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# Cameroon National Strategic Plan For fight against HIV/AIDS and STIs 2021-2023

## Foreword by the Minister of Public Health

The National Strategic Plan (NSP) for the fight against HIV/AIDS and STIs is the guiding instrument for the response to the HIV epidemic in Cameroon for the period 2021-2023. This plan is anchored on the 2016-2027 Health Sector Strategy (HSS) and is oriented towards the consolidation of achievements, the global vision for the end of the HIV epidemic by 2030 and the contribution to achieve the Sustainable Development Goals (SDGs). It was developed on the basis of lessons learnt from the implementation of the previous plan and international and sub-regional orientations and commitments to which Cameroon subscribed.

At the same time, the Head of State, His Excellency Paul BIYA, in his policy of great realisation, of which health is undeniably at the core of social and health policy, endlessly reaffirmed his political will for the well-being of our fellow citizens. Therefore, he instructed the Government to ‘‘provide our health system with the capacity to meet the real needs of the population. This by providing hospitals and health centers with sufficient personnel, equipment and medicines’’ and to work so that in the long run, we end up with "a medical assistance system that would not leave any Cameroonian without care, irrespective of economic status".
For the next three years, the NSP 2021-2023, aims to reduce the HIV incidence, the HIV related morbidity and mortality and the socio-economic burden of the disease on the country's development. The implementation of this plan requires the involvement of all actors in Cameroon (public and private sectors, civil society, religious denominations and grassroot communities). Leadership and coordination will need to be strengthened for greater synergy of actions and efficient use of resources. Thanks to all the national and international teams as well as all the technical and financial partners who have contributed to the updating of this plan.

**Dr MANAOUDA Malachie**
Minister of Public Health

# Acknowledgements

The National Strategic Plan for the fight against HIV, AIDS and STIs for the period 2021-2023 is the result of the commitment of all the actors in the response. This document is a synthesis of a broad national consensus, which was drawn up on the basis of the strengths and weaknesses of the previous plan, taking into account international guidelines. The contributions of the various ministerial departments, civil society organizations, various associations and networks of PLHIV, private and para-public companies and religious organizations have ensured that the opinions and participation of stakeholders, as well as that of beneficiaries, have been taken into account in this planning process for Cameroon's multisectoral response to AIDS, HIV and STIs for the period 2021-2023. The global health crisis of COVID-19 has considerably modified the working conditions of the teams of national and international experts gathered around this mission since March 2020. Nevertheless, NACC has continued the process of developing the extension of the NSP 2018-2022, on one hand to equip itself with a national strategic reference document, and on the other hand to prepare the joint HIV and Tuberculosis funding request for the new funding model 2021-2023 (NFM-3) of the Global Fund (GF). The implementation of this process was made possible thanks to Cameroon's technical and financial partners whose multifaceted contributions were decisive. In this regard, special thanks to UNAIDS, UNICEF, WHO, UNWOMEN, UNFPA, UNDP and ILO, as well as the PEPFAR teams and its attached organizations (USAID, CDC, DoD et Peace corps), representatives of bilateral cooperation and civil society.

I would like to express my gratitude to all institutions and resource persons who have contributed with their commitment and professionalism to the development of this plan.

**Dr. BONONO Leonard**

**Permanent Secretary of the CTG/NACC**

# Abbreviations and Acronyms

| | |
|---|---|
| AEB | Accidental exposure to blood |
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | Antenatal Care |
| ARV | Antiretroviral |
| ART | Anti-Retroviral Treatment |
| CAMNAFAW | Cameroonian National Association for Family Welfare |
| CAMPHIA | Cameroon Population-Based HIV Impact Assessment |
| CBO | Community Based Organizations |
| CTG | Central Technical Group |
| CCM | Country Coordinating Mechanism |
| CSO | Civil Society Organizations |
| COVID-19 | Corona virus Disease-2019 |
| CDC | Center for Disease Control |
| CDI | Community Directed Interventions |
| DHS | Demographic Health Survey |
| DDPEC | Department of Disease Pandemic and Epidemic control |
| DPML | Department of Pharmacy, Medicines and Laboratory |
| DIC | Drop-In Center |
| DUs | Drug Users |
| e-MTCT | Elimination of Maternal to Child Transmission |
| EID | Early Infant Diagnosis |
| FSW | Female Sex workers |
| FSWs | Female Sex Workers |
| GF | Global Fund |
| GIZ | Deutsche Gesellschaft für Internationale Zusammenarbeit |
| HAPP | « HIV/AIDS Prevention Program » |
| HD | Health District |
| HIV | Human Immunodeficiency Virus |
| HSH | Hommes ayant des rapports sexuels avec des hommes |
| HSS | Health System Strengthening |
| HV | Home Visits |
| IBBS | Integrated Bio-Behavioral Survey |
| IDB | Islamic Development Bank |
| ILO | International Labor Organization |
| IP | Implementing Partners (PEPFAR/FM) |
| IUD | Injection Drug Users |
| KP(s) | Key Populations |
| LTFU | Lost to Follow Up |
| MCH | Maternal and Child Health |

| | |
|---|---|
| MoH | Ministry of Health |
| MIC | Multiple indicator Cluster Survey |
| MoT | Mode of Transmission |
| MSM | Men who have sex with men |
| MNCAH | Maternal, Newborn, Child and Adolescent Health |
| MTCT | Mother to Child Transmission |
| NACC | National AIDS Control Committee |
| NFM | New Funding Model |
| NGO | Non-Governmental Organization |
| NHIS | National Health Information System |
| NSP | National Strategic Plan |
| NTCP | National Tuberculosis Control Program |
| OST | Opioid Substitution Treatment/Therapy |
| PEPFAR | President Emergency Fund for AIDS Relief (USA) |
| PITC | Provider Initiated Testing and Counselling |
| PLHIV | People living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PrEP | Pre-Exposure Prophylaxis |
| PEP | Post Exposure Prophylaxis |
| PSA | Psychosocial Agents |
| PW | Pregnant Woman |
| PWDS | Persons with disabilities |
| R2P | Research to Prevention Program |
| RDT | Rapid Diagnostic Test |
| RR | Risk Reduction |
| SDGs | Sustainable Development Goals |
| STIs | Sexually Transmitted Infections |
| SW | Sex Workers |
| TB | Tuberculosis |
| TG | Transgender |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Program |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations International Children's Emergency Fund |
| UNODC | United Nations Office on Drug and Crime |
| UN women | United Nations Entity for Gender Equality and Empowerment of Women |
| UPEC | HIV care and treatment unit |
| UTH | University Teaching Hospital |
| VCT | Voluntary Counselling and Testing |
| VL | Viral Load |

| | |
|---|---|
| WHO | World Health Organization |

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# 1 Introduction

In Cameroon, the fight against HIV/AIDS is a public health priority. As a result of the combined efforts of all actors in the response to the HIV epidemic, remarkable progress has been made and encouraging results achieved.

The continuous decline in new infections (-48%), and deaths (-37%) between 2010 and 2019, as well as the increase in antiretroviral (ARV) treatment coverage for people living with HIV (PLHIV) estimated at 68% in 2019 illustrate this.

These results arise from the dynamism of the response to HIV, political commitment at the highest level, the know-how and involvement of government and civil society actors, with the constant support of technical and financial partners.

Despite these improvements, many challenges remain at the programmatic and financial levels to achieve the set targets and accelerate the implementation of strategic interventions that should lead Cameroon towards the elimination of the epidemic by 2030.

In a context of limited resources and competing priorities, investment in the response must be both strategic and targeted, with a focus on innovation.

In this way: (i) scaling up combined prevention and differentiated testing strategies amongst most-at-risk populations and their partners; (ii) the link to treatment in applying the "test and treat" strategy; (iii) keeping people treated in care (retention) to achieve viral suppression, are the key components of this revised National Strategic Plan (NSP) for the period 2021-2023.
This NSP 2021-2023 is the result of a revision and extension of the previous NSP 2018-2022, based on a review of implementation during the period 2018-2019. It is the result of an inclusive and participatory process of analysis of the situation and the response, results-based planning involving all actors at the decentralized level, the public sector, civil society organizations, the private sector and international partners through broad consultation.

The process of drafting this document was led by the National AIDS Control Committee (NACC), with technical and financial support from UNAIDS.

This revised NSP for 2021-2023 therefore constitutes the single framework for all actors in the fight against HIV/AIDS in Cameroon, the reference for programming activities at national and regional levels, and the essential tool for the harmonisation and alignment of partners. It reflects the vision and commitments of the Government of Cameroon to make decisive progress towards the elimination of AIDS, using all opportunities and resources, both domestic and external.

# 2 Background to the development of NSP 2021-2023

The framework for developing the 2021-2023 NSP has been significantly influenced by the global health crisis caused by COVID-19. Despite these unprecedented constraints, the national dialogue was maintained in a continuous, inclusive and participatory manner. It enabled a large panel of key actors in the response to join the various discussion and exchange forums. Some major milestones marked the development of the 2021-2023 PSN:

- the epidemiological and programmatic review of HIV infection and its co-morbidities in Cameroon was an essential step in understanding the current dynamics of the epidemic and observing the extent to which the national response has been adapted;
- national stakeholders reached a national consensus on the priorities of the HIV response and the revised NSP results framework (down to strategies and interventions) at the Mont Fébé Planning Workshop (March 2020);
- working groups further developed and finalized the process through 3 workshops of elaboration and technical validation bringing together national and international experts, including representatives of civil society and key populations (KPs).

The process was marked throughout by continuous communication and sustained exchanges with the various implementing partners: health professionals, civil society organizations, community based organizations, identity or faith-based organizations; networks of women, young people, PLHIV, KPs, the private and public sectors, professional organizations, development partners, particularly UNAIDS and its co-sponsors (WHO, UNICEF, UNFPA), PEFFAR and its related organizations (USAID, CDC, DoD, Peace Corps).

During the pre-COVID-19 period, technical meetings were held face to face but from March 2020, the confinement imposed by the COVID-19 health crises led to the systematic use of internet videoconferencing platforms.

# 3 Summary of the epidemiological situation of HIV

## *3.1 Overview of the HIV situation in the general population*

Cameroon is facing a mixed epidemic, both generalized and concentrated in certain groups of most at risk populations. The overall HIV prevalence among the adult population aged 15-49 is 2.7% [2.5-3.1] according to the latest Demographic and Health Survey (DHS-V of 2018). The prevalence is on a downward trend since 2004, as shown in Figure 1. In fact, in 2004 HIV prevalence was 5.5%. It dropped to 4.3% in 2011 and 3.4% in 2017. The evolution is similar in both sexes and the gender differential has persisted since 2004, with a sex ratio of about 2:1.

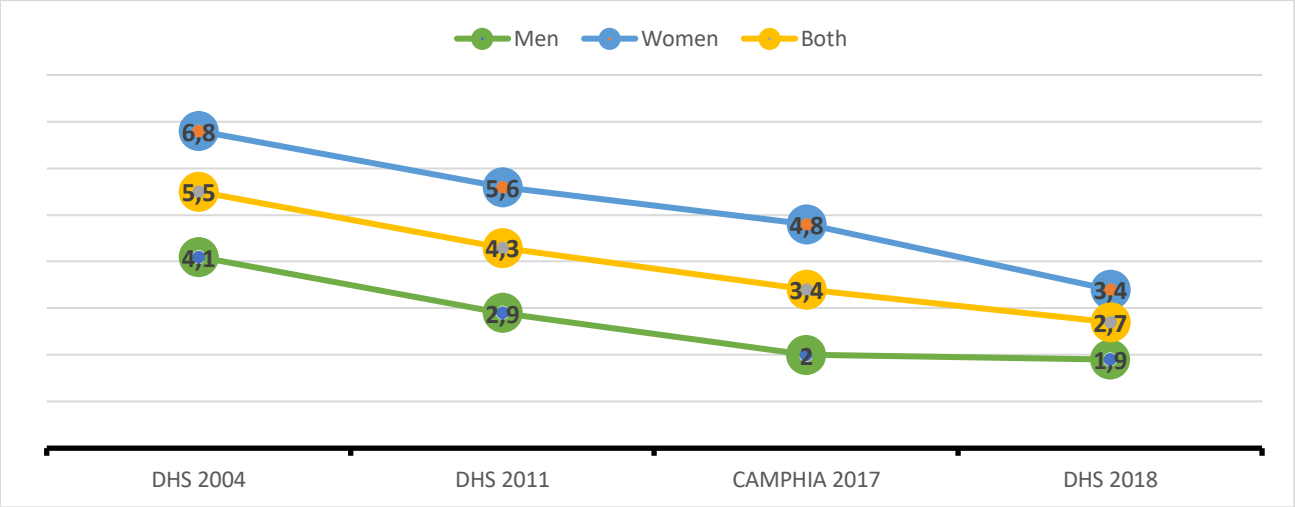


Figure 1: Trends in HIV prevalence among 15-49 years old in Cameroon 2004-2018

## *3.2 Geographical distribution of the epidemic*

The DHS 2018, shows that 06 out of 10 regions have a prevalence above the national average (2.7%), namely: South 5.8%, the East 5.6%, Adamawa 4.7%, North-West 4%, South-West 3.2% and Centre 3.5%. The significant drop in HIV prevalence at the national level is not observed in all regions compared to previous studies. In fact, prevalence is almost stable in the Far North, North and South regions, while the Centre region (with the exception of Yaoundé) shows a relatively small decrease.

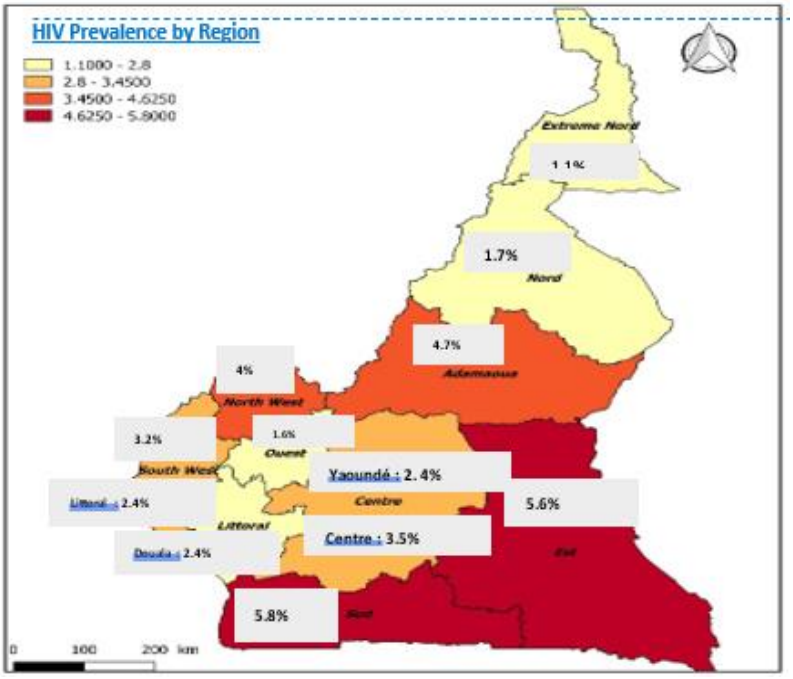


Figure 2: HIV prevalence per Region in Cameroon in 2018

## *3.3 HIV prevalence by age group*

According to the DHS 2018, disparities between age groups and gender remain very significant. While in the ag group 15-19 the prevalence is almost the same for men and women, the gap widens from the age group 20-24. Generally, the prevalence is higher for women than men in the age group 15-49 (3.4% versus 1.9%) and in all age groups after the age of 19. In females, the HIV prevalence starts at 0.8% in the age group 15-19, increases to 6.5% in the age group 35-39 and then drops to 4.9% and 4.8% in the age groups 45-49 and 50-64 respectively (figure 3).

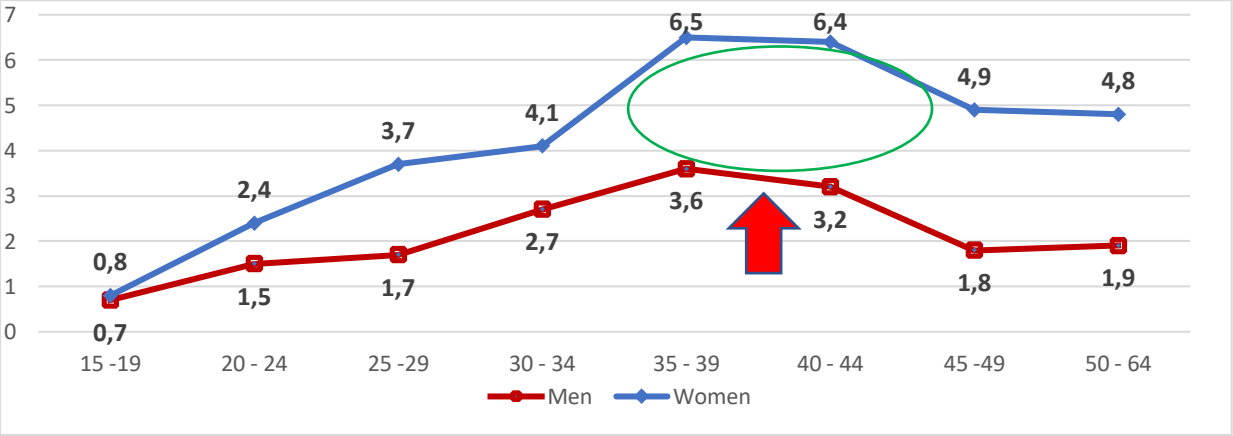


Figure 3 : HIV prevalence by age group in Cameroon in 2018

Amongst men, the prevalence increases slowly, from 0.7% in the age group 15-19 to 3.6% in the age group 35-39, then drops to 1.8% and 1.9% in the age groups 45-49 and 50-64 respectively. The same survey showed that the 25-29 and 30-34 age groups are most affected in both sexes.

An analysis of the evolution of the prevalence rates measured in the DHS since 2004 by age groups show a gradual shift in the acquisition of infection towards a higher age groups between the 2004, 2011 and 2018 DHS. The gender differential, which was particularly accentuated in the 20-24 age group in 2004 and 2011, is relatively less in 2018, but is more pronounced from the age groups 35-39 to 50-54.

Table 1: HIV prevalence by sex and age group measured in DHS from 2004 to 2018

| | DHS 2004 | | | DHS 2011 | | | DHS 2018 | | |
|---|---|---|---|---|---|---|---|---|---|
| **Ages** | F | M | All | F | M | All | F | M | All |
| **15-19** | 2,2 | 0,6 | 1,4 | 2 | 0,4 | 1,2 | 0,8 | 0,7 | 0,8 |
| **20-24** | 7,9 | 2,5 | **5,5** | 3,4 | 0,6 | 2,2 | 2,4 | 1,5 | 2 |
| **25-29** | 10,3 | 5,1 | **7,8** | 7,6 | 3 | **5,5** | 3,7 | 1,7 | 2,8 |
| **30-34** | 9,4 | 8,3 | **8,9** | 7,3 | 5,3 | **6,3** | 4,1 | 2,7 | 3,5 |
| **35-39** | 7,8 | 8,6 | 8,2 | 10 | 5,8 | **8,1** | 6,5 | 3,6 | **5,1** |
| **40-44** | 6 | 5,6 | 5,8 | 7,1 | 4,7 | 5,9 | 6,4 | 3,2 | **4,8** |
| **45-49** | 5,5 | 3,8 | 4,7 | 6,4 | 6,3 | 6,3 | 4,9 | 1,8 | **3,4** |
| **50-54** | NA | 2,5 | NA | 5,6 | 2,9 | 4,3 | 4,8 | 1,9 | 3,5 |
| **55-59** | NA | 1 | NA | Na | 2,9 | NA | 3,4 | 1,9 | 2,7 |

## *3.4 Estimates of the HIV epidemic*

According to 2020 Spectrum, the number of people living with HIV in Cameroon is estimated at 506,432 in 2019, including 33,289 (6.5%) children under 15 for a sex ratio of 1:1 and 308,079 women amongst 474,951 PLHIV aged 15 to 49 (65%).

Table 2: Spectrum Estimates of Number PLHIV 2017 to 2020 (source Spectrum 2020)

| | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| **N° of PLHIV (total)** | 509 989 [448-564] | 507 467 [448-563] | 506 432 [447-559] | 504 472 [443-557] |
| **Children< 15 HIV+** | 33 289 [26-40] | 33 289 [26-40] | 33 289 [26-40] | 33 289 [26-40] |
| **Adults (15-49 yrs)** | 474 213 [414-521] | 474 178 [417-521] | 474 951 [418-523] | 475 954 [419-525] |
| **Women** | 315 871 [277-349] | 316 765 [279-349] | 318 079 [280-350] | 319 369 [279-352] |

| | | | | |
|---|---|---|---|---|
| **Prevalence / adults** | **3,4% [2,9-3,8]** | **3,2% [2,8-3,6]** | **3,1% [2,6-3,5]** | **3,0% [2,5-3,4]** |
| **- Men** | 2,2% [1,7-2,5] | 2,1% [1,6-2,4] | 2,0% [1,5-2,3] | 1,9% [1,4-2,2] |
| **- Women** | 4,5% [3,9-5,1] | 4,4% [3,8-4,9] | 4,2% [3,6-4,8] | 4,1% [3,5-4,6] |

:

### 3.4.1 HIV incidence

Spectrum 2020 estimates show a drop of 48% in new infections in the general population from 33,183 in 2010 to 17,113 in 2019. In 2019, children under the age of 15 accounted for 19.3% (3,308) of new infections and women accounted for 2/3 of new infections in the age group 15-49 (9,043/13,806). While the sex ratio is 1:1 in the age group 0-15, new infections among girls are 3 times higher than among boys in the age group 15-24. Amongst adolescents aged 10-19, girls have about six times more new infections than boys, a difference observed since 2004. In 2019, the age group 15-24 accounted for more than 30% of new infections and the age group 0-9 for about 20%, the latter mainly as a result of mother-to-child transmission of HIV.

The appearance of a very significant difference between boys and girls in the age group 10-19 (sex ratio of 1:6) can only be explained by the early and disproportionate infection amongst girls between 15 and 19 years through sexual transmission. In the general population [15-49 years], the sex ratio remains clearly unbalanced to the disadvantage of women, at about 1:1.8. The incidence of HIV infections per region and Health District (HD) is not homogeneous. Indeed, the North West region, Douala and Yaoundé are the geographical areas with the highest number of new infections amongst women (830-1310), followed by the South West, Centre and Far North regions (730-830).

### 3.4.2 HIV-related deaths

According to Spectrum 2020, there were 14,058 [11,773-16,105] HIV-related deaths in 2019.

Table 3: Spectrum Estimates of Number HIV related Deaths 2017 to 2020 (source Spectrum 2020)

| | **2018** | **2019** | **2020** |
|---|---|---|---|
| **N° of HIV related Deaths** | 16 232 [14-18] | 14 058 [12-16] | 12 685 [10-15] |
| **Adults 15-49 years** | 10 333 | 8 668 | 7 620 |
| **Men** | 4 454 | 3 797 | 3 290 |
| **Women** | 5 879 | 4 871 | 4 330 |
| **Youths 15-24 years** | 965 | 897 | 868 |
| **Boys** | 554 | 513 | 482 |
| **Girls** | 538 | 490 | 460 |
| **Children < 15 years** | 2 572 | 2 515 | 2 367 |
| **Boys** | 1 292 | 1 266 | 1 186 |
| **Girls** | 1 280 | 1 249 | 1 182 |

The trend is also due to a steady decline in HIV-related deaths from 22,244 in 2010 to 14,058 in 2019 (37%). Of these deaths, 2,515 [1,608-3,496], that account for 18%, occurred in 2019 among that under-15, with no difference between men and women.

The incidence-to-prevalence ratio, usually used to illustrate the evolution of the control of the epidemic, shows that the figure of 2.2% reached in 2019 has fallen below the 3% threshold, which is considered to be the target for the control of the epidemic. Cameroon has therefore made progress towards controlling the epidemic.

### 3.4.3 Estimates of mother-to-child transmission and pediatric HIV

According to the Spectrum estimate, the total number of children infected through mother-to-child transmission (MTCT) was 3,308 in 2019, equivalent to an estimated transmission rate including residual transmission through breastfeeding of 14.2%.

The largest numbers of pediatric infections acquired through MTCT come from women who have discontinued ARV treatment during pregnancy and from women who have not received ART at all.

In 2019, an estimated 3,308 new HIV infections occurred in children under 15 years of age (the vast majority by MTCT), representing 19% of all new infections. The total number of children living with HIV in Cameroon was estimated at 31,481 (Spectrum 2020), representing 6.2% of all PLHIV.

## *3.5 In key and vulnerable populations*

### 3.5.1 Key populations

Cameroon has identified as KPs female sex workers (SWs), men who have sex with men (MSM), drug users and especially injecting drug users (DUs and IDU), because they have a much higher risk of HIV infection than the general population.

A total of three IBBS surveys have been conducted among MSM and SWs in Cameroon over the last decade, but there are no estimates of HIV prevalence among DU/IDU yet. Available prevalence data from the 2016 IBBS and population size estimates from the 2018 key population mapping are detailed in the table below.

Table 4: Prevalence and size estimates of KPs in Cameroon (IBBS 2016)

| | **Observed Prevalence** | | **Population size** |
|---|---|---|---|
| | HIV | Syphilis | |
| **SW** | 24,3% [15,1-32,9] | 8,2% | 70 487 |
| **Clients of SW** | No data | | Number of SW x 5 |
| **MSM** | 20.7% [3,9-43,3] | 2.7% | 7 023 |

| | | | |
|---|---|---|---|
| **Transgender** | No data | | No data |
| **DU** | No data | | 9 823 |
| IDU | No data | | 2 453 |

These groups are not uniformly concentrated throughout the country: the majority of high-risk behaviors within KPs are observed in urban areas, in the country's largest cities (Yaoundé and Douala), but also in some secondary cities, as shown by the mapping for the estimation of the size of KPs carried out in 2018 in the 10 regions, particularly in «hotspots".

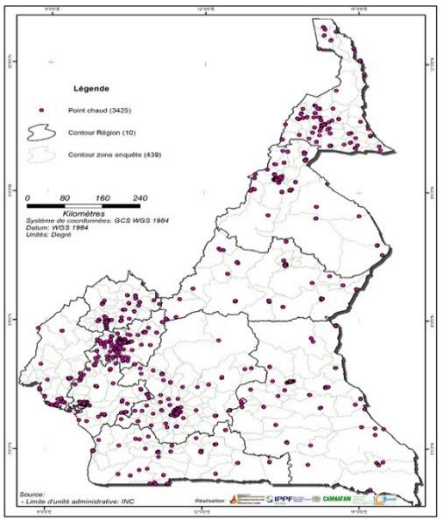


Figure 4: Distribution of hot spots in 2018 (Mapping 2018)

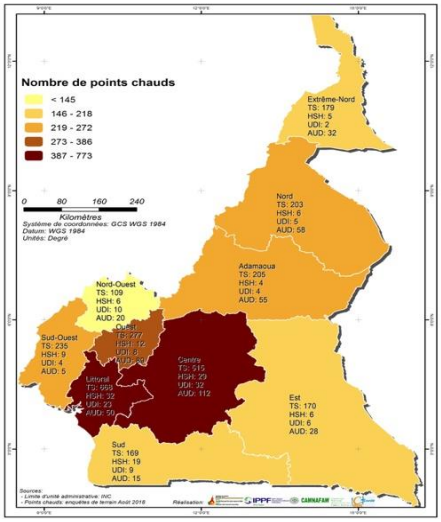


***Figure 5 : Distribution and number of FSW, MSM, IDU and DU hot spots in 2018 (Mapping 2018)***

## 3.5.2 Specific groups

In the 2018 mapping, an estimate of the number of vulnerable adolescents and young people was also done in all identified sites.

The table below also provides detailed prevalence or seropositive rates data for several specific groups:

Table 5: Prevalence and size estimates of vulnerable populations in Cameroon

| | **Prevalence / observed HIV seropositive rates** | **Estimated population size** |
|---|---|---|
| **Pregnant Women** | 5,75% [2,6-9,7] SS 2016 | |
| **Youths and Adolescents** | 15-19 years : M 0,7% et F 0,8%<br>20-24 years : M 1,5% et F 2,4%<br>DHS 2018 | 201 653 [155 615-247 691] |

| | | |
|---|---|---|
| **Detainees** | 2,3% (annual report NACC, 2018)<br>2,5% (annual report NACC, 2019) | 30 689 |
| **Refugees and displaced persons** | 1,5% (annual report NACC, 2019) | 419 789 refugees and asylum seekers<br>976 773 internally displaced |
| **Workers in economic poles** | 7.8% agro-industries / industrial plantations<br>4.1% forestry operations (2.9% in 2019)<br>6.04% construction<br>GFBC annual report, 2019 | 10 434 wood workers |
| **People with disabilities** | 3,9% [2,9-5,5] (annual report NACC, 2015)<br>annual report NACC, 2019 | |

However, there is no recent and reliable estimate of the number of clients of SW or recent prevalence data, even though they are a central group in the dynamics of HIV transmission in Cameroon. In practice, SWs report an average of 1 to 5 clients per day, which provides a basis for estimating the overall and variable number of clients (MoT model for Cameroon in 2012).

### *3.6 Behavioral aspects*

In the DHS 2018, limiting sexual intercourse to a single faithful and uninfected partner (84% of women and 82% of men 15-49 years old surveyed) and regular condom use (77% of women and men 15-49 years old surveyed) remain the main means of preventing HIV infection. Overall, 71% of both women and men know these two means of HIV prevention, a higher score in urban than in rural areas (76% vs. 65% amongst women; 76% vs. 64% amongst men).

In the 15–24-year-old population, only 36% of women and 33% of men had full knowledge of the means of HIV prevention in the DHS 2018. A higher proportion in urban than in rural areas has been observed, (41% vs. 29% among young women; 39% vs. 25% among young men respectively). Complete knowledge about HIV increases with the level of education among young people (from 27% among the uneducated, 47% in upper secondary school, 56% in higher education among women; 9%, 44% and 59% among men respectively). In view of these results, out of school young people must be considered more vulnerable, especially young women (about 6 times more new infections than young men). Promoting programs that keep young girls in school as long as possible is strategic, in a context where 13% of young girls are married before the age of 15 (UNICEF, 2016).

### *3.7 Conclusions on the HIV epidemiological situation analysis*

With a 50% reduction of new HIV infections since 2010 and a reduction in the number of HIV-related deaths by more than a third over the same period, Cameroon is experiencing a real downturn in the HIV/AIDS epidemic. In slow decline, prevalence was estimated at 3.1% in 2019.

The weight of the epidemic remains unevenly distributed, concentrated in 6 regions (South 5.8%, East 5.6%, Adamawa 4.7%, North-West 4%, South-West 3.2% and Centre 3.5%). The 35-39 and 40-44 age groups are the most affected by HIV in terms of prevalence, and women represent 67% of people living with HIV above 15 years of age.

Moreover, the strong dynamics of the epidemic among KPs persists, resulting in high prevalence rates, exceeding 20% in 2016.

It is estimated that 30% of new infections occur amongst young people (15-24 years), in which girls are 6 times more infected than boys in the age group 15-19. The DHS-V 2018 showed that only half of them report having used a condom during their last sexual intercourse with a casual partner: risk behaviors persist. If the age range is widened to 15-24 years, the sex ratio decreases, but remains very unbalanced (3 infected girls for 1 boy).

The large number of pregnant and breastfeeding women not receiving PMTCT services maintains an abnormally high overall rate of MTCT (14%), contributing to 19% of new infections overall.

In total, despite an HIV epidemic that has been significantly declining since 2010, Cameroon continues to face a generalized epidemic, coupled with a high concentration among key populations (SW and MSM). The epidemic affects women more, particularly young girls. The age group of young people (15-24 years) and children exposed to HIV through mother-to-child transmission account for nearly 50% of new infections.

# 4 Synthesis of the national response

## *4.1 Preventing HIV infection*

As of 2011, the KPs identified in the NSPs are SW, MSM, and DU/IDU. Recently, TGs have been added to this category. Adolescents and young people, prisoners, refugees and displaced persons, workers in economic centers and people with disabilities are also receiving more attention as vulnerable populations. These different plans call for the implementation of targeted approaches, taking into account the principles of gender equality, respect for human rights and the absence of barriers to access to health services (NACC, 2010; Mossus-Etounou et al., 2016).
These strategic orientations have been progressively reinforced in successive NSPs.

The strategies implemented aim to strengthen prevention with : (i) communication for behavioral change, through the development of differentiated approaches, according to age groups, favoring the acquisition of skills for the adoption of low-risk behavior; (ii) the provision of a complete or

adapted package of combined prevention services for priority populations; (iii) the strengthening of access to prevention services and the management of accidents involving exposure to blood and biological fluids AEB; (iv) the prevention and management of people presenting signs of STIs.

### 4.1.1 Key populations

The combined prevention program implemented by institutional and community actors has enabled to cover more than 50% of the beneficiaries in 2019 among KPs and vulnerable people. The package of integrated interventions for KPs is defined in the norms and standards guide for combined prevention, implemented by field workers, peer educators, peer navigators and other professionals from sexual health clinics.
The main lessons learned from the implementation are as follows:

- Programmatic performance is weak among SWs;
- The absence of a national risk reduction policy reduces the impact of interventions targeting DU/IDUs: the package of services for IDUs is very limited and only takes into account the sexual transmission of HIV; there is no real RoR/injection transmission program; there is no structured service provision in addictionology; although an initial mapping and population size estimate of DU/ IDUs is available, there is still no bio-behavioral data available for them;
- The interventions implemented for prisoners have been considerably reduced and the gains made during previous years risks being lost;
- The harmonization of the unique identifier code for KPs is not sufficient to guarantee the absence of multi-counting of beneficiaries;
- Efforts are needed to diversify intervention strategies among KPs: how to reach those who do not adhere to interventions by community actors (DIC type, hot spot screening, festive events, etc.)? The peer-educator "mentor" approaches for MSM and KPs should be developed to reach high social class MSM and FSWs and MSM over 40 years of age;
- PrEP provision for FSWs is struggling to be rolled out (only continuous optional provision is offered, the only recommended method for this target); major efforts are needed to accelerate interventions targeting STDs;
- Significant effort is needed to include specific approaches targeting transgender people (no specific interventions for TGs yet) and to accelerate interventions targeting STDs.

### 4.1.2 Prevention in other vulnerable populations

Other vulnerable populations are also targeted by prevention interventions. The definition of other vulnerable populations, which is not always very precise in the NSP, includes workers in economic sites, truck drivers, workers in uniform, people with disabilities, refugees or displaced persons, prisoners and indigenous populations (pygmies, Bororo, and others).

The prevention program implemented by institutional and community actors has made it possible to cover the following beneficiaries in 2019 among other vulnerable populations.

Table 6: Services offered to vulnerable populations in 2019

| | Prisoners | Refugees | PWDS | Workers | young boys out of school | young girls out of school |
|---|---|---|---|---|---|---|
| **Estimated Population** | 30.357 | 170.234 | | 208.959 | | |
| **Number of educational talks** | 17.453 | 19.156 | 34 | 999 | 2.673 | 2.200 |
| **Number of recipients of educational talks** | 260.430 | 415.440 | 365 | 42.456 | 53.410 | 43.839 |
| **Number of individual counselling sessions** | | | | | 72 350 | 58 450 |
| **Number of people counselled for screening** | 21.418 | 1.046 | 2.636 | 10.434 | 46.977 | 42.910 |
| **Number of people tested for HIV** | 21.418 | 1.046 | 1.004 | 10.434 | 46.871 | 42.750 |
| **Number of people who withdrew their result** | | | 1.004 | | 46.618 | 42.492 |
| **Number of people tested HIV+** | 527 | 16 | 6 | 304 | 330 | 494 |
| **Number of male condoms distributed** | | 42.400 | | 100.800 | 15 378 | 12 738 |
| **Number of female condoms distributed** | | 1.800 | | 7.200 | - | 12 700 |
| **Number of lubricating gels distributed** | | 2.400 | | 6.100 | 3 080 | 2 552 |

There is no specific data available on clients of FSW. It is worth noting the need to:

- Clarify exactly what is considered "other vulnerable populations", for example by using the determinants of vulnerability of these groups rather than imprecise categories, such as economic site workers, workers in uniform, or native populations; as such, SW clients are probably a more relevant category amongst these other vulnerable populations;
- Sufficiently consider People with Disabilities (PWD) in the implementation of the response;
- Improve the overall performance of the program for other vulnerable populations.

### 4.1.3 Prevention among adolescents and young people

Within the adolescent and youth population, the level of knowledge about HIV remains very insufficient (see 3.6), unchanged since the Multiple indicator cluster survey (MICS) study of 2014. The targets of 80% coverage in the 4-9, 10-14 and 15-24 age groups are still very far off. For example, less than 10.6% of the 15–24-year-old population (19,000 / 179,600) benefited from the service package of the specific prevention program in 2019.

### 4.1.4 Accidental exposure to Blood and Body fluids (AEB)

It is not possible to assess the implementation of post-exposure prophylaxis (PEP) through the health information system.

Feedback from the care sites visited reveal many difficulties in implementing the procedures planned for the care of AEB, particularly with regard to knowledge of the recommendations and the availability of health staff to meet this demand.

It is important to carry out a detailed situational analysis in order to evaluate the implementation of the AEB management system in Cameroon at all levels of the health system. The evaluation of the system put in place will enable its functionality and its impact on the prevention of infection transmission to be assessed.

### 4.1.5 Elimination of mother-to-child transmission of HIV

The objective of eliminating Mother-to-Child Transmission (MTCT) goes through: (i) systematizing awareness raising for screening and prevention amongst women who consult MCH/FP services; (ii) ensuring that 95% of pregnant women are tested for HIV; and (iii) ensuring that all women diagnosed HIV-positive receive ARVs to reduce the risk of transmission to the child.

The performance of the program in 2019 in terms of testing coverage and ARV coverage for women living with HIV is detailed below.

Table 7: HIV testing and ART coverage in pregnant women from 2017 to 2019

| | **2017** | **2018** | | **2019** | |
|---|---|---|---|---|---|
| | | Planned | Results | Planned | Results |
| **Number of pregnant women seen in ANC** | 789 581 | 915 604 | 761 283<br>**83%** | 939 055 | 737 161<br>**78 .4%**<br>**78.7%** |
| **Number of pregnant women tested for HIV** | 728 908<br>**91. 1%** | 80% | 729 172**95.8%** | 84% | 620 171<br>**76.3%** |
| **No. of pregnant women who withdrew their results** | | 80% | 661 280<br>**90.7%** | 84% | 615 721<br>**98.9%** |
| **No. of HIV+ pregnant women** | 23 817<br>**3.2%** | 26 598 | 23 983<br>**3.3%** | 23 249 | 20 168<br>**3.3%** |
| **No. of partners tested / % HIV+** | 34 502<br>**6.4%** | | 34 903<br>**3.9%** | | 28 691<br>**3.8%** |
| **Number of HIV+ pregnant women received ARV treatment*** | 73.8% | 80.9% | 21 716<br>**90.6%** | 84.4% | 17 146<br>**89.6%** |
| **PW HIV+ who delivered in a health care facility / views within 72 hours** | | | 17 304<br>**72.2%** | | 15 058<br>**74.7%** |
| **No. of exposed infants** | | | 17 214 | | 15 195 |

| | | | | | |
|---|---|---|---|---|---|
| **Number of children being tested for EID** | 50,1% | 65,1% | 11 642*<br>**67.7%** | 72,6% | 14 970<br>**68,4%** |
| **No. of exposed children receiving ARV prophylaxis** | | 17 214 | 14 378<br>**83.5%** | 13 220 | 13 250<br>**87.1%** |

- Although some regions have performances above 80%, there is a wide disparity in ANC coverage within Health Districts;
- In 2018 and 2019, more than 50% of HDs had ANC coverage below 80%;
- These are essentially the HDs of the Far North, South West, North West, South and Centre.

If we look at the geographical distribution of the programmatic results obtained on the screening of pregnant women, the following conclusions can be made:

- The decline in results in 2019 concerns mostly the regions of Adamawa, the North and the Extreme North;
- In 2019, the North and the Extreme North had the lowest screening coverage, less than 80% in a majority of HDs;
- The comparison of programmatic data per HD and region between ANC and screening shows that in the North, Far North and Adamawa, coverage is low in both ANC and screening; while in the other regions, screening coverage is quite satisfactory, in contrast to ANC coverage, which is deficient; in regions in a security crisis, the impact of the crisis could be explained by a drop in the performance of health facilities or poor data reporting.

In total, the overall programmatic performance of the eMCT program is satisfactory, with the intended targets achieved in 2018 and 2019, despite a relative drop in performance in 2019 compared to 2018.

However, several pitfalls remain.

- The aim of eMCT is still a long way off for the moment, with overall ANC coverage at 83% and an assisted childbirth rate at 70%, as a large number of mother-child couples escape PMTCT, which feeds a very high MTCT amongst untreated mothers. It is clear that an emphasis must be placed on community-based activities to fill the gaps in ANC, assisted delivery and mother-child couple follow-up.
- The impact of stock management and supply chain problems on the availability of tests (RDTs, PCR) and pediatric ARVs for prophylaxis appears to have been significant.
- Furthermore, the proportion of pregnant women PW screened for syphilis is low, even if poorly documented (57% in 2016).
- The deficit in the link to treatment is particularly accentuated in rural areas (prioritization on Adamawa, East and Far North) and the prioritization of interventions must therefore focus on the districts with the lowest performance, that is, those with less than 80% ANC coverage and/or less than 80% of pregnant women screened.

These difficulties encountered in implementing the eMCT program require a considerable effort to be able to control the vertical transmission of HIV. The operationalization of the eMCT roadmap has not sufficiently concentrated the efforts of the program and all the implementing actors. The upcoming project to support the elimination of MTCT from HIV/AIDS funded by IDB, is a unique opportunity to respond to these challenges.

### 4.1.6 Screening

Out of a total of 506,432 PHAs estimated by Spectrum 2020, 424,421 knew their status at the end of 2019, representing a performance of **83.8% for the 1st 90**. However, there has been an overall reduction in the number of newly detected PLHIV since 2017, which can be seen in:

- A reduction mainly related to the mobile strategy (less cost-efficient);
- A reduction in the rates of seropositivity observed in fixed, mobile and even blood transfusion strategies, which is probably due to less effective targeting of screening interventions; A better targeting of screening
- A still low contribution of CSOs in the 1st 90s (33% in 2018);
- A low proportion of KPs screened compared to the general population.

The supply chain difficulties experienced in 2019 must be highlighted, as well as the fact that screening is still too much centered on health facilities (fixed strategy + PMTCT) and is still underdeveloped in the community.

Differentiated screening approaches have nevertheless started under the impulse of PEPFAR and are showing encouraging results, particularly in KPs and vulnerable areas. They therefore deserve to be scaled up (index testing, intra-family testing, self-testing).

## *4.2 Comprehensive care for PLHIV*

### 4.2.1 Adults

Cameroon has opted for the "Treat All" strategy at the national level. The commitment of the NSP for the year 2023 is that 92% of PLHIV adults, adolescents and children who know their status are actually receiving antiretroviral treatment by the end of 2023.

To achieve this, various strategies are planned, which are slow to be put in place, which are:

- Improving the link between testing and ARV treatment services;
- The implementation of the policy of decentralization of HIV care;

- Improving the retention of patients on ARVs in care;
- Community intervention to improve adherence and compliance.

The number of PLHIVs on ARV treatment rose from 253.715 in 2017 to 312.214 at the end of 2019, that is, coverage of the programmatic target of 87.2% in 2019 and a performance of 68% for the 2nd 90. A total of 10.403 children under the age of 15 and 219,080 women were receiving ARVs at the end of 2019. More than half of the national active file is concentrated in the Centre (24.9%), Littoral (18.6%) and North-West (11.5%) regions.
Thus, on 31 December 2019:
- Only 6,377 of the 18,641 children under the age of 10 expected have been identified and put on ARVs, that is; ARV coverage of 34.2%.
- Amongst adolescents aged 10-19 years old, 9.980 adolescents out of the 31,040 expected (32.2%) were identified and put on ARVs of:

A better performance was observed amongst young people of 20 to 24 years old, where 48.3% (16027/33183) were put on ARVs.

At the end of 2019, considering the 3 "90s" targets, the HIV cascade in Cameroon is as follows.

Among people receiving ARV treatment, 69% had achieved viral suppression after 12 months of treatment, with a performance of **33.6% for the 3rd 90** (declining compared to 2018).

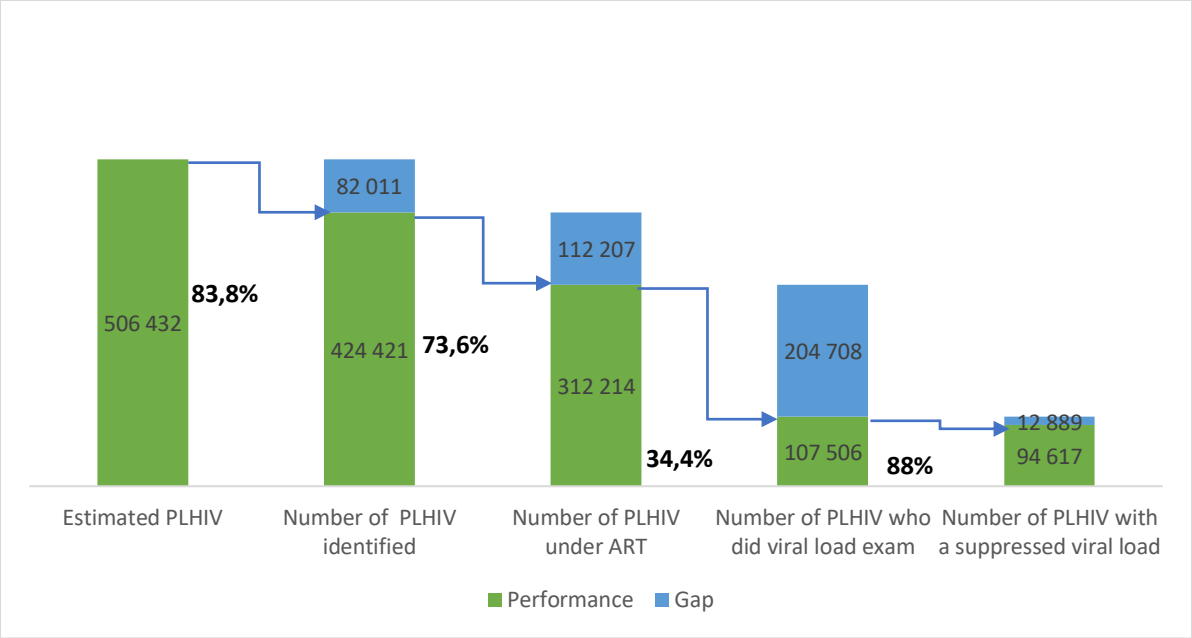


Figure 6: HIV Cascade ‘‘Testing- Treating-Retaining” in Cameroon 2018 and 2019

The main challenges of comprehensive care for PLHIV can be summarised as follows:

- The linkage between testing and care services is not always ensured: to avoid loss of sight among newly detected PLHIV, active (physical) referral should be a priority;
- Care and treatment systems do not take into account the active search for patients who have been tested positive for HIV and have not yet been enrolled in ART;
- Insufficient follow-up of PLHIV in several sites with large active files, impacting retention results in care;
- Non-compliance with national guidelines for the care of PLHIV in some health facilities;
- The chronic difficulties of the sites in obtaining ARVs, which have repercussions on the compliance of PLHIV;
- Collaboration between the community-based structures that offer screening and the health facilities, as well as the mentoring that the latter should provide, are not really implemented or sufficiently developed;
- National stock-outs for several months, especially pediatric ARVs;
- Residual costs (especially informal) of care persist and limit access to care for PLHIV;
- The low level of delegation of tasks in health facilities and to community actors;
- Low implementation of differentiated care models (community-based distribution of ARVs, for example).

The major pitfall is undoubtedly the weak link to treatment for people tested HIV+, which was 74.7% in 2019 (almost a quater of the PLHIV tested are therefore not immediately treated as required by national guidelines). The second pitfall is the attrition of the active file of PLHIV, with more than a quarter of PLHIV leaving care within 12 months of starting ARV treatment

(73% of retention in 2019). This is linked to the overall low and inconsistent retention service package in care, with difficulties in ARV supply to care and treatment sites exacerbating this situation.

### 4.2.2 Children, adolescents and young people

With a total of 16,356 children and adolescents in the active ARV treatment caseload at the end of 2019, Cameroon's "pediatric cohort" is marked by a growing proportion of adolescents. HIV care and treament in this age group is a weak link in the response, with ARV coverage of 23.1% in <10 years old, 34.5% in <15 years old and 27.2% in adolescents. For young people of 20 to 24 years old, coverage is also low (45.9%). There have been no significant change since 2017 in terms of screening, treatment and viral load.
In addition to the difficulties of therapeutic and psychological care at this age, there is the problem of the transition to adult services, which requires close collaboration between pediatric and adult care structures, but also :

- Insufficient decentralisation and delegation of tasks in HIV pediatric care and treatment ;
- Frequent breakdowns in pediatric ARVs and inappropriate formulation;
- Lack of medical and para-medical staff to ensure adequate HIV pediatric care and treatment;
- Weak structural organisation of HIV paediatric care and treatment including child and adolescent friendly services adapted to the needs of children and adolescents.

In order to improve this situation, several strategies implemented should be reinforced:

- Capacity building of pediatric care providers;
- The identification of children living with HIV through the activation of provider-initiated testing and counselling (PITC) at all health facility entry points (including CDTs and Therapeutic nutrition centres);
- Family screening for index cases, whether adults or children;
- Recalling children exposed to unknown status for HIV testing and improving early diagnosis coverage (POC/EID in the technical platforms of health facilities);
- Linking children who have been tested HIV+ to care and treatment services thanks to the deployment of pediatric PSAs in care sites;
- Strengthening links between community stakeholders and health facilities;
- Systematisation of "test and treat" for all age groups of children, adolescents and young people;
- Improving retention and compliance to treatment by strengthening the family approach; following up appointments and active search for those who are absent/lost to follow up; creating support groups and therapeutic classes in health facilities and community structures.

Many challenges are still to be met in order to achieve the 3 "90s" objective, such as reducing the rate of therapeutic failure in this specific group. Discussions with the CIRCB have shown that almost 50% of young people under treatment develop resistance.

### 4.2.3 Management of co-morbidities

Activities for diagnosing HIV infection among tuberculosis patients and managing tuberculosis/HIV co-infection increased significantly in 2017, but this increase has stalled since 2018. HIV testing is carried out in all CDTs across the country.

National guidelines require that every PLHIV be systematically screened for signs of TB, particularly when providers are dispensing ARVs (TB screening).

With regard to the coordination of TB-HIV collaborative activities, a technical working group, whose role is to optimise the fight against TB-HIV co-infection through convergent and integrated health policies, has been set up within DDPEC/MoH, but meets only occasionally. However, this coordination is not really effective, especially at regional and local level. The data reported is often incomplete, whether from the NACC or the NTCP.

With regard to the prevention and control of viral hepatitis, there is a significant delay in scaling up activities and achievements are poorly documented. The rare data available mainly concerns suspected cases of viral hepatitis B and C, genital ulcers (non-vesicular) and urethral discharge.

### 4.2.4 Biological monitoring

At the end of 2019, there were 10 functional laboratories accredited for Viral load implementation, located in 5 of the 10 regions, as well as 7 viral load POCs located in Maroua, Pette, Yagoua, Bafoussam, Foumban, Ngaoundéré and Ambam. At the end of 2018, 40% of eligible patients had had access to a Viral load testing, but this proportion fell to 18% in 2019 due to the stock shortage of reagents observed in the second half of 2019.

The proportion of Viral load suppression in the active file rose from 18.1% in 2017 to 29.6% in 2019, with programmatic coverage increasing (from 48.3% in 2017 to 88.0% in 2019). Population coverage of PLHIV with suppressed CV after 12 months of treatment has increased to 69% in 2019. However, the performance of the viral load completion rate remains low at 33.6%, which is mainly due to difficulties in the supply of viral load reagents.

## *4.3 Community contribution*

Like the countries in the sub-region, the engagement of civil society and the community sector was a strong point in Cameroon's response to HIV in its early days. However, most actors recognise that the sector has been greatly weakened over the past decade. An attempt to reinvigorate civil society began in 2018 with the creation of a Civil Society Platform. This platform

was created in an attempt to address the need for coordination of the many groupings of associations across the country. To date, the platform lacks resources for the effective functioning of this coordination.

At the end of 2017, the desire to make up the gap in terms of access to prevention, testing and treatment has led to the development of a catch-up plan. As part of this plan, CSOs were involved in targeted testing, index testing and linkage to treatment and retention in care (including tracking defaulters and loss to follow up). The CSOs are also involved in communication and awareness-raising on eMCT, particularly in cities, and paediatric HIV care. Unfortunately, the operationalisation of the catch-up plan has only been partial, as the resources mobilised are largely insufficient.

An analysis of the contribution of CSOs to the achievement of the 3 "90" targets was conducted under the aegis of UNAIDS in 2019, which mapped CSOs involved in testing, care and retention in care. The evaluation of the direct contribution of the community sector to the achievement of the 1rst 90 was estimated at **33%**. In the 2nd 90, the community contribution represented **13.9%** of people tested positive in 2018 by CSOs in the 7 priority regions, or 6.1% of people newly tested HIV positive put-on ARV treatment in 2018 throughout the country. On the 3rd 90, the community contribution is not adequately documented and could not be reported here.

Emphasis was not laid on prevention interventions, although most of the CSOs mapped are key actors for Impact 1 of the NSP. There is indeed considerable community engagement in this area, particularly in relation to KPs and vulnerable populations, but also in relation to eMCT and prevention among adolescents and young people. But the contribution of CSOs is not measured accurately enough to be appreciated.

The lessons learned and recommendations made from this analysis of the direct contribution of the community sector to achieving the 3 "90 "targets are as follows:

- Maximising the contribution of civil society attaining the 90-90-90s targets requires the implementation of cross-cutting activities that can reduce barriers to access to services but also strengthen civil society actions at the level of the national response. Thus, emphasis will be placed on building the capacities of civil society actors and raising the awareness of key strategic partners at the national level.
- Within the framework of capacity building of civil society actors, the establishment of an executive secretariat should make it possible to increase the visibility of civil society in the coordination of stakeholders but also as an interface/interlocutor to act on behalf of the whole of civil society towards government partners and technical and financial partners who support the Cameroonian response.
- In addition, in relation to KPs and in the framework of human rights issues, emphasis will be placed on Rights Education and legal support to the targets concerned; but also, on reducing stigma and discrimination through training/awareness raising for health professionals providing care on KPs specific pathologies. Finally, advocacy and awareness-raising actions, through national and regional workshops, will be developed for decision-makers, religious

leaders and law enforcement officials who constitute a force of influence that can positively impact on the reduction of stigma and discrimination within communities.

- In order to reinforce the achievements of civil society in accelerating the response in Cameroon, by targeting the priority areas of intervention, emphasis should be placed on increasing community screening through the strengthening of the peer educator approach. This necessarily involves effective demedicalisation as a strategy to be integrated into national policies and strategies, combined with capacity building of community actors in the management of confidentiality.
- In addition, particular emphasis must also be placed on increasing community mobilisation and strengthening the referral system, which could make it possible to increase the number of people who test positive, while at the same time strengthening the testing index. Community screening should be accompanied by a risk management plan to reduce the number of people lost to follow-up and increase referrals to treatment centres.
- At the level of the second 90, in order to boost the national response, it is important that people who test positive can be put on treatment immediately (test and treat) Community actors will have to commit to strengthen the referral system of the community to treatment centres. To this effect, collaboration between community actors and clinical service providers will need to be strengthened with a view to ensure that interventions in the defined priority areas are complementary.
- In addition, national policy will have to organise a reflection on the decentralisation of health facilities and the multiplication of community care centres, thus bringing services closer to communities.
- With regard to the third 90, through training courses on treatment education, civil society will have to inform communities about the importance of viral load in order to increase demand. However, while focusing on increasing demand, emphasis should also be placed on creating supply, and therefore advocacy should focus on better management of existing platforms, but also on the multiplication and decentralisation of viral load platforms.
- The strengthening of the institutional and political framework requires a better organisation of coordination at the level of civil society.

- With the existence of the platform of civil society organisations, community actors have a framework that should enable them to improve the coordination of civil society actions, to emphasise the quality of interventions, and to produce information that can better highlight the contribution of civil society to the national response in Cameroon.

- Existing mechanisms should be strengthened in order to become a community surveillance mechanism, to eventually collect information for better monitoring, to provide a framework for monitoring, warning and guiding policies and initiatives in the field of prevention, care and treatment. In practice, this will involve combining the warning functions and practices of a Community observatory.

- Key indicators related to prevention, care and treatment and viral load should be monitored and major trends shared with key actors in the response on a periodic basis. Common advocacy agendas should be identified and implemented to address treatment barriers.

The effective implementation of these recommendations should enable community actors to monitor and evaluate the operational plan of NSP within the framework of the 3X90, HIV funding, and community interventions as a whole.

### *4.4 Fight against stigma and discrimination, support, psychological and social care*

Interventions to reduce stigma are largely linked to external funding and rarely led by government authorities or agencies. Barriers related to stigma and discrimination of KPs within health structures (public, private or faith-based) have led to the creation of drop-in centres offering a range of prevention and testing services to MSM and SW in different parts of the country.

Regarding the fight against stigma and discrimination, there is little recent and reliable data on the experience of stigmatisation of PLHIV and KPs in health services, in the community, in the workplace and in families. Efforts have been made to train focal points in CBOs to document and report cases of human rights violations in order to find solutions. These efforts have resulted in the strengthening of the "UNITY" platform and a community observatory on access to care and gender-based violence.

With regard to advocacy and awareness raising interventions on the rights of PLHIV and KPs, apart from the commemorations of World AIDS Day (WAD), there have been few communication actions on HIV towards the public within the framework of this NSP. Those that are carried out across the country are mainly carried by CSOs and target health workers, local government officials and law enforcement.

The efforts of community observatories to collect data on access to services and human rights aspects are not yet taken into account by the public authorities. The last study on the Stigma Index on PLHIV was done in 2012.

There has been no analysis of the national response on gender since 2014. However, a baseline study published by the Global Fund in 2018 revealed the following:

- There are social prejudices and cultural attitudes that hinder access of young girls to sexual and reproductive health services.
- Responses to gender-based violence (GBV) and the link to HIV are weak or inadequate. For example, the RENATA association in Yaoundé remains one of the few organisations linking GBV and HIV, and taking care of young women who are victims of sexual violence.
- As health services struggle to reach men, who have poor health seeking behaviours, the VCT@Work campaign is trying to address this by targeting men in the private sector.

Despite the emphasis on human rights in the 2018-2022 NSP, the multisectoral nature of the HIV response does not allow NACC to address human rights and KPs issues head-on. The various ministerial sectors closely concerned with human rights issues (Justice or the Ministry of Women's Affairs) are less involved. These aspects remain ignored in the ministerial sectoral plans and in the new municipal plans drawn up under the "Fast-tract" strategy for 14 cities.

In order to ensure comprehensive care, including psychological and social care for PLHIV, which goes far beyond the provision of treatment and screening, 1,665 Psychosocial Support Workers (PSAs) have been recruited throughout the country, that is 1,094 adult PSAs and 544 paediatric PSAs. However, it is not yet possible to assess the impact of the PSAs on treatment compliance and retention in the active file because the impact of their psychological and social support activities is not measured (no indicator is yet planned to capture their results).
In order to further improve program performance, it is highly desirable that SPAs come from the communities they serve and are under the responsibility of CSOs to foster the link between health facilities and CBOs. A harmonized curriculum for their training should also be developed. In the same sense, the opportunity of the Community Health Plan and Decentralisation should be seized, through the involvement of decentralised local authorities, which can be made responsible for this specific component.

## *4.5 Situation in the North-West and South-West Regions*

In the North-West and South-West regions, the health situation remains precarious, particularly in certain districts and health areas where health facilities (FOSA) have been destroyed. Some health workers have deserted or been killed and the provision of services has become non-existent. This situation has resulted in a significant reduction in access to basic health services. As of 31 December 2019, the proportions of health facilities declared non-functional were high in the health districts of Ako (50%), Batibo (21%), Nkambe (16%) and Bafut (16%) in the North West (DHIS North-West review report). In the South-West region, 47% of the health facilities remained functional, 28% remained temporarily closed and 13% were partially functional in 2018. The situation improved in 2019, with an increase in functional health facilities to 71% (situational analysis response in the South West 2018).

Despite this deleterious context, the HIV response interventions have been maintained. In the South-West region, the identification of PLHIV remained low but increased slightly between 2018 and 2019, with 45% and 50% of PLHIV identified respectively (DHIS 2018 review report and South-West 2019 annual report). The overall ART enrolment rate of identified PLHIV (new and old) increased from 65% in 2018 to 80% in 2019. The overall evolution of the active file has been positive over the last two years. The positive evolution observed in 2018 could be linked to the reopening of several health facilities (71% of functional health facilities compared to 47% in 2018), the organisation of active search campaigns for those lost to follow-up (LTFU), the strengthening of human resources sites for the search for LTFU (psychosocial

support). The programmatic coverage of ANCs has dropped considerably, from 51% in 2017 to 43.23% in 2018 and 41% in 2019.

The response was more affected in the North West region. Indeed, the enrolment rate on ART has been steadily declining, reaching a 17% drop between 2017 and 2018 and 38% between 2018 and 2019. The volume of active the active file increased gradually during 2019 without ever reaching the 2018 figures. This improvement is linked to the implementation of community-based ARV delivery strategies for people in emergency situations. ANC coverage remained low, decreasing from 56% to 48% between 2018 and 2019 respectively. The health districts of Ako, Bafut and Mbengwi had coverage of less than 40% in 2018 and 2019.

Measures have been taken to mitigate the effects of the crisis: (i) the offer of targeted testing and the linkage to treatment; (ii) the reimbursement of transport costs; (iii) the implementation of differentiated strategies in the dispensing of ARVs (dispensing outside working hours; (iv) the multi-month dispensing of ARV treatment; (v) the grouped collection of ARVs for families; (vi) community-based provision of ARVs in PODICs, within support groups or at home; (vii) provision of ARVs to IDPs as a stopgap measure and to facilitate transfer to new ART sites; and (viii) the creation of a regional working group.

However, difficulties persist, which affect the performance of the programs: (i) Armed confrontations that put the lives of healthcare providers at risk; (ii) "Ghost town" operations; (iii) difficulties in the distribution of inputs and medicines due to difficult geographical access to certain areas because of barricades and the destruction of roads; (iv) the closure or partial operation of certain health facilities; (v) the lack of health staff trained in HIV care and the absence of staff in areas where the conflict is intense; and (vi) the mobility of populations (IDPs and refugees).

## *4.6 Strengthening governance and management of the response*

### 4.6.1 Coordination of the response

The Monitoring and Evaluation Plan for the NSP 2018-2022 did not explicitly define an indicator to measure the quality of governance of the response. However, the program's performance in this area has been assessed through:

- The number of coordination meetings held at all levels;
- The number of consultation frameworks between all the actors of the response;
- The capacity building of the managers of the coordination structure (NACC) ;

On this basis, the governance quality index of the response was evaluated at 58%.

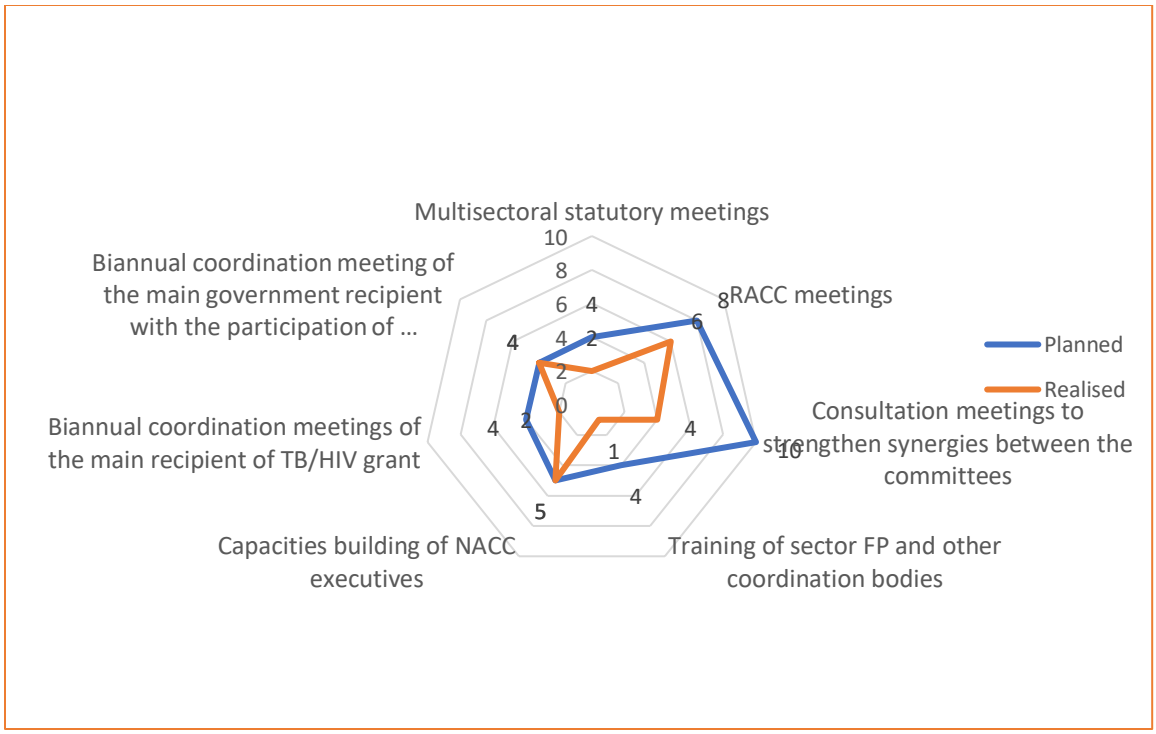


Figure 7: Performance of governance of the response

However, it should be noted that:

- The existence of a fundamental problem of division of labour between the NACC and the MoH Directorates: a necessary rebalancing in favour of the implementing actors;
- The need for an analysis of the governance of the response that re-examines the system as a whole;
- The existence of operational problems linked to the procedures of the technical and financial partners
- The inadequacy of monitoring-evaluation tools that do not allow all the contributions of sectors other than health to be captured;
- The weak inclusion of the community sector. As an example, we can talk about the low inclusion of data from the community observatory for access to healthcare and the low promotion of the good practices in the CBOs.

### 4.6.2 Strategic information

In order to have quality strategic information essential for better decision-making, one of the priorities was to revise and integrate the various existing information systems, to avoid setting up vertical programs (including HIV and TB) and to avoid programmatic overlaps in the information system.

For this purpose, one of the most convincing results is the consolidation of the national DHIS-2 database at the Health information unit/MOH level, the integration of all HIV data and the training of M&E managers in the use of the database.

Concerning the need to have the most reliable and disaggregated data, the estimation and projection of the epidemic was carried out in 2020 using the SPECTRUM software, with the introduction of the NAOMI model for decentralised estimates (region and HD).

The major challenge of integrating community data into the national DHIS-2 database nevertheless persists, with the need to conduct regular surveys to provide information on certain indicators, particularly on prevention and the community contribution to the response.

In the field of research, the agenda has been implemented as planned, apart from the study on resistance and the cost effectiveness of strategies, with:

- Nearly 45 scientific articles on HIV were published in different newspapers between 2017 and 2019;
- The Cameroon Health Research Forum (CaHRef) was organised in 2018 during which 27 abstracts on HIV were presented;
- Cameroon has presented HIV abstracts at international conferences: ICASA (03), INTEREST (02), AFRAVIH (03).
- The Second National PMTCT and child and adolescent HIV Management forum in September 2019 during which 179 abstracts were presented.

### 4.6.3 Funding and resource mobilisation

The overall budget for the implementation of the NSP 2018-2022 has been estimated at CFAF 412 billion, with the Government and international technical and financial partners, the main ones being the Global Fund to Fight AIDS, Malaria and Tuberculosis and PEPFAR.

During the 2018-2019 period, the funds mobilised by the NACC amounts to 51.575.138.446 FCFA, that is 37% of the expected funding, resulting in a financial gap of 63%.

Regarding to expenses, the financial implementation rate is 66% (34 040 760 910 FCFA), which is low if the low rate of resource mobilization is taken into account.

It should be noted that the problem of mobilising domestic counterpart funds for the NFM2 Global Fund HIV grant contributed significantly to the poor performance of the program, especially in 2019.
However, there is still a need to put in place expenditure frameworks that capture the unit costs of interventions, which are essential for assessing their cost-effectiveness.

### 4.6.4 Supply chain management of biomedical products

During the period 2018-2019, the overall performance of the national program was greatly influenced by the system for the supply chain and management of medicines and biomedical products. Infact,17.5% of the ART sites recorded stock-outs for at least one of the HIV tracers' inputs in 2018. This rate reached 80.4% in 2019 with negative repercussions on all areas of activity of the response.

Systemic difficulties related to the supply chain include the following:

- The debts of the state to the Regional Funds and the CENAME;
- The very low level of mobilisation of counterpart funds compared to the Global Fund grant, leading to stock shortages and stock out.

## *4.7 Conclusions on the response to the epidemic*

The mobilisation of community actors have contributed to the progress of prevention among KPs through the implementation of differentiated approaches to prevention services. The provision of services through drop-in centers has accelerated, same for the provision of services by CBOs working with MSM and SWs. Innovative interventions, which were not initially planned in the NSP, have started. These include the provision of PrEP services for KPs. Index case testing approach was introduced in 2017. Despite the success of this approach for the detection of positive people, this approach is now slowed down because of significant risks of breach of confidentiality and insecurity of individuals.

From an overall view, primary prevention remains largely insufficient, while attention and energies have focused more on the detection of positive cases.

The modes of communication, information and referral to sites where prevention and testing services are available and adapted and must be reinforced during the second phase of the NSP.

The combined prevention package should integrate PrEP, with increased awareness, diversification of the modes of taking PrEP and better targeting of beneficiaries.

Improving prevention coverage is closely linked to the diversification of prevention and testing methods (PrEP and self-testing for example), the intensification of prevention messages, the promotion of condom use, and the fight against stigma and discrimination.

Moreover, some populations are insufficiently taken into account in the achievements observed during these two years. These include drug users (in particular IDUs) among KPs, prisoners, PWD among Vulnerable Populations (testing and treatment of STIs are not part of the care package offered to prisoners, PWD and workers in economic centers).

Inspite of the consideration of IDU in the NSP 2014-2017, a genuine Harm Reduction (RoR) program must be undertaken in Cameroon, targeting both IDUs and DUs, with needle exchange for the (few) injectors and Opiate Substitution Treatment (OST) for opiate users. A

national reference guide for the Minimum Package of Addiction Services and a National Program for the Prevention and Management of Addictions should be produced, with the aim of integrating these actions into a broad vision of addiction management.

For vulnerable adolescents and young people, the actions undertaken are very limited and need to be reinforced.

Finally, the e-MTCT program encounters systemic difficulties (ANC attendance, assisted childbirth, availability of commodities, etc.) which hamper its performance, so that we are still far from the objective of elimination. Community interventions are strategic here in order to be able to achieve the objectives set.

Despite significant progress and improvements since 2017, the insufficient performance in the 2nd 90 and the 3rd 90) is mainly linked to difficulties in linkage to treatment, scaling up pediatric care, ARV supply (especially during 2019), the inadequate service package for retention in care; with the common denominator being the low level of community mobilisation for testing, the linkage to treatment and retention in care.

However, this is a major challenge for the future, with the risk of persistent dynamics of transmission of the epidemic and the spread of strains of HIV that are resistant to ARVs, resulting in an increase in the overall costs of care in the long run.

# 5 Vision of the response to the HIV epidemic in Cameroon

**Cameroon's National Strategic Plan for the Fight against HIV/AIDS 2021-2023** has been reviewed and updated in the light of the results of the mid-term review and the determination of national priorities.

It aims to reduce new infections and incidence among adults, adolescents and children, eliminate mother-to-child transmission of HIV, reduce mortality linked to HIV and other co-morbidities, support the improvement of the quality of life of people infected and affected by HIV and other co-morbidities, respect of human rights, the fight against all forms of discrimination and the effectiveness of governance through an efficient and sustainable response.

Cameroon's 2021-2023 National Strategic Plan for the Fight against HIV/AIDS is based *on an approach of national solidarity and a pragmatic approach that guarantees access to prevention, care and support for all those who need it*, in particular those most at risk and vulnerable populations in the regions of Cameroon most affected by HIV. Thanks to multidimensional and multisectoral interventions, the Cameroonian society is protected against infectious risks, particularly those related to HIV, tuberculosis and viral hepatitis. All the lessons learnt over several decades will also be used and capitalised upon the COVID 19 epidemic response in a global public health approach that will protect and preserve the health of the population of Cameroon.

The Government of Cameroon at the highest level and alongside all its national and international partners commits itself to implement the national guidelines for the achievement of the results, impacts, effects and products included in this NSP.

## *5.1 Benchmarks of the national response to HIV for extension*

Cameroon's strategic vision for the national response to HIV for the 2021-2023 extension, is in full agreement with the international movement to "end AIDS as a public health threat by 2030, by reducing new infections, HIV-related deaths and discrimination/stigmatisation".

The benchmarks on which the updated strategic plan is based are in line with the international guidelines which are : UNAIDS Strategy 2016-2021 "Accelerating the response to end AIDS"; WHO's "Global Health Sector Strategy on HIV 2016-2021"; Stop-TB Partnership's "Stop TB" Strategy; "Global Health Sector Strategy on Viral Hepatitis 2016-2021"; WHO/UNICEF/UNAIDS Strategy for the Elimination of MTCT of HIV, Global Partnership for the Elimination of HIV-related Stigma and Discrimination, WHO Guidelines on Testing, Treatment, Prevention among KPs; and Global Fund Strategy 2018-2022 "Investing to End Epidemics".

Cameroon's adherence to the Political Declaration on HIV/AIDS "Intensifying our efforts to eliminate HIV/AIDS" at the High-Level Meeting in June 2016 in New York constitutes the reference framework for the NSP for the period 2018-2022. Cameroon's commitment was based on scientific evidence relating to the rapid intensification of quality HIV treatment, which confirms the therapeutic value of the early initiation of ARV treatment and its generalisation within the framework of the "Test and Treat) approach. From this perspective, Cameroon has adopted a catch-up plan to accelerate the response to HIV and AIDS for the period 2018-2022.

## *5.2 Underlying and guiding principles of the NSP extension plan*


Figure 8: Underlying principles of the PSN 2021-2023

**The NSP Extension Plan constitutes a unique point** at which all national and international partners are involved to achieve results. It ensures the involvement of the various stakeholders in the different phases of planning, from design, to implementation and monitoring and evaluation of programs and interventions. The inclusive and partnership approach increases the quality, effectiveness and relevance of policies and programs.

**PLHIV and KPs are priority of the people-centered response:** The people and places approach will be favoured to direct interventions and resources towards areas of vulnerability or higher prevalence. For Cameroon, PLHIV and populations most at risk are a priority and will need to benefit from quality interventions in the areas of prevention, care and support. The involvement of the population will always be given priority.

**Respect for human rights, gender and equality between women and men:** The NSP Extension Plan intends to integrate a larger number of beneficiaries in order to put a particular emphasis on the reduction of gender inequalities, the promotion and respect of human rights and equity in access to HIV services and comprehensive health services. It develops all the conditions to enable the creation of an enabling environment to remove the obstacles that hinder access to prevention and care, particularly when they are linked to stigma and different forms of discrimination.

**Decentralisation, delegation of tasks to scale up the offer of prevention, treatment and care:** In order to promote a more appropriate response to local contexts, this NSP will be contextualised and operationalised with a view to decentralised implementation based on the principle of delegation of tasks. This decentralisation will provide more opportunities for intervention planning, mobilisation and resource management at the local level.

**Innovation, efficiency and effectiveness of the response:** In the context of accelerating the response, and aligning the demand for joint HIV and TB funding, the founding principles of this approach will direct funding towards high-impact interventions, while introducing innovations and strong involvement of community-based organisations and organisations representing KPs and PLHIV that can bring added value to the national response.

### *5.3 Approach to prioritisation of the Extended Strategic Plan 2021-2023*

Between the end of 2019 and the beginning of 2020, Cameroon conducted two reviews: External review of the NTCP for 2015-2019 and Mid-term review of the HIV NSP 2018-2022. These two separate reviews on tuberculosis and HIV led to recommendations to guide action for the extension of the Strategic Plans 2020-2024 for tuberculosis and 2021-2023 for

HIV. These two plans formed the basis for the development of this joint TB/HIV funding request to the Global Fund for the 2021-2023 cycle, following the prioritisation criteria below:

- Epidemiological evidence for TB and HIV from triangulation of epidemiological data, the dynamics and estimation of the incidence of HIV and TB at the level of the general population, KPs and vulnerable populations
- Analysis of the complementarity of available funding (domestic funding, Global Fund, PEPFAR, IDB (UNICEF) and other TFP partners) and the value of investments for efficiency.
- The implementation of differentiated approaches to prevention, testing, care and social protection for each type of population, based on accompanying innovations.
- Alignment with Cameroon's national strategies and policies, in particular the 2016-2027 health sector strategy, the 2020-2024 Strategic Plan for Tuberculosis and the 2021-2023 Strategic Plan for HIV.
- Taking into account the human rights and gender aspects that affect programs, in order to remove human rights barriers that hinder access to HIV/AIDS and TB services in Cameroon and the Five-Year Plan 2020-2024 for a comprehensive response to human rights barriers that hinder access to HIV and TB services in Cameroon.
- The value of investment (gender equality and equity, efficiency, and achievement of results) in order to achieve impact.

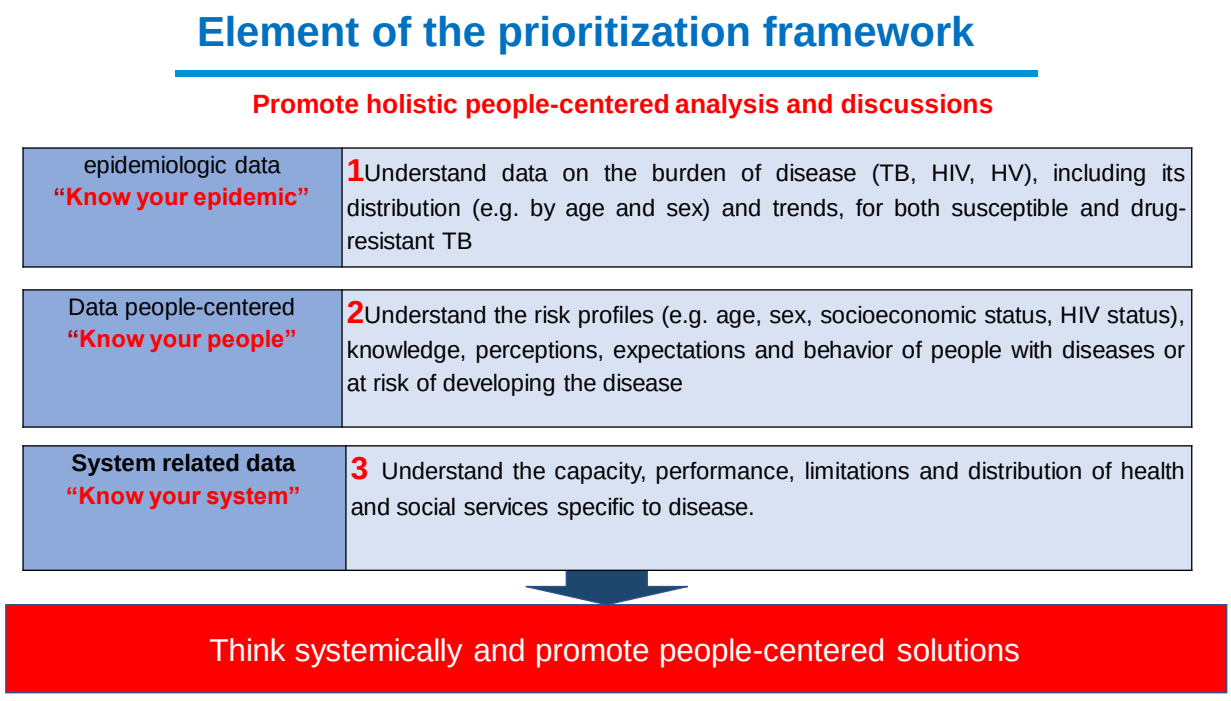


Figure 9: Element of prioritization framework

## Priority target populations of the extended NSP 2021-2023

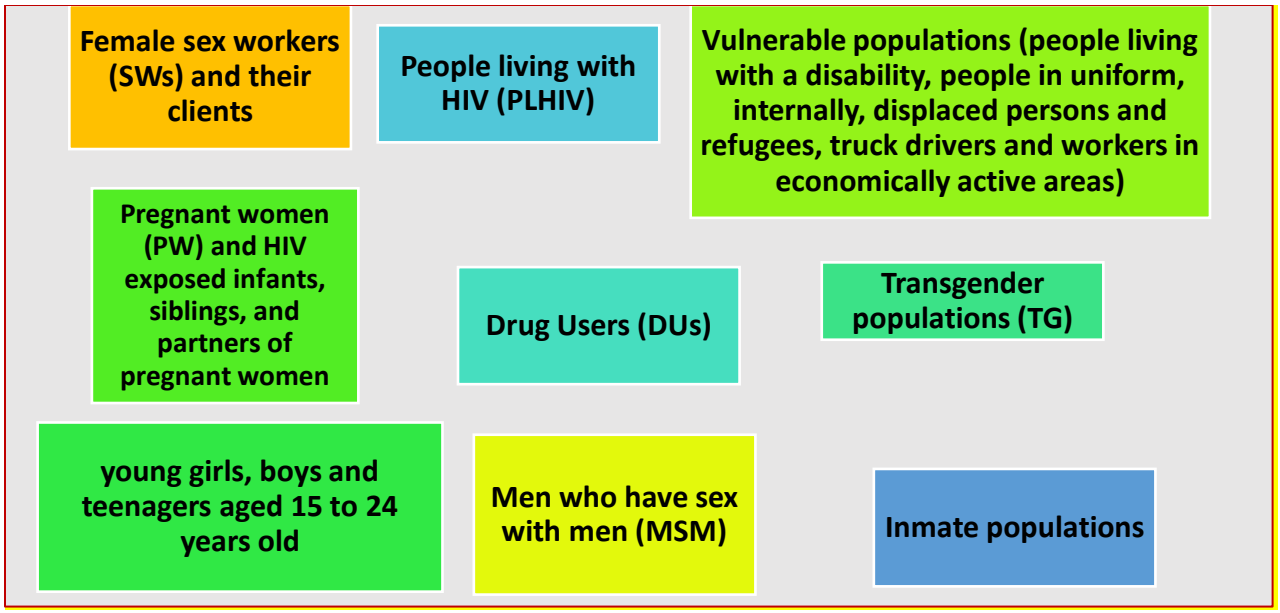


Figure 10: Priority target populations of the extended NSP 2021-2023

# 6. Results Framework

## *6.1 NSP 2021-2023 impact results*

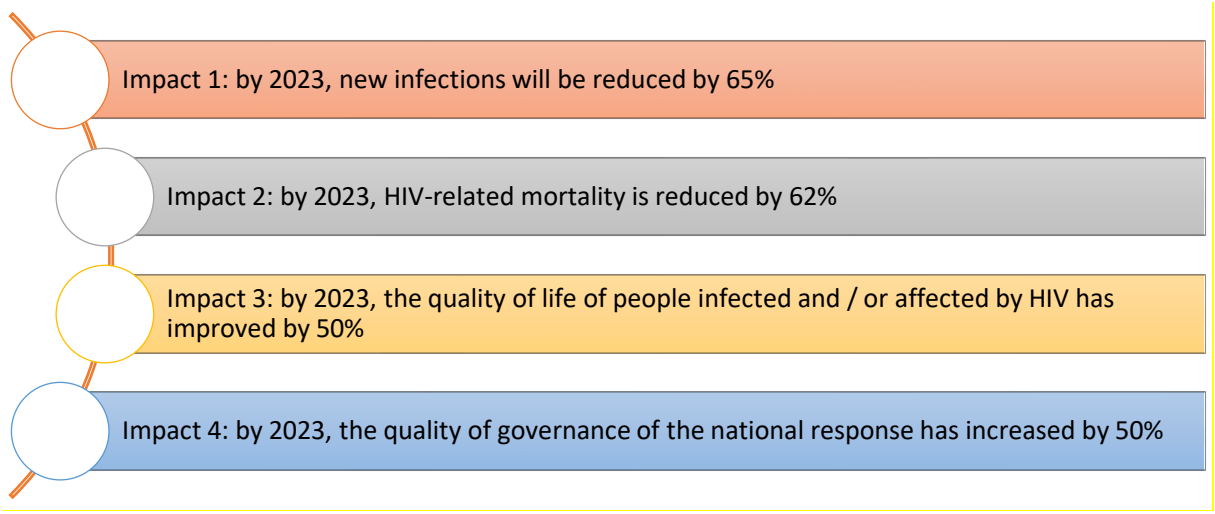


Figure 11: NSP 2021-2023 Impact results

## *6.2 Results chain*

*Impact 1: By 2023, new infections are reduced by 65%*

**Impact 1** aims to reduce new infections by at least 65% by the end of 2023, taking into account achievements in the base year 2019. This results in the development of preventive

action according to a differentiated approach to effectively reach KPs and vulnerable populations. This involves the organised contribution of community actors and their capacity for social innovation, alongside public sector health actors:

Combined prevention, will be strengthened with the support of community actors to reach at least 90% of high-risk key population, using differentiated service approaches, particularly according to the different risk factors and vulnerabilities within each key population group.

With the contribution of community actors, differentiated prevention approaches will be developed for the benefit of 90% of women and men from other vulnerable populations: (i) Pregnant women: HIV prevalence amongst pregnant women was 5.75% according to the sentinel sero-surveillance survey conducted in 2016, (ii) adolescents and young people, (iii) refugees and displaced persons, (iv) prisoners, (v) workers in economic centers and (vi) people living with disability. Also, people who are victims of accidental exposure to blood and body fluids (exposure in health care settings or sexual exposure, including sexual abuse) will receive post-exposure prophylaxis, according to national guidelines.

The provision of adapted prevention services will enable 80% of adolescents and young people aged 15-24 to have appropriate skills to protect themselves from HIV and STIs, and 100% of young people and adolescents with STIs to benefit from free care, particularly in priority districts, using differentiated approaches and with the support of community actors.

The systematic use of condoms during risky sexual relations will be effective among 90% of sexually active people, thanks to the promotion of condom use and the coverage of 50% of national needs for condoms and lubricants which will be distributed free of charge.
Finally, the elimination of mother-to-child transmission of HIV will be reinforced with the support of community stakeholders, through the implementation of the e-MTCT certification process by the end of 2025, raising awareness on PMTCT and HIV testing for 100% of women attending RMNCAH services, HIV testing of 95% of pregnant women expected at first ANC, the retention in care of at least 95% of mother-child pair until the definitive HIV status of the exposed child is known, ARV prophylaxis for exposed children within 72 hours of delivery, early detection and CTX prophylaxis of at least 95% of exposed children, as well as the provision of a modern contraceptive method to 100% of HIV-positive women of childbearing age received in RMNCAH services (public, private, religious or community-based).

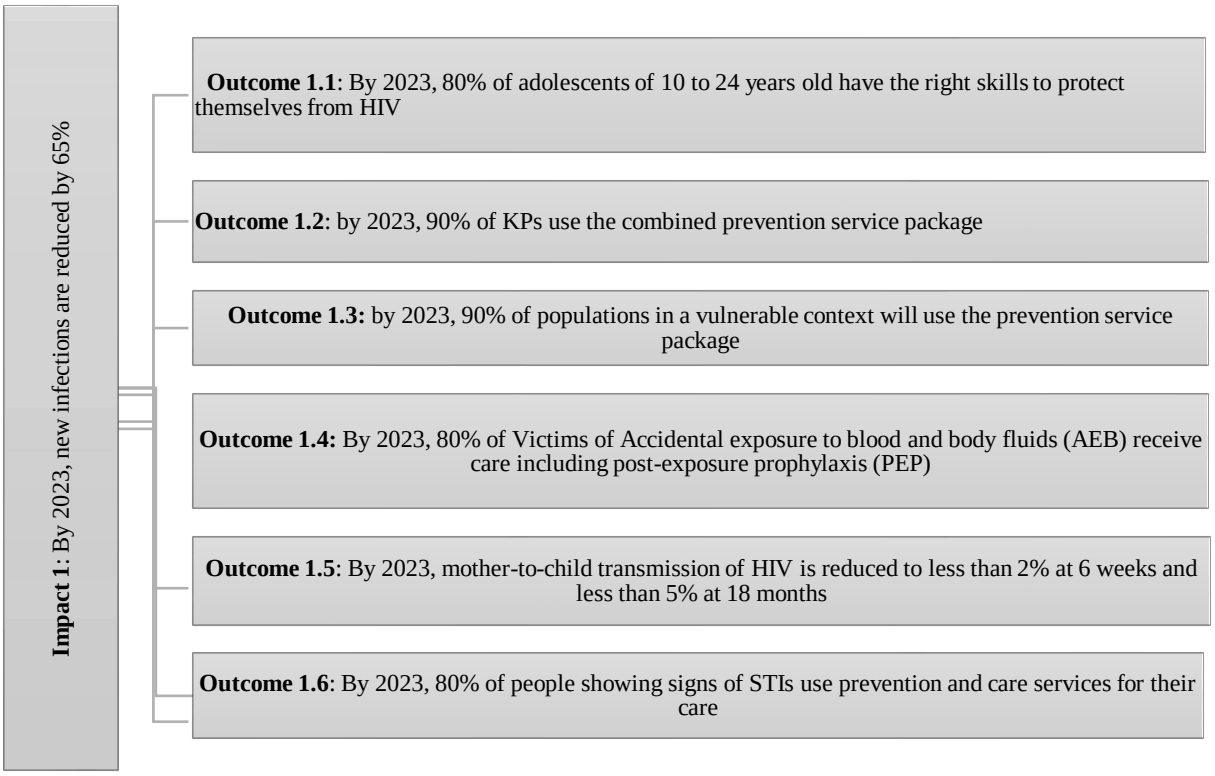


Figure 12: Outcomes for impact 1

### Outcome 1.1: By 2023, 80% of adolescents aged 10-24 have appropriate skills to protect themselves from HIV

It is estimated that among adolescents aged10-19, young girls register about six times more new infections (2097) than young boys (351), a differential observed since 2004, while in the 15-24 age group the ratio was 1 boy for every 3 girls.

Accelerating prevention is a strategic option of high importance in Cameroon, given the persistent high number of new infections and incidence among KPs. This impact result aims to reduce new infections by 60% and is broken down into six effect results that will enable the simultaneous implementation of interventions adapted to the geographical and social context of the target populations at the national level. The aim is to focus interventions on geographical areas and populations at high risk, adolescents and young people aged 15 to 24, some of whom belong to the KPs group. Despite the apparent low prevalence in this population, young people remain subject to a socio-economic and cultural environment that continues to expose them to HIV and STIs.

### Outcome 1.2: By 2023, 90% of KPs (SW, MSM, and IDU) use the combination prevention package of services.

Combined prevention interventions in vulnerable areas should make it possible to reach out to these populations where they congregate (hotspots). They will include the transgender population, which has not been taken into account until now. The mapping of the different

sites, which will be extended to the country's main cities, will enable NGOs to direct their field interventions towards areas of vulnerability and prevalence according to the population and location approach. The system of coordination between actors at regional levels on combination prevention will be strengthened.

The capacities of health professionals in health care institutions in vulnerable sites will be strengthened to provide appropriate services (STI management, HIV and syphilis screening, condoms, PrEP, referral to care) as provided for in the minimum package of services (MPS).

Places where condoms and lubricants are accessible in the vicinity will be identified as part of the mapping exercise. Integration and coordination between the different condom distribution programs will improve access and availability to different populations.

Efforts will also focus on the development and implementation of differentiated, adapted and innovative approaches to promote prevention measures and access to HIV testing and care services, in particular:

- Capitalizing on the use of new communication technologies to raise awareness and promote services (prevention via internet and social networks).
- The adaptation of services to the specific needs of adolescents and young people from KPs, TS and MSM according to norms and standards.
- Reinforcing the availability of services through the extension of sexual health units within NGOs and health centers for better access of KPs to services that meet their specific needs.
- The extension of PrEP for HIV prevention among MSM and SW in sites of higher prevalence according to an operational model adapted to Cameroon.
- Strengthening the skills of health workers on combined prevention around hotspots
- The diversified testing approach (medicalised, community-based and self-testing) to extend test coverage and reach targets beyond 95-95-95 for KPs.
- The strengthening of coordination and networking between the actors involved in the provision of combination prevention services in the intervention sites.

### Outcome 1.3: By 2023, 90% of the populations in vulnerable contexts use the package of prevention services

This outcome is developed according to prevention approaches specific to vulnerable populations, through the promotion of prevention services adapted to their needs. It will include: PW HIV+ prevalence amongst pregnant women being 5.75% according to the sentinel sero-surveillance survey conducted in 2016; adolescents and young people; refugees and displaced persons; prisoners; workers in economic centers and people living with disability. Also, people who are victims of accidental exposure to blood and body fluids (exposure in health care settings or sexual exposure, including sexual abuse) will receive post-exposure prophylaxis, according to national guidelines.

### Outcome 1.4: By 2023, 80% of Victims of Accidental exposure to blood and body fluids (AEB) receive care including post-exposure prophylaxis (PEP)

Victims of AEB and sexual violence under-report their cases to hospital services, as do the providers in contact with these victims. In order to achieve the results, the following strategies will be implemented:

- Updating of the national protocol for the management of AEB and sexual violence;
- Strengthening communication on the prevention of transmission risks among health care providers through information, sensitization and training for behavior change;
- Strengthening communication with the population in order to benefit from the services of the national system;
- Strengthening of the documentation system for AEB and sexual violence in hospitals in order to make immediate referral for prophylaxis
- Strengthening protection measures against HIV infection in the workplace to eliminate transmission of the infection in the health care setting
- Strengthening collaboration between ARV dispensing sites and social centres for the management of sexual violence
- Strengthening the management of cases of AEB in health care settings

### Outcome 1.5: By 2023, mother-to-child transmission of HIV is reduced to less than 2% at 6 weeks and less than 5% at 18 months

This outcome aims to achieve certification of e-MTCTs in Cameroon by 2025. This requires the formal implementation of the e-MTCT certification process by the end of 2025. Sensitisation of women attending RMNCAH services on PMTCT and testing for HIV, syphilis and viral hepatitis will need to be systematic for all women, as well as ANC-1 testing. All pregnant PLHIV will receive care in a health facility, for delivery, for ARV prophylaxis of HIV exposed children within 72 hours of delivery and for early detection according to current PMTCT guidelines, and cotrimoxazole prophylaxis.
The strategies implemented with community support will aim to ensure that at least 95% of mother-child pair are retained in care until the definitive HIV status of the HIV exposed child is known. Finally, in terms of access to SRH, efforts will focus on providing 100% of women LHIV of childbearing age received in RMNCAH services (public, private, faith-based or community-based) with a modern contraceptive method.

### Outcome 1.6: By 2023, 80% of people with signs of STIs use prevention and care services for their care

People suffering from STIs will receive care according to national guidelines.

Table 8: outputs for impact 1

| Outcome | Output |
|---|---|
| **Outcome 1.1: By 2023, 80% of adolescents aged 10 to 24 have appropriate skills to protect themselves from HIV** | Output 1.1.1: by 2023, 80% of adolescents (girls and boys) aged 10 to 14 will benefit from specific quality prevention programs for a complete understanding of HIV |
| | Output 1.1.2: by 2023, 80% of adolescents (girls and boys) between 15 and 24 years old will benefit from specific quality prevention programs for the adoption of lower risk behaviors |
| **Outcome 1.2: By 2023, 90% of KPs use the combined prevention service package** | Output 1.2.1: By 2023, 90% of SWs and MSM have access to a comprehensive package of combined prevention services at all sites |
| | Output 1.2.2: By 2023, 90% of people who use drugs are sensitized and have access to an appropriate package of harm reduction services |
| **Outcome1.3: by 2023, 90% of populations in a vulnerable context will use the prevention service package** | Output 1.3.1: by 2023, 90% of the prison population are made aware of and have access to an appropriate package of prevention services in prisons |
| | Output 1.3.2: by 2023, women and men in vulnerable situations (workers in economic sites, personnel in uniform, people with disabilities, refugees or displaced persons, indigenous population Pygmies, Boboro, etc. and others) are sensitized and have access to HIV prevention services |
| | Output 1.3.3: By 2023, 90% of the needs for condoms (female and male) and lubricating gel for HIV prevention are covered nationwide |
| **Outcome 1.4: By 2023, 80% of people who have suffered an accident due to exposure to blood (AES / LB) or sexual exposure will benefit from treatment including Post-Exposure Prophylaxis (PEP)** | Output 1.4.1: By 2023, all ARV dispensing sites offer PEP for accidents involving exposure to blood or other body fluids (AEB / LB) according to standardized procedures |
| | Output 1.4.2: By 2023, people affected by AEB / LB are sensitized and informed about access to prevention |
| **Outcome 1.5: By 2023, mother-to-child transmission of HIV is reduced to less than 2% at 6 weeks and less than 5% at 18 months** | Output 1.5.1: By 2023, 100% of women who use MNCH / FP services are sensitized on prevention, HIV testing and PMTCT as part of SRH |
| | Output 1.5.2: by 2023, 95% of pregnant women are tested for HIV in public and private health structures and receive the results |
| | Output 1.5.3: By 2023, 95% of pregnant women who test positive for HIV receive ARVs for treatment and to reduce the risk of transmitting HIV to their child |
| | Output 1.5.4: by 2023, 80% of exposed children are tested by PCR from the 6th week of life |
| | Output 1.5.5: by 2023 85% of exposed children are put on prophylactic ARVs and cotrimoxazole |
| **Outcome 1.6: By 2023, 80% of people with signs of STIs have** | Output 1.6.1: By 2023, 80% of people presenting behaviors at risk of infection by STIs (gonorrhea, syphilis, HPV infection) have access to prevention services |

| | |
|---|---|
| **access to prevention and care services for their care** | Output 1.6.2: By 2023, 80% of people with signs of STIs are treated according to national guidelines |

## *Impact 2: By 2023, HIV-related mortality is reduced by 62%.*

Cameroon is committed to achieving the 95.95.95 targets, i.e. (i) 95% of adult, adolescent and child LHIV know their HIV status, (ii) 95% of adult, adolescent and child LHIV who know their status receive antiretroviral treatment, (iii) 95% of adult, adolescent and child LHIV treated with ARVs have an undetectable viral load at 12 months.

The expected results of **impact 2** aim to reduce HIV-related mortality by 62% between 2019 and the end of 2023. This will result in improved knowledge of serological status. The NSP extension plan will focus on implementing a diversified approach to HIV testing. This approach will capitalise on the community-based approaches already in place for better targeting of KPs (community-based screening, self-testing) while strengthening PITC. The delegation of tasks will be implemented to ensure optimal coverage at the level of sites with insufficient number of staff.

Efforts will also focus on improving the supply chain management system to ensure the continuous availability of tests, medicines, laboratory equipment and other commodities.

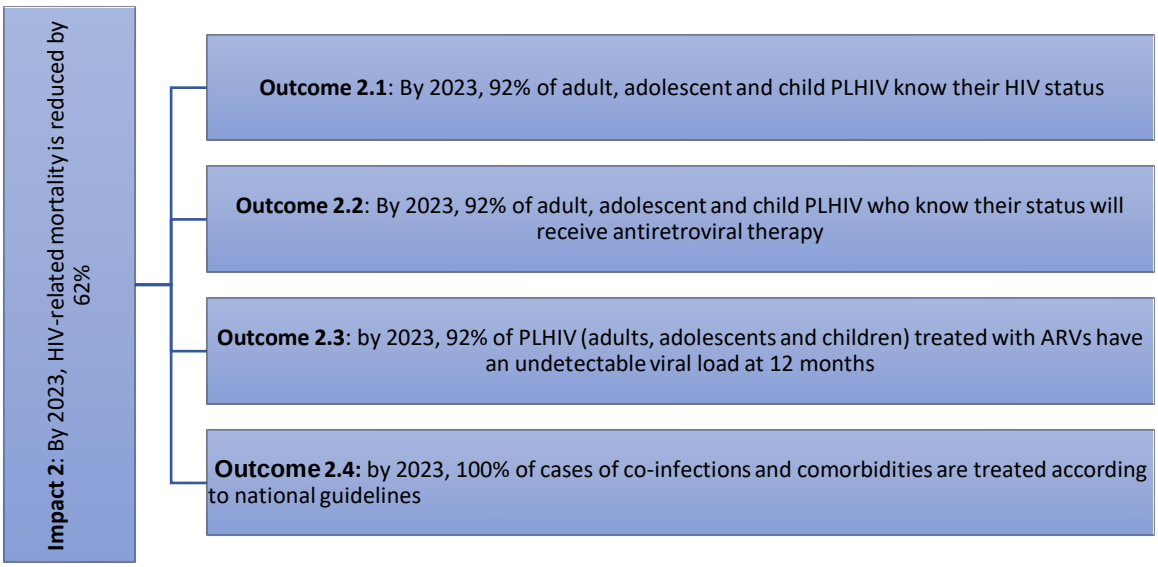


Figure 13:Outcome for impact 2

### Outcome 2.1: By 2023, 92% of PLHIV adults, adolescents and children know their HIV status

To achieve this outcome, a wider range of HIV testing and counselling services must be made available in the country:

- Strengthening the decentralisation of HIV testing at the level of health facilities and community centers by integrating the PITC in private, public and religious health facilities;
- Reinforcing the systematic offer of testing in all health facility entrances, including blood banks, for the general population, particularly young people aged 15-24, pregnant women, exposed children, patients suffering from tuberculosis, STIs, PLHIV and their partners (sexual partners or spouses) by using, among other things, new technologies such as the use of integrated PCR/viral load POCs;
- Strengthening the quality of testing and counselling services in hospital and community settings;
- Reinforcing the promotion of HIV counselling and testing for adolescent girls and women aged 15-49 in community settings, including youth counselling centers run by trained community and health workers;
- Reinforcing testing in couples and according to the family approach based on an index subject (sexual partner and children of index subject, parents (father and mother) and siblings of index children);
- Strengthening the capacities of peer educators and community counsellors for KPs counselling and screening;
- Strengthening the mobilisation of KPs followed by testing by peer educators and community counsellors;
- Strengthening the regular supply of reagents and consumables for VCT services.

In summary, the aim will be to promote the approach of geographic and population-based targeting according to the epidemic for all defined testing strategies.

**Outcome 2.2: By 2023, 92% of PLHIV adults, adolescents and children who know their status are receiving antiretroviral treatment.**

ARV treatment should be offered immediately after diagnosis. This is the main orientation of the "Test and treat" program. It involves orienting and or accompanying (linkage) as soon as possible newly diagnosed HIV+ people to initiate HIV care and treatment. All opportunities should be used to put all PLHIV on antiretroviral therapy as soon as possible, both for those tested in the community and in health facilities.

- The community-based ARV delivery strategy aims to improve the continuum of care for PLHIV. Cameroon adopted community-based ARV provision in 2016 with implementation starting in 2017. According to programmatic data, the community contribution represents 13% of the total of the 2nd 90 (Report of the mid-term review of the HIV NSP 2018-2022,). The aim is to increase and improve the continuum of care for PLHIV and bring the supply of care closer by removing all barriers to access to ARVs.
- The adoption by the Ministry of Health of the policy on biological monitoring of PLHIV by viral load. There are still shortcomings in the scaling up of this directive

with regard to the organisation of the transport circuit and the reporting of results, the demand for the examination by providers, access to the examination in the 10 regions and the strengthening of capacities of service providers.

- Cameroon has adopted Dolutegravir-based regimen as first line treatment according to WHO recommendations on the basis of efficacy, (ii) high genetic barriers, low toxicity and low cost. These characteristics have as benefit improved adherence, viral suppression and improved quality of life of PLHIV. The transition plan to DTG based regimens is progressive and facing implementation challenges related to the resistance of some practitioners and patients to treatment changes and the challenge imposed on the supply chain by this change, which is expressed in terms of numerous stock out in some ART sites.
- Access to therapeutic education for PLHIV as part of their care will be expanded to ensure coverage in all ART sites. The national program will also build on the implementation of the mobile phone and applications system to improve the retention of PLHIV through reminder messages for consultation appointments and ARV drug refill. A protocol for identifying and actively searching for PLHIV lost to follow up will be implemented with the participation of associations.

**Outcome 2.3: By 2023, 92% of PLHIV (adults, adolescents and children) treated with ARVs have an undetectable viral load at 12 months.**

To ensure access to the viral load test, the viral load scaling plan will be implemented. To achieve the objective of 92% retention of PLHIV on ART at 24 months, prevention and active search for those lost to follow-up will be implemented as part of the retention scheme that will be developed with the various associations to ensure coverage in all ART sites (CTA/UPEC, PMTCT sites, CDT). The strategies to be adopted will be

- The scaling up of the deployment of viral load platforms at national and regional level;
- The organisation of networking from decentralised sites to viral load platforms for transport and reporting of viral load results;
- Strengthening the capacity of health providers to collect and use viral load;
- Use of Point of Care (POC) acquired in the context of TB diagnosis and early diagnosis of children by PCR for viral load testing
- Strengthening the demand for viral load by healthcare providers and patients;
- Continuous availability of reagents and other viral load consumables;
- Capacity building for the management of ARV resistance;
- Establishment of a resistance monitoring system at all levels;
- Strengthening the availability of third-line ARVs;
- Improving affordability of HIV resistance testing.

**Outcome 2.4: By 2023, 95% of cases of co-infections and co-morbidities are managed according to national guidelines.**

As part of the management of HIV infection and co-morbidities, all PLHIV are actively screened for TB and, provided INH prophylaxis. Other opportunistic infections and co-morbidities (including hepatitis) will also be investigated and treated. This requires making TB/Hepatitis/syphilis screening among PLHIV systematic and training health providers at ART sites on management of co-infections (TB/HIV, Hepatitis/HIV).

The integration of HIV, TB and hepatitis services will be strengthened by systematically offering HIV testing for all tuberculosis patients and systematically referring patients who test positive to the management units. The implementation of this recommendation requires the strengthening of measures to control tuberculosis infection in TB and HIV treatment centres, and implies close collaboration between the HIV, TB and hepatitis programs.

Table 9: outputs for impact 2

| Outcome | Output |
|---|---|
| **Outcome 2.1: in 2023, 90% of adult, adolescent and child PLHIV know their HIV status** | Output 2.1.1: by 2023, 92% of KPs and vulnerable people will benefit from an adapted testing through targeted approach |
| | Output 2.1.2: by 2023, the permanent offer of HIV testing, initiated by the provider, will be extended to all public, private and community health structures |
| **Outcome 2.2: By 2023, 90% of adult, adolescent and child PLHIV who know their status will receive antiretroviral therapy** | Output 2.2.1: by 2023, 92% of newly diagnosed PLHIV (children and adolescents) are put on treatment |
| | Output 2.2.2: by 2023, 90% of adult PLHIV are kept on treatment |
| | Product 2.2.3: by 2023, 90 %% of PLHIV (adolescents and children) are kept on treatment |
| **Effect 2.3: By 2023, 90% of PLHIV (adults, adolescents and children) treated with ARVs have an undetectable viral load at 12 months** | Output 2.3.1: by 2023, 75% of PLHIV monitored have a viral load according to national guidelines |
| | Output 2.3.2: By 2023, 100% of PLHIV who have a detectable viral load are treated according to national guidelines |
| | Product 2.3.3: by 2023, 100% of accredited laboratories meet the quality standards for viral load performance for PLHIV |
| **Outcome 2.4: By 2023, 100% of co-infections and co-morbidities** | Output 2.4.1: By 2023, 100% of TB HIV co-infected patients receive both anti-TB drugs and ARVs |
| | Output 2.4.2: By 2023, 80% of infected patients will benefit from tuberculosis prevention measures |

| | |
|---|---|
| **will be treated according to national guidelines** | Output 2.4.3: By 2023, at least 80% of patients with an opportunistic infection are treated according to national guidelines |
| | Output 2.4.4: By 2023, all eligible PLHIV on ART receive INH prophylaxis and are treated for opportunistic infections and co-morbidities (including hepatitis) |

***Impact Result 3: By 2023, the quality of life of people infected and/or affected by HIV is improved by 50%.***

Achieving Impact 3 translates into improved quality of life for people living with HIV and their families. The aim is to create an enabling environment to support the implementation of this NSP, and to remove the obstacles that hinder access to prevention and care. Decision-makers and opinion leaders will also be called upon both to facilitate the creation of a protective environment for populations, and to ensure the protection of those working in the field with PLHIV, populations in vulnerable contexts and KPs.

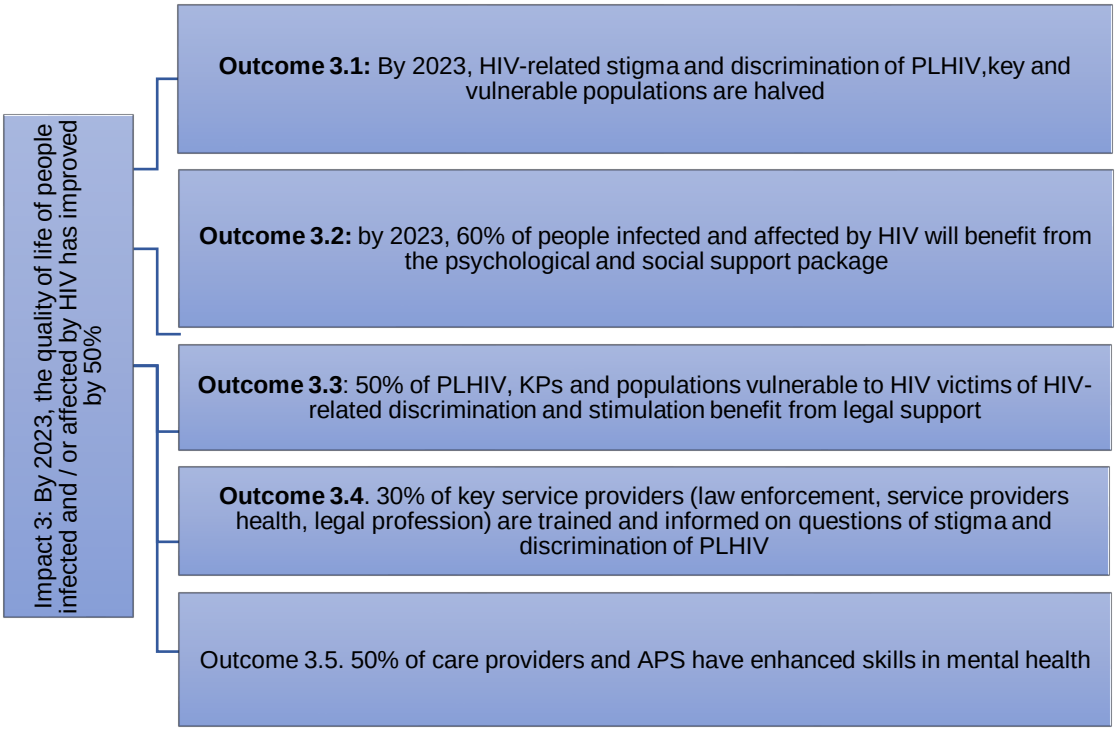


Figure 14: Outcomes for impact 3

## Outcome 3.1: By 2023, HIV-related stigma and discrimination of PLHIV, key and vulnerable populations is reduced by 50%

The aim is to develop advocacy and training interventions for decision-makers and opinion leaders in order to reduce stigma and discrimination in all settings. By building the capacity of health providers' stakeholders on the rights of PLHIV and other vulnerable populations, respect for human rights is ensured. Support will be provided as part of the legal protection of the rights of PLHIV and vulnerable groups (legal assistance, legal training, etc.).

PLHIV and representatives of KPs, will be involved in community mobilisation so that civil society through advocacy contribute to reducing barriers to access to care. Information on the rights of PLHIV, will be developed to combat HIV-related discrimination and stigma.

**Outcome area 3.2: By 2023, 60% of people infected and affected by HIV will benefit from the psychological and social support package.**

An innovative model will have to be created, defining a national package of psychological and social support services for PLHIV, enabling them to benefit from the support corresponding to their needs and those of their families. The partnership between the ministries concerned and community associations will be promoted so that the people concerned have access to the various social services. Strengthening the mobilisation of resources for socio-economic support for PLHIV (empowerment) will be sought through collaborative MOUs with the ministries and social programs concerned (Ministry of Social Affairs and other ministries).

In this context, orphans and vulnerable children and adolescents will also benefit from the package of services adapted to their educational, social and economic needs. The normative references in terms of the care of OVC will therefore be updated, followed by the development of training modules for the actors.

The psychosocial support dynamics for children/adolescents living with HIV must be developed to meet the needs for support for (i) disclosing their serological status, (ii) managing life projects in the context of HIV, life skills interventions, etc. This will contribute to the emergence of young people/adolescents living with HIV who will become leaders and models for boosting both prevention and the use of testing and treatment services by this age group.

**Outcome 3.3: 50% of PLHIV, KPs and vulnerable populations victims of HIV-related discrimination and stimulation benefit from legal support**

- Measures will be directed towards identifying and modelling existing mechanisms of redress for human rights violations as well as updating normative tools for protection. Materials for observing and recording HIV-related discrimination situations will be developed and implemented at the community level.

- The contribution and active involvement of NGOs is crucial to the success of this objective. The different actors will have to develop tools to assist PLHIV that include: listening, individual follow-up, conciliation with the other party, mediation and legal assistance. These tools must be accessible at the local level in all regions, and individual solutions will have to be found. Interventions will focus in particular on:

- The definition of recourse mechanisms and tools for handling complaints of HIV-related discrimination and human rights violations.

- The design and implementation of a community-based monitoring system for reporting cases of stigma and discrimination at the CSO level.

- The development of information materials for PLHIV and KPs on the complaint mechanism and reporting tools.

**Outcome 3.4. 30% of key providers (law enforcement, health providers, legal body) are trained and informed on issues of stigma and discrimination of PLHIV**

Actions include conducting and strengthening advocacy to address barriers and improve the legal environment for the AIDS response. Awareness-raising and training of police and prosecutors on HIV prevention programs for vulnerable and key populations will be strengthened. To combat discrimination, it is necessary to take action at the different levels and in institutions where discrimination is likely to affect PLHIV (the judicial environment, workplace actors, and prison staff)

Awareness-raising workshops for magistrates, lawyers, police officers for the application of non-discrimination laws will be organised and a communication strategy will be implemented. The expected impact is to make them aware of the negative effects of human rights violations on these categories of people and the repercussions on public health. Actors will be sensitised and trained so that they have the necessary tools.

Interventions will focus in particular on

- Strengthening governance and multisectoral coordination at national and regional levels for the implementation of activities

- The development of communication tools to combat stigma and discrimination

- Awareness-raising and capacity building of decision-makers (parliamentarians, opinion leaders, government and justice officials) on human rights, gender and access to HIV prevention and care services.

**Outcome area 3.5. 50% of health care providers and APSs have improved mental health skills.**

The issue of stigma and discrimination in care settings is often reported by different actors and was documented in the stigma index study. PLHIV reported cases of violations of their rights in care settings.

This situation and the negative experiences of PLHIV can lead to mental health problems which is important to take into account.

Interventions will focus in particular on:

- Integration of the mental health approach in the NSP planning, monitoring/evaluation process
- Implementation of awareness-raising campaigns on the fight against discrimination in healthcare settings with the mobilisation of resource persons.
- Introduce modules on Mental Health

Table 10: Outputs for impact 3

| Outcome | Output |
|---|---|
| **Outcome 3.1: By 2023, HIV-related stigma and discrimination of PLHIV, KPs and vulnerable are halved by 2023** | Output 3.1.1: by 2023, 90% of secondary target people (health workers, magistrates, police) will receive an adapted service package to reduce discrimination against PLHIV, KP and vulnerable populations |
| | Output 3.1.2: By 2023, 100% PLHIV, KP and vulnerable populations benefit from human rights protection services |
| | Output 3.1.3: By 2023, the social and legal environment protects PLHIV, KP and vulnerable populations against discrimination |
| **Outcome 3.2: By 2023, 60% of people infected and affected by HIV monitored will benefit from the psychological and social support package** | Output 3.2.1: by 2023, 60% of PLHIV in need benefit from psychosocial support |
| | Output 3.2.2: by 2023, 60% of indigent PLHIV benefit from socio-economic support |
| | Output 3.2.3: by 2023, 60% of identified OVCs will receive the minimum package of services adapted to their needs according to the standards in force |
| **Outcome 3.3: 60% of PLHIV, KPs and vulnerable people benefit from legal support** | Output 3.3.1: 60% of PLHIV, KPs and vulnerable people benefit from legal support Capacity building of key providers on the stigma and discrimination of PLHIV |
| **Outcome 3.4: 30% of key service providers (law enforcement, health providers, legal body) are trained and informed on issues of stigma and discrimination of PLHIV** | Output 3.4.1 Capacity building of key service providers on the stigma and discrimination of PLHIV |
| **Outcome 3.5: 50% of healthcare providers and APS have enhanced skills in mental health** | Output 3.5.1 Strengthening the capacities of healthcare providers on the management of mental disorders related to chronic diseases and vulnerabilities and suicide prevention |

*Outcome Impact 4: By 2023, the quality of governance of the national response has improved by 50%.*

This impact result on the quality of governance will be achieved by strengthening the national leadership of the NACC as a multi-sectoral coordinating body for the national response.

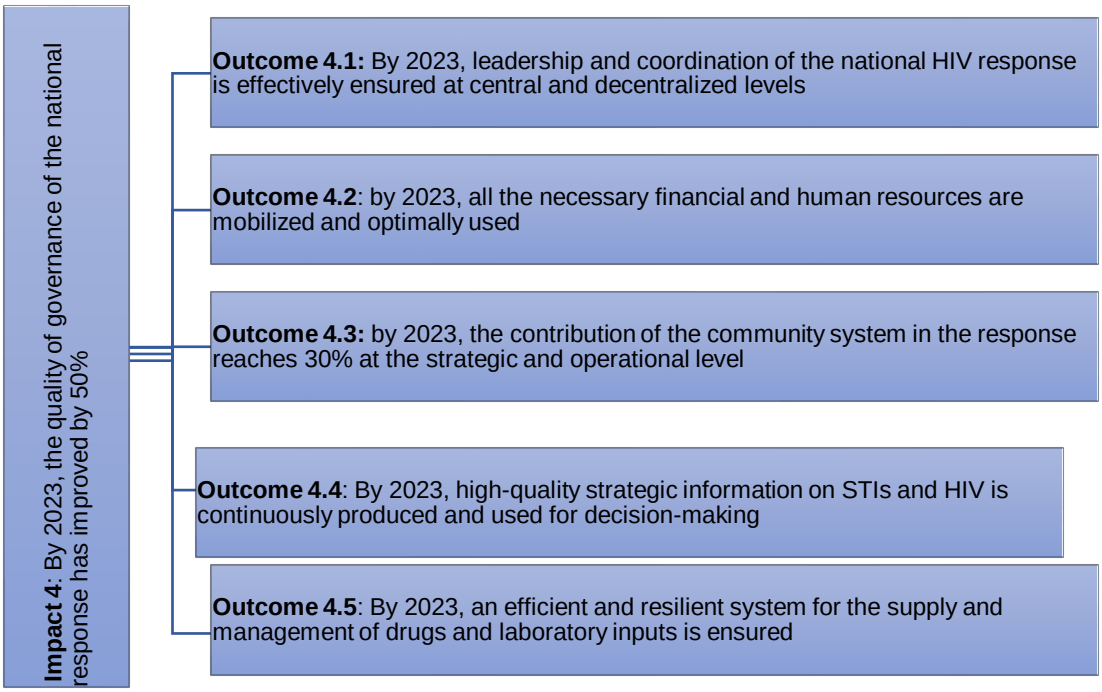


Figure 15: Outcomes for impact 4

## Outcome 4.1: By 2023, leadership and coordination of the national response to HIV is effectively provided at central and decentralised levels.

The proposed strategies aim to strengthen coordination, state leadership and sustainable commitment to sustain the resources mobilised at national and international levels. The achievement of the outcome results mentioned below will lead to the alignment of sectors and partners in the response to HIV within the framework of multisectorality and decentralisation. Multisectoral coordination of the national response is fundamental and is ensured by the Central Technical Group (CTG) at the central level and by the Regional Technical Groups (RTGs) in the country's 10 Regions for the decentralised level. The CTG is the executive body of the National AIDS Control Committee. It is responsible for coordinating the implementation of the national strategy and monitoring the results of the sectors contributing to this response.

The mobilisation of Cameroon's major cities in the national response to HIV, through decentralised local authorities, is essential for the achievement of results.

### Outcome 4.2: By 2023, all necessary financial and human resources are mobilised and used optimally.

The mobilization of national financial resources is ensured through the government's involvement alongside the main technical financial partners, which are PEPFAR and the Global Fund to Fight AIDS, Malaria and Tuberculosis, whose respective contributions represent approximately 46% and 40% of the funds mobilized. At the national level, most of the resources tracked are mobilised from the State.

The main strategies that will be developed aim to strengthen the mobilisation of internal and external resources, the management and reporting of NSP funding and the coordination of the CTG-NACC in the communication and aggregation of financial information. A strategic watch will be developed to guide funding according to the dynamics of the epidemic. This will be possible with coordination developed at all levels, central, decentralised, sectoral, continuous advocacy and strong leadership.

Advocacy with technical and financial partners (TFPs) and sectors for regular financial reporting to the CTG-NACC is essential in order to have a complete financial landscape.

Annual budget monitoring of the NSP (consolidated financial report) must be carried out in order to develop a work plan that takes into account the financial gaps identified. For this, it is essential to establish a link between programmatic and financial monitoring to ensure better prioritisation of high impact interventions. As part of the innovative mechanisms for financing the fight against poverty, it will also be necessary to revitalise private sector and other partners as well as decentralised local authorities.

Finally, within the framework of transparency in the management of available resources and accountability, a programmatic and financial risk management system will be developed. The national response to the HIV epidemic must be effective and efficient at all levels to ensure that the results of implementation, monitoring and the quality of interventions are achieved.

### Outcome 4.3: By 2023, the contribution of the community system in the response reaches 30% at strategic and operational levels.

The implementation of a policy of partnership with community actors (associations and networks of PLHIV, associations of most-at-risk population groups, NGOs and networks involved in the national response to HIV, etc.) in order to strengthen their contribution and active participation in the national response is decisive with regard to the results expected by this NSP, with a view to reducing new infections and mortality linked to HIV, as well as social and psychological support for people infected and affected by HIV.

The strengthening of the institutional, organisational and managerial capacities of partner associations and the revitalisation of the consultation platform are intended to support the scaling up and improvement of the quality of interventions in order to contribute to the achievement of national targets.

### Outcome 4.4 by 2023, quality strategic information on STIs and HIV is consistently produced and used for decision-making.

The MoH has a routine national health information system (SNIS) that covers primary health care and hospital services. This system aims to: (i) promote health information; (ii) put in place modern data collection methods; (iii) rationalise the organisation and management of quality information; and (iv) ensure improved quality of data. It is necessary to revise and integrate the various existing information systems, to avoid setting up vertical reporting systems for health programs (including HIV and TB), and to avoid programmatic overlaps in the information system.

Improving the national monitoring and evaluation system for HIV involves defining and choosing relevant indicators, simplifying and disaggregating collection tools, and integrating community data, in order to allow effective management of strategic information by all institutional and community actors. Beyond the data management aspects, data is also needed for decision-making.

The main tools will be reviewed for an efficient use of the data at the central and decentralised levels. In addition, the feasibility and use of a unique identifier code system for HIV prevention, medical care and the continuum of care in two regions will be evaluated, and finally, generalisation will have to be based on the results obtained.

Finally, as part of the strengthening of the health system (HSS), the HIV information system will gradually be integrated into the National Health Information System (NHIS), thus enabling the Ministry of Public Health to have all strategic information relating to diseases at its disposal.

The development of operational research is an important focus/stake for monitoring the epidemic, with annual revisions of epidemic estimates based on new data. The aim is to strengthen epidemiological and behavioural surveillance by means of bio-behavioural studies among KPs every two years. It also involves conducting studies to monitor resistance to ARV in order to prevent and manage treatment failures.

### Outcome 4.5: By 2023, an effective and resilient system for the supply and management of drugs and laboratory inputs is ensured.

With regard to the supply and stock management (SSM) component, improvements have been made and will be strengthened. These include:

- Capacity building of actors at the peripheral level;
- Contractualization with CENAME and the Regional Funds on the basis of objectives;
- The inclusion of PSM indicators/data in the DHIS2;
- The existence of a national sub-committee in charge of the supply of HIV products led by the DPML;
- The organisation of training/refresher courses for key players in the management of HIV-related health products, in addition to existing supervisory missions.

Table 11: outputs for impact 4

| Outcome | Output |
|---|---|
| **Outcome 4.1: Leadership and coordination of the national response to HIV are effectively ensured at central and decentralized levels by 2023** | Output 4.1.1: By 2023, 100% of response coordination bodies at national and regional levels are functional and multisectorality is strengthened |
| | Output 4.1.2: by 2023, 100% of the cities targeted will be mobilized through local authorities for the fight against HIV |
| | Output 4.1. 3.by 2023, 100% of the sectors will implement operational plans in line with the PSN |
| | Output 4.1.4 by 2023, 100% of bilateral and multilateral cooperation programs are aligned with PSN guidelines |
| **Outcome 4.2: all the necessary financial and human resources are mobilized and used optimally** | Output 4.2.1: by 2023, 100% of the internal and external resources required for the implementation of the PSN are mobilized, taking into account the transition and sustainability of funding |
| | Output 4.2.2: By 2023, a programmatic and financial risk management system is in place and operational |
| **Outcome 4.3: the contribution of the community system in the response reaches 30% at the strategic and operational level** | Output 4.3.1: by 2023, the functionality of the coordination framework of the community system increases by 50% |
| | Output 4.3.2: by 2023, the partnership framework and the contracting system between government institutions and NGOs are established |
| **Outcome 4.4: Quality strategic information on STIs and HIV is used and used for decision making** | Output 4.4.1: By 2023, the Health Information System (HISS) on STIs / HIV / AIDS is operational and efficient |
| | Output 4.4 2: By 2023, a national STI / HIV / AIDS research agenda is developed and implemented |
| | Output 4.4.3: By 2023, partnership between stakeholders in the production and use of quality strategic HIV information is strengthened |
| **Outcome 4.5: By 2023, an efficient and resilient system for the supply and** | Output 4.5.1: By 2023, 100% of facilities offering HIV prevention, care and treatment services are provided with sufficient quality drugs and other health products |

| | |
|---|---|
| **management of drugs and laboratory inputs is ensured** | Output 4.5.2: by 2023, 100% of drugs and tracer inputs for HIV prevention and care actions are stored according to good storage practices |
| | Output 4.5.3: By 2023, quality logistics information on the management of ARVs and other HIV commodities (rapid tests, viral load reagents, isoniazid and cotrimoxazole, condoms) are produced and used for decision-making and improving supply chain performance at all levels |
| | Output 4.5.4: By 2023, coordination and leadership of the HIV supply chain is effectively ensured at central and decentralized levels |
| | Output 4.5.5: By 2023, quality human resources for the supply chain are available at all levels |

# 7. Institutional and organizational framework for implementation in Cameroon

The NSP is the benchmark for all programs that will be implemented as part of the response to HIV. It is being implemented in an organisational and institutional framework that is undergoing major changes: 1. strengthening the planning, coordination, advocacy and resource mobilisation roles of the Permanent Secretariat of the NACC and restructuring (change of statutes and internal reorganisation), 2. strengthening the role and leadership of the Ministry of Public Health both strategically and operationally, 3. consolidating and increasing the accountability of the regional level.

The National AIDS Control Committee is the supreme political, decision-making and strategic orientation body in the fight against AIDS in Cameroon. It is supported by the Permanent Secretariat of the Central Technical Group and the Partners' Forum which make recommendations to the Committee. The NACC has functional links with the Joint United Nations System Team on AIDS which is a coordinating body for the support of the United Nations system to the national AIDS response and the CCM (National Coordinating Body of the Global Fund for HIV, Tuberculosis and Malaria).

For a harmonious implementation of the AIDS response between 2021 and 2023, the Central Technical Group of NACC will be refocused on its coordination activities as defined in the "Three Ones" framework. The CTG/NACC will refocus its interventions on the coordination of the elaboration, revision and reviews of national strategies. Support to civil society coordination bodies and networks, to sectors and to the animation of the partners' consultation framework will also be ensured. Finally, the CGTG/NACC coordinates the monitoring and evaluation sub-systems and provides leadership for the national monitoring and evaluation system as well as the implementation of the national research and study plan.

The elimination of HIV is possible in Cameroon through the implementation of a new paradigm that involves: national commitment and leadership at the highest level; efficiency in the allocation and use of resources; strengthening of the community and health system; governance and national solidarity.

In line with the multisectoral approach, actors from all development sectors will be mobilised within the framework of sectoral operational strategies for the implementation of this strategic plan 2021-2023. This includes the public sector, the private sector and all community actors (associations and networks of PLHIV, associations of most-at-risk population groups, NGOs and networks involved in the national response to HIV, etc.). Multilateral and bilateral partners will provide technical and financial support for the implementation of the NSP.

The decentralisation of the response at regional level, mobilising the various local actors, will be capitalised on and strengthened. The implementation of the regional AIDS plans will allow for better adaptation of strategies to the local context and greater proximity of the offer of prevention and care services to the most at-risk populations and PLHIV depending on the dynamics of the epidemic in Cameroon.

## *7.1 Methods of implementation*

The Strategic Plan 2021-2023 will be implemented on the basis of a budgeted operational plan developed with all partners involved in the fight against HIV/AIDS using a results-based approach.

The "top-down" planning strategy will be implemented by breaking down the national operational plan into annual national multisectoral plans which will be disaggregated into regional and sectoral plans, according to the priorities defined and according to the results-based approach, with the involvement of all stakeholders.

These annual plans will aim to guide the implementation of the NSP. They will provide more details on the prioritisation of actions, the targeting of interventions, geographical coverage and the budgeting of programmed actions. Each of the peripheral, regional and national levels will identify the actions they will carry out, with reference to the NSP and taking into account the context in which the interventions will be carried out.

The main structures/sectors of implementation are:

- The health sector (public and private);
- The public and private non-health services (in particular the sectors in charge of education, youth, armed forces, women, labour, tourism, interior, justice, mines, agriculture and animal husbandry...);
- HIV treatment centres (Heath and Community) ;
- Non-governmental organisations;

- Community-based organisations, including those of PLHIV and KPs;
- Faith-based organisations.

## 7.2 At the public sector level

All ministerial departments and major state institutions, in addition to their traditional public service missions, will be in action through their respective sectoral committees to carry out HIV/AIDS interventions for their staff, users and families. The aim here is to seek a synergy of actions to ensure that PLHIV and other vulnerable populations benefit from existing social services and basic rights (social insurance, health insurance, social rights, assistance allowances for the destitute, etc.).

Each sector will have as its main orientation to provide a response oriented towards the general public, taking into account its sovereign missions. For example, the ministries in charge of education will give priority to HIV education, the ministry in charge of health will be responsible for providing care, and so on.

Active participation in the implementation of the Universal Health Coverage (UHC), which appears to be a real opportunity because the application of this decision will improve access to health services in Cameroon.

### 7.2.1 Ministry of Public Health: an essential place in the implementation of the NSP STI/HIV

The role of the Ministry of Public Health is predominant in the fight against HIV in Cameroon. Its actions cover all the major areas of intervention in the fight. First of all, it provides leadership in the public health sector (prevention, PMTCT, screening and HIV treatment) and then, as President of the NACC, the Minister of Public Health is the guarantor of the coordination of interventions3 in the fight against HIV.

To ensure the effectiveness of the health sector response to HIV, the technical directorates of the Ministry of Public Health, each within the framework of its sovereign missions, interact with the Health Sector Support Section of the CTG/NACC to guarantee equitable access to HIV services. Placed under the authority of a Head of Section, the Health Sector Support Section is responsible for providing the Ministry of Public Health with technical support in the implementation of the health sector response through the development of standards, guidelines and strategic documents for comprehensive care, PMTCT and supply chain management. The diagram below summarises the roles and interactions of the MoH directorates in relation to the HIV response.

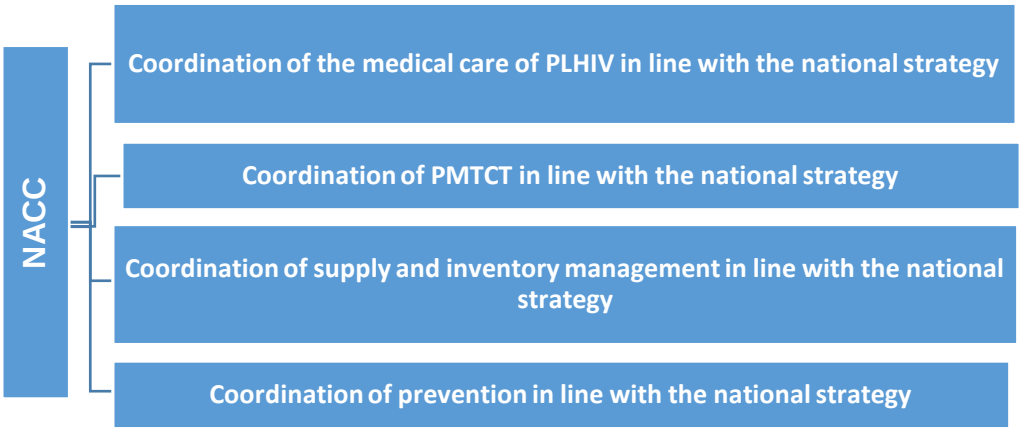


Figure 16: The roles of MOH in the HIV response

### 7.2.2 Civil Society Organisations / Community-based Organisations and Networks

With the support of the NACC and UNAIDS, a Cameroon Civil Society Coalition against AIDS, TB, Malaria and Viral Hepatitis bringing together more than 200 civil society organisations (CSOs) on HIV in the 10 Regions was set up in 2018. A mapping of CSOs and a roadmap on accelerating the community contribution to reach the 3 "95" target has been completed. The structure of the coalition remains very fragile and capacity building interventions are needed in the following areas: (1) the development of planning and management tools (Strategic Plan, Advocacy Plan, Adapted Procedures Manual); (2) the setting up of an executive secretariat (staff, equipment).

With regard to the overall national response, civil society is carrying out most of the activities to combat stigma and discrimination and to create an enabling environment for access to and continued use of HIV services, as well as monitoring people's access to treatment and care and human rights. CSOs also participate in the coordination of the national response through their representatives on the CCM.

All in all, the landscape of community actors is rich in Cameroon; in addition to outreach workers attached to community-based organisations (CBOs) of PLHIV networks or key populations (peer educators, MSM and SW mentors, mother-mentors, peer navigators), there are many community workers attached to health services and local authorities.

### 7.2.3 Private sector

The active participation of the private sector in the process of the national response is effective and is of major importance not only in mobilizing workers in the economic poles, but also in mobilizing national resources. Because of their commitments and social responsibility, private sector companies have an important role to play in protecting employees and their families from HIV and AIDS. However, the private sector has a great potential, until now that is not fully exploited in the AIDS response. Many multinational and national companies have invested heavily in health infrastructure, access to diagnostics, and training of staff to provide effective, quality care to their employees, their families and sometimes to neighboring communities.

In the specific context of the fight against AIDS, private sector companies such as Cameroon's employer organisations (GICAM, CCIMA, ECAM, CAPEF); the Workers' Trade Union Confederation (CSTC) and workplace health promotion organisations (SEE, CCA-SANTE, PHP, CAMRAIL, ALUCAM, CIMENCAM, SABC, etc.) contribute to the national response by providing prevention and care services (and support through the health insurance mechanism) by co-financing interventions.

Other actions carried out through partnerships with mobile phone companies (ORANGE, Camtel, MTN, NEXTEL, etc.) contribute to facilitating the payment of salaries of PSAs in the AIDS-MALARIA-TB programs, with AFRICA-Logistic handling customs clearance for the GF's Pooled Procurement Mechanism. These initiatives will need to be strengthened during the period of the 2021-2023 strategic plan while identifying other Public-Private Partnership (PPP) niches in the areas of extending program coverage, supply chain support, co-investment in prevention and care services, resource mobilisation, etc.

However, it is important to produce an updated Map of HIV and AIDS interventions in the private sector, to document PPP opportunities in order to better capitalise on the opportunities of the enterprises and to support the coordination, implementation and monitoring of the private sector contribution to the response.

### 7.2.4 Development Partners / Technical and Financial Partners (TFPs)

In order to facilitate national coordination and monitoring of interventions, development partners will support efforts through technical and financial support to public, private and civil society actors in line with the NSP. The partners' forum is a space for dialogue and consultation whose mission is to promote the coordination of actions and support from all partners in the response to HIV in Cameroon. The specific tasks of the partners' forum will be to : a) facilitate the exchange of information on the actions of each partner, b) exchange on the national priorities of each year in terms of the response to HIV, c) ensure synergy, complementarity and the absence of duplication in the support for the implementation of the national response, (d) agree on the allocation of resources for HIV with a view to ensuring

geographical equity in the provision of HIV services, (e) assess progress in the implementation of the national response, (f) plan joint supervision and agree on the modalities for its organisation, (g) ensure technical assistance with all other partners.

### 7.2.5 Cameroon CCM

This national coordinating body is under the aegis of the Prime Minister who, on behalf of the entire country, submits applications to the Global Fund and ensures strategic monitoring of grants. The ICN is an essential part of the Global Fund partnership. It has representatives of all stakeholders active in the disease response: multilateral and bilateral agencies, government authorities, non-governmental organizations, civil society, academic institutions, technical agencies, faith-based organizations, the private sector and - most importantly - people living with the diseases.

- Coordinate the development of the country's funding applications
- Designate the Government Principal Recipient and the Community Principal Recipient
- Ensuring strategic monitoring of the implementation of approved grants
- Approve any request for reprogramming
- Ensuring linkages and coherence between Global Fund grants and other national health and development programs

## *7.3 Operationalisation of NSP 2021-2023*

### 7.3.1 Operational plan

At the national level, the operationalisation of this NSP involves the development of a first operational plan (OP) for a period of 3 years (2021-2023), which will serve as the basis for the NFM3 funding request. After the mid-term review of the current NSP, which should take place at the end of 2023, the second phase of NSP implementation will be carried out according to the recommendations made for its updating and taking into account the evolution of the epidemic and the response.

Existing frameworks for consultation and exchange will make it possible to ensure better leadership, alignment and harmonisation of interventions in the national response.

### 7.3.2 Cities approach in Cameroon

The strategy aims to mobilise elected officials (mayors) to solicit their civic contribution to the national response. It is an innovative approach that allows institutional actors to be empowered according to the importance of the epidemic in their locality. The aim is to build an appropriate local response that is included in the communal development plans of councils and budget development so that the needs of the people in the localities where they live can be met.

The NSP 2021-2023 aims to reduce new infections among adults and adolescents, eliminate mother-to-child transmission of HIV, reduce HIV-related mortality, support the improvement of the quality of life of PLHIV and combat all forms of discrimination. Through this approach, Cameroon's main cities can contribute to the achievement of national results by developing local actions from urban areas to their outskirts

### 7.3.3 Roles of the different implementation actors

According to the principles and types of actors presented above, the different roles of implementing actors by level of intervention can be described as follows.

Table 12: Roles of different actors per level in the implementation

| Level | Actors | Roles |
|---|---|---|
| **First Level (peripheral)** | - Actors in prevention and testing<br>- treatment and care actors<br>- Actors of support and protection<br>- Actors in the fight against stigma and discrimination and in the defense of the rights of beneficiaries<br>- - Actors of governance at the peripheral level (city, HD) | - Implementation of interventions / activities in the public, private and community sectors at the local level<br>- Participation in the coordination of interventions / field activities<br>- Data analysis<br>- Production of activity reports and transmission to the second level<br>- Supervision of the implementation of interventions / activities in the public, private and community sectors (including monitoring of the quality of services) |
| **Second level (regional)** | - Actors in prevention and testing<br>- treatment and care actors<br>- Actors of support and protection<br>- Actors in the fight against stigma and discrimination and in the defense of the rights of beneficiaries<br>- Actors of governance at regional level (RDPH, RACC) | - Implementation of interventions / activities in the public, private and community sectors at regional level<br>- Participation in coordination activities of interventions / activities at the regional level<br>- Centralization, synthesis and validation of first level data, transmission of data to third level<br>- Information on regional indicators; production of NSP implementation reports at regional level<br>- Supervision, monitoring and evaluation of the implementation of interventions / activities in the public, private and community sectors (including monitoring of the quality of services) |

| | | |
|---|---|---|
| **Third Level (national)** | - Actors in prevention and testing<br>- treatment and care actors<br>- Actors of support and protection<br>- Actors in the fight against stigma and discrimination and in the defense of the rights of beneficiaries<br>- Governance actors: NACC | - Implementation of interventions / activities in the public, private and community sectors at the national level<br>- Participation in coordination activities of interventions / activities at the national level<br>- Centralization, synthesis and validation of 2nd level data as well as the results of national, regional or local studies and surveys (IBBS, maps, etc.)<br>- Production of various reports (national activity report, dashboard of indicators and epidemiological data, international reports, NSP reviews)<br>- Supervision, monitoring and evaluation of the implementation of interventions / activities in the public, private and community sectors (including the quality of services |

## *7.4 Monitoring and evaluation*

### 7.4.1 Monitoring and evaluation plan

The monitoring and evaluation system is an essential component of the NSP 2021-2023. In order to allow for a scrupulous monitoring and evaluation of its implementation, a Monitoring and Evaluation Plan will be developed as a variation of this NSP. It will constitute the reference framework for assessing the expected results, in particular the level of achievement of the targets set and the relevance, effectiveness and efficiency of the interventions implemented.

The Monitoring and Evaluation Plan will thus aim to: a) Define the performance indicators enabling the NSP 2021-2023 to be monitored and evaluated, b) Identify the monitoring and evaluation tools, c) Describe the data collection and quality control circuit, d) Describe the monitoring and evaluation activities, e) Describe the plan for the dissemination and use of monitoring and evaluation data, f) Align with the 40 recently updated WHO priority indicators.

### 7.4.2 Architecture of the monitoring framework

The NSP monitoring framework will be coordinated at all levels of the national health pyramid (central, regional and peripheral), as well as in the private sector and the community:

- The central level will facilitate the collection, storage, processing and dissemination of strategic information on HIV. This level is made up of the department in charge of

information at the Ministry of Public Health, which manages the National Monitoring & Evaluation System. This department will build on the expertise of a strategic information working group, called the "National Technical Group for Strategic Information on STIs/TB/HIV/AIDS".

- At the regional level, the RDPHP's AIDS Monitoring and Evaluation Unit is responsible for monitoring and evaluating activities in the response to HIV/AIDS. The coordination of monitoring and evaluation activities will be carried out by a group comprising the RDPH monitoring and evaluation service, the monitoring and evaluation focal points of the TFPs, the private sector and civil society;

- At the peripheral level, the district level will be the operational level for the implementation of monitoring-evaluation. The Health District (HD) will be responsible for the monthly collection of data from health and community structures. The coordination of monitoring and evaluation activities will be carried out through the district team.

The monitoring-evaluation system is based on daily data collection at the level of the health and community structures, using collection tools (PMTCT registers, tools for monitoring HIV patients on ARVs, VCT registers, etc.) and input into the health information management system (DHIS2). Each structure compiles its data in a monthly report sent to the HD and carries out its cascades of care. The HD compiles the reports for its health areas. It analyses and validates the data on a monthly basis before the quarterly validation with the RDPH. These validated data are then transmitted to the region and then to the central level. The central level analyses the data received and produces the national report and reports on international commitments (GAM, Universal Access, SDG, etc.).

Feedback is given at each level of the information circuit to all the actors involved in the fight against HIV. A revision of the overall monitoring and evaluation system is proposed to optimise the results of the NSP 2021-2023.

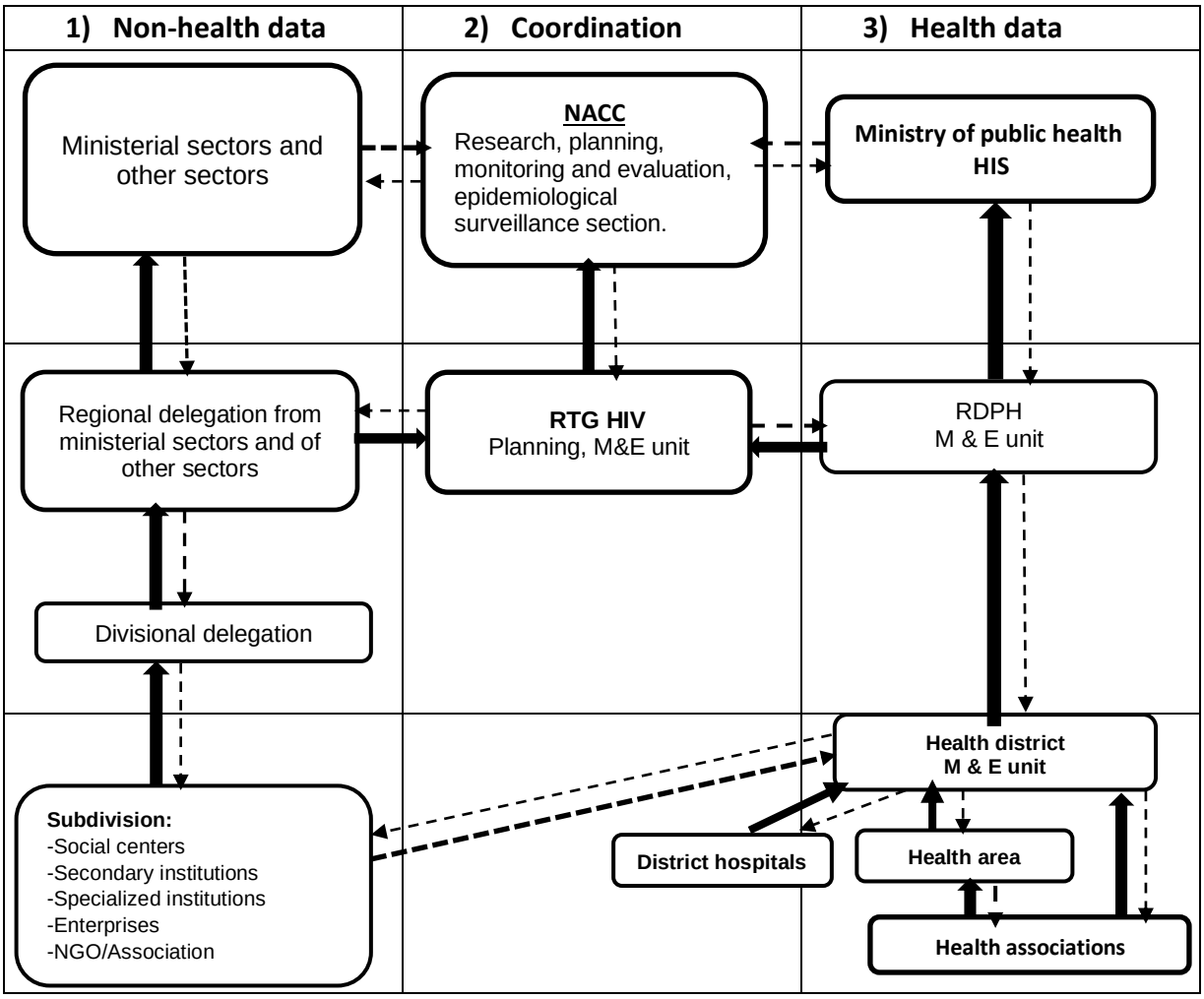


Figure 17: Monitoring and evaluation framework

At central (CTG) and regional (RTG) level, there is a staffed monitoring and evaluation service. Computerized systems built around the DHS2 are used to capture and report health data. The level of availability and completeness will be improved.

### 7.4.3 Monitoring and reporting system

The mechanism put in place must allow for the systematic collection of data for patient monitoring and program performance evaluation. Patient follow-up is carried out through a case reporting and monitoring system. As part of the implementation of NSP 2021-2023, the monitoring and evaluation system will be equipped with an HIV surveillance system that will ensure that activities are carried out in a systematic and standardised manner. The quality of

this surveillance system will be based on the systematic use of the same methods, target populations and tools.

Epidemiological surveillance will be based on the following methods:

- Data analysis across the continuum of care cascades;
- Bio-behavioural surveys or repeated serological surveys to assess changes in the prevalence and incidence (where possible) of HIV infection in high-risk populations such as SW, MSM, transgender and DU;
- Surveillance of the prevalence of HIV infection in tuberculosis patients;
- Repeated serological surveys in the general population during Demographic and Health Surveys (DHS+) or AIDS Indicator Surveys (AIS);
- Surveillance of HIV resistance to ARVs, reporting of AIDS cases and STIs will complement this surveillance;
- Surveillance of STI management in high-risk groups.

### 7.4.4 Survey and research data

NSP 2021-2023 will be subject to an external evaluation in 2023. The objective of this evaluation will be to provide an external and independent assessment of the achievement of the results in terms of impacts and effects. Impact and outcome indicators will be collected from the studies and surveys planned for this purpose.

Therefore, a research agenda is planned within the framework of the NSP 2021-2023 to generate the necessary information at the indicated times.