

THE CONTRIBUTION OF COMMUNITY-BASED ORGANIZATIONS TO THE AIDS RESPONSE IN FRAGILE STATES

BURUNDI / CAMEROON / CONGO
CENTRAL AFRICAN REPUBLIC
DEMOCRATIC REPUBLIC OF CONGO
CHAD



PLATEFORME COALITION PLUS
THE COALITION PLUS CENTRAL AND
EAST AFRICA PLATFORM (PACE)



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We would like to extend our warmest thanks to all those who participated in the individual interviews and those who responded to the online questionnaire.



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ABBREVIATIONS AND ACRONYMS

ADN

Association Djenandoum Naasson (Djenandoum Naasson Association)

AFD

Agence française de développement (French Development Agency)

AIDS

Acquired Immunodeficiency Syndrome

AJPC

Association des jeunes positifs du Congo (Congo HIV+ youth organization)

ANJFAS

Association des jeunes Femmes actives pour la solidarité (National Association of Active Young Women for Solidarity)

ANSS

Association nationale de soutien aux séropositifs et aux malades du sida (National Association of Support for People Living with HIV and AIDS Patients)

ART

Antiretroviral therapy

ARV

Antiretrovirals (drug)

CAR

Central African Republic

CCM

Country Coordinating Mechanism

CNLS

Comité national de lutte contre le VIH/sida (National AIDS Council)

DRC

Democratic Republic of Congo

FOSA

Formation Sanitaire (Health unit)

GBV

Gender-based violence

GDP

Gross domestic product

HIV

Human Immunodeficiency Virus

ICASA

International Conference on AIDS and Sexually Transmitted Infections in Africa

LGBT

Lesbian, gay, bisexual, and transgender

MSM

Men who have sex with men

NFM

New Funding Model

OCHA

United Nations Office for the Coordination of Humanitarian Affairs

OECD

Organisation for Economic Co-operation and Development

OI

Opportunistic infection

OVC

Orphans and vulnerable children

PACE

Coalition PLUS Central and East Africa Platform

PEPFAR

President's emergency plan for AIDS relief

PFM

Global Fund Portfolio Manager

PLWHIV

People living with HIV

PMTCT

Prevention of mother-to-child transmission

PNLS

Programme national de lutte contre le sida (National AIDS Control Program)

PrEP

Pre-Exposure Prophylaxis

PWID

People who inject drugs

RCED

Réseau centrafricain pour l'éthique et les droits des PVVIH (Central African Network on Ethics, the Law and HIV/AIDS)

RECAPEV

Réseau national des personnes vivant avec le VIH (Central African Republic Network of People Living with HIV)

RENAPC

Réseau national des associations des positifs du Congo (National Network of Associations for the HIV+ in Congo)

SDG

Sustainable Development Goal

SR

Global Fund Sub-recipient

SSR

Global Fund Sub-sub-recipient

STI

Sexually Transmitted Infection

SW

Sex worker

TB

Tuberculosis

UN

United Nations

UNAIDS

Joint United Nations Programme on HIV/AIDS

UNFPA

United Nations Population Fund

UNICEF

United Nations Children's Fund

WFP

World Food Programme

WHO

World Health Organization

WSW

Women who have sex with women

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COALITION PLUS

INTERNATIONAL UNION OF
COMMUNITY-BASED AIDS
AND VIRAL HEPATITIS NGOS

■ OUR NETWORK

Network

All countries listed below

Offices

Pantin (France)
Bruxelles (Belgium)
Geneva (Switzerland)
Dakar (Senegal)

Members

100% LIFE, Ukraine
AIDES, France
ALCS, Morocco
ANCS, Senegal
ANSS, Burundi
ARAS, Romania
ARCAD Santé PLUS, Mali
COCQ-SIDA, Canada (Québec)
GAT, Portugal
Groupe Sida Genève, Switzerland
Fundacion Huésped, Argentina
IDH, Bolivia
Kimirina, Ecuador
Malaysian AIDS Council, Malaysia
PILS, Mauritius
REVS PLUS, Burkina Faso



Our thematic, linguistic and geographical networks

MENA Platform: Morocco, Algeria, Tunisia, Mauritania, Lebanon

West Africa Platform: Mali, Guinea, Ivory Coast, Benin, Togo, Burkina Faso, Niger, Senegal

Central & East Africa Platform: Burundi, Rwanda, Cameroon, Tchad, DRC, Congo-Brazzaville, CAR

Indian Ocean Platform: Republic of Mauritius (including Rodrigues island), Seychelles, Comoros, Madagascar, France (Mayotte, Reunion Island)

European Platform: France, Portugal, Romania, Switzerland, Ukraine, Belgium

Americas-Caribbean Platform: Ecuador, Bolivia, Canada (Quebec), Colombia, Guatemala,

France (French Guyana, Martinique, Guadeloupe, Saint-Martin)

Hepatitis C: Brazil, Colombia, Malaysia, Morocco, India

RIGHT PLUS: Spain, Peru, Mexico, Chile, Portugal, Brazil, Bolivia, Guatemala

AGCS PLUS: Algeria, Tunisia, Morocco, Mali, Ivory Coast, Benin, Burkina Faso, Togo, Senegal, Cameroun, Burundi

Lusophone network: Portugal, Brazil, East Timor, Guinea Bissau, Angola, Mozambique, Cape Verde, São Tome and Principe



COALITION PLUS, AN INTERNATIONAL NETWORK OF COMMUNITY-BASED ORGANIZATIONS IN THE FIGHT AGAINST HIV AND VIRAL HEPATITIS

Founded in 2008, Coalition PLUS is an international coalition comprising some one hundred community-based NGOs in the AIDS response in 52 countries, united by issues of common concern:

The community-based approach

Coalition PLUS advocates for the expertise of people infected with, affected by or particularly vulnerable to HIV and viral hepatitis to be fully recognized and for the systematic involvement of their communities in the decision-making process and the development and implementation of health programs that affect them.

Social change

The associations are not only healthcare operators: they also endeavor to change society's perception of people living with HIV, HCV and those most exposed to these viruses in order to combat exclusion. As long as those infected with, affected by or vulnerable to HIV and viral hepatitis are stigmatized, discriminated against and criminalized, efforts to eliminate these epidemics will continue in vain.

The renewal of North-South relationships and promotion of sub-regional dynamics

With decades of combined experience and of working hand-in-hand with the communities primarily affected by HIV and viral hepatitis, the member associations are best placed to make the strategic decisions required to end these deadly epidemics.



THE COALITION PLUS PLATFORMS: GEOGRAPHIC NETWORKS

The Coalition PLUS Platforms: geographic networks

True to the community-based approach that guides all of its actions, Coalition PLUS develops and coordinates a set of networks to promote synergies and the exchange of best practices between structures in order to better respond to the challenges encountered by the populations most affected by HIV/AIDS and viral hepatitis. Today, Coalition PLUS deploys linguistic, thematic and geographic networks around the world. Its geographic networks currently take the form of six sub-regional Platforms:

- ▶ Four Platforms on the African continent, in the Maghreb, West Africa, Central and East Africa and the Indian Ocean.
- ▶ One Platform in Europe.
- ▶ One Platform in the Americas-Caribbean area.

These Platforms aim to strengthen and capitalize on community-based expertise in the fight against HIV/AIDS through capacity-building, support for advocacy and the structuring of community-based research in the Global South.

THE COALITION PLUS CENTRAL AND EAST AFRICA PLATFORM (PACE)

Led by the ANSS, a member of Coalition PLUS, the Central and East Africa Platform (PACE) is a sub-regional network of community-based organizations in the HIV response. Through capacity-building activities and technical support for advocacy, the PACE assists some twenty member associations (Positive Generation, Alternatives Cameroun, Humanity First, AFASO, AFSUPES, Affirmative Action, COLIBRI, ANJFAS, AJPC, RENAPC, Fondation Femme Plus, PSSP, UCOP+, RENAPC, ACCPVV, ASEPVV, ADN, ANSP+, We-Actx For Hope, ANSS) located in seven countries in the sub-region, in order to promote the role of community-based expertise and leadership in the HIV/AIDS response. The PACE Steering Committee is composed of one representative per country. In 2020, the representatives were as follows:

Burundi

Jeanne GAPIYA NIYONZIMA (ANSS)

Cameroon

Jean Jules KAMGUE (Colibri)

Rwanda

Saidi BAZIMAZIKI (ANSP+)

CAR

Patricia OUTIAMA (ANJFAS)

Chad

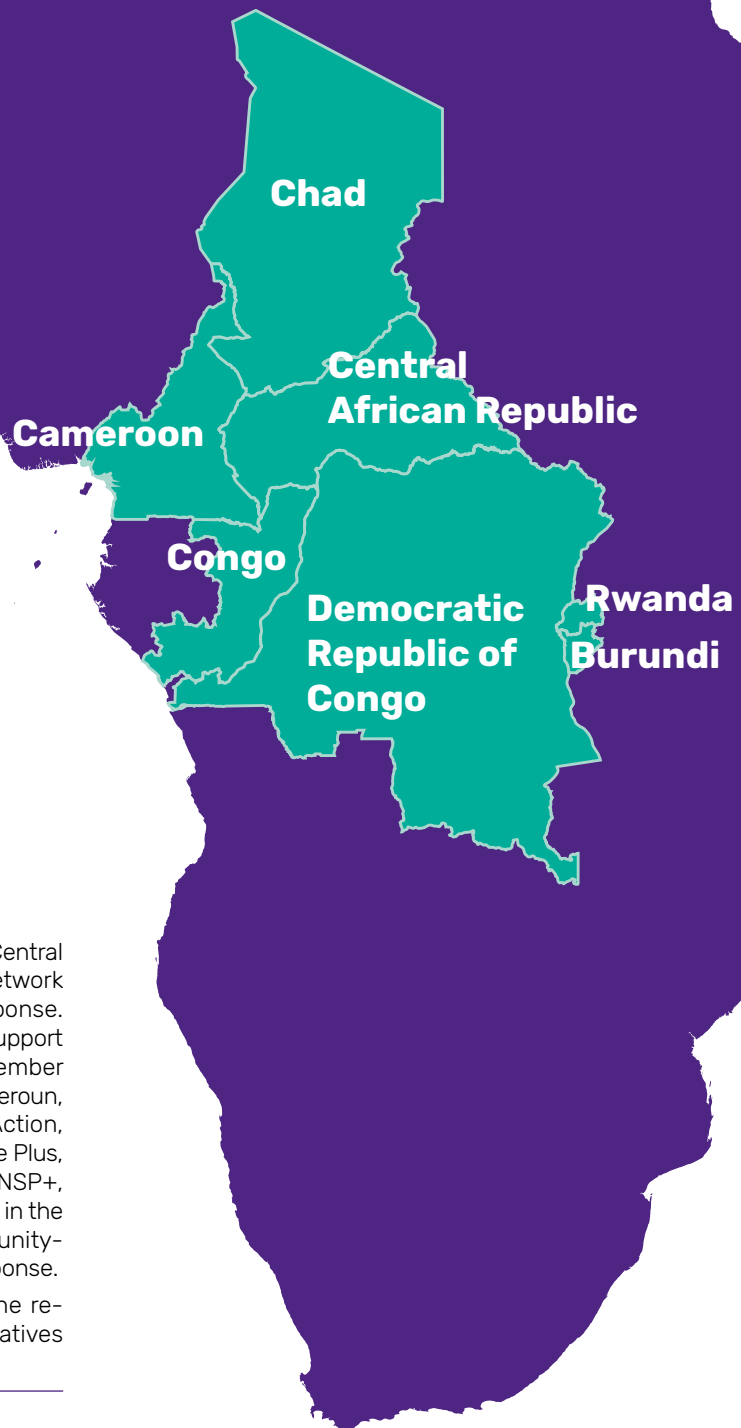
Djimadoum NGADANDE (ADN)

DRC

Bernadette MULELEBWE ISSIKITMB
(Fondation Femmes Plus/FFP)

Republic of Congo

Valerie Esmo MABA MOUKASSA (AJPC)



The ANSS, the PACE and Coalition PLUS receive support from the French Development Agency (AFD). This guide of best practices has been prepared as part of this support. The ideas and opinions expressed in this document do not necessarily reflect those of the AFD.



EDITORIAL

COMMUNITY-BASED CARE IN FRAGILE STATES, BY JEANNE GAPIYA

Given that HIV remains a major health challenge worldwide, what is the situation of fragile states, where health concerns are not always a national priority?

Most of the countries encompassed by the PACE have the common factor of being affected by cyclical socio-political conflicts that significantly deteriorate people's living standards. This is coupled with institutional criminalization in some States and social discrimination of key populations, which hinder their access to care even though we know that they are particularly vulnerable. In addition, in most conflict situations, it is women who are the most exposed to gender-based violence.

This guide of best practices and the experience of the PACE member associations will highlight the extent to which civil society organizations in the HIV response are major agents of social transformation, vital to

national efforts to ensure comprehensive HIV treatment, comprising prevention, medical, psychological and social care, while ensuring the necessary follow-up and support, always within a person-centered approach.

This guide capitalizes on and promotes community-based know-how and regional dynamics in South-South technical support and capacity-building led by the PACE. It brings to light the capacity of community-based actors to ensure a service continuum in the context of fragile States, with tailored innovative strategies.

The nine associations of the PACE that contributed to producing this guide of best practices all operate in different realities and each has to adapt to national challenges. And yet, they are all driven by the same vision: **offering services centered on the real needs of beneficiaries, with particular emphasis on those most marginalized and key populations who have difficult accessing care.**

These associations demonstrate exceptional skills and ability to adapt.

Like Alternatives Cameroun, which provides support for those criminalized by Cameroonian law and victims of arrest against a backdrop of homophobia, and is developing its differentiated health services program.

Like Affirmative Action which has been working since 2016 to further prevention among key populations in a context of a secessionist crisis in the English-speaking regions of Cameroon, marked by clashes between separatists and security forces that have bred widespread human rights abuses.

Like the ANSS, founded in 1993 when Burundi was at war and when the government's priority was to bring an end to the weapons that kill loudly while neglecting another war that kills in silence: AIDS. The ANSS subsequently became a pioneer and community-based benchmark in the HIV response, notably through its provision of comprehensive care, such as ART for PLWHIV, long before the Burundian government received international funding in this area.

Like Fondation Femmes Plus that fights to provide care for women and children who suffer gender-based violence and sexual violence in connection with armed conflicts, in the Democratic Republic of Congo, at a time when the country has been faced with recurrent regional conflicts for several decades.

These are just a few of many examples...

Thanks to their efforts and resilience, these associations are able to influence public policy in favor of key and vulnerable populations as part of the HIV response, thus saving human lives.

However, this advocacy must continue in order to see the introduction of new differentiated and demedicalized approaches, adapted to the needs of vulnerable populations.

Building on this experience and this commitment, the community-based associations within the PACE have once again adapted their services to the new COVID-19 pandemic that threatens to undermine community-based efforts and accentuate the instability of already fragile populations.

Because bringing an end to the COVID-19 pandemic as of 2020 and that of HIV by 2030 are not two separate combats, but **one and the same: the combat to end inequalities and ensure full respect for the human rights of all people.**

DEVELOPMENT METHODOLOGY FOR THIS GUIDE

This guide of best practices capitalizing on the experiences of the Coalition PLUS Central and East Africa Platform (PACE) aims to **document and promote the practices developed by community-based and identity-based actors in the HIV/AIDS response within the context of fragile States**. Nine associations within the PACE were asked to participate in this guide: ADN, Affirmative Action, Alternatives Cameroun, RENAPC, ANJFAS, ANSS, Colibri, Fondation Femme Plus and Humanity First.

Capitalization

In the words of Pierre de Zutter, "Capitalization is to transform the experience into shareable knowledge"¹. In the case of this guide of best practices, the goal is to capitalize on the experiences of the community-based actors in the PACE and to promote the practices they have developed within the context of fragile States. Which is why this guide focuses both on the experience of actors and the different actions put in place as part of the HIV/AIDS response.

Methodology

As this reference document is centered on the experience of community-based and identity-based associations in order to understand the specific nature of their work in these fragile contexts, it has been compiled from testimonials from key individuals within the member associations of the PACE, in line with the community-based approach. This involved various stages:

- ▶ The creation of a **coordination group** managed by the PACE (the Co-Coordinator and Coordination Officer) and composed of the head of the Coalition PLUS Platforms Department, the head of the Coalition PLUS Advocacy Technical Support Department and the person responsible for drafting the guide. This group approved the different stages, the tools produced and used (questionnaires, interview guides, evaluation grid) and the evaluations conducted, and facilitated the organization of interviews.
- ▶ The use of a **remote questionnaire** to collect indications on the crisis situations faced by the different associations. This questionnaire, which was completed by 33 individuals, made it possible to more clearly identify the impact of the context on the associations' activities and to prepare the interview guide.
- ▶ The conduct of some fifteen **semi-structured interviews** with key individuals within the member associations of the PACE.
- ▶ A review of the documentation (particularly activity reports) produced by the member associations of the PACE.

L'IMPACT DE LA PANDÉMIE DE COVID-19 SUR L'ÉLABORATION DE CE RÉFÉRENTIEL

La méthodologie initiale d'élaboration de ce référentiel prévoyait une à deux rencontres présentielles entre les membres de la PACE, sous forme d'ateliers régionaux. Or, le contexte sanitaire lié à la pandémie de Covid-19 n'a pas réellement permis de donner du temps au partage d'expérience. Par ailleurs, l'irruption soudaine de cette pandémie est survenue dans le processus d'élaboration de ce référentiel, non sans rappeler son objet, c'est-à-dire les situations de crise. Dans ce contexte sanitaire contraignant, la méthodologie a dû être adaptée et l'intégralité des entretiens a été menée à distance. Ce référentiel donnera donc lieu à l'organisation d'un ultime atelier, lorsque le contexte sanitaire le permettra, pour offrir véritablement une opportunité de partage des expériences et d'appropriation entre les associations membres de la PACE.

¹ Pierre de Zutter, *Des histoires, des savoirs, des hommes : l'expérience est un capital*, FPH, Paris, 1994, p. 36

CONTEXT AND REASONING

Community-based action: fragile States and crises in Central and East Africa

The term **community-based or community-led associations** refers to organizations that are governed by the community, that is to say organizations “led by the people who they serve and are primarily accountable to them. In the AIDS response, this includes organizations by and for people living with HIV or tuberculosis and organizations by and for people affected by HIV, including gay men and other men who have sex with men, people who use drugs, prisoners, sex workers, transgender people, women and young people².”

The OECD framework³ defines **the fragility of a State as “a combination of exposure to risk and insufficient coping capacity of the state, system, and/or communities to manage, absorb or mitigate those risks. Fragility can lead to negative outcomes, including violence, the breakdown of institutions, displacement, humanitarian crises, or other emergencies.”**

Based on the dimensions of fragility (economic, environmental, political, security and social), the OECD classifies some countries as **extremely fragile** (Burundi, Central African Republic, Democratic Republic of Congo and Chad for the countries covered by the PACE) and others as **fragile** (Cameroon and Congo).

Most of these countries therefore experience humanitarian crises or other emergencies at one time or another.

The term **humanitarian emergency** includes natural disasters (earthquakes, storms, tsunamis) as well as health emergencies (epidemics like Ebola, or more recently COVID-19, etc.) like those experienced by the Democratic Republic of Congo, and man-made emergencies (armed conflicts, environmental degradation, large-scale industrial accidents, etc.) in Burundi, Cameroon, Central African Republic and the Democratic Republic of Congo⁵.

The HIV response in fragile States in Central and East Africa

Most PACE countries have points in common at the political level: the recurring socio-political conflicts, which push public health into the background of national priorities. **As such, what the States covered by the PACE have in common due to these socio-political conflicts is the fact that they are generally not considered priority countries by the leading international actors in the HIV/AIDS response such as UNAIDS, PEPFAR and the Global Fund, as deplored by Médecins sans frontières in its report ‘Le prix de l’oubli’ issued in 2016⁶.** Despite prevalence rates indicative of generalized epidemics (that is to say more than 1% of the general population, with the exception of the DRC, although the reliability of the official figures can be questioned), these countries have not made the HIV response a health or political priority. As a result, HIV/AIDS indicators are not on track to achieve the 90-90-90 target set by UNAIDS.

Consequently, the proportion of people living with HIV and aware of their status fluctuates between 39% (Congo) and 74% (Cameroon) depending on the country; people living with HIV on ART are estimated at between 35% (Congo) and 80% (Burundi), while data concerning people accessing ARV with an undetectable viral load are not available for any of the countries⁷. **In summary, out of an estimated 1,391,000 people living with HIV in these six countries, only 737,000 have access to ARV, i.e. 1 in 2, with no indication as to the effectiveness of treatment.**

2 UNAIDS, *What is a community-led organization?* 2019.

3 Abel, Andrea, et al. (2017), ‘The OECD fragility framework’, in *OECD, States of Fragility 2016: Understanding Violence*, OECD Publishing, Paris.

4 States of Fragility Framework, 2018: <http://www.oecd.org/dac/conflict-fragility-resilience/statesoffragilityframework2018.htm>

5 Definition of humanitarian emergencies adapted from: <https://www.humanitariancoalition.ca/media-resources/factsheets/what-is-a-humanitarian-emergency>.

6 Médecins sans frontières, *Le prix de l’oubli, des millions de personnes en Afrique occidentale et centrale restent en marge de la lutte mondiale contre le VIH*, April 2016, https://issuu.com/msf/fr/docs/hiv_brief_fr_8_pages_lowres

7 2018 UNAIDS data.

Global HIV & AIDS statistics⁸



Burundi



Cameroon



Congo



CAR



DRC



Chad

General population (Million)					
11.4	25.6	5.0	5.1	85.2	15.4
HIV prevalence as a %					
1.0 [0.9 - 1.2]	3.6 [3.1 - 4.0]	2.6 [2.0 - 3.5]	3.6 [2.9 - 4.5]	0.8 [0.6 - 0.9]	1.3 [1.0 - 1.7]
Number of PLWHIV					
82,000 [71,000 - 97,000]	540,000 [470,000 - 590,000]	89,000 [69,000 - 120,000]	110,000 [90,000 - 140,000]	450,000 [370,000 - 530,000]	120,000 [94,000 - 150,000]
New infections					
1,700 [1,000 - 2,800]	23,000 [19,000 - 28,000]	5,300 [3,000 - 9,700]	5,500 [3,500 - 8,100]	19,000 [13,000 - 26,000]	6,500 [4,000 - 9,600]
Number of PLWHIV who know their HIV status					
ND	400,000	35,000	61,000	280,000	ND
Status known by PLWHIV as a %					
ND	74 [65 - 81]	39 [30 - 51]	55 [46 - 69]	62 [51 - 73]	ND
Number of PLWHIV accessing ARV					
65,000	280,000	31,000	40,000	260,000	61,000
Accessing ARV in relation to PLWHIV as a %					
80 [69 - 94]	52 [46 - 57]	35 [27 - 46]	36 [30 - 45]	57 [47 - 67]	51 [40 - 63]
Accessing ARV and virally suppressed as a %					
ND	ND	ND	ND	ND	ND

Despite recent progress in testing and treatment, new infections persist, the proportion of people who do not know their HIV status remains too high, and initiation to ART is insufficient. Moreover, general lack of knowledge on viral load is a concern, particularly in countries suffering recurring shortages in the supply of ARV.

In addition, the countries in Central Africa have particularly high prevalence rates among key populations, **fueling the dynamic epidemic**, that is to say an ongoing epidemiological dynamic among certain population groups who still have little access to prevention and care services. As such, **prevalence is very high among key populations in all PACE countries, with rates for MSM between 3.3% in DRC and 41.2% in Congo. For SW, prevalence rates are between 5.7% in DRC and**

24.3% in Cameroon, while the situation of PWID remains largely undocumented.

In the absence of political commitment in the HIV response (as previously mentioned), and given the existence of a context that penalizes key populations, the 90-90-90 target not only seems difficult to achieve, but also ineffective with no real resolve to impact the dynamic epidemic. In this respect, targeted community-based activities such as those covered in this guide of best practices present an undeniable added value.

The poor level of access to treatment is linked to various obstacles. These countries all have high levels of discrimination and stigmatization against key populations, for example. Same-sex relationships are penalized in Burundi and Chad⁹. This situation reaches its peak in Cameroon with the strict application of discriminatory measures¹⁰ resulting in numerous arrests and the recurrence of homophobic acts against individuals and organizations^{11,12}. That is why Cameroon is considered to practice State-sponsored homophobia with **institutionalized discrimination^{13,14}** that has negative implications for key populations' access to care.

The weakness of healthcare systems is also a shared element between these countries. Health services are notably under-funded and expenditure allocated to health as a percentage of GDP is often below 5% (with the exception of Burundi and the Central African Republic). The result is that patients are often charged for many expenses (whether formally or otherwise) even though HIV-related treatment is often free of charge, which limits access to care for the most vulnerable.

Regular stock shortages also jeopardize patients' access to treatment, whether due to planning and management difficulties, order delays or the fragility of supply systems. In Congo, this is such a recurrent situation that many patients are compelled to turn to second-line treatment and can become desensitized.

In addition, **the recurrent humanitarian crises further diminish these health systems and interrupt or disrupt the implementation of HIV prevention and treatment strategies.** Generally speaking, the relationship between HIV, humanitarian crises and prolonged conflicts are complex. Those affected by humanitarian crises and armed conflicts have heightened vulnerability to HIV, given that humanitarian emergencies generate additional obstacles to the continuity of patient care. These obstacles may concern the availability of health human resources, infrastructure, access to healthcare structures, the availability of drugs and treatment, etc.

During humanitarian crises, exterior aid is only activated for certain global emergencies, and rarely includes the treatment of chronic illnesses such as HIV and its interventions. Yet **one of the common factors in the humanitarian emergencies experienced by PACE countries is precisely that they do not benefit from the global media coverage that results in high levels of external aid.** This is the finding of the Norwegian Refugee Council which ranks Cameroon, the Democratic Republic of Congo, the Central African Republic and Burundi in the top four positions among the 10 most neglected crises¹⁶. **It is therefore up to field workers and the community-based associations involved in the HIV response to find solutions to ensure the continuity of care when a crisis occurs and to develop innovative strategies to reach the most vulnerable and at-risk populations.**

9 In Burundi, the law of November 2008 adopted by the National Assembly imposes a prison sentence of three months to two years and a fine for homosexual relationships. In Chad, the new Penal Code adopted on December 12, 2016 upholds the criminalization of homosexuality, punished by a fine.

10 while the Penal Code in Cameroon condemns same-sex acts. Article 347-1 of the 2016 Penal Code specifies that "whoever has sexual relations with a person of the same sex shall be punished with imprisonment from six months to five years and with a fine ranging from 20,000 Francs CFA to 200,000 Francs CFA." Article 83 of the law of 2010 on cybercrime and cybersecurity, meanwhile, punishes any person who make sexual advances towards someone of the same sex through communication technologies with a sentence of up to two years in prison. This sentence is doubled if these advances lead to sexual relations.

11 ILGA World: Lucas Ramon Mendos, *State-Sponsored Homophobia 2019: Global Legislation Overview Update* (Geneva; ILGA, December 2019).

12 2019 annual report, *Un silence complice : Des violences et violation des droits sur la base de l'orientation sexuelle, l'identité de genre et l'expression des caractéristiques sexuelles au Cameroun*, Alternatives Cameroun and Humanity First.

13 <https://www.humanrights.ch/fr/dossiers-droits-humains/discrimination/concept/formes/>

14 "Systemic or institutional discrimination consists of patterns of behavior, policies or practices that are part of the social or administrative structures of an organization or sector, and which create or perpetuate a position of relative disadvantage for people with psychosocial disabilities". <http://www.ohrc.on.ca/en/policy-preventing-discrimination-based-mental-health-disabilities-and-addictions/10-forms-discrimination>

15 <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS>

16 <https://www.nrc.no/shorthand/fr/the-worlds-most-neglected-displacement-crisis/index.html>



PART 1

COMPREHENSIVE HIV/AIDS TREATMENT IN THE CONTEXT OF FRAGILE STATES

1 COMPREHENSIVE HIV/AIDS TREATMENT IN THE CONTEXT OF FRAGILE STATES

The nine associations that contributed to the drafting of this guide of best practices all illustrate, to varying degrees, the specific role of community-based actors in the comprehensive treatment of HIV in the region. Some, notably due to their years of experience, have even played a pioneering role in the HIV/AIDS response at national level¹⁷. The context of the fragile States in which they are based has systematic implications for their activities: in Cameroon, it is the institutionalized discrimination against key populations¹⁸ and the humanitarian crisis in its English-speaking regions¹⁹ that have the greatest impact; in Burundi, Congo, the Central African Republic, the Democratic Republic of Congo and Chad, it is first and foremost the recurrent humanitarian crises²⁰.

1.1 The specific role of community-based actors in comprehensive HIV/AIDS treatment in the region

THE CHALLENGES OF DEMEDICALIZED CARE IN CENTRAL AND EAST AFRICA

As previously mentioned, the countries in Central Africa are not only far from achieving the 90-90-90 targets set by UNAIDS, but have not shown any resolve to impact the dynamic epidemic. **The acceleration of the response notably requires the adoption of effective and quality community-based solutions in order to better target key populations that meet their specific needs**, such as peer educators, and the shifting of certain tasks carried out by doctors to nurses and community-based health workers (against a backdrop of a number of doctors per 10,000 inhabitants between 0.4 in Chad and 1.6 in Congo).

Demedicalized community-based testing, PrEP, self-testing and community-based PEP are all prevention strategies that have proved successful in reaching key populations. The psychosocial support and support for adherence that are traditionally at the core of the activities of community-based associations must be supplemented by **community-based provision of ARV, which would help both ease the demand on health centers and provide a local approach to promote the well-being of beneficiaries and their adherence.**

¹⁷ See 1.2. Pioneering community-based actors in the HIV/AIDS response at national level

¹⁸ See 1.1 The specific role of community-based actors in comprehensive HIV/AIDS treatment in the region

¹⁹ See 1.3 The resilience of community-based associations in the face of humanitarian crises

²⁰ See 1.3 The resilience of community-based associations in the face of humanitarian crises and 2.3 The advocacy efforts of community-based associations in the face of humanitarian crises

DEMEDICALIZED TREATMENT OF PLWHIV BY COMMUNITY-BASED ASSOCIATIONS

The nine community-based and identity-based member associations of the PACE **all provide demedicalized services to people living with HIV and more specifically to key populations.** Other services are generally introduced as demedicalization advances in a country, in addition to the prevention services and psychosocial care that form the core activities in community-based treatment of PLWHIV and key populations. Below is a brief presentation of the prevention and treatment services provided by the associations that contributed to this guide of best practices:



Services provided by community-based associations



Service	Officiers de santé	ALTERNATIVES AMEROUN	Association des personnes vivant avec le VIH	Association des personnes vivant avec le VIH	Association des personnes vivant avec le VIH	Association des personnes vivant avec le VIH	COLIBRI	Association des personnes vivant avec le VIH	HUMANITY FIRST CAMEROON
Education, awareness-raising/communication for behavior change	■	■	■	■	■	■	■	■	■
Distribution of IEC or prevention materials	■	■	■	■	■	■	■	■	■
PrEP	■	■		■	■		■		■
Community-based demedicalized HIV testing	■	■	■	■	■	■	■	■	■
Community-based provision of ARV		■		■	■		■		■
Psychosocial support and counseling	■	■	■	■	■	■	■	■	■
Adherence assistance and treatment education	■	■	■	■	■	■	■	■	■
STI diagnosis and treatment	■	■				■			■
Viral load tests						■			

Some services have been introduced recently in many countries thanks to the advocacy actions of the PACE, such as community-based demedicalized testing in the Central African Republic and Congo²¹. Others have been around longer, as shown by the examples of the ANSS in Burundi and Alternatives Cameroun²².

Nevertheless, all of these services share common characteristics: they are first and foremost centered on people's needs and seek to address health issues within the framework of a global approach; this is summed up by Doctor Pélagie Nimbona,

National Medical Officer for the ANSS:



« *The added value of a community-based and community-led structure is that it treats the person as a whole, it is more than just a question of medication.* »

The associations seek to provide services **tailored as best as possible to vulnerable populations** and key populations, as underscored by Jean-Paul Enama, Director of Humanity First:

« *Outreach counseling (that is to say when we go out to the person), is a sort of differentiated service. Depending on the specific needs of the person, we provide the service. It is not a blanket service, but a specific service based on the needs of the person, and we adapt to these needs.* »

The context of fragile States in Central and East Africa is a major constraint that provides an incentive to **develop specific strategies to reach key populations**. Outreach approaches involve creating relationships of trust in order to carry out testing at hotspots in particular; the community anchorage of these associations is vital to achieve this, as shown by the example of Affirmative Action explained by its Executive Director, Serge Douomong Yotta:

« *As part of the introduction of activities at hotspots, our field-based colleagues have developed close relationships with establishment owners, and through the building of relationships based on trust, they have been able to provide SW with prevention materials, including testing. We do everything possible to adapt the service package to the context.* »

Prevention targeting key populations is only possible through approaches tailored to effectively reach them within these criminalized contexts; in this regard, Humanity First explains that discretion is often required:

« *it is important to adapt, we use word of mouth and prioritize social networks where we can specifically contact our beneficiaries, like same-sex dating websites and apps. We also rely on a sort of networking, creating a snowball effect so that information reaches our beneficiaries. This enables us to pass on information to our beneficiaries discreetly.* »

The community-based and identity-based associations concur in the observation that if they do not provide differentiated services adapted to vulnerable and key populations, **these populations are not able to access the care they need**, as Joachim Nteten, Program Director at Alternatives Cameroun, explains:



« *LGBT do not feel comfortable anywhere: not at the hospital, in school, in church, nor within their families; we are the bastion that LGBT can rely on for all their needs. We try to bridge this gap because we*

know that, even if they wanted to, traditional services would not have the experience nor the understanding, and would not be comfortable with care and services aimed at LGBT. »

With beneficiaries who are often afraid of going out, **we need to innovate to draw people isolated from care and significantly more at risk than the general population**; Alternatives Cameroun has therefore created the 'chill-out' concept, as Jean-Jacques Dissoke, Advocacy Officer, explains



« *That's why with trans people, we started to establish chill-outs: we rent a space not connected to the association and we involve trans people in preparing the activity, who can invite their friends or colleagues.*

We provide various tools so that they can organize a recreational meeting themselves. During the meeting, we take the opportunity to raise awareness and carry out testing. The previous organization didn't work, as it didn't allow us to reach trans. But implementing this strategy has allowed us to reach many more people. »

²¹ See 2.1 PACE advocacy for demedicalization: combining capacity-building and advocacy
²² See 1.2. Pioneering community-based actors in the HIV/AIDS response at national level

This comprehensive approach that promotes the access of vulnerable and key people to all types of services involves putting in place strategies to overcome the legal and structural barriers in force within all countries. That is why **the PACE community-based and identity-based associations all include structured advocacy in their services in order to remove the obstacles that impede comprehensive care for PLWHIV²³.**

This integrated approach gives community-based organizations additional legitimacy; their opinion counts precisely because they provide tailored services, as Serge Yotta summarizes:



« *If you're relevant, people will listen. I understand that activism has changed [...]. Now in the current context of an increasingly scarce funding, AIDS is no longer a priority, it has been swallowed up by SDG 3, it is no longer central, questions of orientation are bogged down in the broader gender issue, the strategy needs to be adapted. Nowadays, MSM and people with HIV don't want to just sit and cry in a room somewhere. We want concrete proposals and technical expertise. We quickly recognized that we need to adapt how we approach activism, it needs to be highly structured and focused on results.* »

CAMEROON: A CONTEXT OF INSTITUTIONALIZED DISCRIMINATION THAT SUBJECTS IDENTITY-BASED ASSOCIATIONS TO INHERENT TENSION

Article 347-1 of the Penal Code in Cameroon condemns same-sex acts. **This context has damaging effects on people from key populations:** in 2019, at least 1,380 people were victims of violence or a violation of their rights²⁴.

The community-based and identity-based associations in Cameroon are in a constant state of emergency as they are regularly targeted by different threats. Affirmative Action, Alternatives Cameroun, Colibri and Humanity First have all had their premises vandalized. Colibri, for example, had to contend with particularly violent events in 2018, as its President, Jean-Jules Kamgue, explains:



« *In May 2018, we received an anonymous death threat. The letter read: "If you're wise, find some place to hide, your death warrant has been signed, we're coming for you. You can hide underwater, we will still catch you". Three weeks later, the offices were vandalized, the hard drives taken from our computers, attendance sheets ripped out of the registers, and the till looted. We filed a complaint but nothing ever came of it.* »

An extremely oppressive and stressful situation for the personnel. The risk is particularly heightened when activities are run outside the association. The last example dates back to as recently as May 2020, once again targeting Colibri, when 42 people were arrested during a screening campaign organized in the conference room of a hotel:

« *A dozen heavily armed officers from the criminal police force stormed the room. They pulled guns and kalaches on the participants, knocked them about and smashed and broke down all of the hotel's doors without a search warrant. [...] After four hours of illegal imprisonment, violence and inhuman treatment, they took us all away. [...] Given that they had not caught anyone committing a crime by breaking down the doors of the hotel, some police officers held a gun to the heads of trans during the hearing [...] »*

The individuals were eventually freed two days later thanks to the intervention of a lawyer, but in a poor state of health. These events also have serious consequences on the mental health of the people working in the community-based and identity-based associations.

To cope with these threats and emergencies, **the associations have all put in place legal aid and support for individuals arrested,** as explained by Humanity First:

« *We work with a lawyer in cases of violence, when someone is arbitrarily arrested, for example, or when someone is in trouble with the law due to their sexual orientation. The lawyer intervenes to prevent the person being locked away on an offense because once the sentence has been passed, the lawyer can no longer fulfill his role.* »

²³ See Part 2: The advocacy efforts of community-based associations within the context of fragile States

²⁴ See 2.2 Advocacy within a context of institutionalized discrimination: deconstructing constructs at the core of community-led action.

These efforts also involve preventive measures:

« The lawyer also runs educational talks and does a lot of awareness raising because many people become victims simply because they do not know their rights. They don't know that when they are arrested, they have the right to a lawyer. We tell them how to behave in the event of an arrest, what to do and what not to do... »

Context is such an important factor that some people have internalized this stigmatization. The process of becoming peer educators is therefore strewn with difficulties; **training first starts with self-acceptance so that they are able to fight against an environment that criminalizes their existence.** Only militant commitment makes it possible to overcome the fear generated by this context and enable the work of the community-based associations, with the daily risk of an event bringing all this into question, as described by Affirmative Action:

« You're never safe. Arrests for allegation or suspicion of homosexuality are widespread. We take a risk in coming to the office every day, and in leaving the office. The fear of arrest is real, we work with this fear, with this knot in our stomach, so as long as the law exists, as long as the law on cybercrime exists, as long as there is a political exploitation of homosexuality during elections to deceive the population, as long as constructs are not deconstructed, as long as the press does not know how to be a voice for key populations, we will never be safe, there will always be this fear. »

1.2 Pioneering community-based actors in the HIV/AIDS response at national level

Some of the region's community-based actors have played a pioneering role in the HIV/AIDS response in their countries. This is notably the case of the **ANSS in Burundi** and **Alternatives Cameroun**.

THE ANSS: A PIONEERING ASSOCIATION AND COMMUNITY REFERENCE IN THE HIV/AIDS RESPONSE IN BURUNDI



« The ANSS has led the way in the introduction of services adapted to PLWHIV in Burundi. The ANSS' strategy aims to continually extend the cover of HIV/AIDS interventions in the country, notably by strengthening the capacities of public actors. This perspective is unique at regional level, as illustrated by Patricia Rwimo, ANSS National Coordinator. »

FROM COMMUNITY-BASED CARE TO DECENTRALIZED TREATMENT SERVICES

In Burundi, **the ANSS was one of the first associations to provide treatment services for PLWHIV** in 1996, at a time when nothing existed at national level and when international funding from the World Bank and the Global Fund was only made available as of 2004: "It was not until 2006-2007 that hospitals began to set up outpatient treatment centers in Bujumbura.

The service package proposed by the ANSS included multi-disciplinary care from the outset, designed to take into account the different needs of people living with HIV: medical consultation and CD4 count. The medical aspect is supplemented by psychological support in order to focus on patient well-being:

« It was the ANSS that began introducing adherence services and treatment education services for people accessing treatment. People felt more assured with psychological support. »

This pioneering role in comprehensive care for PLWHIV has made the ANSS a benchmark for public health actors:

« **The ANSS supervised personnel at outpatient treatment centers, which is when the public system began to provide treatment. It was community-based actors that initiated and supervised this treatment; what's more, doctors came to the ANSS for training, to see how multidisciplinary care is organized. When outpatient treatment centers were first being brought in, it was the ANSS doctor who carried out consultations.** »

The ANSS has also empowered community-based actors through the creation of the Platform for the Mutual Strengthening of First Line Participants (REMUA) which encompassed six community-based structures (including one public health center), facilitating referrals and counter-referrals. The active list of people being treated by the ANSS currently represents 9% (i.e. around 6,000 people) of those accessing treatment at national level, making it the leading national structure in terms of treatment. This percentage has decreased steadily over the years notably thanks to advocacy for the decentralization of treatment and the integration of treatment of PLWHIV at hospitals and health centers.

THE ANSS: A PIONEERING ASSOCIATION IN ACCESS TO VIRAL LOAD

With regard to viral load tests, it was the ANSS that led to their roll-out in Burundi:

« **Very few machines were accessible, with inadequate access to viral load counts. Since 2013-2014, with the OPP-ERA project²⁵, the ANSS has been able to obtain a viral load test machine. The ANSS was the only association-based structure within the project to have a machine, as viral load tests were usually carried out at referral hospitals.** »

The ANSS remains one of the only Francophone associations to cover the entire HIV care continuum today, from primary prevention to viral load testing.

Continuing its work to mainstream a service at national level, the ANSS advocates to enable a maximum number of people living with HIV to have access to these tests:

« **it is thanks to the viral load tests conducted by the ANSS that three new machines were installed in other hospitals as part of the 2nd phase of the project.** »

The trend is therefore similar in terms of the number of people treated by the association compared to national figures:

« **In 2016, 80% of viral load tests carried out in Burundi were done by the ANSS. With last year's data, 42% of viral load tests at national level were carried out using other machines in laboratories.** »

This further demonstrates the effectiveness of the skills transfer from public health actors implemented by the ANSS.

GRADUAL SPECIALIZATION IN THE KEY POPULATIONS MOST ISOLATED FROM CARE

The ANSS has introduced services adapted to the specific needs of key populations in the form of dedicated days to provide additional differentiated services. This involves specific service organization:

« **within the branches (there are 5 care structures), we have retained two specific days for key populations in Bujumbura. At the other branches, we are aiming for a gradual introduction.** »

With regard to prevention,

« **we carry out targeted testing at hotspots. We also have self-testing in Burundi. In addition, we have introduced a communication system via WhatsApp to help implement strategies to bring key populations to the ANSS.** »

The success of this targeting and the diverse approaches is reflected by a high level of positive test results during screening. In 2019, this rate stood at 9.4% (compared to 0.9% at national level) and as many people referred to treatment.

Once again, the ANSS is continuing to expand its activities to health structures through training initiatives:



« **As part of the Linkages project, we are attempting to raise the awareness of public structures so that they can treat key populations.** »

Thanks to the increased capacity of service providers and the involvement of peer educators, access to care for MSM within public structures is being extended to new provinces. The ANSS is constantly seeking to improve the coverage of its interventions to reach other populations isolated from care. In line with this goal, it wishes to introduce a harm reduction program for PWID. Substantial efforts are underway to put in place viral hepatitis care and treatment activities in Burundi²⁶.

Over the course of this journey that has positioned it as a benchmark structure recognized for the quality of its services, the ANSS has preserved its DNA as a community-based association. This community identity would prove particularly precious during the crisis that hit Burundi in 2015²⁷.

25 The OPP-ERA project was funded by Unitaïd and put in place by a consortium of organizations (Solthis, Sidaction Expertise France) from 2013 to 2019: <https://www.expertise-france.fr/web/guest/fiche-projet?id=224845>.

26 See 2.1 PACE advocacy for demedicalization: combining capacity-building and advocacy

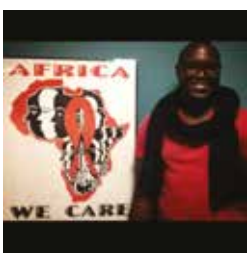
27 See 1.3 The resilience of community-based associations in the face of humanitarian crises

ALTERNATIVES CAMEROUN: FROM CONSIDERATION OF LGBT TO THE IMPLEMENTATION OF SERVICES THAT BENEFIT ALL, BEYOND THE COMMUNITY

The development of Alternatives Cameroun illustrates how an identity-based association has managed to establish a previously inexistent health program in Cameroon.

INITIALLY AN IDENTITY-BASED ASSOCIATION TO SUPPORT DETAINED MSM

The creation of Alternatives Cameroun in the mid-2000s was initially a response to the need to support those criminalized by Cameroonian law when placed under arrests, as explained by Franz



Mananga, its Executive Director:

« We started taking on people with legal problems, people arrested based on their sexual orientation; we would visit them in prison and provide practical help and defend them

at trial. That was the very first service we provided in 2006. »

The introduction of this service led the association to seek to understand the whole picture:

« We carried out a documentary review drawing on archives. We were able to trace the issue back to the first documented case of arrest in 1997. » That was the origin of the Human Rights program established by the association, which now covers various activities:

« The Human Rights program provides practical help to people arrested based on their sexual orientation, but also covers other initiatives: documenting violence, education on human rights (discussion groups and one-on-one or online chats), training on human rights for key actors; **the idea is to show that the struggle for human rights is integrally linked to the struggle against HIV.** »

Shortly after its creation, **the identity-based association took its first steps into the sphere of health:**

« In 2007-2008, we began to turn our interest to health problems. The first step involved understanding the sexual behavior of LGBT and better identifying the needs of MSM through a questionnaire-based study. » This study then led to the launch of the first services: "The Health program was thus the second program introduced for LGBT.»

A third program subsequently rounded off the Health and Human Rights programs, also built on increased awareness of certain needs among LGBTI that were previously not met:

« In 2012, we began to realize that WSW did not have the same status as MSM. » Thus the Gender program came about: "The Gender program aims to bridge the gap between the services received by MSM and WSW. It also seeks to analyze domination patterns within homosexual couples, which can impact HIV transmission just as with heterosexual couples. »

This program allows the association to implement an approach specific to the needs of different LGBTI populations and key populations:

« This has enabled us to better adapt, but also to reach out to the most disadvantaged populations like transgender and intersex people and to establish a concept known as multi-key, people in a situation of vulnerability overlap, such as MSM and SW, WSW and PWUD. »

It is important to note that the development of Alternatives Cameroun has often followed the same structured path: **faced with the awareness of a need and a willingness to fulfill it, the identity-based association has carried out studies in order to better grasp the phenomena at play and provide the most appropriate responses.**

THE GRADUAL DEVELOPMENT OF SEXUAL HEALTH SERVICES²⁸

The progress of the Health program illustrates how the association has gradually put in place services adapted to key populations, eventually becoming a benchmark at national level, equipped with a sexual health center, the Access Center. The association's services have greatly evolved since 2006, and now include: prevention, demedicalized and self-testing, psychosocial follow-up, ARV delivery, counseling, treatment education, support groups, nutritional workshops, practical help to pay for medication, HIV and STI clinical consultations, proctology, dermatology, sexual health and reproductive health consultations.

Alternatives Cameroun has gradually enhanced its service package, sometimes preempting national protocols. For example, **since 2015, full cooperation with Laquintinie de Douala hospital has made it possible to preempt the introduction of community-based provision of ARV at national level:**

« This cooperation has been key to the officialization of community-based distribution in Cameroon. »

This cooperation initially relied on the fact that the doctor working at the hospital also worked at Alternatives Cameroun:

28 Sexual health services for key populations were the subject of a guide produced by the Coalition PLUS West Africa Platform (PFAO): <https://www.coalitionplus.org/wordpress/wp-content/uploads/2020/07/PFAOSexualHealthServicesGB.pdf>.

« That's how we were able to issue prescriptions at Alternatives Cameroun so that patients could collect drugs and treatment at the hospital. »

This system is gradually growing and the identity-based association now collects drugs for its beneficiaries itself on a weekly basis with the agreement of the hospital:

« We negotiated the collection of large quantities of drugs every week with Laquintinie. It was initially for a number of patients who did not feel comfortable going to the hospital themselves, but the list kept growing - it was easier for everyone. At some point we sat down with the hospital and explained that we needed this system to apply to all of our patients. »

This helps avoid losing touch with beneficiaries out of fear of going to the hospital to collect their treatment. This system was thus a precursor of the community-based provision of ARV which would subsequently be adopted:

« **When community-based provision was made official in 2016, it simply officialized what we had already been doing. We were one or two years ahead of many CBOs which needed time to forge a relationship with their referral hospital. We had 300 patients from day one. We are proud to have been the ones to initiate this. Nowadays, there are 500 patients accessing ARV at Alternatives Cameroun.** »

With regard to prevention, the identity-based association put in place demedicalized testing as of 2017:

« In 2017, only psychosocial counselors were able to provide testing. That represented some thirty people in Cameroon. »

The role of Alternatives Cameroun in terms of demedicalized testing is particularly notable with regard to the extension of the system:

« **with the Outreach program and the technical support of the PACE, we attempted to democratize demedicalized testing by extending this service to peer educators, thus equipping 12 associations each with at least a dozen people able to carry out demedicalized testing. These associations have already tested over 3,000 people since the start of 2020.** »

AN AREA OF EXCELLENCE THAT BENEFITS ALL, BEYOND THE COMMUNITY

Alternatives Cameroun has also distinguished itself at national level when it comes to proctology consultations.

« We started in 2011 when 3 of our doctors received training, and since then we've put this service in place with 1,000 consultations, i.e. around 150 consultations per year. »

The identity-based association truly played a pioneering role with regard to this matter in Cameroon:

« Until 2019, only the Access Center provided daily proctology consultations in Cameroon with treatment of 90% of cases on site. »

Once again driven by a desire to extend the coverage of this service, the association has trained doctors in the public sector so that they can provide consultations:

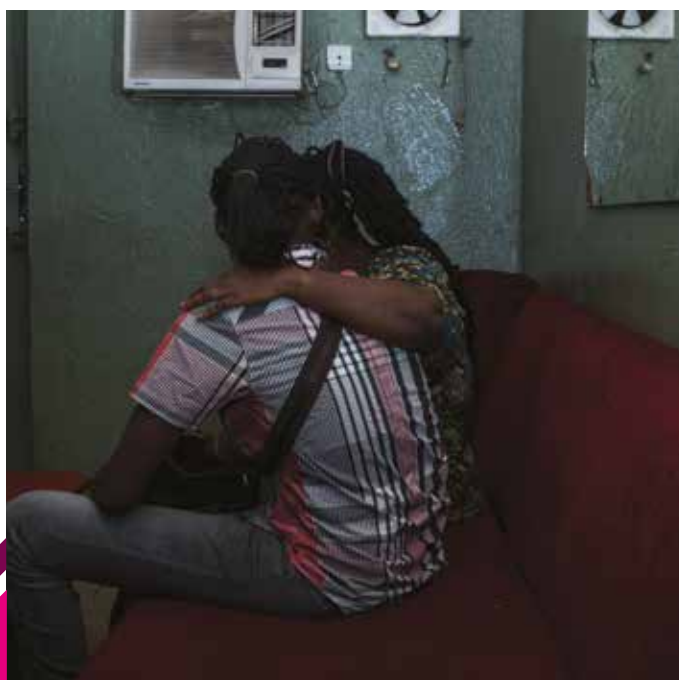
« **In this field as well we began to spread and extend this discipline in Cameroon by training 14 doctors so that they could diagnose and treat proctological problems in their patients.** »

This increased proctology cover provided a response to a real need in Cameroon; after training,

« in just 2 months, 300 consultations were provided. »

This typifies the journey of Alternatives Cameroun, which, through its search for a response to the specific needs of LGBT populations, has become a leading structure in the implementation of new services that benefit far beyond the original target community:

« There is an entire program in place to spread this practice. We really want people to know that when it comes to proctology, it was Alternatives Cameroun that got things rolling. One of the challenges is to demonstrate our expertise as identity-based organizations. **We can contribute our expertise not only to the community we defend, but to the entire population. Our experience in proctology has shown that it is a universal need.** »



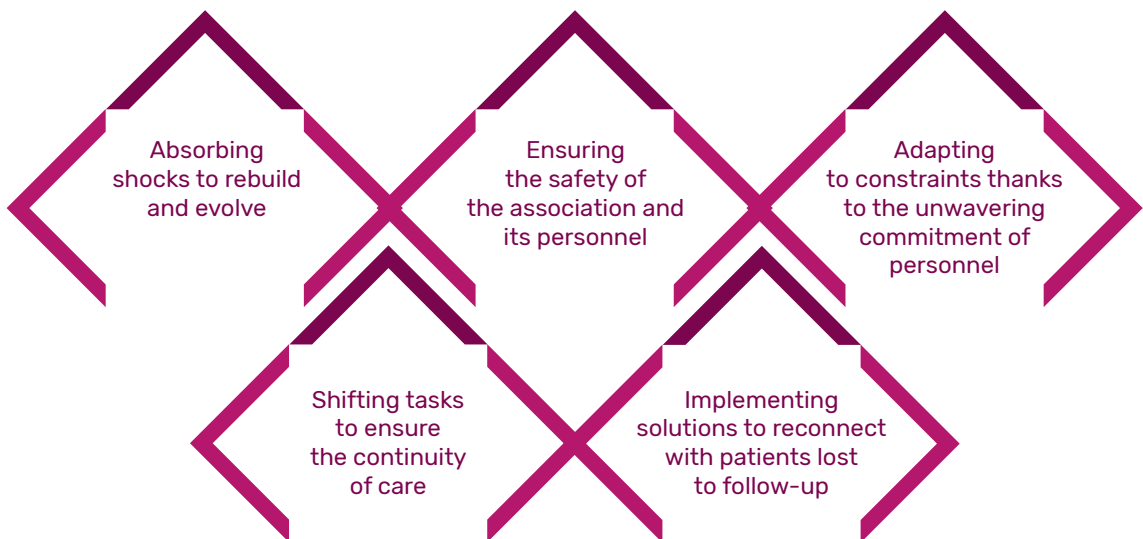
1.3 The resilience of community-based associations in the face of humanitarian crises

The community-based and identity-based associations are regularly confronted with political crises in the region's countries. This is notably the case of the ANSS in Burundi, the ANJFAS in the Central African Republic, Affirmative Action in the English-speaking region of Cameroon and Fondation Femme Plus in the Democratic Republic of Congo. In the face of these humanitarian crises, community-based organizations have shown resilience²⁹.

In these particular situations, they have been able to absorb the shocks in order to **evolve, to ensure the safety of their staff**, adapt to constraints thanks to the **unwavering commitment of their personnel, shift tasks** to ensure the continuity of care and find solutions to **reconnect with patients lost to follow-up**.

All of the PACE associations are also currently faced with the COVID-19 crisis.

The resilience of community-based associations in the face of humanitarian crises



ABSORBING SHOCKS TO REBUILD AND EVOLVE

The civil war in the Central African Republic was a real blow to the ANJFAS, as the association's network covering the entire country was completely destroyed, as described by Patricia Ouitiama, its President:



« Before, we had our focal points in the 16 prefectures of the CAR, but we lost them all after the events. »

The association's multicultural structure was also deeply affected by this inter-communal conflict:

« The ANJFAS encompassed everyone: Muslims, Christians, Buddhists... We lost touch with our Muslim beneficiaries, for example, as they were trapped in neighborhoods we didn't have access to. »

Generally speaking, the magnitude of the civil war proved too great for the association to continue to provide its services in this context, as was the case with many health structures. The community-based association was thus hit hard by the crisis, but the arrival of new members gave it the impetus to rebuild, a process that involved both integration and training:

« we trained all the new members of the board, and the technical coordination members. »

²⁹ There are numerous definitions of the resilience of organizations that are open to debate. The definition adopted here is drawn freely from the following article (in its original French): Bégin Lucie, Chabaud Didier, 'La résilience des organisations. Le cas d'une entreprise familiale', Revue française de gestion, 2010/1 (n° 200), p. 127-142. <https://www.cairn.info/revue-francaise-de-gestion-2010-1-page-127.htm>

In 2013, **the Central African Republic** descended into its third civil war since the start of the 21st century. The inter-communal conflict opposed mostly Seleka Muslim militia against Christian vigilante groups and animists, the Anti-balaka. Over 2013, the Seleka fighters even took Bangui, causing the president to flee. As of January 2014, armed forces were sent in by the UN to protect civilians. Since then, institutional life has once again taken up its course, but 80% of the country remains under the control of armed groups and the massacres of civilians continue.

The ANJFAS is also working to rebuild its pre-civil war structure, with 5 branches out of the initial 16 already up and running. Little by little, the association is getting back on its feet, and has relaunched its awareness-raising activities:

« We go out into the neighborhoods and districts, we raise a lot of awareness. This brings us new cases, new members joining, compared to outreach visits. »

Health structures also refer their patients to the association for psychosocial follow-up of PLWHIV.

New activities have even been developed, particularly a community observatory on access to healthcare in partnership with Positive Generation, a Cameroonian association and PACE member. This observatory has already proved its value, having been instrumental in identifying a treatment shortage in 2019:

« Our patients were coming back to us saying they couldn't get their treatment, it was the same across the country. »

The ANJFAS was thus able to lobby the authorities on this issue, which resulted in the situation being resolved.

The successful rebuilding of the ANJFAS has also enabled the association to expand, so much so that it is now in need of new offices as its old ones have become too small. The ANJFAS has regained its foothold and is now firmly established in civil society in Central Africa, illustrating how the association has managed to absorb the shock of the civil war in order to rebuild and evolve in a hostile context.

ENSURING THE SAFETY OF THE ASSOCIATION AND ITS PERSONNEL

In the face of political crises, the associations have taken measures to ensure the safety of their staff. The crisis in Burundi, for example, has had significant direct impacts on the ANSS. Some staff were forced to flee to escape imprisonment. The remaining personnel had to bear the consequences of the situation, notably in terms of mental health:

« There was a psychological impact on those who stayed behind, they were living in fear. »

Concrete measures were thus taken in order to cope with this constant insecurity:

« We took measures to secure the center, we signed a contract with a professional security firm to secure the entrances and to control visitors. »

The association also sought to prioritize telework for its staff in order to avoid exposing them.

barrages more easily and to get to the ANSS offices:

« ANSS non-medical staff wore scrubs so that the military assumed they were medical personnel. [...] As unmarked and private cars could not easily pass, we used temporary import plates (usually for expatriates) which were allowed through more easily. »

In 2015, **Burundi** experienced a large-scale political crisis in the run up to the presidential elections, the current president, Pierre Nkurunziza, having set his sights on a third term despite the rules of the Constitution. The crisis reached a turning point with the attempted coup d'état and the subsequent exceptionally violent repression of the State that targeted opponents. Instability and insecurity prevailed in Bujumbura over several weeks, during which time some 25,000 Burundians sought refuge in neighboring Rwanda. The restoration of order in the country and the 'normalization' of the situation produced a political deadlock and an absence of dialog with the opposition, while the country found itself isolated at a diplomatic level.



Affirmative Action also had to take similar measures for its branch in Bamenda in northwestern Cameroon, directly affected by the secessionist conflict and the resulting difficulties:

« Once, we got a call from our colleagues who were sheltering under tables and chairs; there had been a mutiny right outside the offices. They were so scared that it took some time for them to recover and work up the courage to open the offices. It was not a direct attack, they didn't come to us armed, but there was a mutiny outside the offices and that is terrifying in itself. Both for the staff and the beneficiaries. »

Following the events, **Affirmative Action responded by mobilizing its partners to reinforce the branch's security** and to provide support for staff:

« we tried to draw the attention of our sponsors [...] and raised concerns about the need for psychological assistance for staff and to reinforce security measures; they responded, not to the full request, but they responded nevertheless. »

This is a recurring issue that the association continues to address:

« We continue to try to mobilize resources to strengthen security measures, for supporters and workers on the ground. »

ADAPTING TO CONSTRAINTS THANKS TO THE UNWAVERING COMMITMENT OF PERSONNEL

The ANSS' ability to adapt relies on the unwavering commitment of its personnel:

« The notion of provider commitment is important; maybe it is something that can be worked on, but in any case it is very important. ANSS staff do not watch the clock. They put themselves out without counting on anything in return. **They give tirelessly of themselves and prioritize the interest of the patient, their commitment has made it possible to limit the fallout.** »

The community life of the ANSS has even been reinvigorated by the crisis:

« Community life has also been consolidated. For example, members have visited other members in hospital, beneficiaries have helped one another and continue to do so today. They visit other beneficiaries like themselves. »

The association has also excelled when it comes to maintaining the service continuum, such as viral load tests:

« We had to succeed at all costs, to show that community-based institutions can successfully track viral load, and for the ANSS, despite the context in Burundi. Despite the crisis, our lab technician had to cover everything. He came in at the weekend, on Sunday, to analyze samples, prevent reagents expiring and ensure that beneficiaries had access to their viral load. He also did the same for patients in public structures. **In 2016, we noted that despite the crisis, the ANSS had carried out the most viral load tests compared to other countries, which enabled us to obtain more machines. That has been our success despite the crisis.** »

The fact that the ANSS is a community-based structure therefore played an important role in this success.

Mutual aid between beneficiaries from the community of people living with HIV was a major factor in ensuring the continuity of care in this context:

Since late 2016, **the English-speaking regions of Cameroon** (Northwest and Southwest, NOSO) have experienced conflicts between government forces and secessionist supporters. This Ambazonia War has been marked by bombings and attacks carried out by separatists that receive violent responses from Cameroonian security forces, thus resulting in widespread human rights abuses and displacements of populations.

«« **The crisis also had some positive consequences: there was true solidarity, a strengthening of mutual aid between members and between beneficiaries, between colleagues, etc.** For example, during the crisis, when staff couldn't get home due to the insecurity in the districts, they could easily stay with another colleague. [...] Representatives of other beneficiaries came to the center to tell us that so and so beneficiary needs such and such, is in x situation... And the ANSS could take action. There was a real spirit of mutual supportiveness and solidarity that we need to maintain and develop. »

SHIFTING TASKS TO ENSURE THE CONTINUITY OF CARE

Against the backdrop of these crises, task shifting proved a winning strategy in ensuring the continuity of care. The ANSS thus adapted to the crisis by adopting concrete solutions to ensure the continuity of its services. The duration of ARV provision, for example, was modified so that patients did not have to travel:

«« **We issued ARV for 2 or 3 months to avoid people having to come to the site. That helped make life easier for patients [...]. Multi-monthly prescription and provision should be given prominence to avoid people coming back multiple times.** »

As staff had difficulties accessing the center, the ANSS also had to ensure a minimum service thanks to significant task shifting:

«« **We made sure there was at least one provider. Nurses can work reception, see people and take parameters: They are trained to conduct consultations, prescribe medication, carry out examinations, etc. They can also work in pharmacies to dispense treatments for STIs and OIs, and take swabs. There wasn't really an impression that activities had come to a halt, even in the midst of the crisis, because the ANSS staff are used to filling in for different roles. They're used to working in tandem and on different services, and there was always a stand in to maintain ANSS activities.** »

But the ANSS also restructured so as not to overload staff:

«« **Services were restructured to provide support for staff at the site. A rotation system was put in place up until the end of the crisis. Doctors and psychologists, etc. took turns. While some were in the office, others were at home.** »

IMPLEMENTING SOLUTIONS TO RECONNECT WITH PATIENTS LOST TO FOLLOW-UP

The crisis in Cameroon has had substantial impacts on the beneficiaries of Affirmative Action's activities:

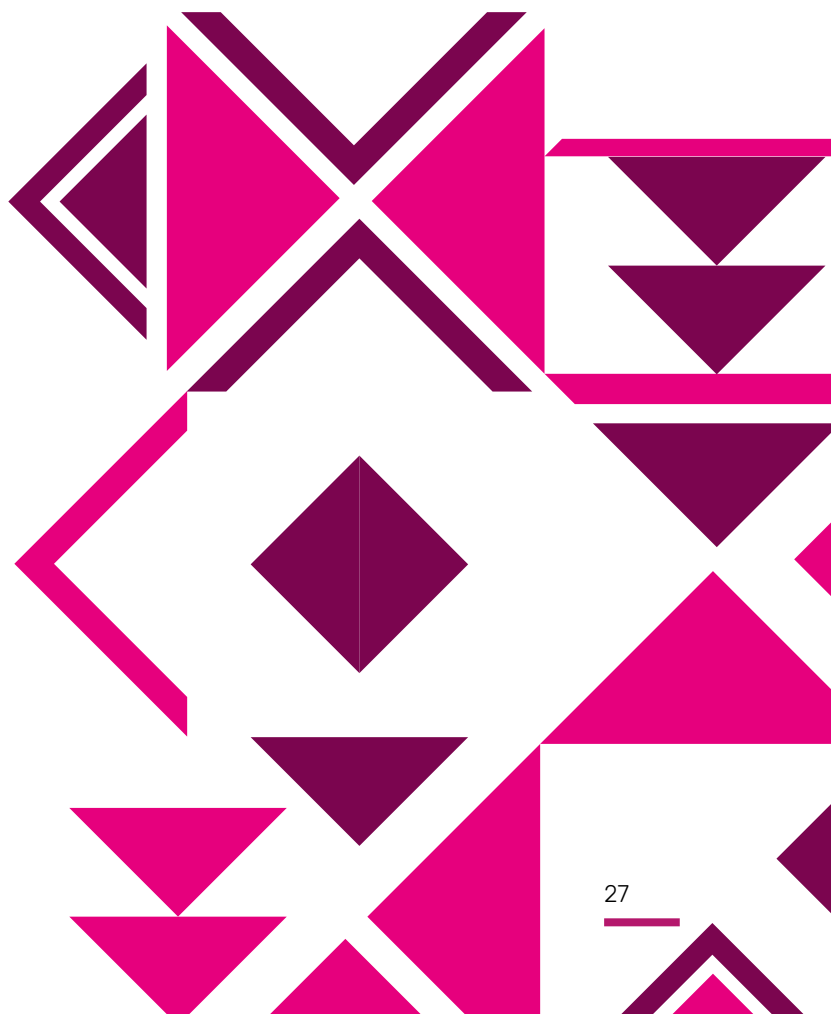
«« **The first impact was the wide-spread displacement because we had a significant active list that we monitored, we had our habits, but in the wake of the Anglophone Crisis, most of our beneficiaries had to move to other towns, particularly Bafoussam, Dschang, Douala, etc. So we lost contact with a large proportion of our active list.** »

To counter this, **the association attempted to ensure follow-up for its beneficiaries that had left the region by referring them to partners:**

«« **We are looking into creating a referral system to other partners in towns where they have settled so that they are not lost to follow-up for good.** »

At this stage, Affirmative Action worked on a case-by-case basis thanks to the field work of mediators with the beneficiaries they were in personal contact with:

«« **When a beneficiary tells us what town they're in, we check which associations are established there. The pilot tracks their client, checks that their client has enough medication, etc. After these questions, they tell them about an association called Alternatives Cameroun, for example, and give them the phone number.** »



FONDATION FEMME PLUS: DEALING WITH THE CONSEQUENCES OF CONFLICTS, PARTICULARLY IN TERMS OF GENDER-BASED VIOLENCE

The Democratic Republic of Congo has been experiencing recurrent regional conflict for several decades, notably in Kasai-Central and in North and South Kivu.

This situation heightens the vulnerability of women and young girls with regard to gender-based violence, with spousal abuse and child marriages exacerbated by the sexual violence directly and indirectly linked to armed conflict and humanitarian emergencies.



As recounted by its President, Thérèse Omari, **Fondation Femme Plus sought to better understand this phenomenon in North Kivu.** Indeed, out of those using the association's services, "15% said they had been abused." The organization of focus groups revealed that this phenomenon did not only affect women but also men in the context of humanitarian crisis: "Men also admitted to having been abused. The women said they had all been victims of violence." In response, **Fondation Femme Plus introduced multi-sectoral assistance for survivors of gender-based violence in partnership with health districts** and with the help of

community mobilizers. An outreach approach was used to contact survivors of GBV: "we used the mobile Voluntary Testing Center to test victims of abuse and then provide couple's counseling." *Fondation Femme Plus also put in place a psychological support structure at health centers: "Fondation Femme Plus introduced counseling services into health structures. Community mobilizers were used to refer people to the structure. That's also how we were able to make progress with statements in order to institute criminal proceedings."* The association then worked with survivors of GBV to facilitate their social reintegration into the community, particularly thanks to the creation of income-generating activities.

Based on this experience, Fondation Femme Plus explains that: "In times of crisis, many needs are not met. **Community-based care is an aspect of healthcare that should not be overlooked during conflict.**"

THE COMMUNITY-BASED RESPONSE OF PACE MEMBER ASSOCIATIONS TO THE COVID-19 HEALTH CRISIS

Within the context of the COVID-19 global health crisis, Coalition PLUS and the PACE created a contingency fund as of March 2020 (with the support of the AFD, among others) to reallocate certain budgets made available to associations and adapt their services to the situation. The aim of this budget was to maintain the service continuum while ensuring measures to prevent the spread of COVID-19.

MAINTAINING THE PREVENTION SERVICE CONTINUUM

The community-based associations have implemented numerous measures to maintaining the prevention service continuum for PLWHIV.

The main measure taken was to **adapt working conditions and conditions for receiving the general public.** Equipment for washing hands

with hand wash for all people entering the premises was systematically installed and physical distancing measures were put in place at sites (between patients and between providers and patients). This sometimes involved the implementation of a specific protocol at the site entrance, as was the case at the ANSS:

« People had to wash their hands, have their temperature taken at the entrance, and respond to a questionnaire on potential symptoms. »

This system allowed for patient triage and referral to the appropriate services in the event of suspected symptoms.

Masks were also mandatory for all people visiting the sites, and technical and support staff were equipped with hygiene equipment (alcohol-based gels, faucet buckets, hand soap, gloves), surface disinfectants, etc. Alcohol-based gels were installed in consultation offices, at reception, in the pharmacy and in laboratories, and within all other services along with surface disinfectants.



Nevertheless, the service package suffered overall from this situation, as Affirmative Action explains:

«*we have seen a real change in our interventions due to the protection measures introduced by the government: all group testing activities were canceled. The testing service package was drastically reduced.*» »

In Chad, ADN also canceled some of its activities:

«*Cooking workshops, treatment committees, treatment education, we put a stop on everything.*»

The associations also raised awareness among their publics on modes of contamination and barrier measures to be adopted on site. ANSS, for example, introduced measures in waiting rooms:

«*We run daily awareness-raising sessions in the morning before starting treatment.*»

Generally speaking, it seems that beneficiaries and staff appreciated the prevention measures taken by the community-based associations to ensure their safety in terms of health. This was also reflected in the strict compliance with barrier measures.

MAINTAINING THE TREATMENT CONTINUUM FOR PLWHIV

Regarding treatment, the continuity of care was ensured, but the services operated were severely limited; when not due to lockdown, people were scared of being contaminated and of leaving their homes, thus resulting in an increase in the number of patients lost to follow-up. Ensuring the continuity of care thus requires an adaptation of services, with a need to reach out to beneficiaries in order to provide certain services, like the AJPC in Congo:

«*For example, now within the context of lockdown, we are providing home delivery of ARV to our beneficiaries as they cannot leave their homes to collect their treatment from centers. We provide home delivery of ARV.*»

Paradoxically, the situation of ADN in Chad differs from the others. Indeed, with the decline in attendance rates at the provincial hospital due to the restricted movements of patients, PLWHIV turned to the association's services en masse. ADN even recorded a peak in non-PLWHIV at the site, having deserted the hospital for fear of COVID-19 contamination.

The community-based associations are attempting to maintain contact remotely, like the ANJFAS in the CAR:

«*We put in place a call strategy, and we have their numbers. We told them they can call us or send a message any time. And if need be, we can dispatch one or two members to visit them in person.*»

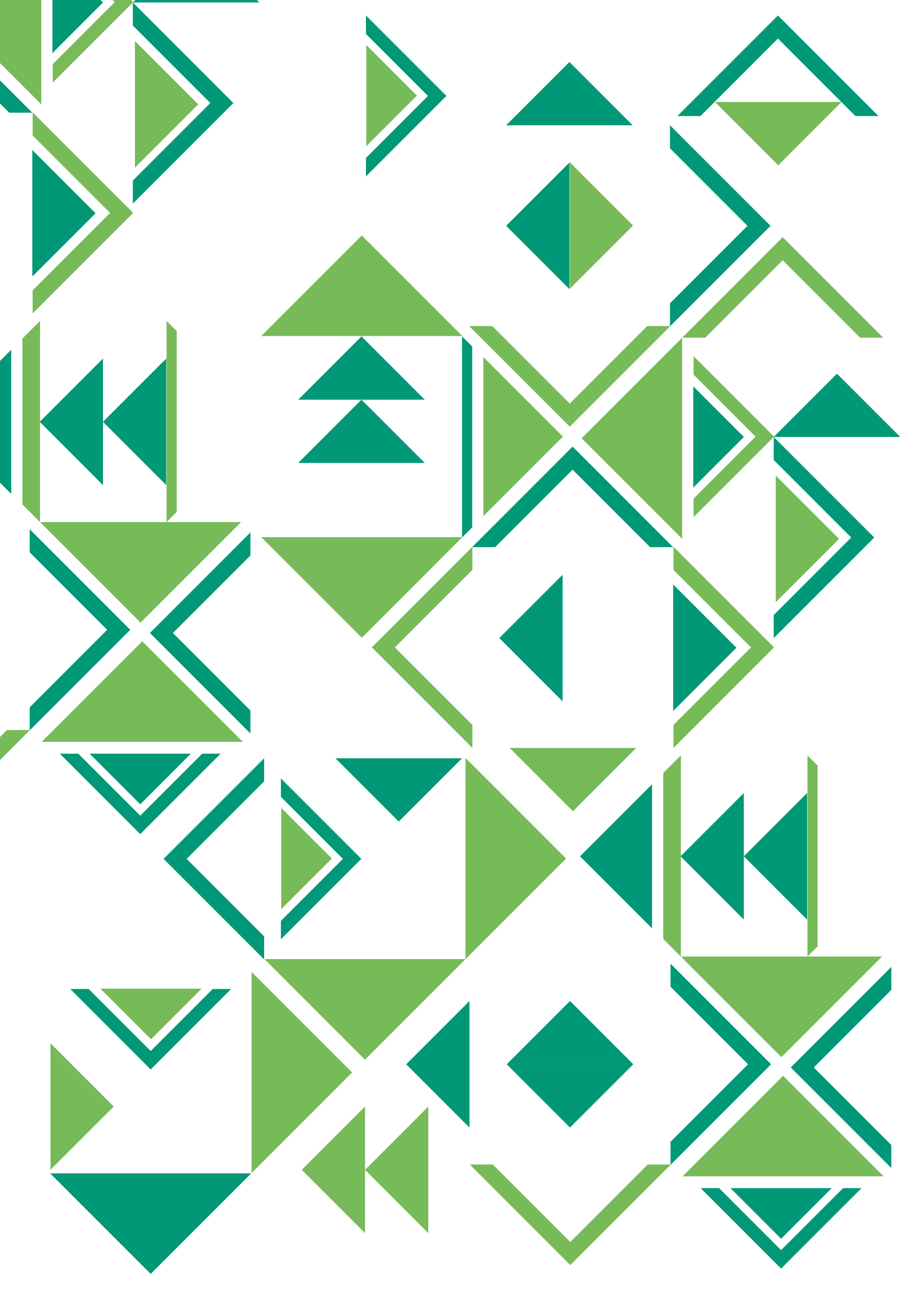
To avoid people having to travel, some associations like ADN extended the renewal period for ARV:

«*The doctor raises awareness at the same time as prescribing products for 3 months so that they don't have to come back. We don't make them wait, we give them the products systematically.*»

RESPONDING TO EMERGENCIES AND THE BASIC NEEDS OF KEY POPULATIONS

The community-based associations have also distributed hygiene kits to protect against COVID-19 and ensure the basic needs of PLWHIV and key populations.

Accordingly, the ANSS distributed **hygiene kits** (buckets, soap, alcohol-based gels, tissues) for the most disadvantaged beneficiaries. In a context where many people make a living from the informal economy, impacted by curfew, social distancing or lockdown measures, **food packs** were also distributed to disadvantaged PLWHIV, key populations, children and adolescents.





PART 2

THE ADVOCACY EFFORTS OF COMMUNITY-BASED ASSOCIATIONS WITHIN THE CONTEXT OF FRAGILE STATES



2 THE ADVOCACY EFFORTS OF COMMUNITY-BASED ASSOCIATIONS WITHIN THE CONTEXT OF FRAGILE STATES

Within the framework of the Coalition PLUS regional Platforms, technical support for advocacy aims to give a more structured approach to strategies to influence public health policies in order to put forward high-impact solutions such as the demedicalization of services to ensure better treatment for key populations by community-based associations.

This is what the PACE sets out to do within a context of declining international funding and stagnating national funding, weak political commitment and a lack of commitment from actors in operationalizing demedicalization³⁰.

The member associations of the PACE all also have experience in advocacy, closely connected to the contexts in which they operate. In this section we explore advocacy experiences in the context of the institutionalized discrimination in Cameroon³¹ and within the context of humanitarian crises³².

2.1 PACE advocacy for demedicalization: combining capacity-building and advocacy

THE ADVOCACY EFFORTS OF THE PACE AND THE ANJFAS IN THE CENTRAL AFRICAN REPUBLIC

In November 2018, the PACE ran a training course for the ANJFAS on demedicalized testing. The goal was to train peer educators in the capital, Bangui. This peer educator training was supported by the participation of Alternatives Cameroun and Humanity First as part of the pooling of community-based expertise within the Platform, as well as the Ministry of Health in order to strengthen its interaction with the ANJFAS.

In addition to the training, the President of the ANSS and the PACE Steering Committee lobbied the technical and financial partners working in HIV/AIDS: the First Lady of the Republic, the national CNLS coordinator, the Ministry of Health, UNAIDS, the French Red Cross, Cordaid, UNICEF and UNFPA. **The aim was to promote the awar-**

ding of subsidies from the Global Fund to the ANJFAS and civil society organizations in order to put in place projects targeting key populations and to initiate the task shifting policy to facilitate the involvement of civil society in the implementation of the UNAIDS catch-up plan.

Regarding the direct results of this lobbying, **the line ministry authorized the ANJFAS to become a Voluntary Testing Center, UNAIDS funded the ANJFAS observatory for Global Fund grants project, and the representative of the French Red Cross and the Director of Cordaid undertook to supply the ANJFAS with inputs for demedicalized testing.** This enabled the creation of a community-based testing site run by peer educators training in demedicalized community-based testing, open five days a week from 8:30 to 12:30.

30 See 2.1 PACE advocacy for demedicalization: combining capacity-building and advocacy

31 See 2.2 Advocacy within a context of institutionalized discrimination: deconstructing constructs at the core of community-led action

32 See 2.3 The advocacy efforts of community-based associations within the context of humanitarian crises

THE ADVOCACY EFFORTS OF THE PACE, RENAPC AND THE AJPC IN CONGO

In May 2019, the PACE organized a regional advocacy workshop in Congo. In addition to enabling the member organizations of the PACE to initiate a more structured advocacy movement in their respective countries, this workshop also allowed for direct advocacy in Congo on two important aspects of demedicalization: **demedicalized community-based testing and community-based provision of ARV**. The workshop provided a forum for dialog with the authorities on community-led activities, as explained by Valérie Maba, President of RENAPC,

« the PACE helped advance approval of community-based testing; we had a general policy but nothing specific. We asked UNAIDS to help us draw up a strategy. Now all we need to

do is put in place the approved activities. [...] On the sidelines of the advocacy workshop, Jeanne Gapiya met with the authorities to explain the role of community-based testing and distribution in the AIDS response. »

In December 2019, a second workshop was held to build the capacities of RENAPC peer educators with regard to demedicalized testing:

« We continued our lobbying during the training. The ministry representative gave her agreement and the Director of the PNLS gave certification, we even had a press conference to make the announcement. »

A partnership with the PNLS now supplies inputs:

« We have established a center at the head office with a team on rotating shifts, and we're now up and running. But there are still difficulties as we do not always have the resources to pay people. »

With regard to community-based delivery, the AJPC has also been granted authorization but there is still work to be done to ensure its operationalization:

« Regarding community-based provision of ARV, this was not yet in place, but we had planned to initiate it as part of the new grant. It was thanks to the advocacy of the PACE that we received authorization. The AJPC is the first association to receive authorization. »

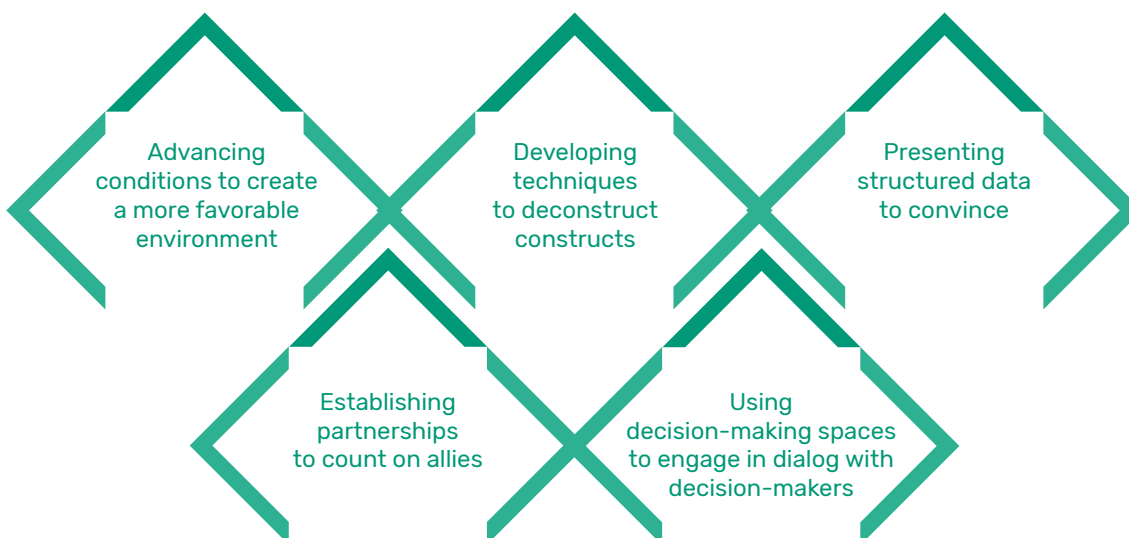
The situation linked to the COVID-19 context, however, made it possible to take the first steps towards operationalization:

« Now within the context of lockdown, we are providing home delivery of ARV to our beneficiaries as they cannot leave their homes to collect their treatment from centers. We provide home delivery of ARV. »

2.2 Advocacy within a context of institutionalized discrimination: deconstructing constructs at the core of community-led action

The institutionalized discrimination suffered by key populations in Cameroon strongly impacts the activities of the community-based and identity-based associations. Nevertheless, these activities

have developed thanks to the constant advocacy and lobbying for access to care and services for key populations. This advocacy is based on five main types of action:



YVES YOMB, LEADING AFRICAN HUMAN RIGHTS ACTIVIST



Born in Cameroon, Yves Yomb was working in banking when he realized that one cause needed defending above all others: the defense of human rights and the recognition of sexual minorities. Yves defended the fundamental right to exist, and beyond that to love and be loved regardless of gender identity or sexual orientation.

A specific event led to this turning point: *"I began advocating when I was a student, but it was the "Top 50" affair that turned me into a true activist"*, he explained in an interview for Coalition PLUS³³. *"In 2006, Cameroonian media published a list of Cameroonian figures presumed to be homosexuals, thus throwing them to the wolves of public condemnation [article in Le Monde dated February 2, 2006³⁴]. It was a very serious matter. My friends and I knew that if we did not take action, nobody would"*.

Yves Yomb thus decided to take on a law that criminalizes homosexuality since 1972 in Cameroon³⁵. Yves Yomb therefore became actively involved in the community-based association Alternatives Cameroun, eventually becoming its director. He was also a spokesperson for Africagay contre le sida, the first Francophone African network in the fight against homophobic violence and HIV. The goals themselves were simple, but risky with regard to the context insofar as only 16 countries in Africa recognize homosexuality: place the spotlight on African gays, and have their rights, and particularly their health and sexual health rights, recognized.

Yves demonstrated on numerous occasions that he would not be scared off by threats, slander and even prison. Once the silence was broken, he never forfeit his basic right to speak, to denounce and to advocate. He took part in the last World AIDS Conference held at the headquarters of the United Nations in June 2016. And yet he was not invited: the UN had refused to accredit 22 associations, the majority of which were LGBTI. Of the many lessons he learned during his struggle, Yves Yomb understood that the right to speak is not something you ask for, it is something you take. And so in front of the United Nations headquarters, he spread the word in major French-speaking media, including Radio France Internationale³⁶.

Yves Yomb' activism was pragmatic and aimed for results, concrete and tangible changes for his community. In order to foster constructive relationships with both governments and technical and financial institutions (World Fund, UNAIDS, WHO), Yves Yomb supported this change and accepted to take on the role of coordinator, becoming Human Rights Advocacy Officer for Coalition PLUS. In this role, he oversaw the integration of Africagay within Coalition PLUS in 2019, becoming the Alliance Globale des Communautés³⁷. Even hospitalized in Paris, he still had so many plans to implement, so many challenges to overcome for his community: ***"I hope that together we will be able to advance the LGBT cause in Africa. Without rights, those most affected by the AIDS epidemic cannot have access to healthcare services: that is what fuels the hidden epidemic that we are battling against"***. Yves Yomb died on June 15, 2020. His journey is an example to all those fighting to defend human rights.

³³ <http://www.coalitionplus.org/droits-sante-lgbt-yves-yomb-agcs-plus/>

³⁴ https://www.lemonde.fr/afrique/article/2006/02/02/des-journaux-camerounais-font-la-chasse-aux-homosexuels_737061_3212.html

³⁵ See Cameroon: A context of institutionalized discrimination that subjects identity-based associations to inherent tension

³⁶ <http://www.rfi.fr/afrique/20160609-sida-sommet-onu-afrique-neglige-plus-vulnerables-vih-cat-cameroun>

³⁷ AGCS PLUS: <https://www.coalitionplus.org/agcs-plus/>



ADVANCING CONDITIONS TO CREATE A MORE FAVORABLE ENVIRONMENT

For the community-based and identity-based associations in Cameroon, advancing the conditions in which they operate means seeking to create a less restrictive environment on a daily basis that at the very least allows them to ensure their activities targeting key populations. It is about seeking to change perceptions in order to create an environment more favorable to key populations.

DEMYSTIFYING SERVICES, INFORMING AND EDUCATING LOCAL TARGETS

Associations first and foremost need to **work on their immediate environment through local outreach**. These approaches are systematically used by Affirmative Action, Alternatives Cameroun, Colibri and Humanity First, all of which have been faced with sometimes recurring attacks on their offices³⁸. These local awareness-raising initiatives aim to ensure that the association can carry out its activities without any backlash from local residents.

For Alternatives Cameroun, for example,

« much work was done to raise the awareness of the responsible authorities for the geographic area prior to the opening of the center. »

This awareness-raising can help demystify the center through **open days**, as run by Affirmative Action:

« We host open days once a month. Everyone can access testing, including women and young people. We try to manage our image and the context in which we operate to avoid being stigmatized. »

Open days provide an opportunity for associations to explain what centers do in simple terms and answer any questions. Letting people see and handle medical equipment can help change perspectives and avoid moral judgments and public criticism in these environments, as Jean-Paul

Enama from Humanity First explains:



« [...] We give out prevention materials and do tests; incidentally, we have people on our active list who are not necessarily from the community, but who we monitor anyway. We run

couples counseling, for example, and similar activities to destigmatize our center. »

38 See Cameroon: A context of institutionalized discrimination that subjects identity-based associations to inherent tension

Some associations have also developed **approaches designed to educate and inform local targets.**

Alternatives Cameroun, for example, raises the awareness of administrative authorities, traditional authorities, law enforcement forces, etc. Humanity First calls these

« local committee meetings. We meet with local administrative and traditional authorities; if they have questions, we reiterate that what we do is in line with national guidelines to combat HIV. »

Sometimes, these initiatives form part of an **outreach strategy promoting local awareness so as to establish alliances at this level. These institutional allies thus play a mediating role between centers and their peers,** as is the case at Colibri:

« We arrange regular meetings with the police chief of the 2nd district to ensure he is an ally. Once he has been made aware of the issues, he can help with problems with other police stations in other districts; he acts as a mediator for other police chiefs. Bringing together all of the city's police chiefs doesn't work. It's like Jehovah's Witnesses: we talk to them one by one, on an outreach basis. »

Colibri applies this individual approach to all of the different groups:

« The same goes for traditional leaders. We use a face-to-face approach. **The idea is to create a snowball effect.** »

But Colibri emphasizes that this strategy is not without its limits:

« We're constantly starting over because of the high turnover rate among administrative staff » ; however, it has proven effective:

« Police chiefs have helped me have several members of staff released. » »

TARGETING BROADER, MORE STRATEGIC CATEGORIES

Creating a favorable environment also involves **measures to raise awareness beyond the local community** that firstly aim to increase understanding of what HIV/AIDS is in order to address specific questions that concern key populations. Affirmative Action, Alternatives Cameroun and Humanity First all use these types of initiatives to raise awareness among broader categories. :

« **These initiatives involve bringing together administrative, health, legal and religious authorities and working on deconstructing their constructs of HIV and key populations. At the end of the workshop they understand that issues of gender, HIV and sexual identity are in fact public health issues.** »

These actions generally target specific groups, such as journalists, as explained by Humanity First:

« We raise the awareness of opinion leaders, we talk to them about testing, access to health services. Journalists spread a lot of homophobia in Cameroon. We try to show them the impact of homophobia on the HIV response. »

Associations like Affirmative Action have faced resistance, which has led them to adapt their message depending on the circumstances, **by adopting public health arguments.** Indeed, as the National Strategic Plan identifies key populations as one of the main targets in the HIV/AIDS response, associations build on this opportunity:

« We look at how we can contextualize our message, bring objectivity to the debate and focus it on the public health dimension, shifting from a position of the victim to that of a stakeholder looking to be part of the response to a situation affecting the country. »

The use of advocacy to raise the awareness of other actors is therefore part of an approach centered on empowerment.

PRESENTING STRUCTURED DATA TO CONVINC: THE REPORT ON VIOLATIONS

The community-based and identity-based associations in Cameroon provide legal support as well as medical and social care for victims, and advocate to repeal discriminatory laws and policies.

The associations document these cases to provide proof of what they argue as part of their advocacy activities. As such, an annual report has been published since 2012 to identify violations. As Humanity First explains,

« **at national level, we publish a report on violations, which is also an advocacy tool as it presents the violations suffered by sexual minorities and puts forward recommendations for the Ministry of Health, the Ministry of Justice and the Human Rights Commission. Not only that but the report is cited in various international publications.** »

The data collection methodology is based on the training of observers spread across Cameroon who collect information to document the different cases and fill out a harmonized collection record. Several methods are used to identify cases of violence and violations. The observers may receive alerts from partner associations, or reports directly from the victim or a third party. Violence is also detected and monitored during community-based awareness activities, for example.

Cases of violations and violence are categorized by type. **Since 2012, the number of cases has continued to climb, illustrating on the one hand that this system has become increasingly sophisticated and, on the other hand, the persistent hostile environment to sexual minorities in Cameroon³⁹:**



Year	Arrests, detention	Scams, blackmail	Physical violence	Sexual violence	Psychological violence	Hate speech	Total
2012	10	7	2	0	4	3	23
2013	9	8	15	0	16	27	75
2014	42	17	5	4	49	55	172
2015	16	27	21	0	49	19	132
2016	35	68	26	7	48	164	348
2017	35	96	110	5	200	132	578
2018	60	198	204	8	509	152	1,134
2019	27	249	192	19	656	237	1,380
Total	234	670	575	43	1531	789	3,842

The production of structured knowledge and its publication is an important aspect of associations' advocacy actions, as it demonstrates the grounding in fact.

Humanity First explains that this is part of a more global strategy to **avoid confrontation in order to concentrate on facts and evidence** in a context where the balance of power between community-based associations and institutions is unevenly matched; the aim is to appeal to reason and bring objectivity to the debate:

« Given the context, we need to avoid actions that bring us into conflict with the government, not protest in the streets... We already know that there is a homophobic law in place. We need to condemn it in a report, otherwise our efforts can be discredited. The government can easily accuse us of breaking the law. »

³⁹ In 2019 annual report, *Un silence complice : Des violences et violation des droits sur la base de l'orientation sexuelle, l'identité de genre et l'expression des caractéristiques sexuelles au Cameroun*, Alternatives Cameroun and Humanity First.

ESTABLISHING PARTNERSHIPS TO COUNT ON ALLIES

The community-based and identity-based associations in Cameroon understood early on the need to establish partnerships and alliances to support their advocacy actions.

Alternatives Cameroun, for example, demonstrates that having structured alliances with several actors helps ensure a response in emergency situations:

« **We have established a network of actors willing to intervene in the event of violations. We call them the gay-friendly authorities, composed of various people: law enforcement, lawyers, magistrates, teachers, health providers, traditional chiefs, etc. We call on these networks to intervene when we identify a case. Nowadays the network has evolved: it is known as the 'RAI' for 'réseau des acteurs d'intervention', a network of local actors that intervene on behalf of key and vulnerable populations in Cameroon. [...] In the event of unfair dismissal, for example, we turn to the right person in the RAI to find a solution. The same goes for arbitrary arrests. It's a system that works well.** »

These partnerships can be **informal and based on the creation of alliances with external actors** who can relay messages at national level thanks to their strategic position. For example, diplomatic representatives who promote human rights, as in the case of Humanity First:

« **We also engage in a lot of backroom diplomacy, we often meet with embassy staff and tell them what we want to put in place. These people act as our representatives, our voice to ministers and congressmen, we tell them what we endure and what we will no longer put up with.** »

This strategy also ensures backing, which, although may not always provide direct results at national level, can be useful in specific situations:

« **Even when it doesn't lead to concrete results, you can see the impact in cases of arrests. For example, we can call on the US embassy which is very proactive on these issues and which can put things in motion. We often get our beneficiaries released thanks to the intervention of these embassies.** »

These allies also take on a mediating role in situations of emergency for the association.

Establishing partnerships also involves creating strong alliances. As Affirmative Action explains,

« **it's important not to work alone, because it is often the sheer force of numbers that protects us.** When we are many, when we produce a press release and we realize that there is a network of human rights defenders, the Human Rights Commission, the AIDS Commission, community organizations, etc. that carries weight, we are not alone and that helps soften the blow, spread the load. Whereas when we're alone and we can't create alliances, it's that much more difficult. »

USING DECISION-MAKING SPACES TO ENGAGE IN DIALOG WITH DECISION-MAKERS

The lobbying actions of community-based and identity-based associations in Cameroon include a constant dialog with decision-makers, at both international and national level thanks to the use of various decision-making frameworks. Alternatives Cameroun explains, for example:

« **[...] at international level, the two main approaches involve the African Commission and the United Nations. But there are minimal impacts because recommendations are not binding at this level.** »

That's why **the key focus of decision-makers is the national level** targeting actors in the health system that are sympathetic to the public health arguments advanced by the associations. It's all about making the most of key opportunities in the form of specific decision-making spaces to discuss with decision-makers:

« **It's easy to get in contact with the Ministry of Health because the National Strategic Plan for AIDS targets MSM as key populations. It's easier to make advocacy proposals in those situations.** »

Yet this dialog is limited to health issues and cannot truly move beyond this scope:

« **When you try to talk about human rights, it becomes irrelevant, nobody wants to listen, they say we're in Cameroon, that's made clear, there is a law that condemns homosexuality so let's stick to the health matter and talk about those problems.** »

The presence of Alternatives Cameroun within the Country Coordinating Mechanisms (CCM) for funding applications to the Global Fund provides an opportunity to enter into this dialog with the national authorities:

« **We have representatives of key populations at the CCM level. It's a gateway that allows us to make proposals.** »

This advocacy at national level, in direct contact with health authorities, leads to concrete results that can change the situation of MSM:

« **MSM are now recognized as targets. We have got authorities more involved with this target. You can see the impact at care centers. Before that there were real difficulties accessing care. Now we can feel barriers lifting, we can feel the environment becoming more favorable.** »

Alternatives Cameroun further explains that, when it comes to transgender people,

« **it is this advocacy that has resulted in [them] being included in the National Strategic Plan as a key population.** This wasn't the case previously. Out of the LGBT population, only MSM were recognized, whereas trans were more exposed and had higher prevalence rates. We relied on evidence. These days, trans are recognized as key populations but we still have problems estimating the size of transgender populations as there are no surveys. There is no specific action targeting trans people either. »

The results of advocacy actions are therefore tangible, but are part of a dynamic process marked by a series of milestones in order to keep aiming for more ambitious targets.

2.3 The advocacy efforts of community-based associations within the context of humanitarian crises

While the community-based associations within the PACE use structured advocacy based on a strategic analysis of their activities, the emergence of crises sometimes forces these organizations to resort to 'firefighting' advocacy to cope with the urgency of these situations. The humanitarian positioning that some associations have adopted in order to continue their activities in crisis situations and their unique advocacy experience in Congo to ensure the continued supply of ART are a case in point. Other examples include the effects of the COVID-19 health crisis on the advocacy of community-based associations.

FONDATION FEMME PLUS: HUMANITARIAN PRINCIPLES, A PASS TO REACH BENEFICIARIES IN SITUATIONS OF ARMED CONFLICT

In situations of armed conflict such as those in Burundi and the Democratic Republic of Congo, the restrictions on movement put in place by the armed forces, regardless of the current leadership or the rebel forces, sometimes compel community-based associations to initiate a dialog to ensure access to beneficiaries or displaced persons.

This dialog is akin to negotiating humanitarian access, as defined by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA):

« Humanitarian access relates to humanitarian actors' ability to reach people affected by crisis, as well as an affected population's ability to access humanitarian assistance and services.⁴⁰ »

To protect itself in these hostile situations, particularly in North Kivu, Fondation Femme Plus asserts a status of a neutral and impartial health structure

« The staff at Fondation Femme Plus were not in danger because we were considered a health structure. We had travel orders allowing us to move around the territory. »

But these situations are restrictive in terms of travel and make it difficult to ensure continued activities. **Fondation Femme Plus thus seeks to negotiate humanitarian access with the armed forces controlling the zone in order to reach populations:**

« In the beginning, getting into refugee camps or going out on roads where conflicts were occurring was a problem. We had to get in touch with senior military personnel, that is to say, work to a certain extent with the administrative services in order to reach those at risk. »

In rebel zones, negotiations made it possible to obtain "a document to access all of the rebel-occupied zones."

Lastly, in these situations, the community-based association plays the role of a humanitarian actor, which involves adapting the program:

« Emergency intervention cannot last more than 9 months, and when an event arises, you need to know how to adapt. »

This leads to new partnerships between the community-based association and humanitarian organizations. These partnerships make it possible to reach populations in their own environments and to keep up with their movements

« The number of refugee camps multiplied. There were high prevalence rates in the camps. We intervened directly via a mobile voluntary testing center. »

These partnerships also involve a certain task shifting:

« Partnerships with humanitarian organizations allow us to provide additional services; for example, if we screen people living with HIV, it's the health staff of the humanitarian organizations in place at the refugee camps who provide treatment. »

RENAPC: FIGHTING THE FIGHT OF THE "SOLE DEFENDER OF THE CAUSE" TO ENSURE DRUG SUPPLY IN A CONTEXT OF RECURRING SHORTAGES

The Republic of Congo generates most of its revenue from oil resources, giving it the region's highest GDP. The World Bank thus classes Congo in the 'Lower middle income' group, whereas other countries in the region fall within the 'Low income' category. In order to establish resource allocation per country, the Global Fund notably uses the World Bank index, meaning that Congo receives a small budget; the country also needs to provide greater financial compensation to fund HIV/AIDS response activities.

Within this framework, as explained by Thierry Maba, advocacy officer at RENAPC,



« the country has chosen to dedicate a budget line to products. The State wanted to handle medication within a context of free access. 3.5bn CFA francs were set to be allocated to the purchase of products. »

This situation quickly created problems:

« It worked initially. But in 2011, there was a stock shortage; until 2016 when there were 8 months of shortages for first line drugs, and one year for second line drugs. Clearly there was a management problem.. »

Actors in the HIV response thus suffered an ongoing crisis, requiring every effort to be made to find drugs. In fact,

« the country was not honoring its commitments in terms of ARV and input purchases and justifying it with the so-called financial crisis. »

The work of community-based organizations thus shows that the problem lay elsewhere:

« Our investigations revealed that this line was still receiving funding from the country's annual budgets. The money was going out but people didn't have access to drugs - the money was being stolen! »

The sole objective of RENAPC's advocacy actions was therefore to ensure the availability of drugs in the country. In 2014, the Global Fund New Funding Model required a country dialog, notably with community-based structures, when submitting a funding request. RENAPC thus capitalized on this forum for discussion in order to make its voice heard and to adopt a risky advocacy strategy:

« In this situation, the State was not our partner, but the main sticking point. It wanted to keep the budget line for drugs because it was padding their pockets. Civil society associations would not stand with us as they could only get funding from the Global Fund for prevention. The Global Fund did not back us because it seemed logical for the State to pay for drugs. Because the Global Fund's aim is to withdraw at some point. We were fighting the battle alone. That was in 2015-2016. **We lobbied for people to receive their medication as the sole defender of our cause!** »

RENAPC thus adopted a radical position designed to draw maximum attention to the situation in Congo:

« We were very radical: if there were no drugs, then we didn't need their project. We couldn't understand why there were no drugs. Drugs are the highest priority; there can't be a shortage of ARV when starting treatment. Allowing the country to keep paying for drugs meant accepting new shortages. »

This position implies a balance of power that consists of using all possible means to achieve a goal. **This advocacy eventually paid off and the Global Fund quickly became an ally, backing RENAPC in its fight.** The Global Fund set up a mechanism to ensure that the State paid its compensation without any effect on drug supply:

« The State had to undertake to pay for the drugs in order to allow for reprogramming: A partnership was co-signed with Unicef, which paid for the drugs, and the State then refunded it. Since then, there have been no more shortages. »

However, the balance sheet for this period remains negative for Congo, which will have to shoulder the consequences for decades to come:

« In 2014, almost 100% of PLWHIV were on 1st line treatment; now, almost half are on 2nd line. There were a lot of deaths. Some people wanted to come off the treatment... [...] because of stock shortages. »

THE ADVOCACY EFFORTS OF COMMUNITY-BASED ASSOCIATIONS WITHIN THE CONTEXT OF COVID-19

The COVID-19 health crisis has greatly affected beneficiaries from key populations, who are all the more vulnerable. As Alternatives Cameroun explains, *“the increased fragility has forced people to return to their family circle and to the homophobia within these families.”* As a result, it is highly likely that this situation will result in increased cases of violence, particularly against LGBT populations.

In addition, the position and advocacy of the community-based and identity-based associations within the PACE has been disrupted by the situation. According to Alternatives Cameroun, *“advocacy for LGBT is no longer heard. It’s all about COVID.”* Moreover, international frameworks for dialog have been shelved, which is affecting planned actions: *“This health crisis has disrupted our advocacy agenda (participation in the June African Commission in Banjul, submission of an alternative report that is no longer possible)”* says Alternatives Cameroun.

Nevertheless, new frameworks for dialog are emerging from the crisis, which the PACE associations are seeking to use to make the community voice heard. The Global Fund, for example, has allowed for the preparation of concept notes including a COVID-19 section, as explained by Alternatives Cameroun: *“There was a country dialog on the national COVID response, a COVID plan to submit to the Global Fund, and civil society was a stakeholder in the review of this conceptual note. Civil society was involved at the highest level.”* However, in Cameroon and many other countries, civil society is not involved in the COVID-19 task force, and as such has set up its own task force: *“The aim is to convey the voice of the community within national bodies, to represent civil society and the community in the fight against COVID so that these groups have a greater chance of being heard at national level. The task force has already worked on the review of the COVID-19 concept note.”* The establishment of this platform is the first outcome of the mobilization of civil society.

In Congo, the health crisis has had positive effects on the position of the AJPC. Thanks to the implementation of the AJPC COVID-19 plan with the support of the PACE, the former has now been identified by local partners as a benchmark community-based structure in related activities, which has enabled the PNLS and the CCN to involve two members of the AJPC in the drafting committee for COVID-19 response funding from the Global Fund.



CONCLUSIONS & OUTLOOKS

**BY ALIOU SYLLA, DIRECTOR OF
THE AFRICA OFFICE - COALITION PLUS**

The documentation and sharing of the experiences and practices developed within the PACE by nine community-based associations illustrates that in particularly difficult and restrictive contexts such as fragile States, community-based actors in the HIV response have been able to put in place and develop differentiated treatment services tailored to vulnerable populations and key groups. The associations have also provided added value by implementing a key community-based principle that places beneficiaries at the core of the response in order to provide them with the best care.

Moreover, in the specific health context triggered by COVID-19, community-based associations have been able to adapt and demonstrate pragmatism, through the development of innovative strategies to ensure the care continuum as well as prevention services, like the introduction of tailored spaces at treatment sites, the distribution of protection and hygiene equipment to beneficiaries, the organization of awareness-raising campaigns in communities, the introduction of remote psychosocial support arrangements, and home delivery of ARV covering several months to PLWHIV.

Far from disincentives, the health challenges and institutional discrimination in these countries have sparked an awareness and a drive to innovate among community-based actors so as to ensure global care for key and vulnerable populations. This guide of best practices highlights this community-based approach that is so vital in order to effectively eradicate HIV/AIDS at national level in countries where public health services expect the patient to come to them and provide a limited service package that is not always adapted to certain population groups.

All of these efforts are accompanied by vigorous and ongoing advocacy for treatment for key populations and for their involvement in the development, introduction and monitoring of policies and programs affecting them. The principle "Nothing about us, without us!" thus becomes a transformative reality for those affected by the disease who, beyond their vulnerability, act as true agents when it comes to prevention, treatment and, consequently, public health.

The PACE is indeed making progress and is establishing itself as a central capacity-building instrument for the development of services centered on the essential aspects set out by the 90-90-90 targets, in particular reaching those populations most difficult to access - geographically or due to social discrimination - and advocacy for task shifting and the demedicalization of the care continuum. It thus represents a clear opportunity for access to strategic data and information on the region's health policies and for the organization of effective forums for sharing and capitalization, generating reliable knowledge products, as demonstrated by this guide.

Of course, not all of these experiences are successful ones, but each contributes its own lessons that can be taken up by other community-based actors. Exchanges between the member organizations of the PACE help identify success factors, limits, impacts, conditions and precautions in terms of replicability. This compilation work also enriches the range of diverse experiences brought together within Coalition PLUS - on both the geographical and sociocultural fronts.

Ultimately, the key role and inclusion of civil society in the management of the underlying causes of health challenges are no longer open to debate given their crucial nature for the development of societal resilience in the long term. The importance of incorporating capitalization into the organizational culture of the Coalition PLUS Platforms as part of a qualitative approach, involving sharing, pooling, learning, improvement and innovation, is now the next step in underpinning this vision.



