exploitation and abuse; and, more recently involuntary repatriation of refugees (Advocates for Human Rights and CAMFAIDS 2016;

Advocates for Human Rights 2014; Advocates for Human Rights and others 2013; Institute on Statelessness 2016; Humanity First and Alternatives-Cameroun 2016).

In this troubling context, with regard to the provision of HIV services, the commitment to the needs of most key populations, with the exception of people who inject drugs, is improving in Cameroon. However, as the following sections lay out, a number of barriers and challenges remain for these groups to fully benefit from what the government and others are trying to achieve.

Human rights barriers to access, uptake and retention in HIV services

Overview

The findings in this section consolidate information derived from the desk review as well as the results of the fieldwork. They illustrate that, with regard to HIV services, there are significant human rights and gender-related barriers to all groups included in the assessment; these are most substantial for key populations, particularly men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners.

Stigma and discrimination and access to health services

Stigma and discrimination against people living with HIV and other key and vulnerable populations remains prevalent in Cameroon although it varies among these groups, including how it affects access to HIV services.

The last *PLHIV Stigma Index* survey was conducted in 2013 (RéCAP+ and GNP+, 2013). It showed that, although people living with HIV experience high levels of stigma in their personal and social environments, they do not generally encounter stigma and discrimination in access to HIV services (KIIs with PLHIV CSOs, May-June, 2017). However, high levels of HIV-related in the community stigma negatively influence uptake of HIV testing and other services for people living with HIV, both those who know their status and those who do not yet know their status. As the desk review found, and as was confirmed by key informants, the socio-cultural meanings attached to HIV remain negative (RéCAP+ and GNP+, 2013; KII with PLHIV representatives, June 2017). According to data from 2014, for example, only 18% of adult males and 14% of adult females in Cameroon expressed accepting attitudes towards people living with HIV (INS, MINSANTE, UNICEF, 2015). There was little to suggest that this had changed.

As a result, according to many key informants, there are still challenges for people living with HIV to come forward to be diagnosed and to access HIV treatment due to their own fear of knowing one's HIV status and additional fears of this becoming inadvertently known in the personal and community environments (KIIs with RECAP+, SUNAIDS, and other PLHIV representatives throughout the fieldwork, May-June, 2017). They noted that, given how coverage of HIV services remains low in Cameroon, particularly for HIV treatment, the national response is not effectively addressing HIV-related stigma in communities, especially self-stigma.

Within sub-groups of people living with HIV, experiences of stigma and discrimination and its effects on access to services varied. People living with HIV in the military, for example, spoke about policies and practices that single them out from their colleagues and contribute to stigmatising attitudes and practices with regard to their assignments and duties, e.g. they are not deployed on external missions. HIV screening is mandatory on entering the military, and

people who test positive are not allowed to join the military. This exclusion contributes to a general atmosphere of intolerance and denial for those servicemen that acquire HIV after enlistment. It was said by key informants, including people living with HIV themselves, that many individuals hide their status for fear of negative consequences on their careers. According to these same individuals, medical confidentiality is not respected, and people living with HIV sometimes receive discriminatory or abusive treatment in health services, particularly from pharmacy staff in some cases (KII PLHIV in armed services; KII ACMS; May 2017).

For other key or vulnerable populations, the situation is more difficult. Prevailing attitudes towards men who have sex with men are very negative across the country, with many individuals continuing to experience stigma, discrimination and violence due to their sexual orientation and gender identity (Humanity First and Alternatives-Cameroun 2016; USAID and others 2016; Nemande 2017; KII with MSM CSO leaders, May 2017). 'Political homophobia' (the use by politicians of homosexuality as a 'threat' in Cameroonian society), as well as culturally and religiously condoned homophobia (the characterisation of homosexuality as an immoral, Western or 'white' influence) continue to play out in Cameroon and drive ongoing verbal and physical harassment, violence and abuse (KIIs with MSM CSO leaders and human rights defenders, and human rights lawyers, May-June 2017; Humanity First and Alternatives-Cameroun 2016; Advocates for Human Rights and CAMFAIDS 2016; USAID and others 2016; Nemande 2017). The observatories and reporting mechanisms operated by LGBT organisations, including the UNITY platform, continue to record such events (Advocates for Human Rights and CAMFAIDS 2016; Humanity First and Alternatives-Cameroun 2016; Johns Hopkins University et al., 2017). While some key informants were of the view that instances of stigma, discrimination or violence had been on the decline in the last 2-3 years, they nevertheless pointed out that the main risks or drivers of negative attitudes and beliefs about men who have sex with men were still present, including criminal laws and homophobic politicians and religious and cultural leaders, amongst other factors, meaning that any improvements could not be assumed to be permanent (Advocates for Human Rights and CAMFAIDS 2016; Humanity First and Alternatives-Cameroun 2016; USAID and others 2016; Nemande 2017; KIIs with MSM CSO leaders, human rights defenders, and others May-June, 2017).

In this environment, it was said that men who have sex with men are reluctant to seek health services, including HIV services, for fear that their identities would become known and that they would experience stigmatising or hostile treatment. The latest survey data bear this out (Johns Hopkins University et al., 2017). Most men who have sex with men do not disclose their sexual identities to health care workers; in 2016, only 8% had made such a disclosure. As a likely result, few have specifically been denied health services or have had negative experiences linked to their status as men who have sex with men. Of the overall study sample in the 2017 survey, 5% had been denied HIV or other sexual and reproductive services and 8% had been mistreated (Johns Hopkins University et al., 2017). There were significant differences among locations where the study was conducted with much lower instances of problems in cities where MSM organizations were more active (Douala and Yaoundé, for example). Those men who have sex with men who were reluctant to attend health services were concerned that their sexual orientation would be revealed without their consent. In 2016, 13%-14% had such concerns (Ibid).

While facing significant levels of stigma, discrimination and violence, female sex workers reported fewer challenges using health services, largely because they felt that they did not need

to disclose their status as sex workers to receive assistance (KIIs Horizons Femmes and Renata, May 2017). According to study data, in 2016, only 14% had disclosed their status as sex workers; and, of the overall sample, less than 1% reported being denied health services, while 4%-6% heard discriminatory remarks or experienced poor treatment (Johns Hopkins University et al., 2017). Seeking services to address physical and sexual violence was more difficult, particularly as few had any expectations that something meaningful would be done for them (Deker et al. 2016; FGD with FSW representatives, Douala, June 2017).

Men who have sex with men or female sex workers who are also living with HIV face additional stigma, including self-stigma. Recent survey data demonstrate the reluctance of these individuals to disclose their HIV status even within their personal environments. For example, only 29% of female sex workers living with HIV had disclosed their status to regular, non-paying partners. For men who have sex with men living with HIV, 50% had disclosed their status to their regular partners and 20% to their casual partners (Johns Hopkins University et al., 2017). Key informants confirmed this, giving a number of different reasons. Female sex workers living with HIV were clearly concerned about their work should their HIV status become known, including negative reactions and consequences from other female sex workers who might gossip about them and disclose their status without consent. They were also concerned about rejection and abandonment in their personal lives, both for themselves and for their children (FGD with FSW representatives, Douala, June 2017).

For men who have sex with men living with HIV, many had already experienced negative reactions from friends and sexual partners, largely because HIV remains heavily stigmatized within MSM social networks despite the long-time efforts of a number of MSM-led CSOs working to change this (FGDs with MSM PLHIV representatives, Douala and Yaoundé, June 2017). These individuals had experienced being socially excluded, being gossiped about, having their status shared with others without their consent, and being rejected by friends and partners. While there was some acknowledgement that more disclosure of HIV status, even within relatively closed social networks, would help challenge HIV-related stigma, many felt that the personal and professional risks would be too great (KIIs with MSM CSO leaders; FGDs with MSM PLHIV representatives in Douala and Yaoundé, May-June 2017). MSM civil society organizations are also stigmatized and are thought to be working only for people living with HIV. Individuals do not participate in programmes or use services provided by the groups for fear that, being seen there, they will be presumed to be living with HIV (KIIs with MSM CSO leaders, May 2017).

According to key informants, including transgender representatives themselves, transgender people continue to face intense stigma, discrimination and violence, particularly transgender women (KII with MSM CSO leaders, May 2017; FGD with transgender representatives, May 2017). Many live in deep isolation and are unwilling to go to health services where they have been poorly treated or humiliated. In addition, most are reluctant to go to civil society organisations where services for men who have sex with men are offered, as they do not perceive these environments to be accepting or able to respond to their specific needs. Transgender men face similar challenges with regard to their health needs.

For people who inject drugs, the social and moral connotations of drug use are negative in Cameroon, especially for injection drug use. There are very few supportive services for people who inject drugs, even amongst civil society organisations working with key populations, meaning that there are only a limited number of groups working to challenge stigma and discrimination, both at the societal level and amongst people who inject drugs themselves.

Due to criminalisation, PWID networks are closed and secretive and not easily reached with HIV-related interventions. Knowledge and understanding about people who inject drugs amongst service providers remains very low, even within those services that are otherwise key-population-friendly (KII with CSOs working with PWID, June 2017).

According to key informants, other groups that continue to experience HIV-related stigma and discrimination include prisoners, adolescents living with HIV, and orphaned and vulnerable children living with HIV. While the Ministry of Justice continues to roll out HIV and TB services in prisons, they do not reach all prisons as yet (KIIs with Sous Direction Santé Pénitentiaire and CSOs supporting HIV programmes in prisons, May 2017; GIZ 2013). As with the external environment, within prison settings, HIV is still associated with negatively perceived behaviours, such as homosexuality and drug use, meaning that prisoners hide their HIV status. Health services in prisons lack confidentiality and privacy, and key informants expressed fear of, and told, about actual instances where an individual's HIV status was shared without his or her consent (KIIs with CSOs supporting HIV programmes in prisons, May 2017).

Adolescent and very young people living with HIV experience self-stigma and fear of their HIV status becoming known to others. They also experience isolation which gives rise to psychosocial challenges, including depression (KIIs MINSANTE (DSF) and CSOs working with adolescent/young people, including PLHIV, May-June 2017). Orphans and other vulnerable children who are HIV-positive struggle to reach and stay in HIV services due to problems finding adults who will take them to facilities. Neglect of these children's needs is said to be because of the stigma against them due to their HIV status and the fact that their parents died of AIDS (KIIs KidAids and CRS, May 2017).

Taken together, the data reveal that actual and anticipated stigma and discrimination either due to HIV status or due to other social statuses, and the violence and abuse that may accompany such stigma and discrimination, are serious barriers for all groups to come to know and accept their HIV status and, following this, to seek and out and be retained in HIV services.

Punitive laws, policies and practices

As noted above, although the Constitution of Cameroon articulates a commitment to human rights for all citizens, certain key and vulnerable populations experience punitive laws, policies and practices. Punitive laws that limit access and uptake of HIV services for these groups include the following:

- For **gay men and other men who have sex with men** (as well as for lesbians and transgender people), Article 347 of the *Penal Code* criminalises sexual relations between persons of the same sex. There are enhanced penalties if one of the participants is a minor. These provisions were not changed when a revised *Penal Code* was enacted in 2016. Additionally, in 2010, a new law addressing cybercrime was enacted containing provisions that penalise communication by electronic means for the purposes of sexual contact between persons of the same sex. There are additional penalties if sexual relations actually take place as a result of the communications.
- For **female and male sex workers**, Article 343 of the *Penal Code* criminalises individuals selling sexual services and those making money from such exchanges. The law does not criminalise clients of sex workers. There are additional penalties for those making money if the individual selling sexual services is below the age of 18.

- For **people who inject drugs**, Articles 9, 101 and 102 of the *Code des drogues* penalises the possession and use of illicit drugs, in any quantity, which include injectable substances such as cocaine and heroin. The law also penalises the possession of equipment for drug use, including syringes. This law effectively blocks the possibility of harm reduction interventions, such as needle or syringe exchange or medically assisted therapy (methadone, for example).
- For **prisoners**, since, on a practical level, access to medical care and food often relies on support from family members or others outside prisons, the provision within the law governing criminal procedures allowing a judicial office to deny family visits can sometimes place an inmate's access to medical care, as well as other aspects of well being, in jeopardy.
- For **adolescents and young people**, the law governing the age of legal capacity prevents independent access for individuals younger than 21 to HIV and other sexual and reproductive health services by requiring the consent of a parent or guardian. Only in emergency situations can a physician, for example, provide medical care without the consent of parents.
- For **women**, in the northern regions of the country, adherence to customary law is strong which further limits the autonomy of women and girls to, among other things, seek access to health services for themselves and their children, including HIV or TB testing and treatment, without the consent of their husbands or a male family member if they are not married. Other problematic provisions include the statutory and cultural practice of perpetrators of sexual assault marrying their victims, including minors, to avoid prosecution.

Finally, two other aspects of current law have the potential to limit access to HIV services although there are no current examples that they have done so. Within the *Code de déontologie des médecins*, under Article 28, a physician may refuse to provide services for personal or professional reasons provided that the individual needing care is not harmed and that appropriate information is provided on where the needed services can be provided. Article 260 of the *Penal Code* criminalises anyone who, by their conduct, facilitates the transmission of a dangerous or contagious disease. While, in theory, this could be applied to the transmission of HIV, no prosecutions as such have ever taken place under this provision (Anyangwe, 2011; KII with human rights lawyers, June 2017).

The Penal Code provisions outlawing sex work and same-sex sexual relations continue to be enforced in Cameroon with significant numbers of men who have sex with men and female sex workers arrested, convicted and imprisoned on an annual basis. According to key informants and desk review sources, including annual reports from the Ministry of Justice, men who have sex with men and female sex workers continue to be arrested, tried, convicted and imprisoned, although the numbers have been declining in recent years (MOJ 2015; Humanity First and Alternatives Cameroun 2016; Advocates for Human Rights and CAMFAIDS 2016; Nemande 2017). The most recent survey data show that, in 2016, 33.5% of female sex workers had been arrested at least once on charges of sex work (reaching as high as 63.5% in Yaoundé); amongst men who have sex with men, it was 14% country-wide (Johns Hopkins University et al., 2017).

Of those men who have sex with men who were arrested, detained and imprisoned, there were harrowing accounts of physical and sexual abuse while in prison, including what international standards define as torture (KIIs with MSM CSO leaders and human rights defenders, and with human rights lawyers, May-June 2017; Advocates for Human Rights and CAMFAIDS

2016; Humanity First and Alternatives-Cameroun 2016). In addition, basic legal rights to be notified of the nature of the charge, to have legal representation and to have a timely and fair trial were frequently delayed or denied. According to key informants, there continue to be reports of forced anal examinations. However, where adequate legal representation is available, any “evidence” obtained through such examinations can be effectively dismissed as without scientific or medical merit (MSM CSO leaders and human rights defenders, and with human rights lawyers, May-June 2017). While the impact of these practices on men who have sex with men is severe, there is a larger context of police abuses in the country, including frequent instances of physical abuse and torture of detainees, a problem that has been singled out by the NCHRF itself as an issue of grave concern (NCHRF 2016).

Female sex workers also present accounts of police harassment and abuse, as well as the failure of police to intervene, particularly where they are raped (Cange et al. 2017; Decker et al. 2016; Johns Hopkins University et al., 2017; Lim et al. 2015). One study has identified lower rates of HIV testing and participation in HIV care for sex workers with previous experiences of violence (Decker et al. 2016). Some sex workers have 'protectors' to whom they pay weekly fees, and these men frequently negotiate with police to have the women released (KII with FSW representatives, Douala, June 2017; KII with human rights lawyers, Yaoundé, June 2017).

With regard to people who inject drugs, their being found with a syringe can be used by police as reason to harass or arrest them. People who inject drugs can be further abused and humiliated by police, even if they are not arrested, including experiencing extortion. Poorer, street-involved people who inject drugs are more vulnerable (KIIs with CSOs working with PWID, and with human rights lawyers, May-June 2017). As a result, people who inject drugs are extremely reluctant to use HIV services except from trusted civil society organisations. These organisations try to provide some form of harm reduction, e.g. clean syringes (but not syringe exchange). However, they incur their own risks in doing so and are unable to have regular or sufficient supplies.

Conditions in Cameroonian prisons remain the subject of national and international concern (Amnesty International 2016; NCHRF 2016; UN Human Rights Council 2013; US Department of State 2016). Constitutional guarantees and national laws to protect prisoners are not enforced nor is there adherence to international minimum standards (NCHRF 2016). For these reasons, access to HIV prevention and treatment services in prisons remains very limited, although efforts are underway by government and technical partners to improve prison conditions and to ensure basic provision of health services (KIIs with Sous Direction Santé Pénitentiaire and CSOs supporting HIV programmes in prisons, May 2017; Amnesty International 2016; GIZ 2013; MOJ 2015; NCHRF 2016; US Department of State 2016).

Finally, with regard to people with disabilities, despite a favourable legal and policy context, key informants noted poor implementation and compliance with human rights and other standards in the country, particularly within health services. Lack of sufficient resources and political will were reasons for this, according to the informants. The HIV-related vulnerabilities of people with disabilities are only recently becoming better understood. As an example, under the PSN HIV 2018-2022, people with disabilities are recognised as a vulnerable population when, in previous PSNs, they were not (KII MINAS, May 2017).

Overall, while the provision of health services for HIV continues to expand for most key and vulnerable populations in the country, the overriding negative context limits access to these

services and their overall health benefit (Beck, Peretz, Ayala 2015; USAID and others 2016; Nemande 2017).

Gender inequality and gender-based violence

With regard to women, including young women and adolescent girls, and to gender issues overall, there continue to be challenges to enforce protective laws and policies. The findings of the Committee on the Elimination of Discrimination Against Women (CEDAW) periodic review mechanism are indicative where the Committee expressed concern that Cameroon, “has not taken sufficient sustained and systematic action to eliminate stereotypes and harmful practices that discriminate against women, including child and forced marriages; female genital cutting (FGC); and, breast ironing.” The Committee further commented on the “persisting high prevalence of violence against women, including rape, and the limited number of investigations and prosecutions in such cases,” “pervasive levels of domestic violence,” and “the existence of a legal provision exempting rapists from punishment if they subsequently marry the victim (CEDAW, 2014).”

In response to these recommendations, as already noted, the Government of Cameroon, amongst a number of other actions, criminalised forced marriage, female genital mutilation and breast ironing. However, key informants acknowledged there was little actual implementation of these policies or others on gender so there was little positive impact on the daily lives of women and girls. This lack of implementation appeared to be due to lack of resources; inadequate communication of policies to all stakeholders that should know about them, including at community levels; and poor coordination across different ministries and entities addressing gender concerns, including HIV-related issues.

Gender inequality and gender-based violence remain cross-cutting concerns in Cameroon, both within the context of HIV and more generally. Available data show that in Cameroon, more than half of women (55%) have suffered physical abuse. It estimated that 13% of Cameroonian women have been sexually assaulted, and up to 500,000 experience rape each year. This abuse is mainly perpetrated by current or recent husbands or partners (Advocates for Human Rights 2014; INS and ICF 2012).

Key informants stressed that within the personal or social environment, sexual violence is not discussed or acknowledged, and this invisibility increases challenges to address it (INS and ICF 2012). Adolescents girls and younger women may not know that they have been victims of gender-based violence as they are not aware of what it is and the legal framework that surrounds it. Survivors may be stigmatized and accused of somehow having invited sexual violence. Despite the health sector’s commitment to provide them, comprehensive services are not easily accessible for all survivors of gender-based violence. There are no shelters or places of refuge, for example, which further inhibits these women from coming forward for fear of reprisal in their personal or family environments (KIIs with CSOs working with women and girls, and MINSANTE (DSF), May 2017).

Key informants spoke about the following additional challenges for women and girls:

- Stereotypes concerning sexuality and sexual activity persist for adolescent girls and young women, namely that they are not, or should not be, sexually active if they are not married. This has an impact on the availability of sexual health education, information and services. In some situations, these young females may be denied health services (such as contraception or HIV testing) when it is assumed they are not sexually active, or because

they are stigmatized when they are (Bureau central des recensements et des études de population, 2015).

- These stereotypes persist in the family environment where adolescent girls and young women cannot discuss questions of sexuality or sexual health with parents or cannot get help from parents to access services, either because they will not give their consent or not help to pay costs (KIIs with MINSANTE (DSF) and CSOs and technical partners working with women and girls, May-June 2017).

Rigid gender norms also fuel violence and abuse against men who have sex with men, female sex workers, and transgender people. Men who have sex with men who are considered 'not masculine enough' are frequently subject to verbal and physical abuse (KIIs with MSM CSO leaders; FGD with transgender representatives in Yaoundé; May-June 2017; USAID and other, 2016; Nemande, 2017). Female sex workers are considered to be 'deserving' of physical and sexual violence (Armisen and Simpoire, 2015; CAMFAIDS, IGLHRC, Lady's Cooperation 2014; Papworth et al., 2014). In 2016, for men who have sex with men, 16.7% reported ever being forced to have sex as compared to 27.3% in 2014 (there was not discussion in the study regarding why the rate may have declined). For female sex workers, 32% reported being forced to have sex (with police or clients, for example), with 52% believing it was because they were sex workers (Johns Hopkins University et al., 2017; Papworth et al., 2014).

For transgender people, rigid gender norms provoke physical and sexual violence, including 'corrective rape'. Because of stigma and discrimination, transgender individuals rarely report such violence, often with severe consequences to their sexual and reproductive health and their risk of HIV infection (Humanity First and Alternatives-Cameroun 2016; FGD with transgender representatives in Yaoundé; May-June 2017). Lesbians and bisexual women also experience physical and sexual violence and have limited access to post-exposure prophylaxis and other needed services (Armisen and Simpoire, 2015; Humanity First and Alternatives Cameroun 2016; USAID and others, 2016; Nemande, 2017).

Finally, according to recent study data, women with disabilities who are sexually active faced heightened risk of sexual violence and those that had experienced violence were either unable or extremely reluctant to seek care for fear of not being believed or of not receiving adequate assistance (De Beaudrap et. al., 2017; KII with MINAS, June 2017).

Gender-related barriers to HIV services remain substantial in Cameroon, for women and girls and for other groups who are perceived to transgress or challenge restrictive gender norms.

Poverty-related barriers

Both desk review results and key informants highlighted the effects of poverty on access and uptake of HIV services across all key and vulnerable populations. The main issues and concerns raised included the following:

- Although some components of HIV treatment, such as ARVs, are free of charge, others are not, including a number of diagnostic tests required either before or after initiation on treatment or for the diagnosis and treatment of opportunistic infections. Thus, lack of funds deters people living with HIV and other at-risk individuals from seeking treatment or causes interruptions in care.
- As ART is only provided in designated referral hospitals across the country, some people living with HIV have significant transport costs to attend monthly appointments. While community-based delivery of ART and longer prescription times (3 months versus 1

month) are being implemented, they are not yet available to all people living with HIV (KII PLHIV representatives, June 2017).

- As already noted, prisoners must rely on support from families or friends for healthcare and other needs in many jails and prisons. Those without such support can be without HIV treatment for periods of time or can lack funds for adequate nutrition to be able to stay on treatment (KIIs with Sous Direction Santé Pénitentiaire and CSOs supporting HIV programmes in prisons, May 2017).
- Adolescents and young people cannot afford the cost of their own care if their parents or guardians do not give consent to it (KIIs with CSOs working with adolescents and young people, May-June 2017).
- For orphans and other vulnerable children, financial pressures on their guardians result in delayed, or no, access to health services, including those for HIV (KIIs with KidAids and CRS, 2017).
- For people who inject drugs, syringes must be purchased and lack of funds is a contributor to sharing of needles. If a dependent person has limited funds and feels s/he must buy drugs, then s/he is unlikely to be able to pay for the cost for HIV care. (KIIs with CSOs working with PWID, May 2017).

Poverty is a crosscutting issue for health and access to health services for much of the population in Cameroon. However, it has very serious impact on access and uptake of HIV services for those groups included in this assessment.

Programs to address and remove human rights-related barriers to HIV services – from existing programs to comprehensive programs

Overview

While there are many human rights and gender-related barriers to access, uptake and retention in HIV services for people living with HIV and other key and vulnerable populations in Cameroon, there are a number of efforts underway to address them. The sections that follow examine specific activities, as well as cross-cutting approaches which integrate human rights or gender components into broader programming efforts. For Cameroon there are either recently completed or current interventions under each of the seven main programme areas that, in all cases, key informants felt were contributing towards positive change. However, across these efforts, there are some over-arching challenges and gaps. These include the following:

- There are still gaps in data and knowledge regarding critical issues for key and vulnerable populations, particularly trends in access, uptake and retention in HIV services. Coverage of ART is not known, for example, and basic data on HIV risks and access to HIV services have never been collected for people who inject drugs or transgender people.
- There is lack of routine evaluation of interventions addressing human rights and gender-related barriers, particularly with regard to how these efforts improve access and uptake of HIV services.
- There is a lack of overall coordination of interventions and responses to address human rights and gender-related barriers, both through CNLS but also amongst key-population-led networks themselves and their partners and allies. A number of civil society organizations carry out similar activities, but they differ in content and approach, e.g.

'know your rights' interventions. There is also a significant amount of duplication, and, in some cases, competition for beneficiaries in order to meet targets linked to funding contracts (KIIs with MSM CSO leaders, May 2017).

- There is also significant competition for funding with many small, key population-led civil society organizations operating on small, time-bound grants meaning that activities are short-term and episodic and cannot be sustained over a long enough period to achieve substantive change. Many activities are small in scale with limited reach.
- Many interventions are carried out in urban areas only and do not reach key and vulnerable populations in rural or remote regions, including the northern regions of the country.
- The legal context continues to provide justifications, whether legitimate or not, for government entities and others not to increase their efforts to remove barriers to HIV services. This includes the NCHRF that, while acknowledging challenges for key populations (and being involved in responding to them informally or 'under the radar'), does not formally include addressing them as part of its programme of activities because of the *Penal Code*. There is a significant contradiction here as the NCHRF does comment on the conditions for inmates in prisons as well as abuses in the administration of justice, for example.
- The intense focus on HIV testing and linking to HIV care, as part of the country's 90-90-90 targets, has narrowed the content and focus of much of the work of key population-led civil society organizations to the extent that interventions to address issues such as self-stigma and building self-esteem and resilience have been side-lined or suspended due to lack of funds and the pressure to meet testing and referral targets.

Recommendations for addressing these overarching challenges, and for moving towards a comprehensive approach to remove human rights and gender-related barriers to HIV services are presented in the discussion below. In addition, **Appendix A** lists an number of **specific activities** under each programme area in order to provide further detail on the content of a comprehensive approach.

Cross-cutting developments

In addition to interventions under the seven main programmes areas, there have been some important cross cutting developments in Cameroon to improve access to HIV services for men who have sex with men and female sex workers:

In 2015, under the auspices of the CNLS, MINSANTE created an Ad Hoc Technical Working Group (TWG) on HIV/AIDS for men who have sex with men and female sex workers and their clients (MINSANTE, 2015). The group has 40 members of which only 5 are key-population-led entities. According to key informants, the creation of the group was more symbolic than practical, and no meetings have taken place for some time (KII with MSM CSO leaders, May 2017).

In September 2016, as part of his remarks to a regional conference on key populations held in Yaoundé, the Minister of Public Health stated, "au Cameroun, l'accès aux soins est ouvert à

tous qu'important les orientations sexuelles ou religieuses (Nemande, 2017)."¹⁰ This was a first major statement by a Minister in support of non-discrimination on the basis of sexual orientation. However, whether and how this has translated into policy and practice is not clear. As the assessment found, there is still very low confidence amongst key population groups that they will be treated well in the health care system.

Also in 2016, the Ministry of Health introduced significant changes in the organisation and delivery of HIV services with a specific emphasis on improving access and uptake of HIV treatment, including amongst key and vulnerable populations. A 'test and start' approach was initiated as well as the roll out of community-based delivery of ARVs. At the time of the assessment, new data on HIV treatment coverage for key or vulnerable populations were not available. However, civil society organizations working with key populations were beginning to see improvements in access and uptake of HIV treatment and other services (KIIs with CHAMP, MSM CSO leaders, MSM PLHIV, others, May-June 2017; CAMNAFAW and IPPF, 2017).

As a further example of increasing support for addressing human rights and gender-related barriers to HIV services for people living with HIV and other key and vulnerable populations, the new PSN HIV 2018-2022 articulates addressing human rights and gender concerns as a core value. It stresses the need for re-doubled efforts to address stigma and discrimination and to respond to and prevent human rights and gender related abuses amongst people living with HIV and other key and vulnerable populations. It also stresses that these groups must be at the centre of removing such barriers to HIV services and recommends that a number of current efforts, such as the key-population-led observatories (see **Section 4.4.7**, below), be sustained and expanded (CNLS, 2017).

There are contradictions in these developments, however. Though addressing human rights issues in the context of HIV services appears to be receiving more attention within the multi-sectoral response, how this is being translated into coordinated actions is not clear. In addition, there are no specific commitments to address the wider context, particularly law and policy change to either remove legal barriers, such as the provisions of the Penal Code, or to enact specific laws or policies to protect people living with HIV and other key and vulnerable populations from stigma, discrimination, violence and abuse.

To strengthen the overall structures and processes for supporting work to remove human rights and gender-related barriers to services, the following over-arching actions should be considered:

- **Study and monitor human rights-related barriers to access and uptake of HIV services for key and vulnerable populations by expanding the mandate and the membership of the national Technical Working Group (TWG) on HIV.** The TWG should play a leading role in monitoring the HIV care cascade by population group and be a place for reflection and co-ordinated action planning, including advocacy, on how to address and resolve human rights-related barriers.
- **Close gaps in knowledge/evidence regarding transgender people and people who inject drugs.** While IBBS surveys are one of the most comprehensive methods for gathering evidence for key populations, they can be complex and resource intensive. Initially, for Cameroon, a rapid situational assessment could be considered as a first step

¹⁰ 'In Cameroon, access to health care is open to all regardless of their sexual orientation or religious beliefs.'

with the participation and leadership of key population-led civil society organizations, as well as transgender individuals and people who inject drugs. Such assessments should include all questions relevant to human rights related barriers to access to services.

- **Routinely evaluate interventions addressing human rights-related barriers, focussing on their effects on uptake and retention in HIV services.** A national consultation should be convened to identify a group of ‘core’ or priority human rights or gender-related interventions to evaluate, leading to the identification of suitable methodologies and a multi-year action plan for undertaking the evaluations. Based on the findings, key-population-led civil society organizations and other stakeholders should work together to launch a continuous learning and quality improvement process, including embedding routine evaluation in all further work to address human rights and gender-related barriers.

PA 1: Stigma and discrimination reduction for key populations

At the time of the assessment, efforts to address stigma and discrimination were largely focussed at the regional, community or individual level with no coordinated national response, either for people living with HIV or for other key or vulnerable populations. The types of activities either underway or completed in the recent past included the following:

A CNLS-appointed working group was in place to monitor and coordinate HIV-focussed stigma reduction activities. This group involved people living with HIV, civil society organizations, the International Labour Organisation (ILO), the Ministry of Justice, the Organization of the Community of Central African States, the Ministry of Labour and Social Security, and UNAIDS (Nemanda 2017). It was not clear during the assessment, however, how active the group was and what specific activities they were currently coordinating.

Between 2014 and 2015, ILO Cameroon provided support to the Government of Cameroon for a comprehensive intervention aimed at reducing stigma and discrimination in the workplace. As part of the project, 92 focal points and counsellors were trained to promote the rights of people living with HIV; policies were reviewed to integrate key principles protecting their rights in two major factories (Sosucam and Chantier Naval); medical staff of 4 health facilities were trained to protect the rights of workers living with HIV; and, 54 staff of the labour inspection division of the Ministry of Labour were trained in 4 regions on documenting human rights violations in the work place. At the time of the assessment, however, the project had ended, and no evaluation had been done to measure its effectiveness or to determine which project components could be sustained in the absence of specific funding. Key informants felt that the initiative was important however, and that HIV-related discrimination in workplaces was still an important issue to address and resolve.

Between 2014 and 2015, ACMS and CAMNAFAW, with Global Fund support, ran a national, multi-media stigma reduction campaign involving radio and television spots, billboards, events, use of social media to engage young people, sensitisation workshops with the law and justice sector, and supporting a theatre troupe. Following the end of the campaign, however, no evaluation was done to gauge its impact. Key informants were of the view, however, that the campaign was effective in raising awareness of HIV as an on-going public health concern for the country and highlighting the problem of stigma and discrimination. They were also of the view that this type of work needed to be sustained over a longer period in order to bring about positive changes in public perceptions of HIV and people living with HIV.

As part of the implementation of the 2016-2017 Global Fund grant, CAMNAFAW organized advocacy meetings in cities and regions with administrative authorities, community-based leaders and health care workers in order to proactively address stigma and discrimination and other potential risks surrounding the local implementation of grant funded interventions aimed at improving access and uptake of HIV services for key populations. As a further effort regarding the Global Fund programme, in 2014 CAMNAFAW developed a comprehensive risk mitigation plan and established a risk management committee to proactively address stigma and discrimination in the programme environment (CAMNAFAW 2014, 2016). At the time of the assessment, CAMNAFAW was not reporting any major barriers or conflicts with the implementation of its Global Fund supported activities (KII CAMNAFAW, June, 2017).

Through CAMNAFAW's grantees under Global Fund, similar local level engagement activities were carried out, largely involving small scale workshops (12 to 15 participants, for example) bringing together local stakeholders such as local key population organizations, police, community leaders, religious leaders, health care workers and others.

Also in 2016, Alternatives-Cameroun together with Affirmative Action, Humanity First Cameroon, and others, developed the flyer "Je suis Kwandengue" ('I'm gay' in the coded language used by the LGBT community) to be distributed to men who have sex with men by peer educators, and made available in drop-in centres of the respective organizations. This effort was meant to address self-stigma and to build resilience and pride across the LGBT constituency in the country.

Finally, a number of key-population-led organizations include components addressing stigma and discrimination, particularly self-stigma and building personal resilience to resist stigma, in peer education and outreach programmes, and through support groups and other activities for their members, including those that are living with HIV. There is a wide variety of approaches which include peer counselling; social activities offered through drop-in centres; psychological counselling; and celebrations of events such as International Day Against Homophobia and Transphobia, the LGBT community's own day of pride and solidarity, and participation in other social and cultural events to raise awareness of diversity and the existence of LGBT people in the country. Additionally, some civil society organizations also offer refuge, or temporary accommodation, to lesbian, gay, bisexual or transgender people who have been driven out by their families or have been thrown out or threatened away from their accommodation.

Across these efforts, some gaps and challenges were evident:

- Comprehensive data on HIV-related stigma and discrimination were not current, and because of this, there were contradictory views on the magnitude of stigma and discrimination in 2017. Some key informants felt it was still a major challenge for the country, while others felt that there had been improvements, particularly since 2011 when the *PLHIV Stigma Index* was conducted. This lack of consensus was a contributing factor to the less than coherent approach across different stakeholders in terms of what was needed to continue to reduce HIV-related stigma in the country.
- Many activities while important, such as the work done in communities to build a supportive environment for key population programming, were episodic or once-off, with no plan for ongoing engagement to ensure that sustained changes occurred and that key population groups were better able to participate in the programmes or services that were provided.

- Key population-led efforts to reduce stigma and discrimination were small in scale and, in some cases, operating independently of each other in the same geographic area (such as in the same city). Most approaches were based on ‘once-off’ activities with limited or no financial or technical capacity to sustain a programme of work long enough to ensure that permanent changes were occurring.
- The commitment by CNLS to include people living with HIV more prominently in HIV service delivery was not being properly implemented, according to key informants, which led to missed opportunities in ART centres, for example, to provide peer counselling and support to newly diagnosed people living with HIV in particular as a way of mitigating self-stigma.

A **comprehensive approach** to stigma and discrimination reduction would include the following general directions with more specific interventions in this area outlined in Annex A:

- **Implement the PLHIV Stigma Index** to establish a clear baseline regarding current levels of stigma in the community. It should be implemented in a way to ensure that the research captures data regarding stigma experienced by people living with HIV, people living with TB and other key populations. The implementation should be coordinated so that those trained to implement the Index can also work afterwards as peer educators or paralegals in their communities working to among other things reduce stigma and resolve disputes relating to it.
- **Support to the creation and implementation of a co-ordinated multi-year action that consolidates and strengthens the efforts of key population networks to reduce stigma and discrimination and positively shift knowledge, attitudes and practices.** A number of civil society organizations have, for more than a decade, employed different strategies to change public perceptions regarding their constituencies. To leverage these efforts, work should be done to develop a more consolidated and coordinated multi-year approach. As a starting point, there should be collective analysis on what has worked and what should be included in the multi-year approach. Technical partners should be engaged to support the development of the consolidated plan and to provide other technical inputs as required to ensure its effective implementation. The expansion of this work is critical to improving the program environment for HIV services and for enabling more individuals from key populations to come forward to health services without fear of negative consequences.
- **Support engagement of people living with HIV, particularly from among other key populations, in the provision of all HIV services.** The programme under CNLS to engage people living with HIV as psycho-social counsellors in HIV treatment centres should be strengthened to ensure that it engages a maximum number of qualified people living with HIV to provide these services and that it also recruits qualified members of other key populations who are also living with HIV. The role of people living with HIV in the continuum of HIV services should be expanded to include HIV counselling and testing. A sufficient number of these should also be trained as peer paralegals and peer educators on legal literacy so as to provide human rights/legal advice and knowledge, along with prevention and treatment counselling.
- **Support key populations to find ways to enable those among their members who are also living with HIV to voluntarily and safely be open about their HIV status within their networks and as part of civil society organizations delivering HIV services to these groups.** Key informants who were MSM/LGBT

leaders who were also HIV+ stressed that, in order to address the still very intense HIV stigma amongst MSM, more of them should be open within their networks about their HIV status. As an example of the challenge, CHAMP has tried to recruit MSM as outreach workers and as 'peer navigators' to link PLHIV MSM to diagnosis and treatment. At the time of the assessment, they had yet to be successful to recruit anyone willing to disclose their HIV status in these roles. The activity is meant to be discrete and is not about being public in the sense media, public speaking, etc. Instead it would involve key-population-led CSOs supporting more members who are living with HIV to become spokespersons and role models for positive living and personal resilience within local MSM networks and as part of outreach and support activities. While the risks of disclosure are very real to PLHIV from key populations, ways can be found to mitigate these risks such as offering full-time employment as peer educators or spokespersons, and by providing support for security needs. The goal is to raise the profile of PLHIV as role models for positive living within key population communities to help reduce HIV-related stigma and to encourage more individuals to use HIV services.

- **Expand programmes to reduce HIV-related stigma and discrimination amongst adolescents and young people, particularly adolescent girls and young women, through stronger multi-sectoral collaboration and coordination.** Different ministries, technical partners, and CSOs are undertaking important work to reduce HIV-related stigma and misperceptions amongst adolescents and young people, especially adolescent girls and young women. The CNLS must take a stronger role in coordinating these efforts.
- **Implement interventions to address HIV-related stigma against and amongst people with disabilities.** Under CNLS and MINAS multi-sectoral partners should develop coordinated interventions to address HIV-related stigma against this neglected population within the national HIV response.
- **Improve policies and practices regarding PLHIV in the military to prevent stigma and discrimination in the workplace and to improve uptake of HIV services.** MINDEF requires collaborative support to establish a more enabling and supportive environment for PLHIV amongst its ranks and to take more ownership for the care and support of them and their families.

PA 2: Training of health care providers on human rights and medical ethics related to HIV

Training of health care workers on HIV service delivery is the responsibility of the MINSANTE. The curriculum includes general content addressing HIV-related stigma and discrimination, but no specific topics for key populations other than people living with HIV. Training of health care workers regarding the needs of these key populations, primarily men who have sex with men and female sex workers, is taken up by other Global Fund and PEPFAR supported entities, mainly CAMNAFAW and CARE through the CHAMP project.

For example, in partnership with CNLS, CHAMP has been training health care workers of their partner hospitals (for the provision of ART) in the cities of Bamenda, Douala and Yaoundé on stigma and discrimination-free HIV service provision to key populations other than people living with HIV. As of 2016, a total of 60 health care workers from HIV treatment sites were trained. The initiative also included the creation of referral networks between key population-led civil society organizations, including those running CHAMP-supported wellness centres, and public health facilities to improve access and uptake of HIV services. Overall, according

to key informants, amongst health care workers and representatives of key populations using these services, there was a high level of satisfaction of the quality and acceptability of the care that was provided (KIIs with CHAMP and peer navigators and wellness centre staff at Alternatives Cameroun, June 2017).

As of 2016, CAMNAFAW, through its grantees, has trained 240 health care workers on confidentiality and on stigma and discrimination-free services for men who have sex with men and female sex workers. A code of good conduct is currently being developed to augment the training and to be adopted by participants in future periods once the training has finished.

Finally, as a way of monitoring service quality, in June 2016, with support from GIZ, FIS launched an interactive platform called “Community Observatory.” Using a toll-free telephone number, or a web-based platform, community users of HIV, TB or malaria services have the opportunity to raise concerns or to pose questions about the content and the quality of the services they receive, including concerns related to human rights and gender. The information collected is meant to inform the Country Dialogue process and the development of the next Funding Request regarding community-level experiences. At the time of the assessment, no current information was available on progress nor was it clear to what extent members of key populations were taking advantage of this opportunity to report negative experiences in health care settings.

Overall, however, these efforts are far from reaching sector-wide coverage and do not specifically address people who inject drugs (although, according to civil society organizations that serve people who inject drugs, people who inject drugs who are living with HIV can receive services in CHAMP-supported facilities). A more **comprehensive approach** to improving the capacity of health care workers with regard to human rights and medical ethics should include the following (see Annex A for more specific interventions):

- **Measure stigma and discrimination in health care settings to get a baseline for the extent of the current challenges.** This should be done in a representative sample of health care facilities that will ensure data from both urban and rural settings as well as facilities across the country. It should also seek to capture stigma and discrimination not only regarding HIV but also TB and membership in other key populations.
- **Create greater awareness about the country's commitment to ensuring access to stigma-free HIV services for all key population constituencies and for all Cameroonians by** (1) supporting the development of a written policy directive by MINSANTE through CNLS to health care facilities that HIV and related-health services are not to be denied to individuals who need them and that non-discrimination on any grounds is a fundamental value across the health care system; (2) based on this support the development of facility-level policies on non-discrimination; and (3) support the development and distribution of patient's rights material and information. Key-population-led CSOs can then be empowered to monitor compliance with the statement, through their existing observatories, for example, and through the structures of the CNLS.
- **Provide training and support for health care workers in both pre-service and in-service settings to offer stigma-free, supportive services to key populations.** Based on lessons learnt from the CHAMP project, noted above, a multi-year plan should be developed for routine training and support that brings about sustained change in knowledge, attitudes and practices.

- **Expand ‘observatoires’ to include monitoring of health facilities for compliance with codes of ethics as well as with guidelines for provision of services to key and vulnerable populations across the health sector.** Current projects can be expanded to include this component, such as the work of human rights observers in communities as well as the project undertaken by Positive Generation that is monitoring the quality of HIV services for people living with HIV. These are good efforts that could be expanded to include a network of well-coordinated civil society partners. Findings obtained from this work could be used in communities to support collaborative problem-solving with health facilities and health care workers. They could also be consolidated regionally and nationally to inform advocacy briefs and advocacy interventions.
- **Improve the skills and commitment of health care workers to provide youth-friendly and stigma-free HIV and sexual and reproductive health services to adolescents and young people.** Current efforts across different sectors to improve HIV and other health services for adolescents and young people, particularly young women, should be comprehensively evaluated and, based on the results, strengthened and expanded to reach more regions and communities where adolescents who need them reside. Adolescent-and-youth-led organizations should be engaged to monitor changes in access and uptake of HIV and other services and to use the results to work collaboratively with health facilities and health care workers to make improvements.

PA 3: Sensitization of law-makers and law enforcement agents

Different stakeholders have carried out interventions to sensitise the police and the judiciary on both HIV-related stigma and discrimination, as well as on the more specific issues for key populations. These efforts have primarily concerned men who have sex with men and female sex workers. None of the activities have directly addressed the needs of people who inject drugs or transgender people.

CAMNAFAW, with Global Fund support, has through its grantees hosted advocacy meetings with magistrates and judges in 5 cities (Yaoundé, Buea, Bafoussam, Garoua, Ngaoundere) with the institutional support of the Ministry of Justice. According to the organisation, this has led to strengthened collaboration between CAMNAFAW’s national/regional coordination offices and the judiciary. This has also led to the judiciary being more ready to work with administrative authorities, the police, civil society organizations and other actors to reduce instances of police abuse and poor administration of justice against key populations (KII with CAMNAFAW, June, 2017).

Similar meetings were hosted by CAMNAFAW and its grantees with the police with the institutional support of the General Delegate of National Security and the State Secretary of Defence in Yaoundé, Douala, Bafoussam, Ngaoundere and Garoua. A total of 111 policemen were sensitized through this activity. Major outcomes, according to CAMNAFAW, included improved understanding of the benefits of education versus repression among key populations, as well as of the role of the police and security services to support access to HIV services for these groups (KII with CAMNAFAW, June 2017). No additional information was available, however, to substantiate whether, from the perspective of key populations, improvements in police attitudes and practices were occurring.

The Ministry of Justice, through the Sous Direction Santé Pénitentiaire, is working with a number of CSOs to support HIV programmes in prisons funded through the Global Fund. This work is often combined with interventions that address TB (see Section 5.5.12, below). The activities comprise HIV testing, including screening on entry, and training and support for prisoners as peer educators. ACMS, JAPSSO and GBFC, as grantees of CAMNAFAW, are among the groups collaborating with the Ministry of Justice. The activity includes working with local prison authorities to understand and support the interventions which currently cover 44 of 77 facilities country-wide. There were no specific human rights dimensions to this work, other than indirectly addressing stigma reduction through peer education activities that primarily focus information and education on HIV, encouraging prisoners to be tested, and supporting PLHIV on treatment.

Across these efforts, there are some important gaps and challenges:

- The focus has been on one-time activities with no efforts to monitor what changes have occurred over time. There was no link, for example, between these interventions and what the human rights *observatoires* (for a description, see under Section 4.5.8, below) capture as a way to measure meaningful change.
- There are no institutional-level interventions such as changes to training curricula for police recruits, or for the education of magistrates, to more formally and permanently include content on HIV-related human rights for people living with HIV and other key populations. It is acknowledged, however, that without changes to the legal context for criminalized populations, this will be difficult to achieve.
- With regard to the Ministry of Justice, most work on HIV in prisons is done by external partners without a specific focus on human rights issues. There is poor coordination and ownership by the MOJ for this work. As a result, many gaps and challenges continue to exist for the reliable provision of HIV services, including HIV treatment and the commitment of the MOJ to address this with any sense of priority is weak. The gaps grow larger for prisoners who are living with HIV upon their release, as there is currently no institutional coordination between the Ministry of Justice and Ministry of Health for continuity of care upon release.

A **comprehensive** approach to changing knowledge, attitudes and practices of law enforcement agents would include the following (see Annex A for more specific interventions):

- **Support cross-sectoral/cross-ministerial collaboration between health, law and justice sectors to support HIV programmes for key populations.** This critical work would improve the understanding across sectors of the importance of public health interventions to support key populations and the need, for example, for the police and the judiciary to support access to services for these groups rather than act as barriers. The CNLS has this mandate and should be more accountable for fulfilling it as it can engage at the leadership and institutional levels which is critical to ensuring broader institutional change while efforts within communities (like those of CAMNAFAW) also continue.
- **Scale up training and sensitisation work with the law and justice sector.** Organisations doing this work should collaborate to identify best practices, and based on this, to develop core curriculum for police and police management as well as for the judiciary to be integrated into pre and in-service education. In both cases, HIV

vulnerability for these professionals should be included. The plan should focus on achieving institutional change.

- **Scale-up community dialogues and other local activities that build positive relationships between local police, judiciary, community leaders and key population constituencies.** Such work is already taking place in Cameroon and should be sustained and extended across the country. However, there should be more emphasis and support for monitoring and measuring the effectiveness of this work in reducing stigma, discrimination and abuse.
- **Develop a policy for the provision of HIV and TB services in prisons.** This should be a joint effort between the Ministry of Justice and the MINSANTE and clearly indicate a ‘shared ownership’ between the two for the provision of HIV and TB services, as well as all health services, to all prisoners including those on remand/awaiting trial. The policy should address transition of prisoners on HIV treatment upon release. It should clearly stipulate HIV-and-TB-related human rights standards.
- **Develop and deliver a training/sensitisation programme for prison workers.** Technical partners and CSOs should assist the Ministry of Justice to develop the materials and to deliver the training. It should include sections regarding stigma and discrimination, including with regard to key populations, prevention of physical and sexual violence, and the critical role of prison workers to support prisoner to use HIV and TB services.
- **Develop and deliver a training/sensitisation programme for prisoners on HIV-and-TB-related human rights.** Again, technical partners and CSOs should the Ministry of Justice develop and implement the programme. Ideally, it can become of component of what peer educators provide to fellow prisoners.
- **Put in place a Technical Working Group to improve collaboration between Ministry of Justice, Ministry of Health, technical partners and CSOs for the delivery of HIV and TB programmes in prisons.** This should be convened by the Ministry of Justice with the support of CNLS. A component of the groups responsibilities should be monitoring the delivery of training/sensitisation programmes on human rights as well as measuring their impact by, for example, repeating assessments like the one completed by GIZ in 2013 on a regular basis.

PA 4: Legal literacy (“know your rights”)

Across the LGBT community, many civil society organizations have conducted interventions with the goal of building knowledge and capacity of individuals and communities regarding human rights, sexual orientation and gender identity (Nemanda, 2017). Similarly, networks of people living with HIV and organizations working with female sex workers and people who inject drugs have also undertaken work on legal and human rights literacy.

As a recent example of these activities, in 2016, Alternatives-Cameroun, with support from CHAMP, organized awareness-raising workshops on human rights for peer educators and community leaders working with men who have sex with men and female sex workers in Douala, Yaoundé, Kribi, Limbe and Buea. A total of 24 MSM peer educators and 25 FSW peer educators were sensitized and capacitated to educate their peers on human rights. The content of the training included HIV and human rights; gender-based violence and HIV; the difference between homosexuality and paedophilia; sexual orientation and gender identity (SOGI);

discrimination and violence on the ground of SOGI; how to securely live one's sexuality, including the consequences of coming out in terms of security; and, justice equality in Cameroon. While key informants felt that the training was important, they highlighted the need for follow-on activities within individuals in communities to apply the knowledge they gain to their personal situations in communities.

Alternatives-Cameroun, through collaboration with ACAPEJ (the Cameroonian Association of Female Jurists), RECAP+, and other partners, has led other activities to deepen the reflection and further build human rights awareness in the LGBT community. These include roundtables; celebrations of the UNAIDS-led "No (to discrimination)" Day and the International Day Against Homophobia and Transphobia; and, participation in a "Support, Don't Punish" campaign for the promotion of drug policies that respect the human rights of people who inject drugs. However, according to some key informants, some of these activities created only short-term awareness of the realities for transgender people and people who inject drugs, for example, and did not lead to greater solidarity or inclusion of their priorities within broader key-population-led advocacy or programming.

Finally, key population-led organizations also integrate 'know your rights' components into other activities, such as HIV and sexual health discussion groups, social and cultural events, and peer education and outreach activities.

While all of these efforts are important, there are some equally important gaps and challenges that include:

- There is no consensus on what the legal and human rights of key populations entail in Cameroon, including the role of global norms regarding sexual orientation and gender identity. During the assessment, some civil society leaders expressed reservations about the contents and modalities of their interventions and their relevance to the lived realities of the individuals they were trying to reach. The legal and human rights of many key populations are not recognised in Cameroon and, consequently, individuals have no opportunities to claim such rights within the national legal context.
- Amongst some key population groups, e.g. sex workers and people who inject drugs, the interest in the protection and promotion of human and legal rights is low, primarily due to experiences where either nothing was gained in doing so or where such attempts generated negative consequences, such as an increase in discrimination and abuse.
- There has been little attention to programs to promote knowledge and implementation of patient's rights. Implementing these programs for people living with HIV and other key populations, women and the disabled would be a pragmatic place to start.

A **comprehensive** approach to improving legal literacy would include the following (see Annex A for more specific interventions in this regard):

- **Support the evaluation of the content and implementation modalities of key population-led human rights/legal literacy interventions and, based on the results, scale-up best-practice approaches.** Key informants were clear that legal literacy work remains important for key population constituencies; however, they were equally clear that some reflection is needed to ensure that implementing these activities leads to improved resilience and agency on the part of individuals and encourages their access, uptake and retention in HIV services.

- **Support the development of cadres of peer human rights educators among people living with HIV and other key and vulnerable populations.** These can be part of CSOs and networks supporting these populations. They can be recruited from community health care workers so that they provide both health and human rights/legal information including referrals to paralegals and lawyers. In addition to providing information and knowledge their role would be to help communities mobilize around specific rights, laws and activities to better protect themselves and get access to health services.
- **Develop and disseminate patients' rights materials regarding how patients should be treated in health care provision and where they can get redress if mistreated.** These materials should be widely disseminated in health care facilities and should be developed to coincide with health care worker training and the development of non-discrimination policies in health care settings, as well as civil society monitoring of health care provision.
- **Scale-up interventions to improve knowledge and awareness of health-related legal and human rights for children, adolescents and young people.** While there remain limitations in law and policy for adolescents and young people to independently access HIV and other sexual and reproductive health services, these groups nevertheless have entitlements in law and policy to benefit from interventions to address their needs. According to survey data and the views of key informants, most adolescents and young people are unaware of their rights in law and policy to access HIV and other SRH services. Increasing awareness is an important step towards greater mobilisation of this population, both to seek HIV services, but also to press for change in law and policy to be more enabling of their specific needs.
- **Scale up interventions to 'popularize' laws and policies meant to protect vulnerable children from exploitation and abuse and to ensure their access to health services.** More collaborative, cross-sectoral efforts are needed to improve knowledge and awareness regarding the legal and policy framework for protecting OVC and for supporting their access to health and social protection services, including those related to HIV.

PA 5: HIV-related legal services

With Global Fund support, two lawyers were recruited in December 2013 by CAMNAFAW, with the participation of key population civil society organization leaders, the supervising committee of the implementation of their risk mitigation plan, the ICN, and the CNLS. The lawyers have been providing legal assistance to men who have sex with men and female sex workers since then, despite professional and personal risks.¹¹ This support is provided to address legal issues that relate to persecution and abuse on the basis of sexual orientation or being involved in sex work. It does not extend to other legal problems. The lawyers have also been participating in sensitisation workshops with members of the law and justice sector. While the two individuals do their best to provide a rapid response to cases of men who have sex with men and female sex workers being detained by police, and have effectively avoided

¹¹ The professional and personal risks of lawyers and human rights defenders working to address LGBT concerns is substantial in Cameroon, both according to the individuals who do this work and to external observers (Nemanda 2017).

prosecution and secured the release of individuals as a result of their efforts, they are clearly not able to provide this support country-wide (KII with human rights lawyers, June 2017).

Key population-led civil society organizations also provide access to legal services for their members and service users. As an example of an intervention that reaches beyond urban centres, Humanity First operates a toll-free telephone line for individuals needing urgent assistance. When required, callers can be linked to one of the lawyers mentioned above for information and advice on how to deal with their legal situation. Key informants gave a number of examples of cases where assistance had been mobilised to secure the release of individuals from jail, for example, as a result of the service, and Humanity First reports on these through its annual human rights report (see **Section 4.5.8**, below).

Given the evident limitation of scope and coverage of this important work, a comprehensive approach to the provision of HIV-related legal services would include the following (see Annex A for more specific interventions relevant to this area):

- **Recruit, train and support peer paralegals** among people living with HIV and other key and vulnerable populations. Given the distinct legal and human rights needs of different populations, it will be necessary to create a cadre of paralegals for each key population. However, these can be recruited from existing community health care workers so that, after training as paralegals, they can provide both health information and legal support. All paralegals will need supervision by and access to a smaller number of lawyers willing and able to work with marginalized populations.
- **Expand the network of lawyers with knowledge and commitment to responding to the legal needs of key population constituencies and to supervise paralegals among them. Key-population-led networks, lawyers and human rights defenders should collaborate to** expand the number of lawyers willing to assist key populations and their paralegals. The two lawyers currently providing this support should be supported to develop a training programme and to provide ongoing mentoring. Supporting the legal needs of people who inject drugs and prisoners should be a component of the training.
- **Support the continuation of the Humanity First toll-free line.** Evidence captured through this assessment shows that there is an on-going need for timely legal assistance, especially in locations outside of Douala or Yaoundé.
- **Support rapid response mechanisms in cases of urgent threats to health or safety among key populations.** Support should be given to the ongoing work of key population-led organizations that provide places of safety, including psycho-social and legal support, for individuals in need of emergency shelter and support. Civil society organizations that currently provide refuge should collaborate on a core package of support as well as a coordinated plan to ensure greater coverage and accessibility of this critical service.
- **Develop and implement a collaborative engagement strategy between key-population-led CSOs and the NCHRF to increase its technical capacity and expand its role to address stigma, discrimination and violence against key or vulnerable populations and to promote their access to HIV services.** Work should begin on a collaborative basis between key population constituencies and other relevant partners to assist the NCHRF to change its current approach. At the very least, the NCHRF should take a strong, public stand against stigma and discrimination in the

provision of health services since this is a legally guaranteed right of all citizens regardless of the contents of other law and policies.

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV

The main activity under this programme area identified by the assessment was monitoring and reporting on the abuses of the legal and human rights for lesbian, gay, bisexual and transgender people. There were no similar national efforts for female sex workers or people who inject drugs. Two concurrent LGBT-led initiatives were underway at the time of the assessment.

- Alternatives-Cameroun and Humanity First Cameroon, with the support of Amnesty International, had established a network of observers across the country to improve the documentation and reporting of human rights abuses against LGBT individuals. A first report of LGBT human rights violations was released at the end of 2016 (Humanity First and Alternatives Cameroun, 2016).
- Another set of 21 organisations, a number of them key population-led, came together in October 2016 under the leadership of CAMFAIDS to create the Unity Platform. It is a national observatory focusing on human rights abuses and violations encountered by LGBT individuals and human rights defenders and was to release its own report on these issues in 2017.

LGBT organisations have also been active in ACHPR and UN mechanisms, including the Universal Periodic Review, and country reporting under the Convention on the Rights of the Child and CEDAW, for example.

In order to address duplication and the limited reach of monitoring interventions, a comprehensive approach to monitoring and reforming problematic laws and policies would include the following (see Annex A for more specific interventions in this area):

- **Support advocacy to change the age of consent for independent access to health services to allow adolescents opportunities to access HIV and other sexual and reproductive health services without parental consent.** In a number of other countries in the region, the urgency of improving the accessibility of HIV services to adolescents, especially older adolescent girls, has prompted reviews and changes of policies and laws regarding legal capacity to consent for health services. Given the increased burden of HIV on older adolescent girls, and the prevailing socio-cultural norms that stigmatise disclosure of sexual activity within this age group, allowing independent access to HIV services is critically important for improved HIV prevention as well as early access to HIV treatment and care.
- **Support the monitoring and public reporting on legal and human rights violations against key populations.** The current efforts through observatories and participation in ACHPR and UN human rights processes should be sustained over a multi-year period. More effort should be made to reach more audiences with the results of the monitoring. The NCHRF also has a role to play to report on national trends.
- **Develop and implement a strategy to build multi-sectoral understanding and commitment to harm reduction programming for people who inject drugs.** Coordinated, cross-sectoral work should begin to engage the health, law and justice sectors in a process of education, commitment and policy development regarding harm reduction for people who inject drugs. Civil society organizations and technical partners should be

actively engaged in these efforts alongside the active participation of people who inject drugs themselves

- **Develop and implement a multi-year, strategic-level plan to change knowledge, attitudes and practices regarding their constituencies amongst senior government officials, politicians and other leaders.** Building on work done in the context of HIV to bring about greater recognition of their needs and realities, key population-led organizations should develop and act on a multi-year engagement plan with senior government officials and politicians to build their support for comprehensive law and policy change to remove legal and human rights barriers.

PA 7: Reducing discrimination against women in the context of HIV

A number of government, civil society and technical partners are engaged in addressing gender-related concerns in the context of access and uptake of HIV services. These efforts include the following:

- Work by MINPROFF, in collaboration with UNFPA, to sensitize partners on policies and strategies related to gender and to improve access to services for women and children, including survivors of gender-based violence;
- Economic support to address poverty (income generating activities offered through the Centres de promotion femme et famille, for example) (MINPROFF);
- Development of youth friendly services, including components on HIV, through training on guidelines and implementation of "Centres Ado" or adolescent health clinics (WHO, MINSANTE (DSF), and CAMNAFAW);
- Work to improve knowledge and awareness regarding HIV and sexual and reproductive health in schools (MINSANTE (DSF), FESADE);
- Work to mobilise communities to address gender-based violence (FESADE);
- Community level activities to engage young people, including adolescent girls and young women, in knowledge and awareness about HIV and sexual and reproductive health (Presse Jeune);
- Community level activities to engage religious and cultural leaders to participate in stigma and discrimination reduction and promote HIV prevention and access to services amongst adolescents and young people (Presse Jeune and others);
- Training by CHAMP of peer educators, psychosocial counsellors, social workers, clinicians and other service providers in three cities (Douala, Yaoundé, and Bamenda) on GBV response principles and first-line response for key populations (CARE).
- Ongoing reporting and advocacy through the human rights observatories on instances of gender based violence against LGBT people.

The collective national response to gender inequality and gender-based violence is much larger than these specific examples, however. A comprehensive mapping of these efforts was beyond the scope of this assessment. As noted earlier, with UNAIDS support, an HIV-related gender assessment was conducted in Cameroon in 2016 which included an assessment of current efforts to address gender-related barriers. However, at the time of the writing of this assessment, the results had not yet been released.

Within the context of what *this* assessment found, the following should be considered in the development of a comprehensive approach to addressing discrimination against women and girls as a barrier to HIV services:

- **Develop and disseminate, through various channels including peer educators, popularised versions of laws and policies meant to protect women and girls from harmful cultural practices and gender-based violence, and to promote their access to HIV and other SRH services.** This should be a collaborative effort between technical partners, relevant government ministries, technical partners and CSOs. Among other things, it should involve the recruitment of peer educators from among community health prevention and treatment outreach workers who can be trained to also provide information on human rights and laws relevant to women and girls, as well as referrals where problems are being experienced. Female genital cutting and breast ironing were criminalised with the enactment of the revised Penal Code in 2016, for example. However, according to key informants, knowledge about these changes has not reached communities where women and girls most at risk of such practices reside. Greater, collaborative and well-coordinated efforts, particularly between government and civil society partners, are needed to address this gap.
- **Support youth-focussed or youth-led CSOs to work with other youth in communities for stigma reduction, human rights and legal literacy and to promote access to SRH services.** There should be strong components of peer-to-peer engagement, particularly for adolescent girls and young women and for young people living with HIV, as well as young people to work with health care workers in health facilities to reduce stigmatising attitudes and practices deterring young people from access HIV and SRH services.
- **Develop a cadre of paralegals, representative of young women in all their diversity, to provide education, mediation and legal support.** There should be strong components of support young women to challenge stigma and discrimination against them in the provision of HIV and SRH services, as well as to prevent gender-based violence and to support survivors to access health and legal services.
- **Scale up and sustain training and engagement of local cultural and religious leaders to challenge harmful gender norms, to prevent gender-based violence and to encourage use of HIV services.** CAMNAFAW and others are currently implementing such activities but similar efforts have not yet reached all communities. As the work expands, there should be greater attention to monitoring change.
- **Expand comprehensive programmes to support survivors of gender-based violence.** This should be jointly led by the Ministry of Health and the Ministry of Justice with strong collaboration from CSOs and technical partners.
- **Support civil society organizations working with women and girls to monitor the implementation of Penal Code provisions against such acts as forced marriage, sexual abuse and sexual assault, female genital cutting and breast-ironing.** The human rights *observatoires* could be as a model for this work. Current efforts can also be consolidated and better coordinated for more reach into rural and remote communities where women and girls have less knowledge and awareness regarding protective laws and policies, less agency to seek redress and, as a result, more vulnerability to these types of criminal acts.

- **Key population-led civil society organizations, technical partners, CNLS should expand coverage of the integrated approach to addressing and preventing gender based violence amongst key populations based on the results of the current pilot phase.** Good efforts are underway through the CHAMP project and other local partners to provide a comprehensive approach to preventing and responding to gender based violence against key populations. Once these initial efforts are evaluated, such services should be expanded based on the findings.

PA 8: Addressing poverty-related barriers to HIV services

There is no comprehensive approach in Cameroon to addressing poverty-related barriers to access and uptake of HIV services. The Ministry of Health has taken important steps, however, to address some issues.

Starting in May 2007, ARVs were provided free of charge in Cameroon. In addition, MINSANTE has established reduced prices for diagnostic and monitoring tests for HIV care, including for viral load testing. However, for some people living with HIV, even reduced costs of services remain a barrier and, as has been previously noted, compliance with standard price lists is not consistent.

The CNLS has been rolling-out community-based delivery of ARVs through civil society organizations, once initiation to treatment has been carried out at the health facility level, so as to bring HIV treatment closer to people living with HIV and to decongest HIV treatment centres. Progress has been slow, however, and some key informants raised concerns about the structure and funding for the programme that made it difficult for them to participate.

Under the proposed new NSP, there is a commitment to address the poorest people living with HIV with a comprehensive package of needs-based practical supports, including financial assistance. However, a similar commitment was made in the 2014-2017 PSN with very low success as a result of lack of funds, amongst other challenges (MINSANTE, 2017a).

In relation to facility-level compliance with reduced user-fees for HIV services, in 2017, the PLHIV organization Positive Generation launched a tool called *Treatment Access Watch* to monitor access to HIV treatment in Cameroon, including compliance with standard costs. The project supports observers who collect and submit data on access to HIV care from 85 health centres, which is 80 percent of all facilities in Cameroon that provide HIV services. A quarterly report is published with data on indicators such as the percentage of CD4 or viral load examinations performed according to the standard price list. For the latest report, for example, covering 39 facilities in February, 2017, 100% of facilities offered viral load at the stipulated cost of CAF 5,000 while 24% imposed additional charges for CD4 tests above the stipulated price of CAF 2,500 (Positive Generation, 2017).

In the past, different civil society organizations received funding for provision of practical support to people living with HIV, including funds for transport. At the time of the assessment, however, these programmes were no longer operating. Only civil society organizations working with orphans and other vulnerable children were continuing to provide support to families or caregivers to ensure that children are able to access health services, including those that are HIV+ (KidAids, CRS, Swaa-Littoral).

A more comprehensive approach to addressing poverty-related barriers to HIV services would include the following:

- **Expand work by networks of people living with HIV and other key populations that monitor the accessibility and quality of HIV services to include practices of extra charges for services or non-adherence to MINSANTE directives regarding free services or reduced prices.** Civil society organizations engaged in this work should routinely report on the results of the monitoring and use such evidence to maintain and strengthen advocacy efforts with MINSANTE and others to remove all financial barriers to HIV services and to call for a comprehensive, coordinated approach to address the needs of the poorest people living with HIV, including those from all key populations. More targeted and better coordinated efforts are needed to identify the poorest people living with HIV and their families and households, and to provide a package of support that maintains them in HIV programmes while at the same time supports their transition back towards economic self-sufficiency.

Investments to date and costs for comprehensive programming

With regard to funding for human rights interventions, of 30 implementing entities requested to provide financial data on funding sources and amounts for human rights or gender related programming, only 8 responded during the data collection period. **Table 2**, below shows the amounts of funding that were reported under each programme area.

Table 2: Funding by programme area 2015-2-16

Programme Area	2015 (US\$)	2016 (US\$)
Stigma and discrimination reduction	117 833	126 642
Training of HCW on human rights and medical ethics	-	18 824
Sensitisation of law-makers and law enforcement agents	-	84 714
Legal literacy	-	22 567
Legal services	11 765	4 706
Monitoring and reforming laws and policies	18 016	12 795
Reducing HIV-related discrimination against women	-	-
TOTAL	147 614	270 248

Although sources of funding were not consistently given by these respondents, the listed funders included Amnesty International, Rainbow Fund, African Council of AIDS Service Organisations, and Heartland Alliance. Mostly, such grants were for small amounts of US\$10,000 or less. In addition, funding sources included Global Fund and PEPFAR but with insufficient information to identify these amounts in country level allocations for either funder (see below). Changes in funding amounts between years are likely a result of incomplete data rather than changes in programme priorities.

Data was captured on allocations under the Global Fund (not for disbursements or expenditure) for 2016 and 2017 according to each programme area. This data is shown in **Table 3**, below.

Table 3: Allocated funds from Global Fund 2016-2017

Programme Area	2016 (US\$)	2017 (US\$)
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Stigma and discrimination reduction	26 715	396 504
Training of HCW on human rights and medical ethics	152 131	138 481
Sensitisation of law-makers and law enforcement agents	85 773	85 773
Legal literacy	28 136	15 280
Legal services	12 863	17 150
Monitoring and reforming laws and policies	24 934	1 834
Reducing HIV-related discrimination against women	78 006	84 705
TOTAL	408 558	739 726

Between 2016-2017, across a total budget of US\$11 million in grant funds, US\$1.2 million was allocated for activities to address human rights and gender-related barriers. The significant increase in funding for stigma reduction between 2016 and 2017 was due to support for a national stigma reduction campaign in 2017. The reasons for differences in funding levels for other activities were not clear from the data. There are large investments by Global Fund to support interventions for women and girls across the continuum of HIV programmes and to address gender-based violence. These are not shown in the table as it was difficult to distill the specific human rights components from the data. The amounts reflect activities to address HIV-related stigma amongst adolescents and young people, particularly adolescent girls and young women, as well as to train young women as peer educators.

Between 2015 and 2016 (no data was available for 2017), PEPFAR allocated US\$3.2 million (2015) and US\$4.1 million (2016) for a package of HIV prevention and treatment programmes for key populations (primarily men who have sex with men and female sex workers) that included components of stigma reduction, health care worker training, community dialogues, provision of legal advice, and interventions regarding gender, but the specific amounts for each of these items were not disaggregated.

Opportunities for scaling-up interventions

The findings of the assessment demonstrate that there is strong momentum and commitment amongst most HIV stakeholders to improving access to HIV services for people living with HIV and other key and vulnerable populations in Cameroon. Global Fund and PEPFAR support, in particular, has provided important opportunities for developing and implementing human-rights-focussed interventions and, along the way, for improving capacity amongst stakeholders in this domain. As new funding cycles approach, there are opportunities to further strengthen and expand this work.

Key population constituencies are strong and resilient in Cameroon despite the punitive legal and socio-cultural context. What they have lacked is adequate levels of investment as well as multi-year funding commitments that support their core mandates that include, but are not limited to, HIV issues.

Finally, the PSN HIV 2018-2022 provides for an expanded policy context for human rights and gender-related interventions in the context of the HIV response (MINSANTE, 2017b). Under Impact Result 3, which addresses creating favourable environments, stronger protections for the legal and human rights of people living with HIV and other key populations

are called for, and there is a recognition of the important role of civil society, including key population constituencies, for leading advocacy for law and policy change.

All of these present opportunities for further scale-up of interventions to address and remove human rights and gender-related barriers. However, to fully take advantage of these opportunities, the following items should be addressed:

- Mechanisms for coordination amongst key population networks and constituencies should be established or strengthened.
- Gaps in national network structures should be addressed, particularly for female sex workers since, at the current time, there are no FSW-led organizations or networks in Cameroon.
- CNLS structures should be improved or changed. The Ad-Hoc Working Group, for example, has not proved effective at leading and coordinating a national approach to addressing key population priorities. Key populations are not effectively represented in other structures, particularly the TWG on HIV treatment.
- Technical assistance is needed in some areas, for designing and implementing evaluations, and for the development of a harm reduction strategy.

V. Projection of Funding Needs for Comprehensive Programmes for HIV

The projected funding needs for comprehensive programmes to address human-rights and gender-related barriers to HIV and TB services are shown below.

Table 3: Estimated funding needs for comprehensive programming for HIV (US\$)

Programme Area	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Stigma and discrimination reduction	1,105,987	509,678	844,233	418,535	906,706	3,785,140
Training of health care workers on human rights and medical ethics	223,930	337,335	146,148	97,623	271,217	1,076,252
Sensitisation of law-makers and law enforcement agents	300,328	134,590	263,240	131,130	263,240	1,092,528
Legal literacy	70,389	36,661	51,008	52,466	51,008	261,533
HIV-related legal services	294,639	197,105	197,105	276,566	180,737	1,146,152
Monitoring and reforming laws and policies	349,004	247,886	185,038	189,278	151,897	1,123,104
Reducing HIV-related discrimination against women	571,946	490,207	431,123	402,452	490,207	2,385,935
Other activities	8,820	379,774	507,199	379,774	507,199	1,782,766
TOTAL	2,925,043	2,333,236	2,625,094	1,947,825	2,822,211	12,653,408

The limited financial data captured by the assessment suggests that, from other sources besides PEPFAR, for 2016, the level of funding for human rights interventions reached

US\$680,000, including from the Global Fund and other sources, and that this increased to at least US\$740,000 in 2017 from Global Fund sources alone. Sustained over 5 years, this would amount to US\$3,5 million, or approximately 25% the projected US\$12,6 million needed to fully implement a comprehensive approach. During the 2018-2020 period, the country will allocate approximately US\$5 million in Global Fund resources to support expansion of efforts to remove human rights and gender-related barriers. Additional investments from PEPFAR and other funders currently supporting this work should build on this amount meaning that the country will take a substantial step forward towards leveraging the additional financing needed to ensure that the comprehensive approach can be fully implemented over the remaining years.

VI. Baseline Findings: TB

The findings of the assessment for TB are presented as follows: an overview of the TB epidemic in Cameroon, with specific attention to the key and vulnerable populations included in the assessment; information on trends in access and uptake of TB and TB/HIV services to illustrate the extent of current gaps; an overview of the general context for the TB response with a particular focus on the components addressing human rights and gender; an analysis of human rights and gender-related barriers to TB services; an analysis of current efforts to address barriers, including gaps, challenges, and recommendations for a more comprehensive approach; and, finally, an analysis of opportunities for scaling up current efforts over a five-year period.

Overall, TB remains a significant health concern for Cameroon. There is some overlap in the TB and HIV epidemics, meaning that a number of human rights and gender-related barriers identified under HIV also apply in the context of TB. Understanding of human rights and gender in the context of TB is low amongst most stakeholders, however, and at times the assessment team struggled to gain information regarding human rights or gender-related barriers. What information that was obtained pointed to ongoing challenges of stigma and discrimination in communities; lack of compliance with workplace health and safety standards; and poor commitment to TB management in prisons. In response to these challenges, there are some efforts underway to address them; however, most are small in scale or address human rights or gender concerns in the context of TB only in a peripheral sense. More detail on these issues is provided in the following sections.

Burden of TB amongst key and vulnerable populations

In 2015, WHO estimated that there were 49,000 new cases of TB (all forms) in Cameroon for a population incidence of 212/100,000 (WHO 2016). At the country level, there are gaps between estimated and reported cases where, in 2014, the PNLT identified only 26,500 cases or 49% of the WHO estimate of 54,000 for that year.¹² TB notification rates were highest for the cities of Yaoundé and Douala (PNLT 2014b).

Under the TB PSN, the PNLT identifies people living with HIV, health care workers, prisoners, refugees and asylum seekers, and children as key and vulnerable populations. People who inject drugs are also a high-risk population for TB but are not identified as such by the country. No national survey of TB prevalence has been completed in recent times in Cameroon, meaning that a significant gap remains in understanding how TB affects different groups in the country, including key or vulnerable populations. In 2012, a study of TB in prisons showed a case detection rate 11 times greater than the comparable national figure, despite the implementation of HIV and TB prevention and treatment programmes in the prisons (GIZ 2013; Noeske et al. 2014). Overcrowding, lack of ventilation and lack of provision of health services (including TB screening and treatment) were among the factors suggested by the study to explain the differences. The study also found that HIV/TB co-infection rates were lower in prisons than in the general population (11% versus 32% at the time of the study) indicating the important contribution of prison conditions in driving the higher burden of TB in this population (in the general population, high rates of TB infection are directly linked to high rates of HIV infection).

¹² The national figure is derived from programme data while the WHO estimated is modeled. This partially explains the difference.

According to the PNLT, there was a 35% increase in the number of TB cases in the East region between 2013 and 2014. This was attributed to the influx of refugee populations from the Central African Republic in that period. Whether refugees were previously exposed to TB or acquired it as a result of displacement and camp conditions was not investigated. Finally, the PNLT estimated that in 2013, only 4.4% of the estimated 10% of all TB cases that occurred amongst young children (0-5 years) were detected (PNLT 2014b).

In 2014, HIV prevalence was 36% among individuals infected with TB (all forms) and 32% for those with bacteriologically confirmed pulmonary TB. There was a wide variation in HIV prevalence among TB patients between regions from 18% in the Far North to 60% in the North-West (PNLT 2014b). The PNLT is still investigating the causes of these variations. There are no consolidated data on the prevalence of TB amongst people living with HIV nor for sub-groups of people living with HIV, such as men who have sex with men, female sex workers or people who inject drugs. TB remains the primary cause of HIV-related mortality in the country (Agbor et al. 2014).

Current trends in access and uptake of TB services

Data on access and uptake of TB services, particularly for those populations most affected by the disease are almost non-existent. In 2015, the treatment success rate varied widely across the country reaching as high as 85% in the North to as low as 45% in Yaoundé (WHO, 2016; PNLT 2014b). No further disaggregated data is available. Key-population-led groups that support drop-in centres provide TB screening and referral for TB treatment, particularly for newly diagnosed people living with HIV. However, no further programme data on proportions of these individuals that are diagnosed with, and treated for, TB is available. This lack of data presents a challenge then for further quantifying the extent of barriers that exist and for whom, and for tracking progress in efforts to remove the barriers.

Overview of the policy, political and social context relevant to human rights-related barriers to TB services

For the most part, the same overall legal framework regarding human rights and gender in the context of HIV also applies for TB in Cameroon. There are no TB-specific laws for humans (there are for bovine TB).

The TB PSN 2015-2019 is the guiding policy document for the national TB response. The strategy does not comprehensively address human rights or gender issues in the context of TB, a point that has been raised repeatedly by TB advocates (FIS 2014; National TB Community Coalition 2017; KII with National TB Coalition, May 2017). However, the plan does take note of on-going, community-level stigma and self-stigma regarding the disease and supports repeating of the knowledge, attitudes and practices (KAP) study (see below) as well as an enhanced role for civil society organizations at community level, which includes sensitisation and awareness activities to improve knowledge and attitudes towards TB.

Finally, there are no laws or policies that impose compulsory treatment for TB, including MDR-TB. However, in prison settings for example, there are some practices regarding involuntary isolation (see below).

Human rights and gender-related barriers to TB services

The findings in this section consolidate information derived from the literature review as well as the fieldwork. They show that human rights and gender-related barriers to TB services do exist and that they are primarily comprised of community level stigma regarding TB disease,

in part as a result of lack of information about TB, as well as negative associations with TB; lack of capacity and commitment in prisons to effectively manage TB, with overcrowding being a primary driver of this problem; significant challenges related to poverty and the cost of health services; and, lack of compliance with health and safety laws and policies to protect health care workers, prison workers and others from being exposed to and acquiring TB disease.

Stigma and discrimination

Both the desk review findings and the key informant interviews confirmed that TB-related stigma and discrimination occur in Cameroon. This happens largely within the personal and community environments of those affected by the disease. For example, the recently released KAP study found that more than half of respondents felt that those living with TB were rejected in their communities, even amongst those with some knowledge of the disease (Bekang et al. 2016). In general, however, across survey participants, awareness about TB was low. Another study has shown that personal misperceptions about TB (that it is a fatal condition) resulted in delayed diagnosis and treatment (Yakam et al. 2013). Still another has shown similar delays as a result of individual self-stigma and fears of family and community level stigma should their illness become known (Barnabas 2010).

In the view of key informants, both the PNLT and amongst TB advocates, community-level stigma, and stigma in the personal and family environment, and within communities, prevents individuals at risk of TB or already exposed to the disease from acknowledging signs and symptoms and seeking care at health facilities, including TB diagnostic units (CDTs) (KIIs with PNLT and National TB Coalition, May 2017; FIS 2014; National TB Community Coalition 2017). Individuals frequently seek assistance from traditional medical practitioners, for example, before finding their way to health facilities, often with advanced symptoms of TB disease (KII with PNLT, May 2017).

Punitive laws, policies and practices

A number of aspects of the punitive legal context described in **Section 4.4.3**, above, also affect TB, particularly the influence of the punitive legal environment in deterring key population groups from using health services. HIV-related treatment interruptions, in police cells and in prisons, also affects those on TB treatment, for example. Key informants gave no examples of involuntary confinement of TB patients who defaulted on or refused to accept TB treatment in any settings, including hospitals.

Prison overcrowding, and the high turnover of inmates held in temporary detention, create ideal conditions for TB exposure amongst inmates and staff despite the efforts of the Ministry of Justice to improve the situation with support from technical partners (KIIs with Sous Direction Santé Pénitentiaire (MINJUSTICE) and civil society organizations supporting HIV programmes in prisons, May 2017; GIZ 2013). The practice of segregation of prisoners with TB is common, and while it may serve the purpose of infection control where there are very few other options, it contributes to stigmatisation and to the reluctance of other prisoners to come forward for TB screening, diagnosis or treatment (KII with Sous Direction Santé Pénitentiaire (MINJUSTICE) and JAPSSO, May, 2017).

Finally, refugees and asylum seekers without official status or proper documents are reluctant to use public health services, including CDTs, or those services provided specifically in refugee camps for fear that their situation will be discovered and that they will be arrested and deported (KII with CRS, June 2017). Given the high case detection rate for TB in regions

where there are high numbers of refugees, this is a particular concern (KII with PNLT, May 2017).

Gender inequality

According to PNLT programme data and WHO estimates, there is a higher burden of TB amongst adult males than females (PNLT 2014; WHO 2016). This may be due to higher incidence of TB amongst male prisoners as well as the fact that uptake of HIV treatment is lower for males than females in the country. As noted above, however, in the absence of a national TB prevalence survey, further findings are limited.

Issues of gender and gender inequality may also be a factor in low coverage of TB screening and treatment for children. It is primarily mothers or other women caregivers who bring children to health facilities and where, in certain parts of the country, women must have consent from their husbands to go to facilities this will also influence access for children (KIIs with KidAids, AFASO and CRS, June 2017).

Poverty and socio-economic inequality

A number of poverty-related barriers to HIV services are the same for TB. People living with HIV who are destitute will similarly not be able access TB treatment, due to user fees (see below) or transport costs, for example, in the same way that they are prevented from accessing HIV services. Also, individuals infected with MDR-TB face catastrophic costs associated with the lengthy process of diagnosis and treatment, and this contributes to low case detection as well as losses to follow-up once treatment is initiated (FIS, 2014; KII with PNLT, May, 2017).

Through the desk review and key informant interviews, the assessment identified some additional poverty-related challenges specific to TB. These were:

- TB screening is not free (it costs CAF1,000), and this influences whether or not individuals go to health facilities and the timing at which they go in relation to the progression of TB disease. In addition, the cost of diagnostics, such as chest x-rays, cause additional delays as well as loss to follow-up of individuals whose initial TB screen indicates a likely presence of the disease (FIS, 2014; KIIs PNLT, National TB Coalition, May, 2017);
- Some households and communities are far from CDTs and the cost of transport is a factor in delaying diagnosis and treatment (KIIs with PNLT and National TB Coalition, May, 2017);
- TB case notifications are higher in areas of the country that are socio-economically depressed, particularly amongst the urban poor (KII with PNLT, May, 2017);
- As noted previously, adequate food and nutrition, and access to external health services, for inmates relies on the support of family members. Prisoners who are destitute or abandoned by their families have more limited access and are frequently malnourished which affects both susceptibility to TB infection as well as the continuity and success of TB treatment once they are diagnosed (KIIs Sous Direction Santé Pénitentiaire, PNLT and JAPSSO, May-June, 2017).
- Finally, poverty and lack of funds also prevent orphans and other vulnerable children who may be TB-exposed from accessing health facilities or CDTs because their guardians cannot afford the cost of transport or fees for TB screening and treatment (KIIs with KidAids and CRS, May-June, 2017).

Harmful working conditions and exploitation

The assessment identified these main issues raised by key informants regarding workplace conditions and TB:

- Conditions in prisons, particularly overcrowding, poor infrastructure, and poor stock management of supplies and commodities (including protective equipment such as masks) mean that health care workers in prisons and other prison staff have heightened risk of TB exposure (KIIs PNLT and Sous Direction Santé Pénitentiaire, May, 2017);
- Similarly, within health facilities, including CDT, poor infrastructure, and poor stock management for protective devices such as masks, create a heightened risk of TB exposure for health care workers (KII PNLT May 2017);
- Inadequate health services for forestry workers (long distances and inadequate levels of service from mobile clinics) result in lower rates of TB screening and poorer uptake of TB treatment due to long distances to health facilities, including CDTs (KIIs with PNLT and GFBC, May-June, 2017); and,
- Similarly, within refugee camps, levels of health services are not adequate leading to lower levels of TB-related screening, diagnosis and treatment (KIIs with PNLT and CRS, May-June, 2017).

No programme data were available during the assessment to augment these observations, however.

Programs to address barriers to TB services – from existing programs to comprehensive programs

The assessment identified very few specific interventions aimed at addressing or removing human rights or gender-related barriers to TB services. Given the rate of co-infection in the country, interventions addressing barriers to HIV services will also address those related to TB for co-infected individuals. However, a main constraint in the way of a more comprehensive approach was that TB was largely regarded from the medical perspective and not from the community or patient-centred perspective. This meant that knowledge and understanding of the human rights-related components of effective TB programming was very low across all stakeholders.

Although there is a commitment to civil society organization involvement in the provision of TB services at community level, and a platform has been put in place to coordinate this with support from the Stop TB Partnership, there has been very little implementation. The primary reason for this has been lack of funding (the support for the platform does not include interventions), and lack of timely disbursement of available funding by the PNLT (from the TB component of the Global Fund grant, for example), according to the National TB Coalition members. This issue has been highlighted as part of the country dialogue process and addressing it has been put down as a pre-condition of further engagement in the process on the part of the National TB Coalition (National TB Coalition, 2017).

TB issues are also not well addressed within efforts to deal with human rights barriers to HIV services. Amongst key-population-led civil society organizations, for example, TB-related issues are not very prominent in human rights work, although in some instances, as part of health services, TB screening and support for co-infected individuals on TB treatment are provided. Given the high prevalence of HIV amongst key populations, particularly men who

have sex with men, female sex workers and people who inject drugs, it would be expected that there would also be high prevalence of TB. However, as an example of the gap in integrating TB considerations, the recent IBBS surveys amongst men who have sex with men and female sex workers, for example, did not include any questions or indicators for TB.

The following sections describe the limited number of current interventions, as well as a comprehensive approach. In addition, **Annex B** lists a number of **specific activities** that provide further detail on the comprehensive approach.

PA 1: Stigma and discrimination reduction

It is within the mandate of the members of the National TB Coalition to work at the community level to, amongst other things, address TB-related stigma and discrimination. This should be done by improving knowledge and awareness about TB in communities, and supporting individuals to access TB services, as well as to successfully complete their treatment. However, according to key informants, funding to support this work has not been consistent, and, as a result, this work is not currently being carried out country-wide (FIS 2016, 2017; National TB Coalition 2017; KIIs with PNLT and National TB Coalition, May 2017).

Work to address TB-related stigma and discrimination is clearly very limited. A comprehensive response would involve the following activities.

- **Develop and implement a collaborative, multi-year action plan to address TB-related stigma and discrimination on a countrywide basis.** The plan should be based on evidence and understanding of the different forms and effects of stigma and discrimination amongst sub-populations and in specific settings (TB in prisons, for example, or amongst vulnerable children) and contain targeted approaches relevant to these specific groups or circumstances. Technical partners have a role to play in supporting the PNLT to facilitate the development of the action plan. As suggested in the HIV section, measurement of stigma related to TB should occur in both communities and in health care settings to establish the extent of the current challenges.
- **Scale up activities to build resilience of individuals living with TB in communities to resist stigma.** Community-level CSOs, including those that are members of the National TB Coalition, that work to support individuals throughout the TB diagnosis and treatment process also have opportunities to implement activities, including support groups and community dialogues, to increase the ability of individuals and communities to confront and resist TB stigma, including the self-stigma and community stigma it engenders. A complementary strategy would involve encouraging individuals successfully treated for TB to share their stories and to ensure that, amongst those that are encouraged to tell their stories, there is broad representation of diversity across the different populations most affected by the disease.

PA 2: Training of health care providers on TB-related human rights and medical ethics

Comprehensive, TB-specific training of health care workers on human rights and medical ethics has not taken place. One organization, JAPSSO, has included TB-related topics in its sensitisation work with health care workers on HIV and TB-related stigma reduction.

- **Undertake a review of existing TB guidelines and training materials to ensure that human rights and gender dimensions as well as ethics are comprehensively covered.** Where this is not the case, these materials should be revised. The review should ensure that HIV and HIV-related rights are covered in TB

training and TB and TB-related rights are covered in HIV training, particularly for those components addressing the treatment of co-infected individuals.

PA 3: Sensitization of law-makers and law enforcement agents

There are no current interventions working to improve support amongst the law and justice sectors for TB programmes, including for prisoners and other detainees. Recommendations for addressing barriers in prisons are included under **Section 5.5.11**, below.

PA 4: Legal literacy- Knowing your TB-related rights

There are no current interventions that address improving legal and human rights literacy amongst constituencies most affected by TB aside from those that work with people living with HIV and other key populations. However, within these efforts, there is no TB-specific content.

- **To address this gap, the PNLT, the National TB Coalition and technical partners should collaborate to strengthen knowledge and awareness about laws and policies for workplace health and safety for key affected populations.** Health care workers, prison workers and others should be routinely made aware of existing laws and policies regarding workplace health and safety, as well as non-discrimination, and mechanisms for claiming compensation and for seeking redress for violations of laws and policies.

PA 5: TB-related legal services and access to justice

There are no current efforts to provide TB-specific legal services. To address this gap, the following action should be considered.

- **Peer paralegals, lawyers and networks supporting human rights, legal literacy and access to justice for people living with HIV and other key populations should also provide legal support to people living with TB.** In strengthening and expanding access to legal services for people living with HIV and other key populations, specific components addressing TB-related discrimination should be included. Also, amongst the specific competencies to be fostered in a network of lawyers or legal services providers (as described under **Section 4.5.7**, above), addressing TB should be included. These specific TB-related competencies should include addressing workplace discrimination; bringing claims against employers for hazardous working conditions and lack of protective measures; for ensuring access to compensation and other benefits, including in the event of TB-related death; and addressing instances of unlawful confinement of TB patients in healthcare or other settings.

PA 6: Monitoring and reforming TB-related laws, policies and regulations

There are no current efforts supporting monitoring of TB-related laws or policies. To address this gap, the following actions should be considered.

- **Strengthen workplace health and safety protections for health care workers, prison workers, agro-workers, and others.** The PNLT in collaboration with multi-sectoral partners, including civil society, should routinely assess and improve laws, policies and mechanisms to protect the health and safety of employees working in settings where there is high risk of exposure to TB.

PA 7: Addressing gender-related barriers to TB services

Interventions to address gender-related barriers to access and uptake of HIV services will also improve access to TB services, particularly for people living with HIV. While the PNLT has

identified the need to address the gap in men's uptake of TB services, for example, implementation of specific interventions had not yet started at the time of the assessment. To address this gap, the following action should be considered:

- **Conduct a gender assessment of the HIV and TB responses using the UNAIDS/Stop TB Partnership tool.** Following the assessment, national action planning should occur to address the results.

PA 8: Improving confidentiality and privacy

There was no current work being done on protecting confidentiality and privacy for TB patients in health care facilities and other settings. To address this gap, the following action should be considered:

- **Undertake a situational assessment of confidentiality and privacy for people living with TB in health care facilities and other settings and develop an action plan to address the results.** While confidentiality and privacy concerns were not always raised by key informants, some did suggest that management of TB patients in health facilities exposed them and their diagnosis to other patients without their consent. To better understand this issue, PNLT, in collaboration with the National TB Coalition, should undertake an assessment and develop an action plan to address the results should significant issues be identified.

PA 9: Community mobilisation for people living with TB

In addition to the recommendations under **Section 5.5.3**, above, **community support groups for people living with TB should be convened and linked to community level interventions addressing stigma and discrimination** and improving human rights/legal literacy.

PA 10: Improving TB services in prisons

Within the prison system, organisations such as ACMS, JAPSSO and GBFC support the Ministry of Justice to implement TB interventions in some prisons (44 out of a target of 77 are currently covered). Important gaps remain for other facilities not covered by these interventions. The following actions should be considered to address these gaps:

- **Develop a joint MINSANTE and MINJUSTICE policy to ensure that all detainees have access to health services, including TB treatment, throughout their period of detention, including while in police cells.** These needs should be addressed through clearer directives as well as through increased technical and operational support to ensure that needed services, including medications, are accessible.
- **Accelerate efforts to limit the use of pre-trial detention and to improve the process and conditions of pre-trial detainees.** This issue has been identified outside of the context of TB by other stakeholders. A plan is in place to change this practice; however, accelerated implementation is needed.

PA 11: Addressing poverty and socio-economic inequality

Some civil society partners provide practical support, including funds for transport or nutritional support, for example. However these efforts have become rarer as adequate funding is no longer available (KII with National TB Coalition, May 2017). The National TB

Coalition also undertakes advocacy to raise awareness of the costs of TB treatment on individuals and families and the effect this has in deterring timely diagnosis and treatment of the disease (FIS, 2014; National TB Coalition, 2017).

The PNLT has a plan to conduct a study of the 'catastrophic costs' of TB illness on individuals and households. The results will better inform an analysis of how the cost of TB illness affects poor and vulnerable households and constitutes a barrier to effective TB diagnosis and treatment, especially in the case of MDR-TB. Work should be done to ensure that the study plan includes people living with HIV and other key populations, particularly people who inject drugs.

A comprehensive approach to addressing barriers related to poverty would involve the following:

- **Based on the results of the study of the impact of the catastrophic costs of TB care, support civil society advocacy for social protection interventions to address the costs of TB illness.** It is widely accepted that temporary financial assistance schemes or practical support interventions improve access and uptake of TB services, particularly with regard to MDR-TB.
- **Step up advocacy for the elimination of user fees for all aspects of TB diagnosis and treatment.** Many key informants, including the PNLT, raised the cost of TB diagnosis as an important barrier to improving access and uptake of TB services. The PNLT and its partners, including civil society organizations working in communities, should collaborate on a strategy to have the user fees removed, particularly given the urgency of improving the detection and treatment of TB across the country.

Current funding for programmes to remove barriers to TB services

The assessment captured very little information on current levels of funding directed towards efforts to remove barriers to TB services. One implementer, FESADE, provided information to indicate that, between 2015 and 2016, approximately US\$47,000 from Global Fund was spent to train health care workers, civil society organizations, municipal leaders and others (not described) on human rights and medical ethics in the context of TB. In addition, the US\$80,431 provided to JAPPSO, also from Global Fund, and included in the HIV funding analysis, support stigma and discrimination reduction for both HIV and TB.

Global Fund data for TB allocations for 2016 and 2017 showed the following:

Table 4: Allocated funds from Global Fund 2016-2017

Programme Area	2016 (US\$)	2017 (US\$)
Stigma and discrimination reduction	19 816	18 803
Training of HCW on human rights and medical ethics	46 510	-
Sensitisation of law-makers and law enforcement agents	12 075	12 075
Legal literacy	14 293	-
Legal services	-	-
Monitoring and reforming laws and policies	15 384	20 325
Reducing HIV-related discrimination against women	-	-

Improving privacy and confidentiality	-	-
Community mobilisation for people living with TB	-	-
Improving TB services in prisons	44 054	6 324
Total	152 131	57 526

As for other possible investments, given the findings of the assessment regarding the low level of knowledge and understanding of human rights and gender in the context of TB, these amounts are likely to be very low.

Opportunities for scaling-up interventions

There are some limited but important opportunities for scaling up interventions to address human rights or gender-related barriers in the context of TB. The main opportunity centers around the role of the National TB Coalition which remains active and committed to working on human rights priorities, despite that absence of sufficient funding to do so. Other opportunities involve leveraging expanded work with people living with HIV and other key populations on human rights and gender in the context of HIV through the introduction of TB-specific components. As these groups are at high risk of TB because of the high HIV burden, this integration of efforts represents an important way forward. For strategic planning, it is very necessary to improve the quality and quantity of data on the differential burden of TB across different sub-populations and groups. The plan to conduct a TB prevalence survey will help to address this. It is important to ensure that that the study captures the burden of TB across all key population groups, particularly those with the highest HIV prevalence, in addition to more data on access and uptake of TB services for these same groups.

In order to create more opportunities for scaling-up TB-related human rights work, the following action should be considered:

- **Improve knowledge and capacity of all TB stakeholders regarding the human rights dimensions of the TB epidemic in Cameroon and effective strategies to address and resolve human rights challenges.** Excellent resources are now available through the Global Fund, WHO, Stop TB Partnership and others to guide this work (Global Fund, 2017b; Stop TB Partnership, 2015).
- **Develop an integrated approach to addressing human rights and gender-related barriers for HIV and TB services.** This is especially important given the rate of co-infection. The results of efforts to improve data on TB burden by sub-population will help to inform this work by being clearer about which individuals and groups have higher rates of co-infection than others.

To support the implementation of the comprehensive response, the following items should be addressed:

- The PNLT does not currently have sufficient capacity to lead and coordinate a multi-stakeholder effort;
- Additional technical support is needed to improve knowledge and capacity within the PNLT regarding the human rights dimensions of TB and relevant tools and approaches to address them;

- Mechanisms need to be improved for sub-granting between the PNLT and community partners; and
- M&E systems need to be adjusted to include indicators for TB-related stigma and other human rights dimensions.

VII. Costs for comprehensive programs to remove human rights related barriers to TB services

Table 4, below, shows the projected funding needs for comprehensive programmes to address barriers to TB services.

Table 4: Estimated funding needs for comprehensive programming for TB (US\$)

Programme Area	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Stigma and discrimination reduction	392 774	267 705	186 000	267 705	392 774	1 506 957
Training of health care workers on human rights and ethics	29 910			29 910		59 821
Sensitisation of law-makers and law enforcement agents	71 874	-		71 874	-	143 748
Legal literacy	106 584	88 040	-	106 584	-	301 209
TB-related legal services	146 320	146 320	146 320	146 320	146 320	731 600
Monitoring and reforming laws and policies	8 820	8 820	8 820	8 820	8 820	44 100
Reducing discrimination against women in the context of TB	96 115		-	96 115	-	192 230
Improving confidentiality and privacy	-	90 386	-	-	-	90 386
Community mobilisation for people living with TB	54 699	54 699	54 699	54 699	54 699	273 494
Improving TB services in prisons	48 767	132 206	-	-	33 077	214 050
Other activities	-	370 954	-	243 529	-	614 483
TOTAL	955 863	1 159 130	395 839	1 025 557	635 690	4 172 078

As already noted, the assessment was not able to capture all data on current investments to address barriers to TB services. What was available suggests that this funding reached only as high as US\$150,000 in 2016. There is some distance to go, then, for all stakeholders to mobilise the approximately US\$1,000,000 per year that will be needed to fully implement the proposed comprehensive approach to human rights-related barriers to TB services.

VIII. Limitations and Next Steps of the Baseline Assessment

Monitoring Progress

Monitoring progress on the human rights and gender-related dimensions of the HIV and TB responses requires both quantitative and qualitative components.

Annex C gives a proposed set of indicators and baselines for measuring the quantitative aspects of progress towards the removal of human rights and gender-related barriers to access and uptake of HIV and TB services.

With regard to the qualitative aspects of subsequent assessments, the following items should be considered:

- A comprehensive desk review to capture new sources on efforts to address human rights and gender-related barriers as well as new sources on on-going challenges for key and vulnerable populations. Particular attention should be paid to capture the results of evaluations and demonstrated best-practice models.
- Key informant interviews and focus group discussions with relevant stakeholders probing:
 - Changes in the overall programme environment and whether the situation has improved or deteriorated;
 - Changes in levels of service uptake and retention; and,
 - Changes in experiences with the quality and acceptability of services provided.

The same conceptual framework used for this baseline assessment should guide data analysis and the development of recommendations.

Limitations

The assessment encountered some limitations. For the **desk review** component, very little or no human rights or gender-related information was available for some groups, particularly transgender people, people who inject drugs and men who have sex with men.

For the **fieldwork** component, not all stakeholders were available for interview during the period of data collection. Also, data collection occurred primarily in Yaoundé and Douala, and although many informants had knowledge and experience with regard to other regions of the country, the direct experiences of those living in these regions was not captured.

Finally, participation in the **finance and costing component of the assessment** was very limited. Of 30 stakeholders requested to provide this information on their interventions to address human rights and gender related concerns in the context of HIV or TB, only 8 responded with relevant information and 3 responded that they would not provide information. This was in spite of repeated follow-up attempts, and assurances of confidentiality of data. While the data that was received is included in the assessment results, it is far from the original objective of capturing comprehensive information on sources and the use of funds for current efforts to address barriers to HIV and TB services.

Despite these limitations, and with the exception of the financial component, sufficient data was available to describe detailed trends in Cameroon regarding human rights and gender-related barriers to HIV and TB services, as this report has done, and to support the proposed

recommendations for a comprehensive approach to programming to address and remove these barriers.

Next Steps

This baseline assessment will be used as the basis for dialogue and action with country stakeholders, technical partners and other donors to scale up comprehensive programs to remove human rights and gender-related barriers to HIV and TB services in Cameroon. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in order to share the assessment results for consideration and discussion towards using existing opportunities to include and expand programs to remove these barriers to services and to support country partners to develop a 5-year plan to move from the current level of programming towards the achievement of a comprehensive approach. In this 5-year plan, it is envisioned that the country will set priorities as well as engage other donors to fully fund the comprehensive programmes involved.

Finally, in order to build the evidence base regarding programmes to reduce barriers to HIV and TB services, the Global Fund will commission follow-up studies at mid- and end-points of its 2017-2022 strategy to assess the impact on access to HIV and TB services of the expanded programmes put in place under the 5-year plan.

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X. ANNEX A: COMPREHENSIVE PROGRAMMES TO REDUCE HUMAN RIGHTS AND GENDER-RELATED BARRIERS TO HIV SERVICES

Ref	Programme Area	Ref	Activity	Assumptions	Main Implementers	Cost
1	Stigma and discrimination reduction	1.1	Repeat PLHIV stigma index with strong key population and TB component	Follow-up survey in Year 5.	PLHIV networks and technical partners	412 162
		1.2	Develop multi-year action plan for KP networks to coordinate/strengthen stigma reduction activities and implement community activities.	Main planning in sessions in Years 1,3,5. Regional stigma reduction interventions.	KP networks	662 724
		1.3	Media campaigns on HIV and human rights for PLHIV and other key populations	2 per year up to Year 3	CNLS, PLHIV and other KP networks	197 673
		1.4	Integration of issues of PWID in HIV stigma reduction plans and interventions	1 per region per year.	PLHIV and other KP networks with PWID	32 595
		1.5	Strengthen psycho-social support interventions to address self-stigma	1 intervention per region per year.	KP networks	828 656
		1.6	Deploy more PLHIV/KP human rights peer educators outside of Yaounde/Douala	5 per 5 regions.	KP networks	442 500
		1.7	Support PLHIV who are KPs as spokespersons/role models	2 per region.	PLHIV and other KP networks	151 580
		1.8	Review/revised HIV workplace policy and provide training/sensitisation.	Materials, workplace sessions, training of workplace inspectors.	Ministry of Labour and CNLS.	402 556
		1.9	Programme management and M&E			654 694
			<i>SUB-TOTAL</i>			3 785 140

2	Training of health care workers on human rights and medical ethics	2.1	Media campaign regarding commitment to non-discrimination in provision of health services.	Campaign done in Year 1 and 3.	CNLS and MINSANTE	197 673
		2.2	Reinforce of ethics/human rights components of training curricula (pre-service)	Curriculum review in Year 1, follow-up in Year 4.	MINSANTE	78 656
		2.3	Training/retraining on medical ethics/human rights (in-service)	TOT approach in Year 1-3. 50 per region.	MINSANTE	107 910
		2.4	Community meetings with KPs and health facilities	4 per year, 20 pax, per region	MINSANTE and KP networks	80 000
		2.5	Train CSOs on medical ethics/human rights	Workshops in 5 regions for 40 pax.	CNLS	70 200
		2.6	KAP study of health care workers on PLHIV and other KPs (baseline & follow-up).	Study done in Year 2 and Year 5. Includes action planning to address results.	CNLS, MINSANTE, PLHIV and other KP networks	333 506
		2.7	Programme management and M&E			208 307
			<i>SUB-TOTAL</i>			1 076 252
3	Sensitisation of law-makers and law enforcement agents	3.1	Strengthen coordination between CNLS, MINSANTE and MINJUSTICE for removing barriers to HIV services.	4 meetings per year, 15 pax.	CNLS, MINSANTE, MINJUSTICE	31 200
		3.2	Update police training curricula and provide training.	Development of materials and training in 20 districts.	CNLS, MINJUSTICE and technical partners	198 210
		3.3	Update training curricula for judicial officers/magistrates and provide training.	Development of materials and training in 10 regions.	CNLS, MINJUSTICE and technical partners	93 060

		3.4	Training for prisons (management and staff) on HIV/TB human rights	TOT approach. 1 workshop per region for 25 pax for Years 1-3.	MINJUSTICE and technical partners	210 600
		3.5	KP-led community dialogues and activities with police, judiciary, traditional leaders	8 per year, 20 pax, per 6 regions.	MINJUSTICE and KP networks	316 800
		3.6	National advocacy meetings with parliamentarians	1 day meetings for 30 pax, 2 per year.	PLHIV and KP networks, and CNLS	31 200
		3.7	Programme management and M&E			211 457
			<i>SUB-TOTAL</i>			1 092 528
4	Legal literacy	4.1	Support PLHIV and other KP networks to develop common set of tools/materials for improving human rights and legal literacy.	Development in Year 1, review/revision in Year 4. Includes printing/dissemination.	PLHIV and other KP networks	37 910
		4.2	Capacitate PLHIV and other KP peer educators to roll out human rights/patient rights education, integrating where possible into existing groups/mechanisms	10 peer educators per region as TOT. Training in Year 1,3,5.	PLHIV and other KP networks	58 500
		4.3	Strengthen capacity of CSOs working with prisons on rights literacy.	National workshop for 40 pax in Year 1,3,5.	MINJUSTICE, CSOs and technical partners	35 280
		4.4	Roll-out literacy on policies, regulation, laws and rights to prisoners.	TOT approach. 2 workshops per region for 30 pax each for Years 1-5.	MINJUSTICE, CSOs and technical partners	81 750
		4.5	Programme management and M&E			48 092
			<i>SUB-TOTAL</i>			261 533

5	HIV-related legal services	5.1	Train and support cadres of paralegals who are PLHIV and/or other KPs for community education and support on relevant laws/regulations, mediation and dispute resolution, and referral.	5 per region. Training in Year 1, follow-up support in Years 2-5. Includes coordination and back-up legal support.	PLHIV and other KP networks, legal networks	417 956
		5.2	Train traditional and religious leaders to know relevant rights and laws related to women, PLHIV and KPs; resolve disputes; and, reduce discrimination, stigma and violence.	1 sessions per region for 20 pax., Years 1-3.	PLHIV and other KP networks, legal networks	39 600
		5.3	Continue to support for rapid response mechanisms for sex workers, MSM, trans and PWID to protect against harassment, violence, extortion, arbitrary arrest--provincial coordination	0,25 of FTE in 5 regions for coordination. Includes back-up legal support.	KP networks	94 544
		5.4	Train and support more lawyers to provide legal support for PLHIV and KPs, including harm reduction for PWID.	Annual national workshop for 40 pax.	PLHIV and other KP networks, legal networks	114 800
		5.5	Strengthen the capacity of the National Human Rights commission to respond to KP-related human rights violations and to conduct trainings/dialogues	National process to develop TA plan. Stakeholder engagement. Reporting.	Technical partners, KP networks, NCHRF	257 416
		5.6	Programme management and M&E			221 836
			<i>SUB-TOTAL</i>			1 146 152
6	Monitoring and reforming laws and policies	6.1	Advocacy and policy development for change in age of consent for health services.	Planning, coordination, advocacy activities and materials.	MINAS, CSOs and technical partners	159 886

		6.2	For PWID, support development of and advocacy for policy and regulatory framework supporting harm reduction.	Situational assessment followed by planning, coordination, advocacy activities and materials. Annual meeting for follow-up.	KP networks, technical partners, PWID	248 625
		6.3	Development of HIV workplace policy for MINDEF--policy development	Review in Year 4.	MINDEF and technical partners	115 926
		6.4	Support coordinated, country-wide human rights observatory.	Observatory in each region with national coordination and consolidated annual reporting.	KP networks	472 971
		6.5	Support civil society participation in ACHPR and UPR processes--development of briefs	Years 2 and 5. Including developing briefs and budget for meetings/stakeholder engagement.	CSOs and technical partners	125 696
		6.6	Programme management and M&E			269 545
			<i>SUB-TOTAL</i>			1 123 104
	Reducing HIV-related discrimination against women	7.1	Development and dissemination of 'popularised' versions of protective laws and policies for women, girls and children-	Includes materials development, printing/dissemination and community mobilisation.	MINAS, CSOs and other national partners	365 910
		7.2	Strengthen stigma reduction interventions for adolescents, including AGYW.	Development of interventions and national coordination. 1 intervention per region.	CNLS, MINAS, CSOs and other national partners	983 756
		7.3	Develop cadre of peer paralegals for young women and for women--	5 per region. Training and support in Year 1.	CSOs, technical partners and legal networks	313 828

			programme description and materials	Follow-up support in Years 2-5.		
		7.4	Scale-up effort to engage cultural and religious leaders to address harmful gender norms, including gender-based violence, and to encourage access to HIV services.	Training of 40 leaders plus support for dialogues.	CNLS	96 640
		7.5	Roll-out integrated, rights-based approach for addressing and preventing GBV amongst KPs.	Development of programme guide. TOT approach. 1 workshop in 5 regions for 20 pax.	KP networks	68 710
		7.6	Supporting monitoring of laws and legal standards, including CEDAW and CSW comments/reports-- development of breifs	Years 2 and 5. Including developing briefs and budget for meetings/stakeholder engagement.	Gender-focussed CSOs and technical partners	95 296
		7.7	Programme management and M&E			461 794
			<i>SUB-TOTAL</i>			<i>2 385 935</i>
8	Other activities	8.1	Support evaluations of interventions to address human rights barriers.	National and local/project evaluations starting in Year 2.	All partners	1 483 816
		8.2	Convene Human Rights Technical Working Group to monitor/guide comprehensive approach implementation	Annual meeting for 30 pax.	CNLS, PLHIV and other KP networks and technical partners	44 100
		8.3	Conduct mid- and end-term follow-up baseline assessments	In Year 3 and 5.	ICN	254 850
			<i>SUB-TOTAL</i>			<i>1 782 766</i>
			TOTAL			12 653 408

XI. ANNEX B: COMPREHENSIVE PROGRAMMES TO REDUCE HUMAN RIGHTS AND GENDER-RELATED BARRIERS TO TB SERVICES

Ref	Programme Area	Ref	Activity	Assumptions	Main Implementers	TOTAL
1	Stigma and discrimination reduction	1.1	Repeat the KAP study	Study and action planning Year 1. Repeat in Year 5.	PNLT and technical partners	333,506
		1.2	National media campaigns to reduce TB-related stigma	1 in year 2 and 4.	PNTL and National TB Coalition	131,782
		1.3	Expand community interventions to address stigma and discrimination	1 per region.	National TB Coalition	750,000
		1.4	Programme management and M&E			291,669
			<i>SUB-TOTAL</i>			<i>1,506,957</i>
2	Training of health care workers on human rights and ethics	2.1	Reinforce of ethics/human rights components of training curricula (pre-service)	Year 1 and Year 4.	PNLT	29,910
		2.2	Reinforce of ethics/human rights components of training curricula (in-service)	Year 1 and Year 4.	PNLT	29,910
			<i>SUB-TOTAL</i>			<i>59,821</i>
3	Sensitisation of law-makers and law enforcement agents	3.1	Policy development for provision of TB screening/treatment to detainees in holding cells--policy development	Develop policy and disseminate through national meeting for 40 pax. Review in Year 4.	PNLT and MINJUSTICE	115,926
		3.2	Programme management and M&E			27,822
			<i>SUB-TOTAL</i>			<i>143,748</i>

4	Legal literacy	4.1	Activities to strengthen knowledge and awareness regarding laws and policies for workplace health and safety in the context of TB--materials development.	Development materials. Disseminate through 2 workshops per region for 30 pax. Review in Year 4.	PNLT and National TB Coalition	242,910
		4.2	Programme management and M&E			58,298
			<i>SUB-TOTAL</i>			301,209
5	TB-related legal services	5.1	Sustain, scale-up legal services for people living with TB--recruitment and training of paralegals	Included under 5.1 in HIV component.	National TB Coalition	590,000
						141,600
			<i>SUB-TOTAL</i>			731,600
6	Monitoring and reforming laws and policies	6.1	Support annual meetings of National TB Coalition, PNLТ and technical partners to provide monitoring.	3 day meeting per year for 30 pax.	National TB Coalition and PNLТ.	44,100
			<i>SUB-TOTAL</i>			44,100
7	Reducing TB related discrimination against women	7.1	Undertake gender assessment of HIV/TB response using UNAIDS tool. Develop action plan to address results.	Assessment and action planning in Year 1. Follow-up in Year 4.	CNLS and PNLТ	155,024
		7.2	Programme management and M&E			37,206
			<i>SUB-TOTAL</i>			192,230
8	Improving confidentiality and privacy	8.1	Undertake situational assessment and develop action plan to address results.	Study and action planning in Year 2.	PNLT and National TB Coalition	72,892

		8.2	Programme management and M&E			17,494
			<i>SUB-TOTAL</i>			90,386
9	Community mobilisation for people living with TB	9.1	Create/sustain support groups for people living with TB	3 per 20 districts, 12 meetings per year, 10 pax.	National TB Coalition	59,760
		9.2	Support People living with TB as spokespersons/role models in communities.	2 per 20 districts.	National TB Coalition	160,800
		9.3	Programme management and M&E			52,934
			<i>SUB-TOTAL</i>			273,494
10	Improving TB services in prisons	10.1	Advocacy and policy development for pre-trial detention reform	Policy development Year 1. Advocacy Year 2.	PNLT, CSOs working with prisons, and technical partners	79,943
		10.2	Develop joint MINSANTE/MINJUSTICE HIV/TB policy for prisons	Policy development Year 1. Regional sensitisation for prisons in Year 1 and Year 4.	MINSANTE, MINJUSTICE and technical partners	92,678
		10.3	Programme management and M&E			41,429
			<i>SUB-TOTAL</i>			214,050
11	Other activities	11.1	Programme evaluations	5 large/small evaluations in Years 2 and 4.	All partners	487,058
		11.2	Catastrophic costs of TB survey	Survey in Year 2.	PNLT	127,425
			<i>SUB-TOTAL</i>			614,483
			TOTAL			4,172,078

XII. ANNEX C: BASELINE INDICATORS AND VALUES FOR MEASURING PROGRESS

Table 5, below, sets out a proposed set of indicators and baselines for measuring the quantitative aspects of progress towards the removal of human rights and gender related barriers to access and uptake of HIV services. The proposed indicators are in addition to coverage and uptake indicators across the continuum from HIV services, and including harm reduction interventions, with each being disaggregated by age, sex and population groups, as required or recommended by the Global Fund for its grant receiving countries (Global Fund, 2016b).

Table 5: HIV -related indicators and baselines

Indicator	Baseline value	Source/Year
Stigma and discrimination		
% of population reporting denial of a health care service (disaggregated by population)	MSM=5% FSW=1% PWID=no data Transgender=no data PLHIV=2%-5%	Johns Hopkins University et al., 2017; RéCAP+ and GNP+ 2013
% of population reporting poor treatment in health services, including lack of confidentiality (disaggregated by population)	MSM=8% FSW=4%-6% PWID=no data Transgender=no data PLHIV=4%	Johns Hopkins University et al., 2017; RéCAP+ and GNP+ 2013
% of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV.	Males=86% Females=82%	INS, MINSANTE, UNICEF 2015
Violence and abuse		
% of population reporting instance of physical violence in past 12 months (disaggregated by population)	MSM=22.6% FSW=33.5% PWID=no data Transgender=no data PLHIV=12% AGYW=27%	Johns Hopkins University et al., 2017; RéCAP+ and GNP+ 2013;INS and ICF 2012
% of population reporting instances of abuse/extortion by police in past 12 months (disaggregated by population)	MSM=14% FSW=33% PWID=no data Transgender=no data PLHIV=0.5%	Johns Hopkins University et al., 2017; RéCAP+ and GNP+ 2013.
Training and sensitization activities		

# and % of HCWs trained on professionalism/medical ethics	No consolidated data.	This assessment.
# and % of police trained on legal and human rights of PLHIV and other key populations.	No consolidated data.	This assessment.
# and % of judicial officers trained on legal and human rights of PLHIV and other key populations.	No consolidated data.	This assessment.

Access to justice

# of individuals provided with legal advice or services to address legal/human rights challenges.	No consolidated data.	This assessment.
# of lawyers/paralegals/advocates trained to provide legal assistance	No consolidated data.	This assessment.

Law and policy reform

# and type of laws and policies promoting/protecting HIV-related rights of PLHIV and other key and vulnerable populations.	No specific policies for KPs.	This assessment.
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Table 6, below, sets out a proposed set of indicators and baselines for measuring progress towards the removal of human rights and gender related barriers to access and uptake of TB services. The proposed indicators are in addition to coverage and uptake indicators across the continuum from TB services as required or recommended by the Global Fund (Global Fund, 2016b).

Table 6: TB-related indicators and baselines

Indicator	Baseline value	Source/Year
Stigma and discrimination		
# and % of individuals diagnosed with TB experiencing stigma/discrimination in health care settings.	No data.	
# and % of individuals diagnosed with TB experiencing poor service, including lack of confidentiality	No data.	
# of individuals reporting treatment interruptions in police or prison settings.	No data.	

Training of HCWs

and % of HCWs trained on human rights and ethics in the context of TB. No consolidated data.

Legal service and access to justice

of lawyers/paralegals trained and available to offer TB-related legal services No data.

of individuals diagnosed with TB using a legal service in the past 12 months No data.

of individuals diagnosed with TB experiencing discrimination in the workplace No data.

of individuals experiencing discrimination that sought and received redress No data.