

# Mid-term Performance Evaluation of the “Continuum of Prevention, Care and Treatment (CoPCT) of HIV/AIDS with Most at-Risk Populations in Cameroon (**CHAMP**)” Project



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# ACRONYMS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CAMNAFAW	Cameroon National Association for Family Welfare
CBO	Community-based organization
CDC	United States Centers for Disease Control and Prevention
CHAMP	Continuum of Prevention, Care and Treatment of HIV/AIDS with Most-at-risk-Populations in Cameroon
CMWA	Cameroon Medical Women Association
CNLS/NACC	Comité National de Lutte contre le SIDA/National AIDS Control Council (NACC)
CoPCT	Continuum of prevention, care and treatment
COP	PEPFAR Country Operational Plan
COSW	Clients of sex workers
CRS	Catholic Relief Services
DOD	United States Department of Defense
DIC	Drop-in center
EPEM	Enhanced Peer Mobiliser Model
FP	Family planning
FSW	Female sex worker
GBV	Gender-based violence
GRC	Government of the Republic of Cameroon
HAPP	HIV/AIDS Prevention Program
HCT	HIV counseling and testing
HIV	Human immunodeficiency virus
ICT	Information and communication technology
IEC	Information, education, and communication
KIDSS	Key Interventions to Develop Systems and Services for OVC Populations in Cameroon
KP	Key population
KPLHIV	Key population living with HIV
LRA	Linkage and referral agent
M&E	Monitoring and evaluation

MARP	Most-at-risk population
MER	PEPFAR Monitoring, Evaluation, and Reporting
MSM	Men who have sex with men
NACC	National AIDS Control Council
NGO	Non-governmental organization
OVC	Orphans and vulnerable children
PE	Peer educator
PEPFAR	President’s Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PN	Peer navigator
POC	Point-of-contact
PWID	People who inject drugs
QA	Quality assurance
QI	Quality improvement
SOP	Standard operating procedure
SOW	Scope of work
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TB	Tuberculosis
TG	Transgender
UIC	Unique identifier code
USG	United States Government
VCT	Voluntary counseling and testing
VL	Viral load
USAID	United States Agency for International Development

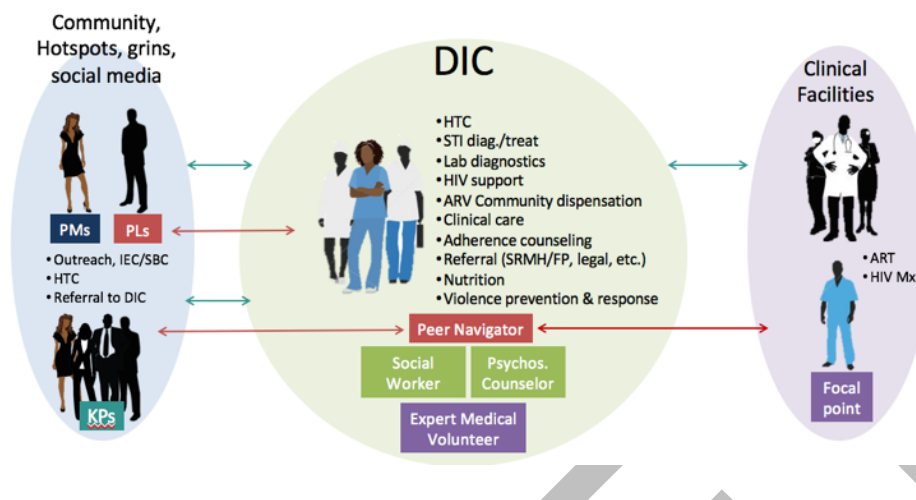
# Executive Summary

The USAID/West Africa, Cameroon field office requested a mid-term performance evaluation in 2017 to determine which approaches are best contributing towards the USAID-funded “Continuum of Prevention, Care and Treatment (CoPCT) of HIV/AIDS with Most at-Risk Populations in Cameroon (CHAMP)” program’s purpose to “improve the Government’s and civil society technical capacity to implement evidence-based prevention, care and treatment services to key populations (KPs) in Cameroon,” and the extent to which this program purpose will likely be achieved at the end of the program in 2019. This Executive Summary presents highlights of the evaluation findings and summarized recommendations, followed by the full report which includes further detail.

Review of findings from this mid-term evaluation show that the USAID and PEPFAR-supported CHAMP program has made significant strides in expanding services to key populations in Cameroon over the life of the project to date, despite significant challenges and violence directed towards KPs. While CHAMP’s predecessor program, the USAID HIV/AIDS Prevention Program (HAPP), focused on the provision of prevention services from 2009-2013, CHAMP has since 2014 expanded services across the full cascade from HIV/AIDS prevention to treatment and retention. While HAPP had a relatively small budget under \$1 million a year, CHAMP is an \$18.5 million program over 5 years, with concurrent scale-up of key populations reached with prevention, testing, linkage to, and retention in treatment in Yaoundé, Douala, and Bamenda city clusters. The Global Fund and PEPFAR are the major donors for KPs in Cameroon and have worked closely to align and harmonize efforts and monitoring approaches, including a joint PEPFAR/Global Fund KP cascade assessment in 2016 that was organized through the LINKAGES project working through CHAMP.

Particularly notable advancements are the introduction of enhanced peer education and mobilization (EPEM) models for outreach and extensive microplanning used to identify new individuals and new networks beyond traditional peer to peer contacts for intensified case finding, and key populations living with HIV (KPLHIV) receive extensive support from peer navigators, counselors and linkage and retention agents in both community-based drop-in-centers (DICs) and in linked referral health facilities providing ART initiation and tertiary care. The drop-in center “one-stop shop” model now has added community-based ART dispensation at the DIC, and there has been systematic engagement, collaborative training and partnership between CHAMP and the Government of the Republic of Cameroon, other PEPFAR agencies including CDC and DOD, and the Global Fund, to reinforce the provision of improved quality services to KPs and to build capacity and coverage and data within the national program. Prevention efforts led by CHAMP and the Global Fund have contributed to a documented decline in HIV prevalence among female sex workers in Cameroon in recent years. Moreover, CHAMP’s research initiatives have produced high-quality data to document the KP epidemics in Cameroon, allowing for far more accurate measurement and tracking of results of prevention, care and treatment approaches.

## CHAMP model of CoPCT



In line with PEPFAR's pivot, the CHAMP model represents a paradigm shift in provision of HIV/AIDS services to key populations in Cameroon. The evaluation findings indicate that the program has reached a significant milestone in moving the KP response and is poised to continue building the program through several key recommendations to further the reach, quality and coverage of the project moving forward. The highest priority recommendations are listed first below, with brief descriptions following of all recommendations for each of the cascade steps.

### Highest Priority Recommendations

- Continue to collaborate with Global Fund and CAMNAFAW to ensure synergy of proposed programming in new concept note (e.g. drug use, PrEP, self-testing/peer-mediated testing, human rights advocacy, and legal services)
- Encourage leadership and capacity development of KPs at CBOs, including via exchanges and mentorship between CBOs and across countries within the region
- Expand and systematize use of Information, Communication Technology (ICT) and social media to reach MSM
- Continue to identify opportunities to reach clients and partners of KPs in hotspots
- Explore feasibility of expanding STI services available at DICs (e.g. benzathine treatment for syphilis, hepatitis vaccinations, etiological diagnosis of STIs, and anal health)
- Explore feasibility of including private sector health providers in provision of HIV and STI-related services at DICs and for referrals, including for ART initiation and STI treatment
- Expand community dispensation of ARVs at DICs for stable clients
- Expand community initiation of ART at DICs, including Yaoundé and sites serving FSW, via demonstration projects and studies to build the evidence base

- Expand provision of psychological services, including care provided by counselors, peer navigators, social workers, and psychologists, at DICs and linked health facilities
- Deepen collaboration with KIDSS program and other partners to provide services for vulnerable children of FSW, as well as adolescent girls and young women in or near KP hotspots
- Address pervasive challenges in conducting timely and accessible viral load testing, including exploring feasibility of new models of service delivery, e.g. dried-blood spot testing, procurement and use of GeneXpert at drop-in-centers (DICs)
- Continue to use findings from research studies (e.g. IBBS, longitudinal cohort study, stigma index, dual HIV/syphilis testing) to inform data-driven rational targets for numbers of positives (HTC\_POS) and other related programming
- Develop an analytic plan, including M&E and technical staff, to direct data collection, analyses, and visualizations with data feedback mechanisms
- Work with USAID to streamline routine reporting on MER indicators

### **Reach, Prevent, and Mobilize**

The evaluation team identified numerous strengths for this cascade step. In FY17, the CHAMP program implemented an enhanced peer education and mobilization model (EPEM) to recruit members of key populations from social networks into HIV testing and counseling services, facilitating impressive results. Other major strengths include: the program's focus on having peer educators conduct networking in the community; holding community social events; promoting messaging that communicates the benefits of treatment; the use of refined risk assessments and screening to include gender and sexual diversity, violence and drug use; addressing the intersecting stigma of HIV and KP status(es); use of gatekeepers to safely reach risky hotspot areas at night; the provision of STI kits; engaging MSM through ICT and social media; and the use of detailed hotspot mapping informed by research in partnership with JHU.

Challenges identified in this cascade step include a suboptimal ratio of peer leaders to beneficiaries; all clinical services not being available at all drop-in centers (e.g. STI, hepatitis, syphilis screening, clinical examinations); cost and availability of treatment beyond STI kits covered by CAMNAFAW; poverty and lack of resources; ICT work being nascent among some CBOs; and due to extensive stigma and discrimination, many KPs preferring to remain hidden.

The key recommendations for reach are:

- Continue process of microplanning with activities, targets, and services among peer leaders given evolving data and resources
- Continue to provide more social support (social activities, support groups)
- Intensified psychological staffing and counseling services, especially as treatment numbers increase, including issues related to gender and violence



- Explore how city campaigns could raise awareness of services, benefits of treatment, reduced side effects, testing, etc. (including reinforcing message that all Cameroonians deserve 100% access to treatment with zero discrimination)
- Collaborate with the Global Fund around drug use, following their mapping exercise (USAID could potentially collaborate on a pilot model)
- Continue to implement security measures for community outreach
- Need to coordinate and standardize ICT work among MSM CBOs (including using incentivized scheme to increase online outreach)
- Continue to expand OVC services

## **HIV Testing**

The second cascade step for this evaluation was HIV testing services, for which the evaluation team identified numerous strengths including: the presence of CBO-run and accredited drop-in centers (DICs) providing HIV rapid testing; the EPEM model facilitating an increase in community-based testing within new networks; additional STI testing and treatment services offered via CHAMP's research studies; targeted testing of children of positive FSW, as well as clients of FSW; and free services with no extra fees typical of many facilities in Cameroon.

Key challenges identified include reduced positive yield due to extensive HIV testing and counseling outreach, and also likely reflecting the benefits of the program's prevention efforts, resulting in more beneficiaries testing negative over time; the reluctance of some beneficiaries testing positive to notify their partners; and a desire among beneficiaries for more comprehensive services beyond HIV, such as basic primary healthcare, including STI testing and treatment.

The key recommendations for HIV testing services are:

- Explore peer assisted self-testing, with peers available for immediate follow up (including considering use of oral fluid testing)
- Continue expansion of STI testing and treatment (HBV, syphilis) with HIV testing (also consider other primary healthcare services, to generate demand)
- Task shifting of testing from nurses to lay workers
- Continue to expand index testing, both in terms of mothers to children and sexual/injecting partners, as part of targeted outreach
- Continue testing clients of FSW, and other high risk individuals in the hot spots, which will destigmatize testing and may include others who do not identify as KP
- Continue to track testing methodologies, including mobile testing, grins (small groups), EPEM, ICT/social media, etc. to determine whether recruitment varies in terms of age, risk, HIV yield, and other risk factors critical for program development and targeting

## **Linkage to Treatment**

The evaluation team identified numerous strengths for the linkage to treatment cascade step in the CHAMP program, highlighting the shift from the predecessor HAPP program's prevention focus to

CHAMP's full continuum of prevention, care, and treatment services. These strengths include the program's investment in dedicated staff and resources to support linkages; advancements in systematizing bidirectional referrals between CBO-supported peer navigators and linkage and referral agents (LRAs) based at referral health facilities; monthly meetings of a consortium of stakeholders to address/increase linkage; increased investment at the CBO level in coaching and coordination with peer navigators, psychologists, and counselors to reinforce linkage best practices; extensive follow-up to improve the acceptance of diagnosis by beneficiaries; improvement in client tracking due to the matching of a beneficiary's CHAMP-assigned unique identifier code (UIC) with the national ART code assigned by the referral health facility; ART initiation on-site at the Alternatives drop-in center; successful advocacy by CHAMP to waive test fees at initiation, including eligibility testing fees that have traditionally been charged at many partner clinics and hospitals. It should be noted that CHAMP coordinated TA through the LINKAGES project, which conducted training for UIC monitoring among both CHAMP and CAMNAFAW (Global Fund) following the joint PEPFAR/Global Fund KP cascade assessment and this collaboration continues through further harmonization of data collection systems in 2018.

Key challenges for this cascade step include the need for more data to appropriately monitor and evaluate the length of time for linkage to treatment; unsupportive/disengaged focal points at some facilities; long waiting times particularly at non-CDC referral sites; continued stigma and discrimination towards KPs at some health facilities; continued reports of unnecessary fees and tests from some facilities; not all facilities having formal focal points/agreements with CBOs; and issues of denial of diagnosis, geographical transience, and psychological trauma affecting KPs.

The key recommendations for linkage to treatment are:

- Systematize analysis of data on number of days between diagnosis and initiation
- Use counseling data to identify specific client concerns or characteristics that require differentiated support to ensure successful linkage
- Consider expanding agreements and focal points to new facilities
- Engage in regular QA/QI process to identify supportive/engaged focal points and troubleshoot at facilities where focal points are unsupportive/disengaged
- Continue stigma and discrimination trainings among healthcare providers and facility staff at all levels, expanding beyond clinicians to engage anyone who may encounter patients
- Protect confidentiality by reducing questions about KP status at each service delivery point

## **Treatment**

Several key strengths were noted for the treatment services cascade step, including 6 of the 8 drop-in centers have implemented ART community dispensation, with the remaining two planning to do so in early 2018; development of pharmacies on-site under the mentorship of partner health facilities; innovative partnership between Alternatives and Laquintinie hospital in Douala allows for the provision of a medical doctor on-site at the Alternatives drop-in center facilitating on-site treatment initiation; more partner clinics and hospitals have clinical providers sensitized to KP needs and concerns due to CDC-supported KP-friendly trainings; and implementation of the handshake model between peer

navigators and linkage and retention agents is creating better connections between CBOs and facilities and resulting in better treatment outcomes for beneficiaries.

Several significant challenges were noted, including that many patients are being shut out of community dispensation due to extensive problems with viral load testing, which is required for stable patient status which is the eligibility criteria for community-based ART at DICs; even stable patients are not always able to receive 3 month prescriptions, in part due to continuing ARV supply chain issues; current policies restrict ART initiation to doctors and ARV dispensation to doctors and nurses, creating additional barriers for drop-in centers to provide ART initiation and dispensation; some beneficiaries continue to experience fatigue and/or drowsiness due to the efavirenz component of the primary first-line regimen, especially in the first month of treatment; sensitivity training has not been universally applied at all partner health facility sites or all provider levels, or with other facility staff; mobility of KPs; and persistence of fees charged at health facilities.

The key recommendations for treatment are:-

- Systematic multi-month prescriptions for all stable patients (3 months)
- Task shifting for initiation from doctors to nurses
- Continue to explore shift to better ART regimens (i.e, dolutegravir) and work with supply chain to ensure necessary supply of medications for new patients as dispensation scales up
- Continue to work with lab to ensure that space is appropriate and can handle increased demands as more beneficiaries access treatment
- Monitor ratio of follow up for PLHIV -- clinicians, counselors and peer navigators
- Demonstration sites for ART initiation in FSW and additional MSM sites to support community initiation (data driven with clinical partnership between hospitals and CBOs)
- Continue to monitor/provide ARV dispensation when KPs are in prison
- Use of technology for PLHIV to support each other, and coordination between peer navigators and CBOs (WhatsApp, listservs, etc)
- Fees specified and fixed (timing, prices)

## **Retention**

In terms of strengths for the retention cascade step, CHAMP has invested in the provision of psychological counseling, adherence counseling, support groups, expanded follow up by peer navigators and counselors, and client satisfaction feedback loops; increased awareness of the benefits of treatment; supported monthly coordination meetings between CBOs and referral health facilities; and successfully advocated for the provision of multi-month prescriptions at some sites.

Numerous challenges continue to hinder the retention of beneficiaries in the clinical cascade, including a need for further programming to address mental health issues; substance use/addiction counseling; job training and economic strengthening; counseling for FSWs on navigating relationships/partners; fear of stigma and discrimination; need for family counseling; need for additional services for children of FSW; periodic/temporary need for shelter for those experiencing family rejection and violence; lack of

second-line ARV regimens; and repetitive questioning of KPs to name their KP status throughout the treatment process at all service delivery points at some referral hospitals (among stigmatized KPs and without auditory privacy).

The key recommendations for retention are:

- Expand support groups
- Expand psychosocial counseling training and staff - mix of peer navigators, lay counselors, social workers, clinical psychologists
- Integrate more services for women with children if possible
- Provide family counseling options
- Formalize legal support to supplement collaboration with CAMNAFAW
- Continue client feedback loops
- Continue to expand program involvement from KPs including KPLHIV
- Continued KP sensitivity training of health providers to reduce stigmatizing behaviors

### **Viral Load Monitoring**

The evaluation team determined that the viral load monitoring cascade step is experiencing many significant challenges. However, several important strengths were still noted, including that an increasing number of patients are receiving viral load testing, sample collection is now occurring at many of the drop-in centers, free viral load testing campaigns are periodically arranged for KPs, and there is an increasing understanding of what an undetectable viral load means for one's health and in terms of onward transmission of HIV. The evaluation team identified numerous urgent challenges, including excessive delays (>3 months) in processing viral load tests in some sites, which is delaying ART community dispensation and clinical monitoring of patients; frequent stock-outs and expiration of reagents at many sites; demand further reduced by high cost of viral load testing (5000 CFA, equivalent to about \$10); the inadequacy of periodic free campaigns; and other tests being added on with additional fees.

The key recommendations for viral load monitoring are:

- Immediate action required to follow up on delayed viral load samples with CDC and CHAMP with LRAs and PNs and CNLS RTG point-of-contact (need for regular schedule to monitor this situation moving forward, and to work out fees for KPs)
- Explore dried blood spot VL testing
- Continue to explore point-of-care VL testing at DICs (GeneXpert can also test for STIs and TB)

### **Cross-Cutting Issues**

The evaluation team reviewed several cross-cutting issues, including enabling environment and program management. Key cross-cutting recommendations include:

#### Enabling Environment

- Continue sensitization of health care providers and facility staff at all levels

- Continue to use the PLHIV Stigma Index for advocacy and to improve programming
- Systematize and formalize national coordination of a technical working group for key populations, including CHAMP, CAMNAFAW, and CNLS
- Continue collaboration with CAMNAFAW and Global Fund for provision of legal services
- Explore potential for legal retainers for lawyers within CHAMP
- Explore ARV dispensation to KPs in prison
- Continue to frame human rights messages – the right to health access
- Continue to reinforce sense of patient rights for non-discrimination in access to quality health services in line with WHO and UNAIDS guidelines
- Continue to train/sensitize police to reduce interference to public health efforts and consider rewarding better community protection agents as allies for their role as positive change agents in the fight against HIV
- Support KPs in leadership development and strengthen their opportunity for career progression
- Continue to foster networks and alliances among all KPs (FSW, MSM, TG, and PWID)
- Ensure trauma response is incorporated into GBV screening
- Continue advocacy to limit fees and standardize fees and required tests within health system

#### Program Management

- Reinforce communication between CHAMP and CBOs, and between CBOs themselves, for capacity building, quality improvement, and learning
- Encourage capacity building efforts to engage KPs and build leadership within KP communities
- Prioritize technical support staff and identify additional technical resources, including HQ support and medical student interns
- Emphasize importance of psychological support to programming
- Ensure appropriate use of social networks to target programming
- Reinforce clinical management components of program
- Reinforce data analysis and use for improved programming

#### **Monitoring and Evaluation**

CHAMP has shown great recent improvement in its monitoring and evaluation (M&E) systems. The team has instituted routine data quality checks at all sites ensuring that data entered into CommCare is accurate. The team has focused on key PEPFAR MER indicators - KP\_PREV, HTS\_TST (including POS), TX\_NEW, and VL testing. In addition, CHAMP stands out among countries with its mobile data collection system, Nsamba (CommCare) implemented with nearly all CBOs. Use of a UIC enables Nsamba data to be linked to other data sources - e.g. the OVC program with CRS and facility data. In addition, the CBOs demonstrate clear tracking of key MER indicators on a monthly (and weekly) basis. Basic measures of success - targets reached, linkage to treatment are regularly tabulated and shared within each CBO and with CHAMP.

Major challenges include: extensive PEPFAR reporting requirements, especially during the emergency period, have limited bandwidth of people who could conduct data analysis and use; Nsamba has limited analytical capabilities - CBO M&E staff typically download data into Excel for analysis; M&E staff have

limited data analysis and visualization skills beyond Excel pivot tables and basic charts; lack of a comprehensive, updated overall analytic plan for the project leads to ad hoc, one-off analyses conducted by different CBOs without any learning or coordination on best practices or broadly applicable findings; incomplete transition from paper registers to electronic systems invites poor data quality and consumes staff time and resources; and significant time is spent on repeating the same basic reports which, if streamlined, could free up time for additional analyses.

The key recommendations for monitoring and evaluation are:

- CHAMP should develop an analytic plan, including M&E and technical staff, to direct data collection, analyses, and visualizations
- CHAMP should develop an M&E training plan incorporating software packages as well as data analysis for program improvement
- CHAMP should work with USAID to streamline routine reporting on MER indicators. Demonstrated success in improving data quality over the past several months indicates the project is ready to transition to less frequent reporting on key MER indicators which would keep USAID informed while allowing CHAMP staff to expand their M&E efforts beyond weekly MER check-ins. Development of a basic dashboard, updated biweekly will allow USAID to see results and flag any major issues
- CHAMP should develop an M&E guide for CBOs to ensure all are on the same page - using the same definitions across sites
- CHAMP should review - in conjunction with technical staff - the variables in Nsamba
- CHAMP should review Nsamba security concerns around data versus improved quality in program delivery
- CHAMP should prioritize research and evaluation which demonstrates the value of the community-based model for ART. DICs should be evaluated for their effectiveness in linkage and adherence for treatment

### **Executive Summary Conclusion**

As noted above, CHAMP has shown great improvement through each step along the prevention, care and treatment cascade through the development of state of the art approaches and best practices for KPs. The team has instituted routine data quality checks at all sites ensuring that data entered into CommCare is accurate and is increasingly using data and research to develop and track innovative approaches. From its start in 2014, CHAMP has reached approximately 60,000 KPs in target areas with prevention and testing services, linked over 1600 KPs to treatment, and contributed, along with the Global Fund, to a documented decline in estimated HIV prevalence among female sex workers from 37% in 2009<sup>1</sup> to 24% in 2016.<sup>2</sup> Following Cameroon's adoption of HIV treatment for all in FY17, the program saw a dramatic expansion of services and an increase in the number of KPs being initiated on life saving treatment, through treatment literacy, counseling and peer navigation. CHAMP is now poised to expand

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<sup>1</sup> Tamoufe U, Medang R. Sero-epidemiological and behavioural investigation of HIV/AIDS and syphilis in Cameroon sex workers: Final report. Yaoundé: UNFPA, Johns Hopkins University and Global Viral; 2010.

<sup>2</sup> 2016 IBBS Report among Key Populations in Cameroon: FSW and MSM. Yaoundé: Johns Hopkins University; 2016. Preliminary report validated by Ministry of Health, March 2017.

through the introduction of community-based ART at all drop-in centers (DICs) in Yaoundé, Douala and Bamenda with on-going data collection activities underway to document successes and provide data for quality improvement processes.

DRAFT

# Introduction

## Evaluation Purpose

The USAID/West Africa, Cameroon field office requested a mid-term performance evaluation to determine which approaches are contributing towards the USAID-funded “Continuum of Prevention, Care and Treatment (CoPCT) of HIV/AIDS with Most at-Risk Populations in Cameroon (CHAMP)” program’s purpose to “improve the Government’s and civil society technical capacity to implement evidence-based prevention, care and treatment services to key populations in Cameroon,” and the extent to which this program purpose will likely be achieved at the end of the program in 2019.

## Evaluation Questions

The evaluation team sought to answer questions related to two key evaluation objectives as follows:

- **Objective 1 of scope** - To determine the extent to which CHAMP’s program purpose is likely to be achieved by April 2019
  1. What is the current level of achievement of targets?
  2. What are challenges encountered so far and how have these been addressed?
  
- **Objective 2 of scope** – To determine which approach is effectively contributing towards the CHAMP program purpose:
  1. What are specific lessons learned from the CHAMP program that can be applied in the future?
  2. What approaches can be prioritized to improve overall program performance in the second half of implementation?

# Project Background

## HIV Epidemiology to Date

Cameroon is in the midst of a generalized HIV epidemic with overall prevalence of 4.3%, according to 2011 data.<sup>3</sup> Age and gender variations are significant with a substantially higher rate among women (5.6%) than men (2.9%). While HIV prevalence is less than 5% in the general population, prevalence among key populations such as men who have sex with men (MSM) and female sex workers (FSW) is significantly higher. A 2009 study estimated HIV prevalence of 37% among FSW<sup>4</sup>, and a 2011 IBBS study estimated HIV prevalence of 44.4% in Yaoundé and 25.5% in Douala for MSM.<sup>5</sup> In September 2017,

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<sup>3</sup> Comité National de Lutte contre le Sida (CNLS), UNAIDS. Rapport national de suivi de la déclaration politique sur le VIH/SIDA Cameroun: Global AIDS Response Program (GARP). Yaoundé: CNLS, 2014.

<sup>4</sup> Tamoufe U, Medang R. Sero-epidemiological and behavioural investigation of HIV/AIDS and syphilis in Cameroon sex workers: Final report. Yaoundé: UNFPA, Johns Hopkins University and Global Viral; 2010.

<sup>5</sup> Park JN, et al. HIV prevalence and factors associated with HIV infection among men who have sex with men in Cameroon. J Int AIDS Soc. 2013;16(Suppl 3):18752.



JHU/Metabiota as part of the CHAMP project, published IBBS data from 2016 for key populations in Yaoundé, Douala, Bamenda, Bertoua, and Kribi.<sup>6</sup> The study estimated overall HIV prevalence of 24.3% for FSW and 20.7% for MSM, with significant variations by city. HIV prevalence estimates were 21.1% for FSW and 43.1% for MSM in Yaoundé; 30.3% for FSW and 20.5% for MSM in Douala; 33.9% for FSW and 1.7% for MSM in Bamenda; 18.7% for FSW and 7.2% for MSM in Bertoua; and 13.6% for FSW and 3.0% for MSM in Kribi. This study also estimated population sizes of 8,948 FSW and 4,967 MSM in Yaoundé, 9,105 FSW and 5,069 MSM in Douala, and 1,334 FSW and 705 MSM in Bamenda. A recent World Bank study estimated 112,580 FSW nationally, with 6,596 in Yaoundé, 7,557 in Douala, and 1,975 in Bamenda.<sup>7</sup>

Antiretroviral treatment (ART) coverage in Cameroon is estimated at 32%, with 205,359 people living with HIV (PLHIV) on ART.<sup>8</sup> Limited data is available on ART coverage for KP in Cameroon, with some evidence of substantially lower ART coverage for KP than for the general population. One 2014 study found that across seven cities in Cameroon, between 0% to 25% of FSW and MSM living with HIV were on ART.<sup>9</sup>

## National HIV Response

Even though Cameroon's National HIV/AIDS Strategic Plans (NSP) have identified KP as a priority, funding in this area has been limited and primarily financed by PEPFAR and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). Based on the most recent National AIDS Spending Assessments, 3.4% of HIV/AIDS-related expenditures were allocated under KP programming in 2014. This decreased to 2.1% in 2015.

A review of the previous NSP (2011-2015) shows that the Cameroonian government did not implement activities targeting KP.<sup>10</sup> The follow-on NSP (2014-2017) included KP programming as a priority area<sup>11</sup> and this was retained in the Global Fund New Funding Model concept note (January 2016 - December 2017).<sup>12</sup>

## PEPFAR Cameroon

PEPFAR Cameroon's annual budget has steadily increased from \$14.25 million in its FY 2011 Country Operational Plan (COP) to \$46.61 million in FY 2017 COP – investments in KP programming have historically ranged from \$3 - \$4 million since FY 2011. USAID is the only PEPFAR agency supporting community-based KP interventions.

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<sup>6</sup> 2016 IBBS Report among Key Populations in Cameroon: FSW and MSM. Yaoundé: Johns Hopkins University; 2016. Preliminary report validated by Ministry of Health, March 2017.

<sup>7</sup> World Bank. Mapping Female Sex Workers in Cameroon for HIV Program Design and Implementation, 2016.

<sup>8</sup> PEPFAR Cameroon COP 2017 Strategic Direction Summary, Cameroon, 2017.

<sup>9</sup> Holland CE, Fau PE, Billong SC, Tamoufe U, LeBreton M, Kamla A, et al. Antiretroviral treatment coverage for men who have sex with men and female sex workers living with HIV in Cameroon. *J Acquir Immune Defic Syndr*. 2015;68(Suppl 2):S232-40.

<sup>10</sup> Mid-Term Review of Cameroon HIV/AIDS National Strategic Plan, 2011-2015.

<sup>11</sup> Mid-Term Review of Cameroon HIV/AIDS National Strategic Plan, 2014-2017.

<sup>12</sup> Global Fund New Funding Model Concept Note, Cameroon (2016-2017).

## CHAMP and KP Program Shifts

The *Continuum of Prevention, Care and Treatment (CoPCT) of HIV/AIDS with Most at-Risk Populations in Cameroon* (CHAMP) project is a five-year (April 2014-April 2019) cooperative agreement between USAID and CARE International in Cameroon in collaboration with Johns Hopkins University (JHU), Global Viral (GV)/Metabiota, Moto Action, and seven local community-based organizations with the overarching goal to reduce HIV/STI infections and related morbidity and mortality, and ease the impact of HIV on the socioeconomic development of Cameroon.<sup>13</sup>

The CHAMP project is the successor to the HIV/AIDS Prevention Program (HAPP), funded by USAID and implemented from 2009 to 2013 in Cameroon, focusing on the provision of prevention services for most-at-risk populations (MARPs).<sup>14</sup> Significant achievements of HAPP included inclusion of MARPs in the National HIV/AIDS Strategic Plan and Global Fund concept note, condom and lubricant distribution and promotion, support for drop-in centers with volunteering doctors, systematic integration of prevention and care services, publication of IBBS data highlighting elevated HIV prevalence among MSM in Yaoundé and Douala, and the use of evidence-based geographic targeting of services. The HAPP program also revealed continuing challenges, including pervasive stigma and discrimination towards MARPs and PLHIV, low rates of testing among MARPs, limited and unstable treatment access, prohibitive costs for lab and ARV initiation, non-formal referral linkages to care and treatment facilities, and limited social welfare support.

The original CHAMP proposal submitted by CARE in 2014 focused on implementation of a continuum of prevention, care, and treatment services for key populations in five cities (Bertoua, Yaoundé, Douala, Bamenda, and Kribi). Relative to HAPP, CHAMP represented a significant financial and technical expansion of services, including an expansion of the role of drop-in centers, with the development of formal referrals and active case management for linkage and retention in care and treatment. As proposed, CBO capacity was to be developed through the creation of centers of excellence in Douala and Yaoundé, then expanded within the 5 provinces. While few KPs were able to access treatment services under HAPP, a major focus of CHAMP has been to improve the linkage of KPs to care and treatment. Likewise, CHAMP's package of services has included an increase in STI screening and treatment.

In 2015, PEPFAR globally adopted a strategic "pivot" towards populations at greatest risk and in geographic areas of greatest HIV burden, including at the sub-national level. Additional changes for PEPFAR Cameroon included the adoption of PEPFAR's Monitoring, Evaluation, and Reporting (MER) indicators and aggressive targets being set for the scale up of Test and Start, focused on ART initiation and retention.

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<sup>13</sup> CHAMP Revised Supplemental Program Description, 2016.

<sup>14</sup> HIV/AIDS Prevention Program (HAPP) Assessment, 2013.

In response to these policy changes, CHAMP proposed several significant shifts. This included a geographic shift from five to three cities (Douala, Yaoundé, and Bamenda), covering 11 sub-national units:

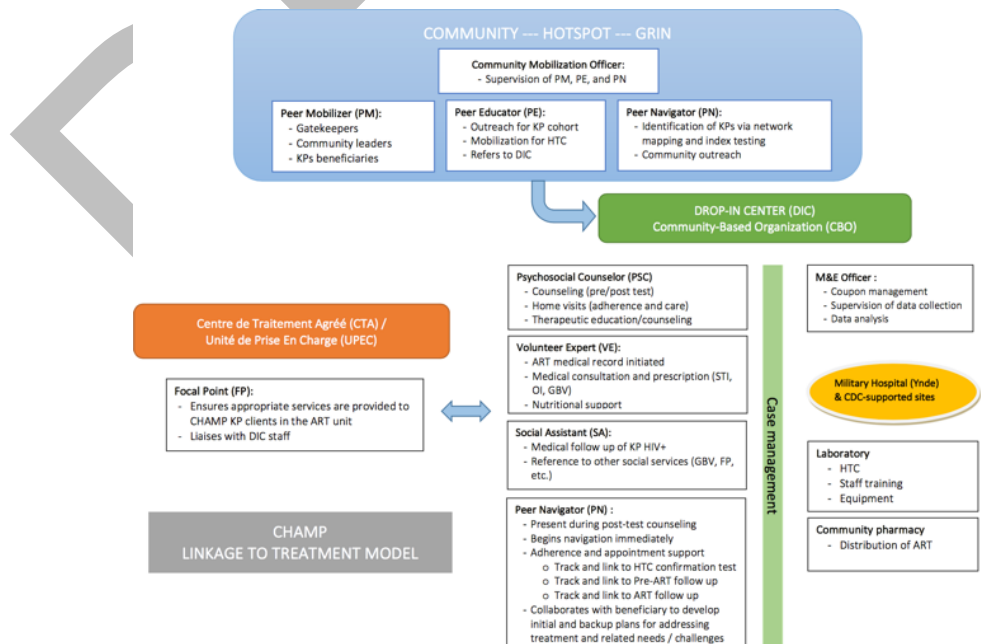
- Yaoundé: Djoungolo, Nkolndongo, Biyem Assi, Cite Verte, and Efulan health districts.
- Douala: Deido, Cite des Palmiers, Nylon, Bonassama, and New Bell health districts.
- Bamenda: Bamenda health district, which covers the city of Bamenda.

The programmatic shift included: (1) increasing the number of members of KP to be tested for HIV/AIDS; (2) improving ART coverage for KPs by making every effort to put all those who test positive into care and treatment, and (3) improving retention in treatment through stronger linkages between facility and community-based services and stronger community-based support for adherence and client follow-up.

The revised CHAMP framework has aimed to achieve the program purpose of “improving the Government’s and civil society technical capacity to implement evidence-based prevention, care and treatment services to key populations in Cameroon” through the following results: Result 1 – Technical competence of implementing of community and government partners to design, manage, and implement programs for key populations increased; Result 2 – Enabling environment for key populations HIV/AIDS programing strengthened; and Result 3 – Quality assurance/quality improvement and monitoring and evaluation systems strengthened among continuum of prevention-to-care (CoPTC) implementing partners.

CHAMP has developed an in-depth illustration of the program’s approaches to client flow through the continuum, with an emphasis on client mobilization approaches for HIV testing and case management for PLHIV at DICs in collaboration with referral sites:

### CHAMP Client Flow Algorithm Model



CHAMP has led and is planning to lead a series of research initiatives relevant to key populations in Cameroon. These include the 2016 IBBS & Viral Load Study, cohort studies, testing pilot studies (self-testing and HIV/Syphilis duo testing), Stigma index study, and a client study (modes of transmission). Findings from these studies are intended in part to inform and improve programming. For instance, CHAMP intends to use findings from the 2016 IBBS study addressing correlates of ART use to better understand factors that either inhibit ART use (e.g. health-related stigma for FSW and weekly alcohol consumption for MSM) or promote it (e.g. often receives emotional and social support for FSW and STI test in past year for MSM).<sup>15</sup>

In FY17, CHAMP began to identify and collaborate with institutions with expertise in working with orphans and vulnerable children (OVC) and HIV/AIDS among children. To this end, CHAMP has begun a collaboration with the Catholic Relief Services' "Key Interventions to Develop Systems and Services for Orphan and Vulnerable Children Populations in Cameroon" (KIDSS) program, including offering a package of testing and other social support services to children of FSW and their peers.

## **CHAMP Consortium and Partners**

The CHAMP consortium includes Johns Hopkins University (JHU), Metabiota (formerly Global Viral), and Moto Action.<sup>16</sup> CARE International is the prime recipient responsible for overall program management and coordination with external stakeholders; capacity building of CBO partners on rights-based KP and youth friendly programming, service delivery, project management and organizational development; Quality Improvement/Quality Assurance/M&E/Accountability; and development of a private sector engagement strategy and gender strategy, and knowledge management and learning. JHU is the principal sub-recipient responsible for the design and implementation of operational research in collaboration with Metabiota; capacity building for CARE and CBO staff on operational research; technical support on the design and implementation of feedback mechanisms from KPs to inform service enhancements; and design of the referral and client tracking system. Metabiota is responsible for implementation of operational research under JHU coordination, and strengthening of QA/QI through evaluation of effective training using ICT. Moto Action leads design and production of BCC materials, organizes MARP Forums on key programmatic themes, and manages the sub-grant for ESPK/Cap Santé.

In earlier years, FHI 360's LINKAGES project has provided technical assistance to CHAMP, including on innovative HIV cascade programming models; developing, operationalizing, and monitoring a minimum package of services for FSWs and MSM who report experiencing GBV; evaluating the effectiveness and functionality of the CHAMP UIC; STI testing and treatment policy; and ICT and innovative modalities for conducting outreach and recruitment.<sup>17</sup>

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<sup>15</sup> 2016 IBBS Report among Key Populations in Cameroon: FSW and MSM. Yaoundé: Johns Hopkins University; 2016. Preliminary report validated by Ministry of Health, March 2017.

<sup>16</sup> CHAMP Revised Supplemental Program Description, 2016.

<sup>17</sup> CHAMP Quarterly Reports for FY 2017, 2016-2017.

CHAMP has historically partnered with a number of CBO implementers, including Alternatives Cameroun, Horizons Femmes, ASAD, CMWA, Humanity First Cameroon, ESP CAP Santé, Affirmative Action, RENATA, Alcondoms, and ACAFOR. These CBO implementers have been responsible for planning and implementation of community outreach and other service delivery interventions; DIC-based service delivery (IEC, counseling, nutritional support, etc.); participation in operational research planning and implementation, mentoring of newly recruited CBOs on rights-based approach and standards of practice; management of operational relationships with partner health facilities (referrals and counter-referrals); piloting of GBV prevention and management strategy; representation of KPs in the Strategic Advisory Committee and community-based advocacy; and new DIC set-up for service delivery to KPs.

CHAMP has also partnered with two NGO implementers: CAMNAFAW and SWAA Littoral. These NGO implementers are responsible for community-based clinical services (STI management, FP, sexual and reproductive health, post-exposure prophylaxis, GBV care and support, other specialized services) for MSM and FSW; and HTC, referrals and counter-referrals interface with public health facilities. CAMNAFAW is the Principal Recipient for the Global Fund in Cameroon.

## **Evaluation Methods and Limitations**

The evaluation team conducted interviews and site visits with key program stakeholders between October 30<sup>th</sup> and November 17<sup>th</sup>. Informants included: representatives of the CHAMP program; CARE-USA and CARE-Cameroon; USAID/West Africa, Cameroon field office; U.S. Department of Defense, Cameroon; U.S. Centers for Disease Control and Prevention, Atlanta; U.S. Centers for Disease Control and Prevention, Cameroon; Cameroon Ministry of Public Health's National AIDS Control Council (CNLS), Department of Disease Control (DLMEP), and Department of Operational Research (DROS); Hopital Laquintinie and Mboppi Baptist Hospital in Douala; Global Fund to Fight AIDS, Tuberculosis, and Malaria; Global Fund principal recipient Cameroon National Planning Association for Family Welfare (CAMNAFAW); Catholic Relief Services, Cameroon; and community-based organizations Affirmative Action, Alcondoms, Alternatives, Cameroon Medical Women's Association (CMWA), Horizon Femmes, Humanity First, and RENATA. The team also conducted 11 focus groups with program beneficiaries, including KPLHIV.

The team used a modified version of the FHI 360 LINKAGES cascade assessment framework, which has been utilized to conduct joint interagency (including USAID, CDC, Global Fund, and local National AIDS Control Councils) assessments of key populations programming in Malawi, Cameroon, Central Asia Republic, Swaziland, Haiti, Angola, Nepal, Cote d'Ivoire, and Botswana.

The evaluation team focused on understanding the technical components of services offered for each cascade step, as well as how services were interlinked across cascade steps. At service delivery sites, the team sought to understand beneficiary flow through the cascade of services, service data, as well as perspectives of service providers. In addition, the evaluation team reviewed inputs relevant to

monitoring and evaluation, including programmatic data for each cascade step, M&E systems at the CBO and CHAMP level, patient tracking across the cascade, data quality, and data use for program planning and clinical management. While the evaluation team was able to gather sufficient data to present findings and recommendations for each cascade step and several cross-cutting issues, due to limitations of time and resources this evaluation cannot be considered a research activity generalizable to other settings, nor a comprehensive data gathering/validation exercise. Sites were chosen as a convenience sample based on where CHAMP has implemented programs for MSM and FSW.

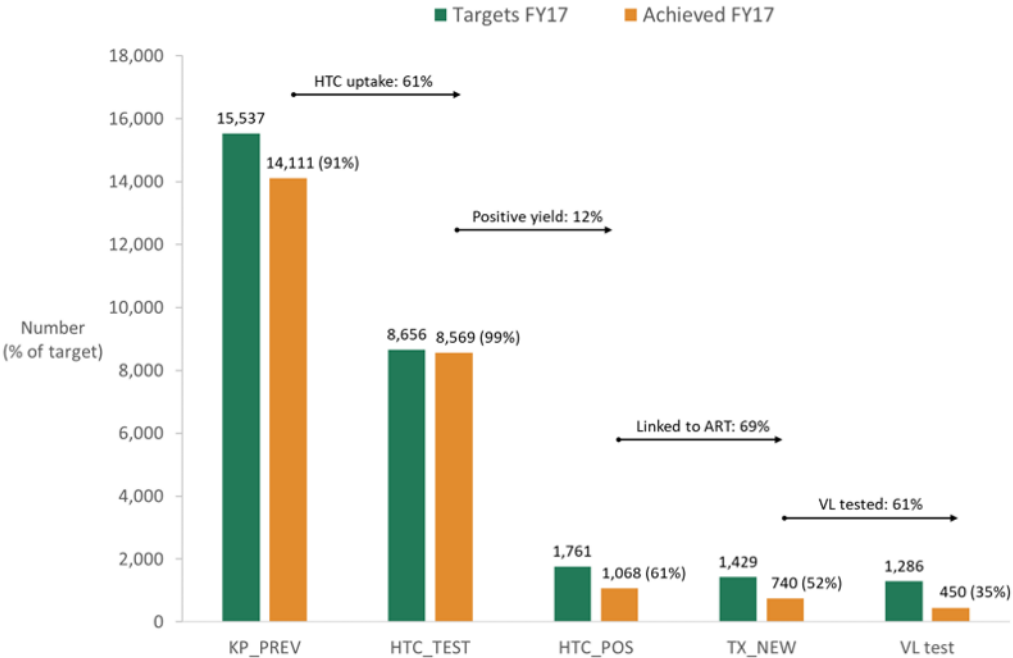
## Summary of Findings and Recommendations

The summarized findings and conclusions are grouped according to key segments of the cascade — reach, test, linkage to treatment, treatment, retention, viral load monitoring, cross-cutting issues, and monitoring and evaluation. Under each cascade heading, there is a summary of key strengths, challenges, and recommendations, as well as targets where relevant.

### CHAMP Cascade Results – FY17

In FY17, CHAMP came close to meeting its targets in most of the cascade steps for FSW and MSM. A description of the results for each target follows in the discussion of the cascade steps.

### FSW HIV cascade performance in FY17



# MSM HIV cascade performance in FY17



## Reach, Prevent, and Mobilize

### Targets:

KP\_PREV is a PEPFAR MER indicator defined as the number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required. For FY17, CHAMP's targets, as set by the PEPFAR Cameroon Country Operational Plan (COP), for KP\_PREV were 15,537 FSW and 8,794 MSM. CHAMP achieved most of its KP\_PREV targets, reaching 14,111 FSW (91% of target) and 7,476 MSM (85% of target). Factors affecting CHAMP's performance in FY17 are discussed below.

### Strengths:

The first cascade step for this evaluation was "reach, prevent, and mobilize," for which the evaluation team identified numerous strengths. In FY17, the CHAMP program implemented an enhanced peer mobilizer model (EPEM) using referral chain recruitment modalities to recruit members of key populations from social networks into HIV testing and counseling services. This model facilitated the achievement of impressive results in Q3 and Q4 of FY17 in reaching new networks and increasing testing and reach and identifying more new positives than in previous quarters. In addition, the program's focus on having peer educators conduct networking in the community and holding community social events (e.g. social activities, grins) significantly expanded the program's reach. Likewise, the program has promoted messaging that communicates the benefits of treatment, which along with the linkages provided by CBOs to treatment services, has increased the willingness of people to come forward. Other strengths identified by the evaluation team include the use of refined risk assessments and screening to

include gender and sexual diversity, violence and drug use; addressing the intersecting stigma of HIV and KP status(es); use of gatekeepers to safely reach risky hotspot areas at night; the provision of STI kits; engaging MSM through ICT and social media; and the use of detailed hotspot mapping informed by research in partnership with JHU.

### **Challenges:**

Several challenges were identified in this cascade step, including a suboptimal ratio of peer leaders to beneficiaries; all clinical services not being available at all drop-in centers (e.g. STI, hepatitis, syphilis screening, clinical examinations); cost and availability of treatment beyond STI kits covered by CAMNAFAW; no programming specifically for injecting drug users; security (when visiting high risk areas); several psychological problems and trauma for KPs; poverty and lack of resources; ICT work being nascent among some CBOs; and due to extensive stigma and discrimination, many KPs preferring to remain hidden.

### **Recommendations:**

- Continue process of microplanning with activities, targets, and services among peer leaders given evolving data and resources
- Continue to provide more social support (social activities, support groups)
- Intensified psychological staffing and counseling services, especially as treatment numbers increase, including issues related to gender and violence
- Explore how city campaigns could raise awareness of services, benefits of treatment, reduced side effects, testing, etc. (including reinforcing message that all Cameroonians deserve 100% access to treatment with zero discrimination)
- Collaborate with the Global Fund around drug use, following their mapping exercise (USAID could potentially collaborate on a pilot model)
- Continue to implement security measures for community outreach
- Need to coordinate and standardize ICT work among MSM CBOs (including using incentivized scheme to increase online outreach)
- Continue to expand OVC services

The “reach” cascade step is crucial for ensuring that communities are engaged and aware of clinical and social support services, and are mobilized to address human rights concerns relevant to key populations, including stigma and discrimination. In recent years, PEPFAR has focused on the KP\_PREV indicator to capture achievements made for this cascade step. In addition to meeting KP\_PREV targets for total number of community members reached with prevention services, highly-performing key populations programs incorporate programming to address a variety of health and social support needs.

As stated above, the CHAMP program has made impressive strides in reaching new social networks and providing comprehensive programming to attract and retain beneficiaries in services. In order to continue to reach new networks and deepen ties with existing networks, it is recommended that the program continue to conduct microplanning with peer leaders, and in particular, to refine ICT work with



MSM CBOs and expand OVC services, including provision of services for children of FSW. In addition, the program should continue to expand social support programming and provision of psychological services, including services addressing gender and violence, all of which keep beneficiaries engaged and reinforce HIV prevention. While the program has made important gains in conveying the benefits of HIV testing and treatment, these messages could be spread more widely by collaborating with city campaigns and by continuing to reinforce the message that all Cameroonians deserve full access to treatment without discrimination. Inclusion in the new Global Fund concept note of programming to address drug use offers another productive opportunity to widen and reinforce KP networks served by CHAMP. Finally, and particularly in light of several high-profile incidents of violence affecting FSW beneficiaries in 2017, the program should continue to implement security measures for community outreach.

## HIV Testing Services

### Targets:

HTC\_TST is a PEPFAR MER indicator defined as the number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results. For FY17, CHAMP's targets, as set by the PEPFAR Cameroon Country Operational Plan (COP), for HTC\_TST were 8,656 FSW and 5,377 MSM tested. CHAMP achieved most of its HTC\_TST targets, reaching 8,569 FSW (99% of target) and 4,623 MSM (86% of target). HTC\_POS is a PEPFAR MER indicator defined as the number of individuals who received positive test results. For FY17, CHAMP's targets for HTC\_POS were 1,761 FSW and 1,396 MSM. CHAMP fell short of its HTC\_POS targets, reaching 1,068 FSW (61% of target) and 509 MSM (36% of target). CHAMP calculated their positive yield results, or the percentage of beneficiaries testing positive, as being 12% for FSW and 11% for MSM.

Though CHAMP's positive yield results were significantly below their positive yield estimates (20% for FSW and 26% for MSM, based on prior IBBS studies), they were quite close to the "new HIV positive yield" figures identified in the 2016 IBBS study (13.4% for FSW and 13.2% for MSM). The IBBS study defined "new HIV positive yield" as estimated HIV prevalence minus those who self-reported positive. In addition, the IBBS had a more specific definition of KP to target those engaging in higher risk behaviors (FSW who practice sex work as their primary income; MSM who report anal sex in past year) compared to CHAMP's broader definitions of KP (FSW are women who report sex in exchange for money or goods, and MSM are men who report sex with men). Additional factors affecting CHAMP's performance in FY17 are discussed below.

### Strengths:

The second cascade step for this evaluation was HIV testing services, for which the evaluation team identified numerous strengths. One major strength of the program is the presence of CBO-run and accredited drop-in centers (DICs), providing HIV rapid testing by trained and accredited counselors, including post-test confirmation. In addition, the use of the incentivized EPDM model in recent quarters has increased the proportion of those reached who are being tested. Likewise, the EPDM model has facilitated an increase in community-based testing, offering more options for KPs to test regularly and to

provide testing services within new networks. Another strength emerges from CHAMP's research studies, with participants in the Duo Syphilis study being eligible for dual testing for syphilis and HIV, an important incentive given elevated co-infection rates among many KPs. The program also benefits from a recent shift to targeted testing of children of FSW, as well as clients of FSW. In particular, the 6% positive yield among clients of FSW underlines the importance of providing continued testing services for this population. Finally, beneficiaries reported satisfaction with all testing services being provided for free - a noted contrast to many health facilities in Cameroon where clients are required to pay out-of-pocket fees for many services, including HIV testing.

### **Challenges:**

The evaluation team identified several challenges for this cascade step. One challenge - reduced positive yield due to extensive HIV testing and counseling outreach - reflects the maturity of the program, as many positives closer to existing KP networks were tested in early program years and no longer require testing services. Reduced positive yield also likely reflects the benefits of the program's prevention efforts, resulting in more beneficiaries testing negative over time. Another significant challenge is the reluctance of some beneficiaries testing positive to notify their partners. Finally, for many KPs, after years of HIV outreach, the major draw to visit a drop-in center is no longer HIV testing but rather a desire to access comprehensive services, such as basic primary healthcare, including STI testing and treatment. In focus groups, beneficiaries expressed interest in having greater access to syphilis treatment (e.g. benzathine), hepatitis B screening and vaccinations, and in reducing stock-outs of commodities such as STI treatment kits.

### **Recommendations:**

- Explore peer assisted self-testing, with peers available for immediate follow up (including considering use of oral fluid testing)
- Continue expansion of STI testing and treatment (HBV, syphilis) with HIV testing (also consider other primary healthcare services, to generate demand)
- Task shifting of testing from nurses to lay workers
- Continue to expand index testing, both in terms of mothers to children and sexual/injecting partners, as part of targeted outreach
- Continue testing clients of FSW, and other high risk individuals in the hot spots, which will destigmatize testing and may include others who do not identify as KP
- Continue to track testing methodologies, including mobile testing, grins (small groups), EPEM, ICT/social media, etc. to determine whether recruitment varies in terms of age, risk, HIV yield, and other risk factors critical for program development and targeting

The recommendations for this cascade step are designed both to improve targeting of higher risk beneficiaries, as well as to offer more options for testing. Targeting can be improved via an expansion of index testing, including mothers to children and sexual/injecting partners, testing of clients of FSW and other high-risk individuals in hot spots, and conducting analysis of testing methodologies relative to various risk factors. Likewise, additional testing options could be offered via varied modalities such as

peer assisted self-testing, expansion of STI testing and treatment with HIV testing, and task shifting of testing from nurses to lay workers.

## Linkage to Treatment

### Targets:

TX\_NEW is a PEPFAR MER indicator defined as the number of adults and children newly receiving antiretroviral therapy (ART) in the reporting period. It is an indicator used as one measure of the success of a program in achieving linkage to treatment for program beneficiaries testing positive. For FY17, CHAMP's targets for this indicator were 1,429 FSW and 1,026 MSM. CHAMP fell short of its targets, with 740 FSW (52% of target) and 345 MSM (34% of target). Of 1,068 FSW testing positive in FY17, 69% were linked to ART. Of 590 MSM testing positive, 68% were linked to ART. Though below target, the proportion of KP linked to ART reflects significant improvement over previous years (14% for FSW and 1% for MSM in FY15; 31% for FSW and 57% for MSM in FY16). Factors affecting CHAMP's performance in FY17 are discussed below.

### Strengths:

The evaluation team identified numerous strengths for this cascade step, highlighting the shift from the predecessor HAPP project's prevention focus to CHAMP's full continuum of prevention, care, and treatment services. The program has invested in dedicated staff and resources to support linkages, including accompaniment (as part of the "handshake model") of beneficiaries by peer navigators and the provision of transportation reimbursements. Likewise, the program has made advancements in systematizing bidirectional referrals between CBO-supported peer navigators and linkage and referral agents (LRAs) based at referral health facilities. In addition, coordination between CBOs and health facilities is reinforced by monthly meetings of a consortium of stakeholders to address/increase linkage. At the CBO level, the program has invested in coaching and coordination with peer navigators, psychologists, and counselors to reinforce linkage best practices. In turn, peer navigators and counselors provide extensive follow-up to improve the acceptance of diagnosis by beneficiaries. Client tracking has improved with the matching of a beneficiary's CHAMP-assigned unique identifier code (UIC) with the national ART code assigned by the referral health facility. At the Alternatives drop-in center in Douala, ART initiation occurs on-site, further reducing barriers to linkage. Finally, the program has succeeded in waiving test fees at initiation, including eligibility testing fees that have traditionally been charged at many partner clinics and hospitals. These program strengths have together contributed to an admirable decrease in time from testing to treatment initiation, and a continued improvement in the rate of linkage from testing to treatment.

### Challenges:

The evaluation team identified several challenges for this cascade step. Even as some data indicate a decrease in time from testing to treatment initiation, more data is needed to appropriately monitor and evaluate the length of time for linkage to treatment. Likewise, several challenges persist at the facility level, including unsupportive/disengaged focal points at some facilities, long waiting times particularly at

non-CDC referral sites, continued stigma and discrimination towards KPs at some health facilities, continued reports of unnecessary fees and tests from some facilities, and not all facilities having formal focal points/agreements with CBOs. In addition, issues of denial of diagnosis, geographical transience, and psychological trauma affecting KPs all hinder efforts to increase linkage to treatment.

### **Recommendations:**

- Systematize analysis of data on number of days between diagnosis and initiation
- Use counseling data to identify specific client concerns or characteristics that require differentiated support to ensure successful linkage
- Consider expanding agreements and focal points to new facilities
- Engage in regular QA/QI process to identify supportive/engaged focal points and troubleshoot at facilities where focal points are unsupportive/disengaged
- Continue stigma and discrimination trainings among healthcare providers and facility staff at all levels, expanding beyond clinicians to engage anyone who may encounter patients
- Protect confidentiality by reducing questions about KP status at each service delivery point

CHAMP has recently made significant strides in improving the rate of linkage to treatment for beneficiaries testing positive. Recommendations for this cascade step are designed to improve these numbers further, ensuring that beneficiaries initiate treatment and do so with minimum delay. CHAMP's CommCare patient tracking platform already collects valuable data on the number of days between diagnosis and initiation for beneficiaries receiving services from each CBO site. Analysis of these data can be systematized to improve program planning and rectify gaps in service. CHAMP already collects extensive counseling data on beneficiaries, including those testing positive. These data can be systematically analyzed to offer differentiated support to improve linkage. Likewise, improvements can still be made at partner health facilities to facilitate linkage, including expanding partner agreements and adding focal points, troubleshooting when focal points are unsupportive/disengaged, expanding stigma and discrimination trainings, and reducing questions about KP status at each service delivery point.

## **HIV Treatment**

### **Strengths:**

The evaluation team noted numerous strengths for this cascade step. Of greatest note, 6 of the 8 drop-in centers have implemented ART community dispensation, with the remaining two planning to do so in early 2018. This process has occurred in tandem with the development of pharmacies on-site under the mentorship of partner health facilities. As a result, beneficiaries are increasingly able to receive ARV refills at drop-in centers, rather than at clinics and hospitals. The innovative partnership between Alternatives and Laquintinie hospital in Douala allows for the provision of a medical doctor on-site at the Alternatives drop-in center facilitating on-site treatment initiation. Likewise, more partner clinics and hospitals have clinical providers sensitized to KP needs and concerns due to CDC-supported KP-friendly trainings. These strengths together have contributed to an increasingly short time to ART initiation for

beneficiaries. At the same time, the implementation of the handshake model between peer navigators and linkage and retention agents is creating better connections between CBOs and facilities and resulting in better treatment outcomes for beneficiaries.

### **Challenges:**

Several significant challenges were noted for this cascade step. Of urgent importance is that many patients are being shut out of community dispensation due to extensive problems with viral load testing. Current protocols require that HIV patients receive two viral load test results indicating viral suppression, at six months and at one year after treatment initiation, which classifies them as “stable patients” and thereby eligible for community dispensation. However, the evaluation team found that beneficiaries faced many barriers in receiving these required viral load test results. In addition, even stable patients were not always able to receive 3 month prescriptions, in part due to continuing ARV supply chain issues. Beneficiaries reported a desire for a one-stop-shop model for treatment, with many expressing interest in community initiation and dispensation at DICs. However, current policies restrict ART initiation to doctors and ARV dispensation to doctors and nurses, creating additional barriers for drop-in centers to provide ART initiation and dispensation. While beneficiaries reported fewer issues with treatment side effects than with earlier treatment regimens, some beneficiaries continue to experience fatigue and/or drowsiness due to the efavirenz component of the primary first-line regimen, especially in the first month of treatment. Other significant challenges for this cascade step include that sensitivity training has not been universally applied at all partner health facility sites or all provider levels, or with other facility staff; mobility of KPs; and persistence of fees charged at health facilities.

### **Recommendations:**

- Systematic multi-month prescriptions for all stable patients (3 months)
- Task shifting for initiation from doctors to nurses
- Continue to explore shift to better ART regimens (i.e. dolutegravir) and work with supply chain to ensure necessary supply of medications for new patients as dispensation scales up
- Continue to work with lab to ensure that space is appropriate and can handle increased demands as more beneficiaries access treatment
- Monitor ratio of follow up for PLHIV - clinicians, counselors and peer navigators
- Demonstration sites for ART initiation in FSW and additional MSM sites to support community initiation (data driven with clinical partnership between hospitals and CBOs)
- Continue to monitor/provide ARV dispensation when KPs are in prison
- Use of technology for PLHIV to support each other, and coordination between peer navigators and CBOs (WhatsApp, listservs, etc)
- Fees specified and fixed (timing, prices)

Recommendations for this cascade step revolve primarily around expanding treatment modalities, and ensuring barriers to treatment are reduced or eliminated. Several important policies to pursue are the task shifting of treatment initiation from doctors to nurses, the expansion of treatment initiation at community sites, including for FSW and for sites in Yaoundé, and ensuring ARV dispensation for KPs in

prison. Likewise, barriers need to be eliminated for classifying beneficiaries as stable patients and ensuring 3 month prescriptions, including reinforcing the supply chain of medications and the capacity of labs to handle increased demands. As treatment numbers increase, it will be critical to carefully monitor the ratio of service providers (including clinicians, counselors, and peer navigators) to beneficiaries. Technology may play an important role in increasing support for KP PLHIV, including coordination between peer navigators and CBOs. Finally, in order to further curtail excessive fees imposed on patients, an important policy to pursue would be for health facilities to specify the timing and prices of all treatment-related fees.

## **Retention in Clinical Cascade**

### **Strengths:**

Several strengths were identified for this cascade step. The program has implemented activities and provided resources dedicated to improving retention of beneficiaries in the clinical cascade. These include provision of psychological counseling, adherence counseling, support groups, expanded follow up by peer navigators and counselors, and client satisfaction feedback loops. In addition, through a variety of activities, the program has increased awareness of the benefits of treatment, further incentivizing retention and limiting loss-to-follow-up. In addition, retention has been reinforced via monthly coordination meetings between CBOs and referral health facilities, and through the provision of multi-month prescriptions at some sites.

### **Challenges:**

Numerous challenges continue to hinder the retention of beneficiaries in the clinical cascade. These include a need for further programming to address mental health issues, substance use/addiction counseling, job training and economic strengthening, counseling for FSW on navigating relationships/partners, fear of stigma and discrimination, family counseling, the need for additional services for children of FSW, and periodic/temporary need for shelter for those experiencing family rejection and violence, particularly when facing incidents of violence. In addition, while community dispensation has helped many beneficiaries to be retained on treatment, the lack of second-line ARV regimens creates complications for beneficiaries either struggling with or resistant to first-line regimens. Finally, the repetitive questioning of KPs to name their KP status throughout the treatment process at all service delivery points at some referral hospitals (among stigmatized KPs and without auditory privacy) may also be a barrier to retention.

### **Recommendations:**

- Expand support groups
- Expand psychosocial counseling training and staff - mix of peer navigators, lay counselors, social workers, clinical psychologists
- Integrate more services for women with children if possible
- Provide family counseling options
- Formalize legal support to supplement collaboration with CAMNAFAW

- Continue client feedback loops
- Continue to expand program involvement from KPs including KPLHIV
- Continued KP sensitivity training of health providers to reduce stigmatizing behaviors

Recommendations for this cascade step build on existing CHAMP programming and address continued barriers in retaining KPLHIV in the clinical cascade. Several recommendations address psychological and social support needs, including the need for more support groups, counseling training and staff, and family counseling. Many FSW would benefit from integration of services with children, including OVC services. Likewise, additional formal legal support would benefit many beneficiaries. Finally, strengthening client feedback loops and expanding the involvement of KPs, including KPLHIV, in programming would reinforce retention in the clinical cascade.

## Viral Load Monitoring

### Targets:

CHAMP defines the indicator for VL Test Output as the number (proportion) of KPs tested for viral load. In FY17, CHAMP's targets for this indicator were 1,286 FSW and 923 MSM. CHAMP fell short of these targets, with 450 FSW (35% of target) and 243 MSM (26% of target) receiving a viral load test. As discussed below, underachievement of these targets largely reflected factors outside CHAMP's control in FY17.

### Strengths:

The evaluation team determined that this cascade step was experiencing many significant challenges. However, several important strengths were still noted. These include that an increasing number of patients are receiving viral load testing, sample collection is now occurring at many of the DICs, free viral load testing campaigns are periodically arranged for KPs, and there is an increasing understanding of what an undetectable viral load means for one's health and in terms of onward transmission of HIV.

### Challenges:

The evaluation team identified numerous urgent challenges, including excessive delays (>3 months) in processing viral load tests in some sites, which is delaying ART community dispensation and clinical monitoring of patients. Likewise, many health facility sites are experiencing frequent stock-outs and expiration of reagents. Demand is further reduced by the high cost of viral load testing (5000 CFA, equivalent to about \$10), the inadequacy of periodic free campaigns, and other tests being added on with additional fees. Finally, uninterrupted power supply is not available at all drop-in centers, thereby potentially compromising samples in the event of power outages.

### Recommendations:

- Immediate action required to follow up on delayed viral load samples with CDC and CHAMP with LRAs and PNs and CNLS RTG point-of-contact (need for regular schedule to monitor this situation moving forward, and to work out fees for KPs)

- Explore dried blood spot VL testing
- Continue to explore point-of-care VL testing at DICs (GeneXpert can also test for STIs and TB)

Recommendations for this cascade step address the urgent crisis of viral loading testing delays. CDC and CHAMP have agreed to set up a meeting with LRAs and PNs and the CNLS RTG POC to address these barriers, including working out fees for KPs. As alternatives to the current system, use of dried blood spot testing and point-of-care VL testing at DICs (including use of GeneXpert) can be explored for future approval and implementation.

## **Cross-Cutting Issues**

### **Enabling Environment**

#### **Strengths:**

The evaluation team identified some key strengths and improvements in creating an enabling environment. In the national context, KPs are included in the Cameroon National Strategy, as well as the Global Fund New Funding Model concept note and the PEPFAR COP, with the intention of developing KP friendly and appropriate services. Cameroon participated in the PLHIV Stigma Index 2.0 pilot study, which will provide data necessary to support advocacy around stigma and discrimination. Some sites have begun to offer legal services, in collaboration with CAMNAFAW and others, for GBV and to support those who are arrested. Beneficiaries also have a strong sense of their right to quality health services with zero discrimination, in line with the WHO and UNAIDS guidelines.

#### **Challenges:**

There are many challenges that remain as barriers to key populations accessing health services. Overall, poverty and social upheaval remain significant challenges. In focus group discussions, many beneficiaries noted poverty as a challenge to accessing facility services, as not all fees for visits and tests are waived. Long term beneficiaries were concerned that services that had previously been covered by CHAMP are no longer covered through the package of services that CDC provides. Facilities do not consistently apply fees for various services, nor is a standard package of services offered across facilities. This is a challenge for beneficiaries who may be unable to afford the additional tests or fees and may therefore be prohibited from obtaining “stable” status and starting community dispensation. Additionally, KPs continue to face increased stigma and discrimination and violence at all levels, including self-stigma (KP- and HIV-related), within KP groups, families, health centers/providers, communities, and society at large. Though health facility POCs have attended stigma reduction trainings, not all facility staff are trained, which leads to challenges when the trained facility POC is unavailable or transfers to another facility, and KPs must engage with untrained staff. Preliminary data from the PLHIV Stigma Index 2.0 pilot study in Cameroon has shown increased rates of stigma and discrimination for KPs accessing healthcare services, as compared to Uganda and Senegal. KPs continue to require significant psychosocial support, and services for GBV and mental health. Though some progress has been made with alerting police to health-related community outreach activities, there is still significant violence and



arrests by police in hotspots. Likewise, there are additional challenges with providing ART to KPs in prison.

### **Recommendations:**

- Continue sensitization of health care providers and facility staff at all levels
- Continue to use the PLHIV Stigma Index for advocacy and to improve programming
- Systematize and formalize national coordination of a technical working group for key populations, including CHAMP, CAMNAFAW, and CNLS
- Continue collaboration with CAMNAFAW and Global Fund for provision of legal services
- Explore potential for legal retainers for lawyers within CHAMP
- Explore ARV dispensation to KPs in prison
- Continue to frame human rights messages – the right to health access
- Continue to reinforce sense of patient rights for non-discrimination in access to quality health services in line with WHO and UNAIDS guidelines
- Continue to train/sensitize police to reduce interference to public health efforts and consider rewarding better community protection agents as allies for their role as positive change agents in the fight against HIV
- Support KPs in leadership development and strengthen their opportunity for career progression
- Continue to foster networks and alliances among all KPs (FSW, MSM, TG, and PWID)
- Ensure trauma response is incorporated into GBV screening
- Continue advocacy to limit and standardize fees and required tests within health system

Recommendations for this cascade step incorporate a variety of approaches to reinforce the growth of an enabling environment for key populations to access health services. At the national policy level, greater collaboration between stakeholders is encouraged through the development of a national technical working group for key populations. This would reinforce the existing collaboration between CAMNAFAW and Global Fund for the provision of legal services, as well as a potential approach to include legal retainers for lawyers within CHAMP's programming. Within the health system, it is recommended that human rights messages continue to frame health access, including reinforcing a sense of patient rights for non-discrimination in access to quality health services. Likewise, continued advocacy is needed to limit and standardize fees and required tests within the health system. Health providers and facility staff at all levels could benefit from further sensitization training to KP issues, as could police to reduce police interference with public health efforts. Within prisons, additional measures could be taken to ensure KPs maintain access to ARVs. At the community level, KP community members could benefit from leadership development and progression, including via the fostering of KP networks and alliances. Finally, additional research is needed on enabling environment issues, including via the PLHIV Stigma Index, which CHAMP is using for advocacy and to improve programming.

## **Program Management**

### **Strengths:**

CHAMP has made significant improvements in their active management of CBOs. CARE shares a common vision with the CBOs. WhatsApp has helped to increase the frequency of communication, and has allowed for the transfer of best practices between CBOs and Peer Navigators. The weekly meetings between CBOs and their CHAMP POCs have helped to improve communication and allow for real-time course correction and sharing of best practices. Additionally, the shared data platform, CommCare, enables consistency across CBOs and will allow for comparable data analyses across CBOs.

### **Challenges:**

Many challenges must still be addressed in regards to CHAMP program management. CHAMP has a significant staff load that has not been fully rationalized with the current technical needs of the program. Staffing and management turnover continue to be a challenge to consistency and institutional memory. CBOs also require additional technical support, specifically regarding recruitment from social networks, clinical management, and psychosocial counseling including gender-based violence. CBOs are supporting increasing numbers of beneficiaries, and provider caseloads have been increasing without a full understanding of the optimal beneficiary to peer or counselor ratio.

### **Recommendations:**

- Reinforce communication between CHAMP and CBOs, and between CBOs themselves, for capacity building, quality improvement, and learning
- Encourage capacity building efforts to engage KPs and build leadership within the KP communities
- Prioritize technical support staff and identify additional technical resources, including HQ support and medical student interns
- Emphasize importance of psychological support to programming
- Ensure appropriate use of social networks to target programming
- Reinforce clinical management components of program
- Reinforce data analysis and use for improved programming

Recommendations for program management address several continued areas for growth and improvement within CHAMP. Communication has improved due to recent measures, yet could still be reinforced for capacity building, quality improvement, and learning. KP leadership can continue to be developed via capacity building efforts, and technical support can be improved in part with HQ support. Psychological support can be emphasized for improved programming, as can the appropriate use of social networks, reinforced clinical management program components, and reinforced data analysis and use.

## **Monitoring and Evaluation System**

### **Strengths:**

CHAMP shows great improvement in monitoring and reporting since the DP visit in August. The team has instituted routine data quality checks at all sites ensuring that data entered into CommCare is

accurate. The team has focused on key MER indicators - KP\_PREV, HTS\_TST (including POS), TX\_NEW, and VL testing. For example, data entered into paper registers is transcribed into Nsamba by CBO staff within 24 hours. The data is then examined by CHAMP - comparing paper registers with Nsamba to ensure data matches.

CHAMP stands out among countries with its mobile data collection system, Nsamba (CommCare) implemented with nearly all CBOs. Subsequent training among CBO staff in Nsamba and how it works has enabled M&E staff to download and use the data for monitoring and program improvement. Use of a UIC enables Nsamba data to be linked to other data sources - e.g. the OVC program with CRS and facility data. Furthermore, outside data is input into Nsamba with recording of other UICs (e.g. from treatment facilities). By inputting this data the team has sidestepped the issue of multiple HIS until these systems can be harmonized.

The CBOs demonstrate clear tracking of key MER indicators on a monthly (and weekly) basis. Basic measures of success - targets reached, linkage to treatment are regularly tabulated and shared within the CBO and with CHAMP. For example, all CBOs have indicator targets and results displayed prominently in their offices. Each CBO has an M&E person assigned who regularly reviews the data as well as performs data analysis - primarily ad hoc depending on staff needs. For example, analyses are requested by technical staff (e.g. doctor). Finally, CBOs use data for advocacy as well as program improvement. For example, working with GBV program data, the staff was able to successfully advocate for more GBV programming.

### **Challenges:**

Extensive PEPFAR reporting requirements, especially during emergency period, have limited the bandwidth of people who could conduct data analysis and use. Weekly reporting to CHAMP and to USAID has consumed significant time and effort on behalf of the M&E staff and others - thus limiting their ability to do data analysis on both MER and other program indicators. Narrow focus on MER indicators leaves out other program indicators around quality of services, coverage of target population, and patient tracking, hindering the project's and PEPFAR's goals around the prevention, care, and treatment continuum.

Nsamba (CommCare) has limited analytical capabilities - CBO M&E staff typically download data into Excel for analysis. While an excellent data collection tool, CommCare needs to be supplemented with a data analysis/visualization tool such as Excel or Tableau. Additionally, a statistical package (R, Stata, SAS) would be helpful for more complex analyses. M&E staff have limited data analysis and visualization skills beyond Excel pivot tables and basic charts. Staff are eager to enhance their analytic skills and do more advanced analysis of data for program improvement - especially beyond MER indicators and basic cascades.

Lack of a comprehensive, updated overall analytic plan for the project leads to ad hoc, one-off analyses conducted by different CBOs without any learning or coordination on best practices or broadly applicable findings. An updated analytic plan with key questions and the means to answer those

questions would help direct M&E staff in better data collection, analysis, and visualization. Incomplete transition from paper registers to electronic systems invites poor data quality and consumes staff time and resources. In addition, double entry of data (both paper and electronic) means that counseling staff are not benefiting from the real time information that electronic records can provide - e.g. days since last visit, past referrals - that would improve patient management. Significant time is spent on repeating the same basic reports which, if streamlined, could free up time for additional analyses. There is no common automated dashboard of key MER indicators - CBOs appear to share data with CHAMP via Nsamba and complete their own individual cascades that are not shared with others. A common dashboard with key MER indicators, updated regularly would save significant time and effort around routine reporting. In addition, CHAMP could regularly share this dashboard with USAID/Cameroon, thus focusing biweekly check-ins on significant issues and not review of the cascades (unless flagged).

Finally, frequent data quality checks for Nsamba should be programmed into an Excel template for quick checks and corrections. Significant staff time is taken up by frequent data quality checks (twice weekly) where basic checks could be programmed into the Nsamba questions - preventing staff from entering wrong data, and flagging any errors for quick correction.

### **Recommendations:**

- CHAMP should develop an analytic plan, including M&E and technical staff, to direct data collection, analyses, and visualizations. Changes in the program since its inception necessitate a revised analytic plan. Questions developed with staff will inform data collection as key indicators are identified with corresponding calculations - e.g. days from test positive to treatment initiation requires data on the date someone tests positive and the date treatment begins. In the era of Test and Start, it is important to identify where this is successfully being implemented and among which KP. Analysis of this indicator will help flag barriers to Test and Start and where program staff need to focus.
- CHAMP should develop an M&E training plan incorporating software packages as well as data analysis for program improvement. The project has been responsive to M&E staff requests for training in Nsamba and EpiInfo. Going beyond training in data collection tools, the staff needs training in how to analyze the data collected. Advanced training in Excel and how to do analyses and visualizations would help staff to go beyond basic pivot tables (descriptive data) to do more analyses such as days from Test to Start, frequency of KP encounters, variations in age/sex/KP regarding testing and treatment etc. These analyses would help program staff better target key populations, improve quality of services and manage performance of CBOs and individuals (i.e. peer educators, peer navigators).
- CHAMP should work with USAID to streamline routine reporting on MER indicator. Demonstrated success in improving data quality over the past several months indicates the project is ready to transition to less frequent reporting on key MER indicators which would keep USAID informed while allowing CHAMP staff to expand their M&E efforts beyond weekly MER check-ins. Development of a basic dashboard, updated biweekly will allow USAID to see results and flag any major issues.

- CHAMP should develop an M&E guide for CBOs to ensure all are on the same page - using the same definitions across sites. Key MER indicators should be further clarified with CBOs so that it is clear what terms are being used - e.g. “community mobile” in HTS\_TST can refer to many non-facility, non-DIC outreach with or without a vehicle (e.g. van). Whereas DICs should be reported under “community VCT”. Additional custom indicators should be developed, preferably using Nsamba data. For example, “Days from Test Positive to Treatment Initiation” would use two dates collected by Nsamba. The indicator should be disaggregated by CBO, age/sex, and location (type of modality - e.g. DIC, hospital). Reference sheets should be developed and shared with all partners. Data should be reviewed regularly for program improvement. Research and other longer-term analyses (e.g cohort study) should be included as part of the guide in terms of identifying data needs and sources for these studies as well as alignment of data definitions and calculations.
- CHAMP should review - in conjunction with technical staff - the variables in Nsamba. The questions in Nsamba are oriented towards SOPs for counseling staff without clear consideration of the data collection needs. For example, “HIV\_test” has multiple answers which confuses analysis, such as “unclear, unknown, positive, negative, --, NULL”. A thorough review should address peer educator needs for information as well that converts into data for program analysis. Care should be taken to not lose any valuable longitudinal information.
- CHAMP should review Nsamba security concerns around data versus improved quality in program delivery. At this time, data is not stored locally on tablets due to security concerns (e.g. lost or stolen tablets, phones). However, this means that program staff such as peer educators do not have on hand information that would be helpful in providing services - e.g. days since last visit, recent referrals. The project should look at ways to enhance individual security around locally stored data - encryption, password protection, auto-lockout - to allow for better use of the data by program staff. This would have the added benefit of program staff being more invested in the quality and use of data collected. At other levels, access to data should be controlled based on “need-to-know”. Geo locations should be automatically encrypted once entered and further transfer of the data to higher levels should have automatic offsets so that any mapping that is done does not identify specific locations. Other personally identifiable information (name, address) should not go beyond the first level (ideally, it’s not collected at all).
- CHAMP should prioritize research and evaluation which demonstrates the value of the community-based model for ART. DICs should be evaluated for their effectiveness in linkage and adherence for treatment. A process evaluation would examine the various components of successful DIC-based initiation and dispensation for replication in other DICs.

## Next Steps

### Recommendations for Next Steps

The evaluation findings indicate that the CHAMP program has reached a significant milestone in moving the KP response and is poised to continue building the program through several key recommendations to further the reach, quality and coverage of the project moving forward. The highest priority recommendations are listed below:

- Continue to collaborate with Global Fund and CAMNAFAW to ensure synergy of proposed programming in new concept note (e.g. drug use, PrEP, self-testing, peer-mediated testing, human rights advocacy, legal services)
- Encourage leadership and capacity development of KPs at CBOs, including via exchanges and mentorship between CBOs and across countries in the region
- Expand and systematize use of Information, Communication Technology (ICT) and social media to reach MSM
- Continue to identify opportunities to reach clients and partners of KPs in hotspots
- Explore feasibility of expanding STI services available at DICs (e.g. benzathine treatment for syphilis, hepatitis vaccinations, etiological diagnosis of STIs, and anal health)
- Explore feasibility of including private sector health providers in provision of HIV and STI-related services at DICs and for referrals, including for ART initiation and STI treatment
- Expand community dispensation of ARVs at DICs for stable clients
- Expand community initiation of ART at DICs, including Yaoundé and sites serving FSW, via demonstration projects and studies to build the evidence base
- Expand provision of psychological services, including care provided by peer counselors, peer navigators, social workers, and psychologists, at DICs and linked health facilities
- Deepen collaboration with KIDSS program and other partners to provide services for vulnerable children of FSW, as well as adolescent girls and young women in or near KP hotspots
- Address pervasive challenges in conducting timely and accessible viral load testing, including exploring feasibility of new models of service delivery, e.g. dried-blood spot testing, procurement and use of GeneXpert at drop-in centers (DICs)
- Continue to use findings from research studies (e.g. IBBS, longitudinal cohort study, stigma index, dual HIV/syphilis testing) to inform data-driven rational targets for numbers of positives (HTC\_POS) and other related programming
- Develop an analytic plan, including M&E and technical staff, to direct data collection, analyses, and visualizations with data feedback mechanisms
- Work with USAID to streamline routine reporting on MER indicators

The evaluation team believes each of the recommended next steps has the potential to significantly improve programming for key populations, building on existing strengths and addressing challenges as CHAMP continues through the final phase of its five-year program. With successful implementation of these steps, it is anticipated that CHAMP will more fully realize its mandate to meet the needs of key populations across the continuum of prevention, care, and treatment of HIV/AIDS in Cameroon.

## **Conclusion**

From its start in 2014, and particularly from FY16 to FY17, CHAMP has shown great improvement through each step along the prevention, care and treatment cascade through the development of state

of the art approaches and best practices for KPs. CHAMP has cumulatively reached approximately 60,000 KPs in target areas with prevention and testing services and contributed, along with the Global Fund, to a documented decline in estimated HIV prevalence among female sex workers. Following Cameroon's adoption of HIV treatment for all in FY17, the program saw a dramatic expansion of services and increase in the number of KPs being initiated on life saving treatment, through treatment literacy, counseling, and peer navigation. In the final phase of the program through mid-2019, CHAMP is poised to continue to expand through the introduction of community-based ART at all drop-in centers in Yaoundé, Douala and Bamenda, with on-going data collection activities underway to document successes and provide data for quality improvement processes.

DRAFT

# Appendices

## List of Key Documents

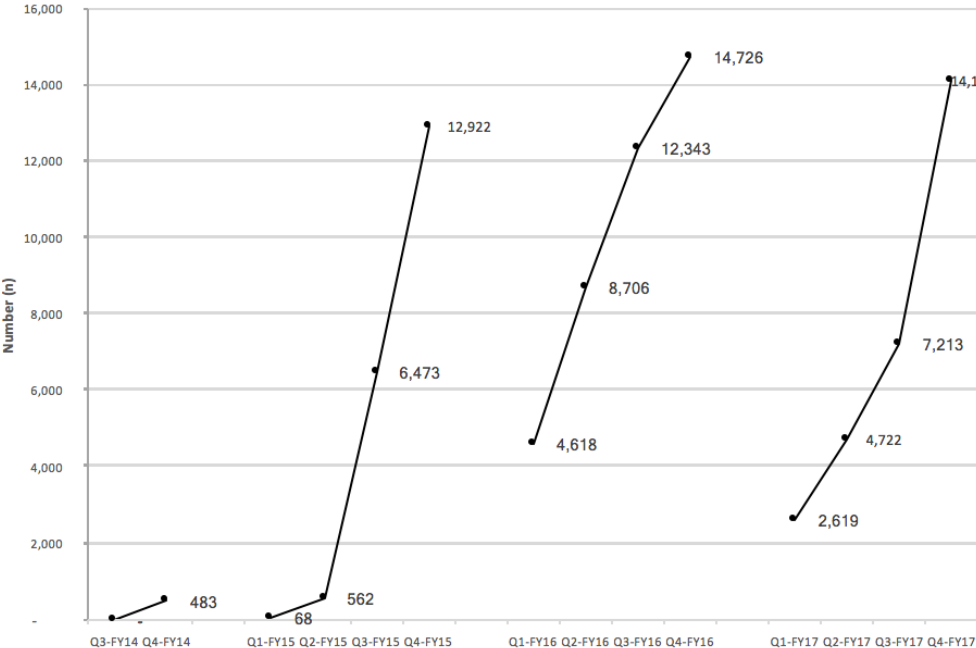
1. Tamoufe U, Medang R. Sero-epidemiological and behavioural investigation of HIV/AIDS and syphilis in Cameroon sex workers: Final report. Yaoundé: UNFPA, Johns Hopkins University and Global Viral, 2010 (*English*)
2. Mid-Term Review of Cameroon HIV/AIDS National Strategic Plan, 2011-2015 (*French*)
3. National Gender Policy of Cameroon, 2011-2020 (*English*)
4. HIV/AIDS Prevention Program (HAPP) Assessment, 2013 (*English*)
5. Park JN, et al. HIV prevalence and other factors associated with HIV infection among men who have sex with men in Cameroon. *J Int AIDS Soc.* 2013 ;16(Suppl 3):18752 (*English*)
6. Comité National de Lutte contre le SIDA (CNLS), UNAIDS. Rapport national de suivi de la déclaration politique sur le VIH/SIDA Cameroun: Global AIDS Response Program (GARP). Yaoundé: CNLS, 2014 (*French*)
7. Multiple Indicator Cluster Survey, 2014 (*French*)
8. John Hopkins University/Global Viral research to prevention study, Cameroon (2014) (*English*)
9. Mid-Term Review of Cameroon HIV/AIDS National Strategic Plan, 2014-2017 (*French*)
10. CHAMP 5-Year Performance Monitoring and Evaluation Plan, 2014-2019 (*English*)
11. CHAMP Revised Supplemental Program Description, 2016 (*English*)
12. CHAMP Annual Report (2016) (*English*)
13. CHAMP Meeting Reports/Newsletters – 2016 (*English*)
14. CHAMP Quarterly Reports for FY 2017, 2016-2017 (*English*)
15. KP Regional Meeting Notes (2016) (*English*)
16. Report from the PEPFAR Clinical Cascade Consultation in Cameroon, 2016 (*English*)
17. Technical Recommendations: Core Package of Interventions for AGYW in Cameroon, 2016 (*English*)
18. Technical Recommendations: PMTCT and KPs Cameroon, 2016 (*English*)
19. 2016 IBBS Report among Key Populations in Cameroon: FSW and MSM. Yaoundé: Johns Hopkins University; 2016 (*English*)
20. World Bank. Mapping Female Sex Workers in Cameroon for HIV Program Design and Implementation. Washington DC: World Bank, 2016 (*English*)
21. Global Financing Facility investment case, 2016 (*French*)
22. Global Fund New Funding Model Concept Note, Cameroon (2016-2017) (*French*)
23. 2016 IBBS Report among Key Populations: FSW and MSM. Yaoundé: Johns Hopkins University; 2016. Preliminary report validated by Ministry of Health, March 2017 (*English*)
24. PEPFAR Cameroon COP 2017 Strategic Direction Summary, 2017 (*English*)
25. PLHIV Stigma Index 2.0 Pilot Study Slides (2017) (*English*)
26. **Not yet available.** New Cameroon HIV/AIDS National Strategic Plan
27. **Not yet available.** Global Fund New Funding Model Concept Note (2018-2019)



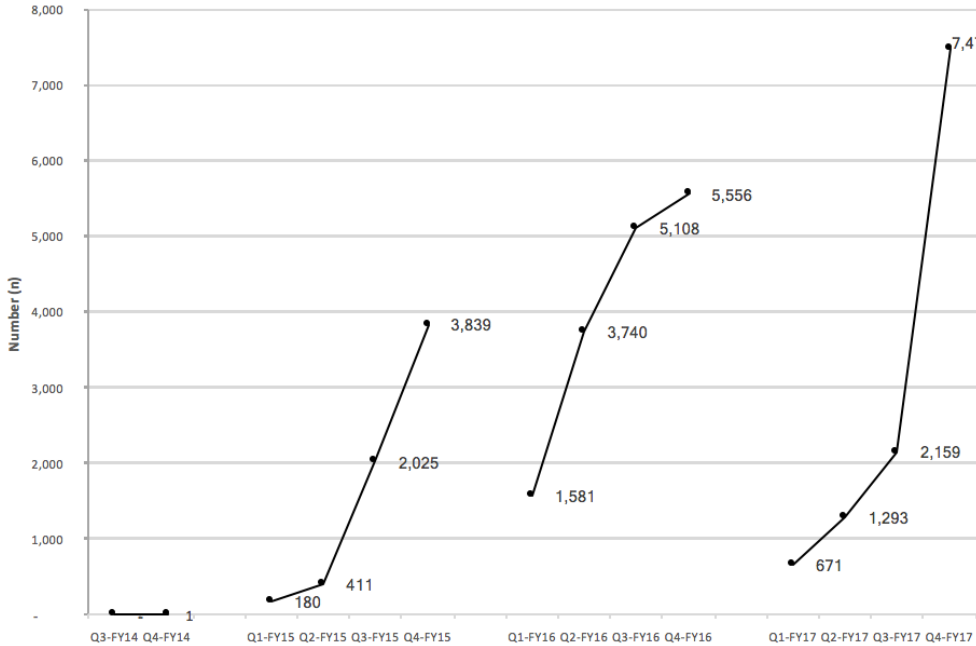
# Prevention, Care, and Treatment Cascades and Program Data

## CHAMP Program Data – FY14-FY17

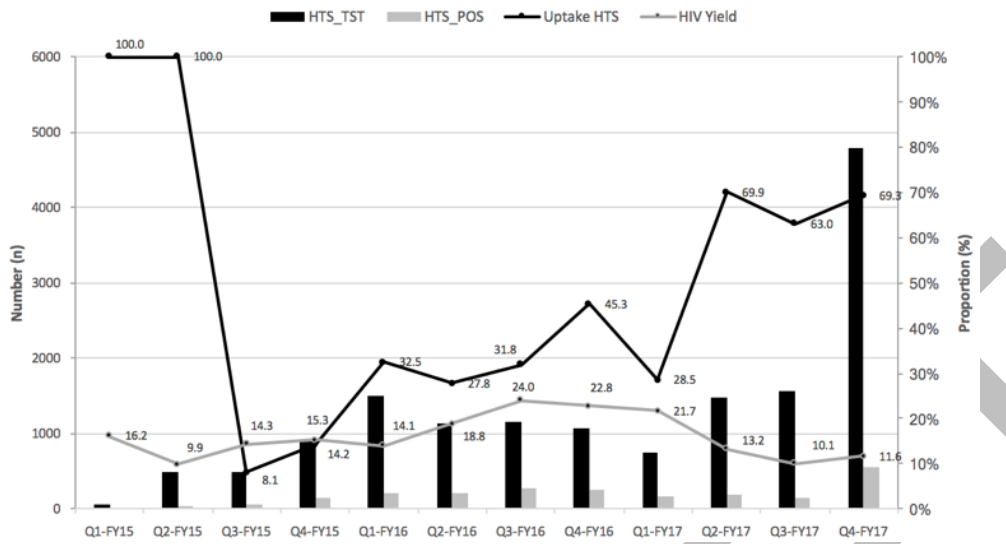
Cumulative annual reach among FSW: Oct'14-Sep'17



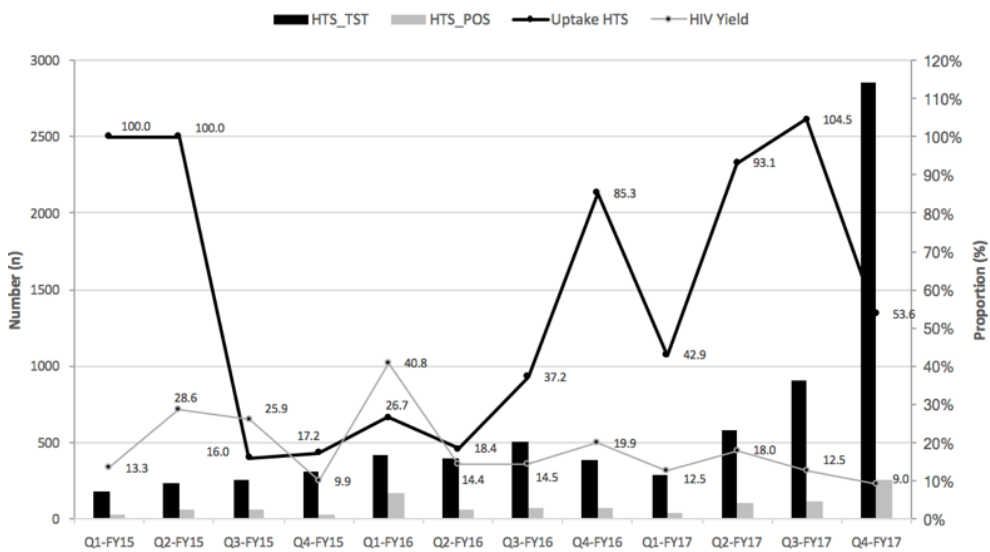
Cumulative annual reach among MSM: Oct'14-Sep'17



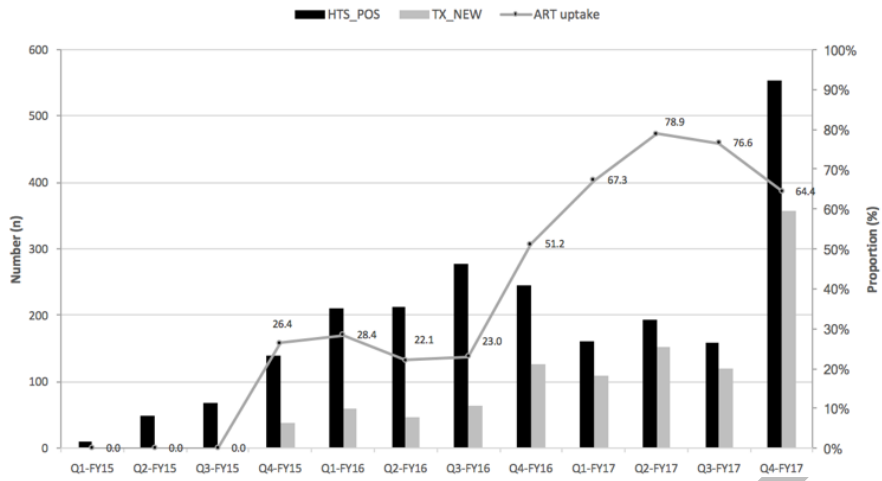
### HIV testing and positivity among FSW: Oct'14-Sep'17



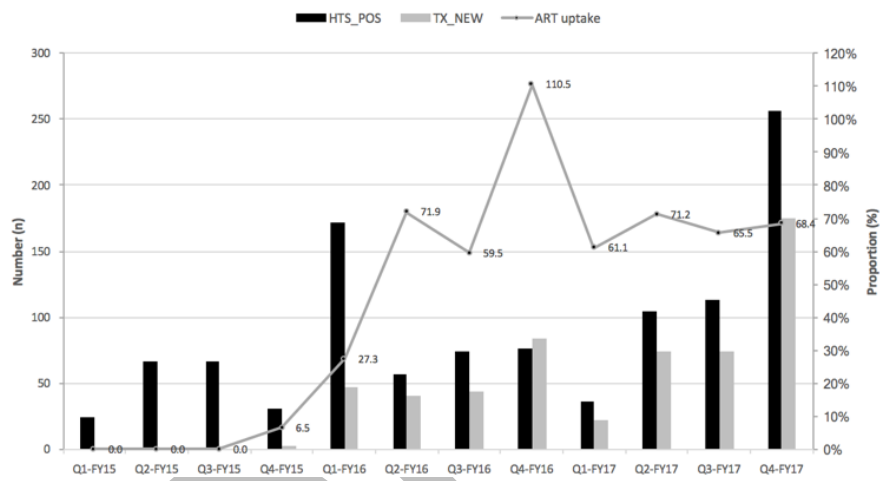
### HIV testing and positivity among MSM: Oct'14-Sep'17



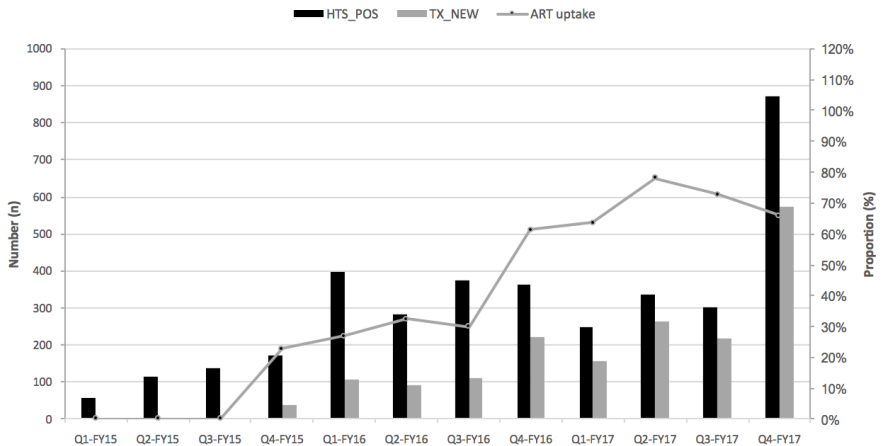
### FSW newly enrolled on ART: Oct'14-Sep'17



### MSM newly enrolled on ART: Oct'14-Sep'17



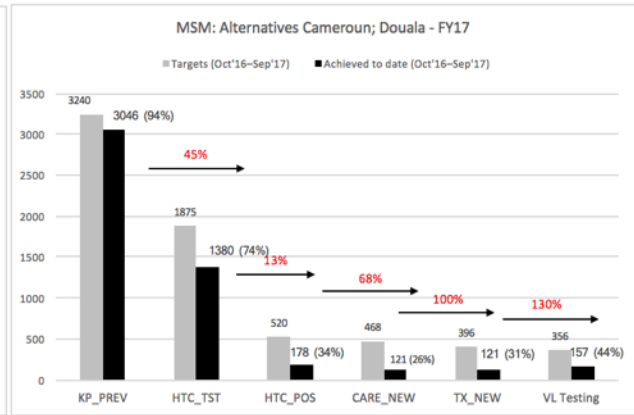
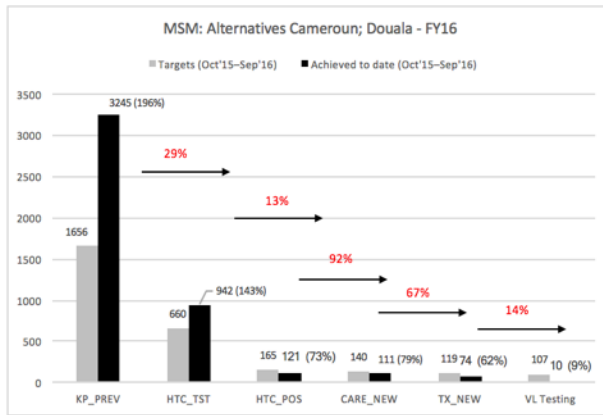
### KP newly enrolled on ART: Oct'14-Sep'17 (includes FSW, MSM and clients of FSW)



# CBO Cascades – FY16-FY17

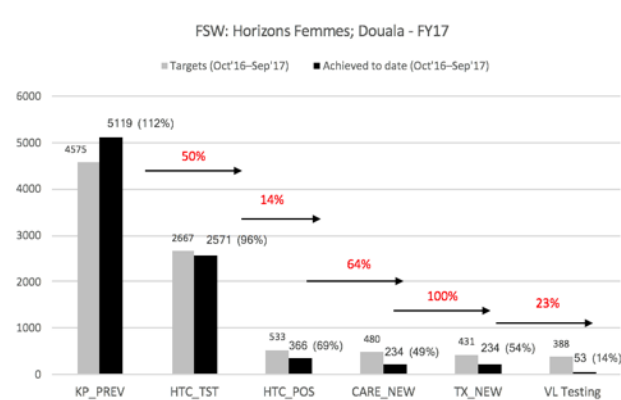
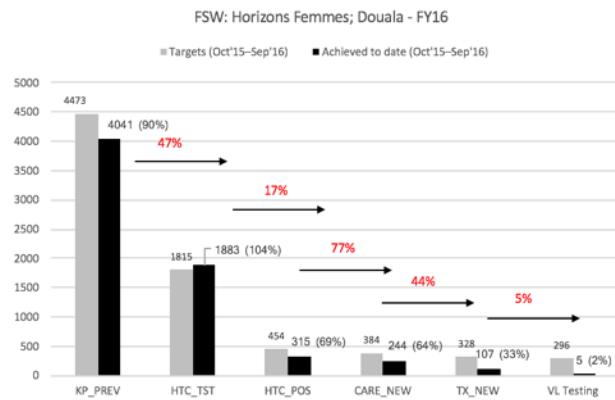
## Alternatives – Douala

### HIV CASCADE FOR FY16 AND FY17



# Horizons Femmes – Douala

### FSW: ANNUAL CASCADE FOR FY16 And FY17



# Alcondoms - Douala

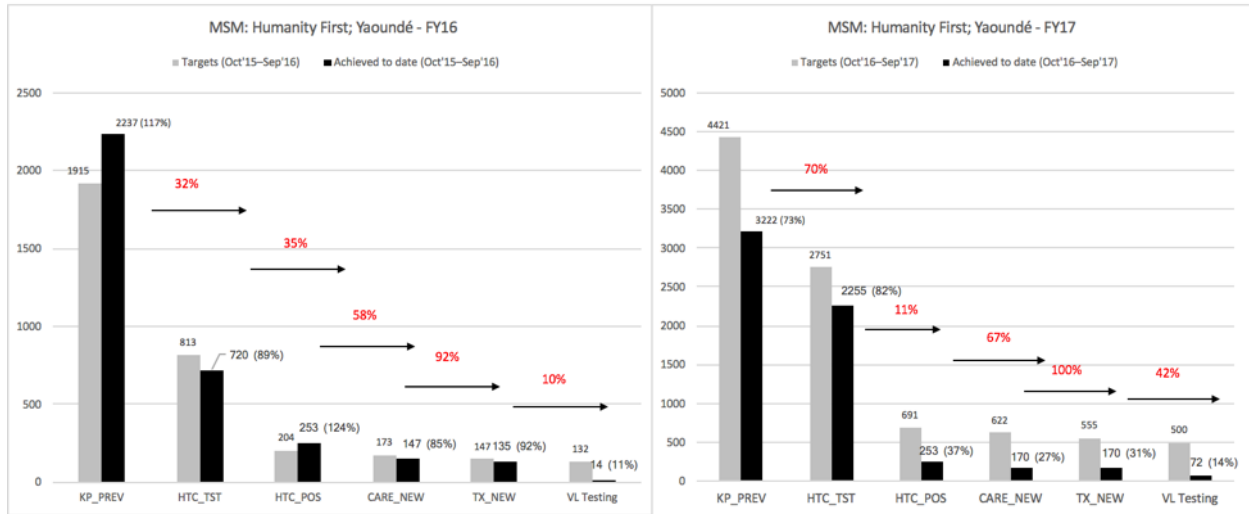
## REALISATIONS

MSM	NEW	OLD	TOTAL
Kp-prev	628	54	682
HTC-TST	213	21	234
POS	29	9	38
TX-NEW	35		35

TS	NEW	TOTAL
Kp-prev	33	682
HTC-TST	27	234
POS	7	38
TX-NEW	7	35

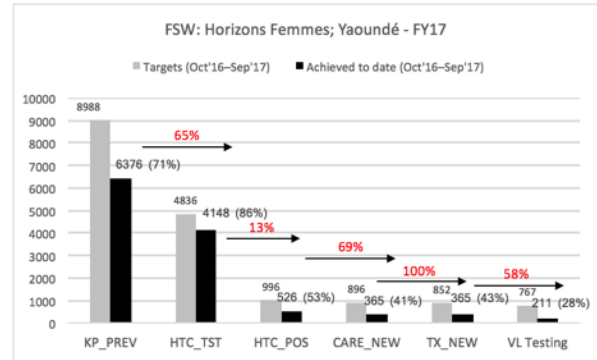
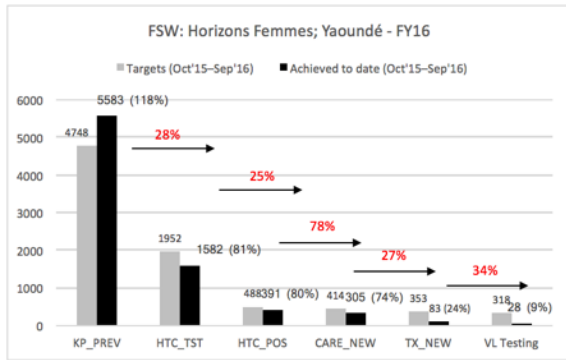
# Humanity First - Yaoundé

## Overview of HIV cascade



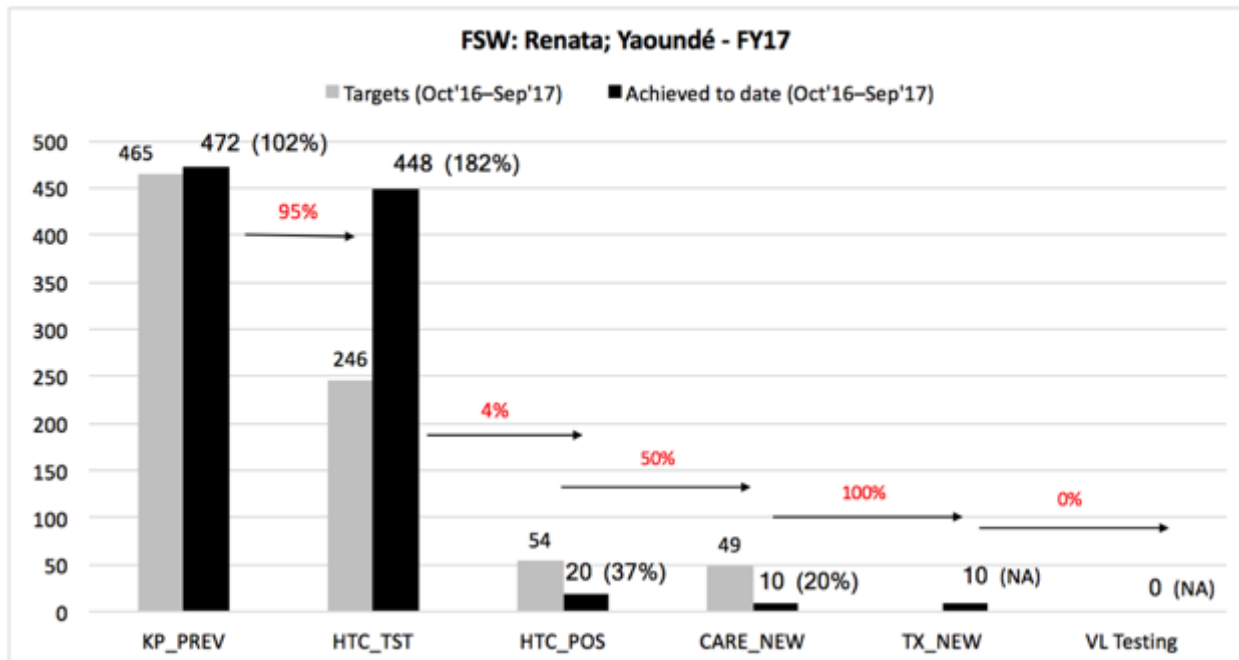
## Horizons Femmes – Yaoundé

### FSW: HIV Cascade - Horizons Femmes Yaounde, FY16 & FY17



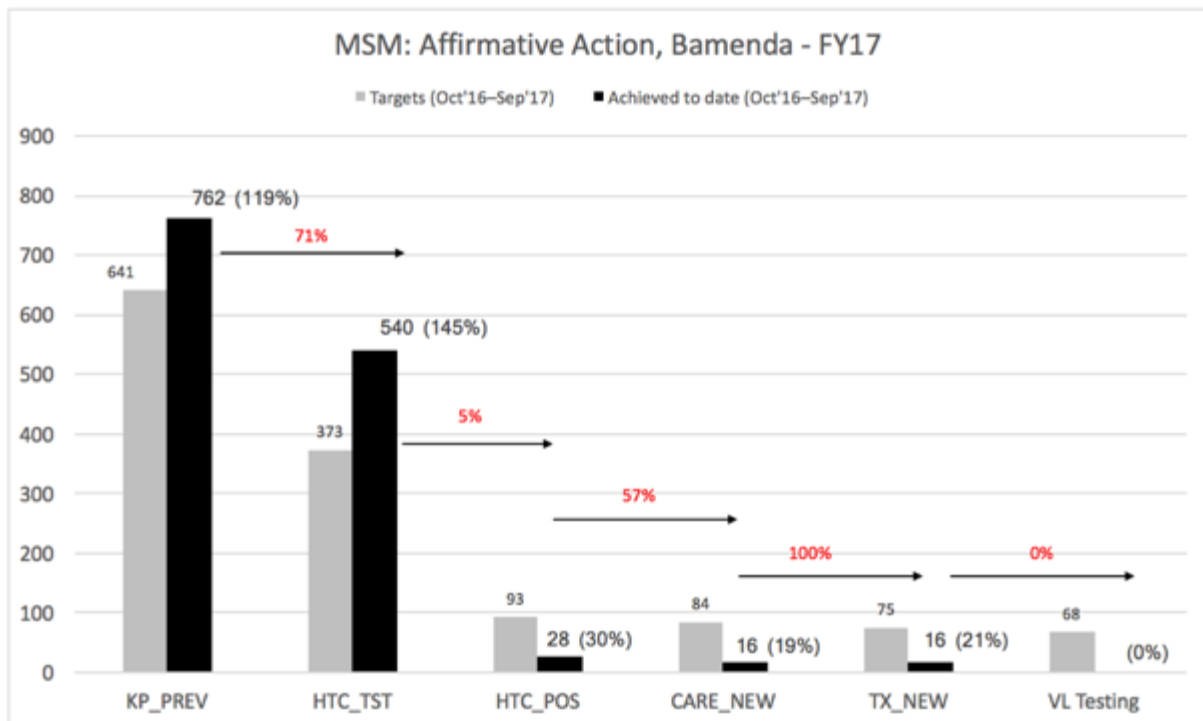
## RENATA – Yaoundé

### FSW: HIV cascade FY17



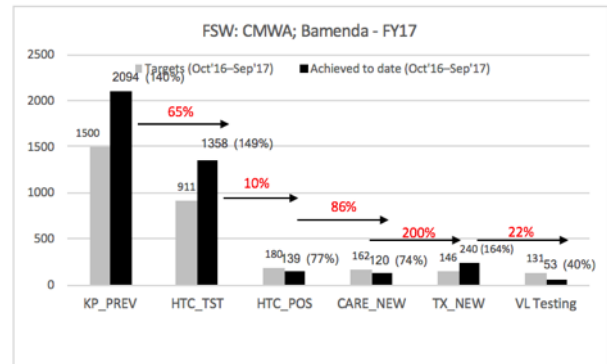
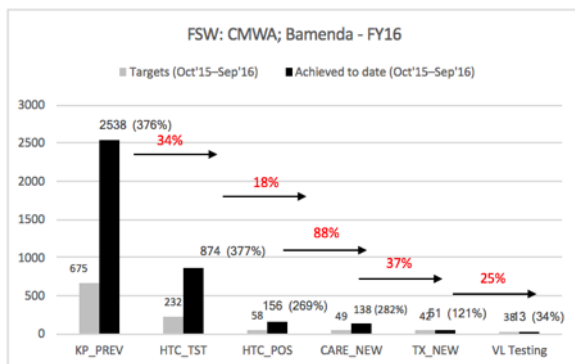
## Affirmative Action - Bamenda

# Overview of HIV cascade



## CMWA - Bamenda

# Overview of HIV cascade (FY16 – FY17)





## Evaluation Team Composition

Name	Organization	Title
Cameron Wolf, PhD, ScM	USAID/Washington	Senior HIV/AIDS Advisor for Key Populations
Jessica Rose, ScM	USAID/Washington	Senior Technical Advisor, Strategic Information
Patrick Hazelton, MPP, MA	GH Pro for USAID/Washington	Key Populations Programs Consultant
Megan Murdock	USAID/Washington	Administrative Assistant



## Evaluation Framework and Tools

### LINKAGES HIV CASCADE FRAMEWORK (ADAPTED FOR CHAMP MID-TERM EVALUATION, NOV 2017)

Qualitative Cascade Assessment		
Cascade Step	Key Questions	Target Group for Questions
 <b>Identify key populations:</b> Number of people in a specific KP group in a given locality (size estimation)	<ol style="list-style-type: none"> <li>1. Are size estimates for KPs available for this geographic area (i.e., hot spots, city, or region)?</li> <li>2. Is this data appropriate for providing baseline data of the KP group in need of CoPCT services?</li> <li>3. What are the sources of the size-estimate data?</li> <li>4. How are KP members connected to HIV-prevention services?</li> </ol>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• NGO/CBO service providers</li> </ul>
<b>CHAMP 2017 Probes</b> <i>(Focus on Strengths, Challenges, Priorities)</i>	<ol style="list-style-type: none"> <li>5. How have the results of the 2016 IBBS (JHU/CHAMP) affected knowledge of the number of KP people in Cameroon?</li> <li>6. How have the results of the 2016 IBBS affected knowledge of the number of KP people in Yaoundé, Douala, and Bamenda?</li> </ol>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> </ul>
 <b>Reach key populations:</b> Number of individual KP members reached by community outreach workers or through other programming	<ol style="list-style-type: none"> <li>1. What strategies are being used to reach KP?</li> <li>2. What HIV-related services are currently provided?</li> <li>3. What activities do you implement that increase the demand and use of HIV services by KPs?</li> <li>4. What strategies do you use to promote demand for HIV testing, care, and treatment services? Be specific on each point of the</li> </ol>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• NGO/CBO service providers (including staff and peer volunteers)</li> </ul>




## Qualitative Cascade Assessment

Cascade Step	Key Questions	Target Group for Questions
	<p>cascade.</p> <p>5. How do you communicate the positive benefits of medical treatment for HIV to beneficiaries? How do they respond?</p> <p>6. What system is used to provide referrals to HCT?</p>	
<p><b>CHAMP 2017 Probes</b> <i>(Focus on Strengths, Challenges, Priorities)</i></p>	<p>7. To what extent is CHAMP conducting hotspot mapping in all focal districts and working with CBO partners to micro-plan and monitor outreach interventions?</p> <p>8. How has use of the enhanced peer mobiliser model (EPM) affected the reach of KPs?</p> <p>9. How is CHAMP using social media and other online social platforms to reach KPs, especially MSM?</p> <p>10. To what extent are KPs reached online being registered with a UIC and tracked through points of service delivery along the cascade?</p> <p>11. How is CHAMP using “gatekeepers” and community leaders to improve recruitment of KPs?</p> <p>12. How is CHAMP addressing low treatment literacy, “double stigma,” self-stigma, gender-based violence, and concerns about confidentiality and privacy among KPs?</p> <p>13. How is CHAMP using the Nsamba client tracking and data collection system to track clients along the cascade?</p> <p>14. How are condoms and lubricants being allocated and distributed to KPs?</p>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• NGO/CBO service providers</li> </ul>
<p> <b>Test key populations:</b> Number of KP members who received HCT and their test results</p>	<p>1. Describe the HIV testing services available in this area for KPs (who and where)?</p> <p>2. What opportunities are there to provide more community-based and rapid HIV testing?</p> <p>3. What approaches are used to promote HCT?</p>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• NGO/CBO service providers (including staff and peer volunteers)</li> </ul>
<p> <b>Diagnose PLHIV:</b> Number of KP members who received HIV-positive test results and post-test counseling</p>	<p>4. Do you offer testing services for KPs when they come in for other services? Which services? Is this systematic?</p> <p>5. What types of referrals to HIV testing are currently being implemented? How can referrals to HCT be improved?</p> <p>6. How long (on average) does a client have to wait for HCT services (from entry to clinic to receiving result)?</p> <p>7. What percentage of clients tested receive their test results? How can the drop-off be reduced</p>	<ul style="list-style-type: none"> <li>• HCT service providers (including health facilities, NGO drop-in centers, outreach services, confirmation test sites, others)</li> <li>• Key population beneficiaries (accessing HCT)</li> </ul>



### Qualitative Cascade Assessment

Cascade Step	Key Questions	Target Group for Questions
	<p>between testing and collection of results?</p> <p style="padding-left: 20px;">a. Are same-day test results provided? How long do clients have to wait for results?</p> <p>8. Do clients have to travel to another location for confirmation of a positive HIV test result? If yes, describe the process and time required.</p> <p>9. Is client feedback on satisfaction with services documented? If so, how?</p> <p>10. How are HIV-negative clients followed-up for HIV-prevention services?</p> <p>11. How are HIV-positive clients linked or referred to care and treatment sites?</p> <p>12. How do you ensure that beneficiary privacy and confidentiality are protected? (Is the policy posted?)</p> <p>13. How do you communicate to beneficiaries that their privacy and confidentiality will be protected?</p> <p>14. How do you ensure that KPs feel welcome and respected?</p>	
<p><b>CHAMP 2017 Probes</b> (Focus on Strengths, Challenges, Priorities)</p>	<p>15. To what extent are KPs able to make use of web-based referrals and appointments for HTS and other psychosocial and clinical services at DICs?</p> <p>16. How are the unique identifier code (UIC) system and Nsamba CommCare platform being used to provide HTS?</p> <p>17. What options are available to KP clients who prefer to access services at non-KP focused sites?</p> <p>18. To what extent are lay counselors playing a role in the provision of community-based HTS, including rapid finger prick testing and piloting of oral testing?</p> <p>19. How is CHAMP supporting DICs to ensure that the promotion and provision of HTS are catered to the specific needs of FSW, MSM, and TG?</p> <p>20. How is CHAMP supporting DICs, both relay and stand-alone, to ensure that the promotion and provision of HTS are integrated with onsite STI diagnosis and treatment services, as well as GBV prevention and care, sexual, reproductive health and family planning, and other relevant services?</p>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• NGO/CBO service providers (including staff and volunteers)</li> </ul>

### Qualitative Cascade Assessment

Cascade Step	Key Questions	Target Group for Questions
	21. How is CHAMP supporting KPs who elect to seek services in health facilities other than those with formal relationships to CHAMP? 22. How is the “test and triage” approach being used for HTS, including the delivery of oral fluid HIV testing through trained peer educators/navigators? 23. To what extent are HIV self-testing (HIVST) and PrEP being considered as part of the package of services for KPs?	
 <b>Enroll in care:</b> Number of HIV-positive KPs enrolled in clinical care	1. How do HIV-testing providers follow-up to ensure that diagnosed PLHIV reach and enroll at the care site? 2. What are the key factors (enablers or barriers) affecting enrollment in the care process? 3. How do you ensure that beneficiary privacy and confidentiality are protected? (Is the policy posted?) 4. How do you communicate to beneficiaries that their privacy and confidentiality will be protected? 5. How do you ensure that KPs feel welcome and respected? 6. Are there peer navigators, case managers, or others to guide or accompany newly diagnosed PLHIV to care and treatment sites? 7. What is the process to enroll clients in care? 8. What services are provided during this pre-ART period (including management of OIs)? 9. What are the main challenges or causes of attrition during pre-ART? 10. Describe the process of assessing ART eligibility for a patient. 11. What are the reasons for deferring ART in those who are eligible? 12. Describe how a client transitions from enrollment in care to ART initiation. 13. How do testing and treatment providers communicate the positive benefits of medical treatment for HIV-positive beneficiaries? How do they respond?	<ul style="list-style-type: none"> <li>• NGO/CBO service providers (including staff and peer volunteers)</li> <li>• HCT service providers (including health facilities, NGO drop-in centers, outreach services, confirmation test sites, others)</li> <li>• Care and treatment sites</li> <li>• PLHIV groups (accessing HCT)</li> </ul>
<b>CHAMP 2017 Probes</b> <i>(Focus on Strengths, Challenges, Priorities)</i>	14. How have recent policy changes, such as Test and Treat, affected to what extent KPs are enrolled in care vs. initiated and sustained on ART?	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> </ul>

## Qualitative Cascade Assessment





Cascade Step	Key Questions	Target Group for Questions
 <b>Initiate ART:</b> Number of HIV-positive KP members enrolled on ART in accordance with the nationally approved protocol or WHO standards	<ol style="list-style-type: none"> <li>1. What is the time lag between enrollment in care and initiation on ART?</li> <li>2. What steps are taken to support adherence (i.e., adherence counseling sessions, treatment buddy, family adherence supporter)?</li> <li>3. How do ART providers follow-up to monitor adherence (pill count, questions during patient visits)?</li> <li>4. Where do patients go to pick up their ART pills? How frequently? Do they have a buffer supply on hand?</li> <li>5. How do you manage the side effects of ART?</li> <li>6. Describe how patients are reminded of their appointments.</li> <li>7. What system is used to follow-up on missed appointments?</li> <li>8. What community-based support services for those on ART (e.g., PLHIV support groups) are available?</li> <li>9. What motivates PLHIV to remain on ART?</li> <li>10. What are the reasons for attrition during ART care?</li> <li>11. How do you ensure that beneficiary privacy and confidentiality are always protected? (Is the policy posted?)</li> <li>12. How do you communicate to beneficiaries that their privacy and confidentiality will be always be protected?</li> <li>13. How do you ensure that KPs never feel unwelcome or disrespected as they continue in treatment?</li> <li>14. What fees are present that beneficiaries have to pay to initiate and remain on ART? If patients cannot pay those fees, what happens?</li> <li>15. What methods do you use to follow up on patients who have died or self-transferred to other sites? How could this be improved?</li> </ol>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• NGO/CBO service providers (including staff and peer volunteers supporting adherence)</li> <li>• Care and treatment sites</li> <li>• PLHIV groups (accessing HCT)</li> </ul>
 <b>Sustain on ART:</b> Number of HIV-positive KP members known to be alive and on treatment 12 months after initiation of ART		
<b>CHAMP 2017 Probes</b> <i>(Focus on Strengths, Challenges, Priorities)</i>	<ol style="list-style-type: none"> <li>16. How is CHAMP working with CBO partners and the government to roll out an <i>Integrated Stigma Mitigation Intervention</i> to address stigma in the healthcare setting and to improve clinical competencies in the delivery of services to KPs?</li> <li>17. How is CHAMP using peer navigation to improve referral, linkage, adherence counseling, and psychosocial services to KPs?</li> </ol>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• NGO/CBO providers</li> <li>• Care and treatment sites</li> <li>• PLHIV groups (accessing HCT)</li> </ul>

### Qualitative Cascade Assessment





Cascade Step	Key Questions	Target Group for Questions
	<ol style="list-style-type: none"> <li>18. How is the Nsamba client tracking system being used to ensure clients effectively access referral services and are not lost to follow up?</li> <li>19. How are “Hub and Spoke” service delivery models in focal districts being used to address transportation costs and time requirements and to minimize loss-to-follow-up?</li> <li>20. How are CHAMP-supported high-volume drop-in centers (DICs) being used to provide services, including dispensation of ART and drawing of laboratory samples?</li> <li>21. How is CHAMP coordinating with other PEPFAR recipients, including CDC and DOD, to provide KP clinical services?</li> <li>22. How is CHAMP coordinating with Baptist Health Cooperation which is supporting Nkwen Baptist Health Centre?</li> <li>23. To what extent are treatment personnel being included in outreach activities with HTC, including relay counselors to ensure clients are effectively linked to referral sites?</li> <li>24. To what extent is CHAMP working with CBO partners and local leadership to promote regular (monthly) meetings between clinic, DIC staff, and relay counselors to review data, ensure clients are effectively tracked, and address barriers in a timely fashion?</li> <li>25. How is CHAMP working with CBO partners and service providers within focal sites to develop and implement differentiated treatment models to improve linkage to care and treatment to both public and private facilities?</li> <li>26. To what extent are CBOs that provide services focused on one key population subgroup supporting broader provision of services to other groups?</li> <li>27. How is the program ensuring that children of sex workers are provided with a standard package of OVC services?</li> <li>28. How is CHAMP working with CBO partners and the government to provide guidance at focal and referral sites on implementation of test and treat for key populations?</li> <li>29. To what extent are CBO partners providing nutritional support for the first six months for</li> </ol>	

Qualitative Cascade Assessment		
Cascade Step	Key Questions	Target Group for Questions
	<p>those newly initiated on ART?</p> <p>30. To what extent are referrals being made with other partner agencies including the World Food Program and KIDSS?</p> <p>31. How are partners trained on advanced adherence counseling, including the LIFE STEPS approach?</p> <p>32. How is the Nsamba platform used to track clients and provide services related to initiation and retention on ART?</p> <p>33. To what extent are stable patients able to visit a facility every three to six months, rather than every month?</p> <p>34. To what extent is the program using different modalities for supporting clients to opt for treatment outside of DICs and CHAMP-supported facilities, i.e. with the provision of fee vouchers?</p> <p>35. How is the program strengthening referral and management of STIs and opportunistic infections (OIs)?</p> <p>36. How is CHAMP working with MOPH and other relevant partners to avoid stock-outs of ARV drugs?</p>	
<p><b>VL</b> <b>Suppress viral loads:</b> Number of HIV-positive KP members on ART with suppressed viral load (&lt;1000 copies/ml)</p>	<p>1. Are ART patients routinely monitored using viral load tests? Please describe the criteria for and frequency of viral load testing.</p> <p>2. Describe the availability of viral load machines, and the process and cost of tests.</p> <p>3. How do you monitor and report on the viral load data?</p> <p>4. Is there a plan to scale-up viral load testing in the country?</p> <p>5. What challenges are there in terms of supply systems for ARV drugs and lab reagents?</p>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• Care and treatment sites</li> </ul>
<p><b>Cross-cutting Issues</b></p>	<p>1. Are there punitive laws and policies in place against KPs that may affect access to services?</p> <p>2. Are there reports from KPs on stigma and discrimination in the health care setting? If so, please describe what instances are reported.</p> <p>3. How can stigma and discrimination in health care settings be reduced?</p> <p>4. How are HIV-positive clients tracked across the cascade?</p> <p>5. Are user-friendly, reliable, and confidential data systems, including the use of unique</p>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• NGO/CBO service providers</li> <li>• Health facility staff</li> <li>• Key population beneficiaries (accessing HCT)</li> <li>• PLHIV groups (accessing HCT)</li> </ul>

Qualitative Cascade Assessment		
Cascade Step	Key Questions	Target Group for Questions
	<p>identifier codes, in place to track clients through the HIV cascade?</p> <p>6. What data are needed to monitor the HIV CoPCT over time?</p>	
<p><b>CHAMP 2017 Probes</b> (Focus on Strengths, Challenges, Priorities)</p>	<p>7. How is the program addressing and preventing gender-based violence (GBV) and other kinds of violence for KPs?</p> <p>8. To what extent is CHAMP engaging advocacy groups and journalists to promote an enabling environment for KP services?</p> <p>9. To what extent is CHAMP collaborating with CAMNAFAW and other partners for provision of services to KPs?</p> <p>10. How is CHAMP providing capacity building for M&amp;E, including an increase in data aggregation, analysis and use?</p> <p>11. How are M&amp;E systems being standardized between facilities and CBOs?</p>	<ul style="list-style-type: none"> <li>• CHAMP program staff</li> <li>• NGO/CBO providers</li> </ul>

Quantitative Cascade Assessment		
Cascade Step	Key Questions	Possible data sources/methods
 <p><b>Identify key populations:</b> Number of people in a specific KP group in a given locality (size estimation)</p>	<ol style="list-style-type: none"> <li>1. How many key-population members socialize in this geographic location?</li> <li>2. Where do key populations socialize?</li> </ol>	<ul style="list-style-type: none"> <li>• PLACE</li> <li>• PLACE Lite</li> <li>• Capture/recapture</li> <li>• RDS</li> <li>• Mathematical models</li> </ul>
 <p><b>Reach key populations:</b> Number of individual KPs reached by community-outreach workers or through other programming</p>	<ol style="list-style-type: none"> <li>1. Where can key populations be reached by services?</li> <li>2. How many key population members are reached by services during a specific time period?</li> </ol>	<ul style="list-style-type: none"> <li>• PLACE</li> <li>• PLACE Lite</li> <li>• Outreach program data</li> </ul>
 <p><b>Test key populations:</b> Number of KPs who received HCT and their test results</p>	<ol style="list-style-type: none"> <li>1. How many tests are conducted in target geographic areas?</li> <li>2. How many unique key-population members are tested?</li> </ol>	<ul style="list-style-type: none"> <li>• Outreach program data</li> <li>• PLACE</li> <li>• Population-based surveys</li> </ul>
 <p><b>Diagnose PLHIV:</b> Number of KP members who received HIV-positive test results and post-test</p>	<ol style="list-style-type: none"> <li>3. How many key-population members who did not previously know they were HIV-positive tested positive for HIV?</li> <li>4. What proportion of key-population members tested test positive for HIV?</li> </ol>	<ul style="list-style-type: none"> <li>• Outreach program data</li> <li>• PLACE</li> <li>• Population-based surveys</li> <li>• Household surveys</li> </ul>

## Quantitative Cascade Assessment

Cascade Step	Key Questions	Possible data sources/methods
counseling	<ol style="list-style-type: none"> <li>5. What proportion of people who test positive for HIV receive their results?</li> <li>6. What is the length of time from seroconversion to diagnosis?</li> </ol>	<ul style="list-style-type: none"> <li>• Mathematical models</li> </ul>
 <b>Enroll in care:</b> Number of HIV-positive KP members enrolled in clinical care	<ol style="list-style-type: none"> <li>1. What proportion of key-population members who tested positive for HIV are linked to care within 6 months? 12 months?</li> <li>2. Describe patterns of engagement in care: How frequently do visits occur?</li> <li>3. What proportion of key-population members who are linked to care are retained in care at 3, 6, 9, 12, and 18 months after linkage to care?</li> </ol>	<ul style="list-style-type: none"> <li>• PLACE</li> <li>• Government, NGO, and private health facilities' records</li> <li>• Electronic medical records</li> <li>• Patient reported outcomes</li> </ul>
 <b>Initiate ART:</b> Number of HIV-positive KP members enrolled on ART in accordance with nationally approved protocol or WHO standards	<ol style="list-style-type: none"> <li>1. What is the indication/current guideline for ART initiation?</li> <li>2. What is the length of time from linkage to care to ART initiation?</li> <li>3. What proportion of key-population members enter care with an indication for treatment (e.g., AIDS)?</li> <li>4. What is the length of time from linkage to care to first indication for treatment?</li> <li>5. What are the popular treatment regimens in this setting? What proportion of key-population members are initiated on each of these regimens?</li> </ol>	<ul style="list-style-type: none"> <li>• Clinic records</li> <li>• Electronic medical records</li> <li>• Pharmacy data</li> </ul>
 <b>Sustain on ART:</b> Number of HIV-positive KP members known to be alive and on treatment 12 months after initiation of ART	<ol style="list-style-type: none"> <li>1. What proportion of key-population members are adherent to ART at 3, 6, 9, 12, and 18 months after ART initiation?</li> <li>2. What is the length of time from ART initiation to loss to follow-up?</li> </ol>	<ul style="list-style-type: none"> <li>• PLACE</li> <li>• Pharmacy data</li> <li>• Electronic medical records</li> <li>• Patient reported outcomes</li> </ul>
 <b>Suppress viral loads:</b> Number of HIV-positive KP members on ART with suppressed viral load (<1000 copies/ml)	<ol style="list-style-type: none"> <li>1. What is the length of time from linkage to care to first viral load measurement?</li> <li>2. What is the length of time from ART initiation to first viral load measurement?</li> <li>3. What are the patterns of viral load monitoring?</li> <li>4. What proportion of key-population members have a suppressed viral load at 3, 6, 9, 12, and 18 months after ART initiation?</li> </ol>	<ul style="list-style-type: none"> <li>• Electronic medical records</li> <li>• Viral load laboratories</li> <li>• Supplemental viral load monitoring</li> </ul>



### Quantitative Cascade Assessment

Cascade Step	Key Questions	Possible data sources/methods
	<ol style="list-style-type: none"><li>5. What is the cumulative incidence of virologic suppression at 3, 6, 9, 12, and 18 months after ART initiation?</li><li>6. What is the cumulative incidence of virologic failure at 3, 6, 9, 12, and 18 months after ART initiation?</li><li>7. What are the characteristics of key-population members most (and least) likely to receive viral load monitoring?</li></ol>	

DRAFT





# Qualitative Interview Guides





## Tool A. NGO/CBO Service Provider

Country: \_\_\_\_\_ Reviewer: \_\_\_\_\_  
 City/Location: \_\_\_\_\_ Date: \_\_\_\_\_

Name of primary person interviewed: \_\_\_\_\_  
 Position: \_\_\_\_\_  
 NGO/CBO: \_\_\_\_\_

Name/position of each additional interviewee: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Cascade Step	Key Questions
 <b>Identify key populations</b>	1. Are size estimates for KPs available for this geographic area (e.g., hot spot, city or region)?
	2. Is this data appropriate for providing baseline data of the KP group in need of CoPCT services?
	3. What are the sources of the size-estimate data?
	4. What strategy is used to identify key populations?
	5. How are KP members connected to HIV-prevention services?
 <b>Reach key populations</b>	1. What strategies do you use to reach KPs?
	2. What HIV-related services do you currently provide?
	3. Please describe your outreach strategies.
	4. How do you create demand for HIV services?
	5. What strategies do you use to promote the understanding of HIV care and treatment?
	6. What system is used to provide referrals to HCT?
 <b>Test key populations</b>  <b>Diagnose PLHIV</b>	1. How can referrals to HIV testing be improved?
	2. What approaches are used to promote HCT?
	3. Describe the HIV-testing services available in this area for KPs (who and where)?
	4. Do you directly provide HCT services?
	5. Is provider-initiated testing applied for KP members who come in for other services?
	6. How long (on average) does a client have to wait for HCT services (from entry to clinic to receiving result)?
	7. Are there opportunities to provide more community-based and rapid HIV testing?
	8. Are same-day test results provided? How long do clients have to wait for results?
	9. What percentage of clients receive their test results? What could be done to reduce the drop of clients between testing and collection of results?
	10. Do clients have to travel to another location for confirmation of a positive HIV-test result? If yes, describe the process and time required.




Cascade Step	Key Questions
	11. Is client feedback on satisfaction with services documented? If so, how?
	12. How are HIV-negative clients followed for HIV-prevention services?
	13. How are HIV-positive clients linked or referred to care and treatment sites?
 <b>Enroll in care</b>	1. How do you follow up to ensure that diagnosed PLHIV reach and enroll at the care site?
	2. What are the key factors (enablers or barriers) affecting the enrollment in care process?
	3. Are there peer navigators, case managers, or others to guide or accompany newly diagnosed PLHIV to care and treatment sites?
	4. What process is used to enroll clients in care?
	5. What services are provided during this pre-ART period (including management of OIs)?
	6. What are the main challenges or causes of attrition during the pre-ART period?
	7. Describe the process to assess ART eligibility for a patient.
	8. What are the reasons for deferring ART in those that are eligible?
	9. Describe how a client transitions from enrolment in care to ART initiation.
 <b>Initiate ART</b>	1. What is the time lag between enrollment in care and initiation on ART?
 <b>Sustain on ART</b>	2. What steps are taken to support adherence (adherence-counseling sessions, treatment buddy, family adherence supporter)?
	3. How do ART providers follow up to monitor adherence (pill count, questions during patient visits)?
	4. Where do patients go to pick up their ART pills? How frequently? Do they have a buffer supply on hand?
	5. How do you define side effects and how do you manage them?
	6. Describe how patients are reminded of their appointments.
	7. What system is used to follow up on missed appointments?
	8. What community-based support services (e.g., PLHIV support groups) are available?
	9. What motivates PLHIV to remain on ART?
	10. What are the reasons for attrition during ART care?
 <b>Suppress viral loads</b>	1. Are ART patients routinely monitored using viral load tests? Please describe the criteria for and frequency of viral load testing.
	2. Describe the availability of viral load machines, and the process and cost of tests.
	3. How do you monitor and report on the viral load data?
	4. Is there a plan to scale up viral load testing in the country?
	5. What are the challenges in the supply systems for ARV drugs and laboratory reagents?
<b>Crosscutting Issues</b>	12. Are there punitive laws and policies in place against KPs that may affect access to services?
	13. Are there reports from KPs on stigma and discrimination in the health care setting? If so, please describe the kind of instances that are reported.
	14. How can stigma and discrimination in health care settings be reduced?
	15. How are HIV-positive clients tracked across the cascade?
	16. Are user-friendly, reliable, and confidential data systems, including the use of unique identifier codes, in place to track clients through the HIV cascade?
	17. What data are needed to monitor the HIV CoPCT over time?




## Tool B. Health Facility Service Provider

Country: \_\_\_\_\_ Reviewer: \_\_\_\_\_  
 City/Location: \_\_\_\_\_ Date: \_\_\_\_\_

Name of primary person interviewed: \_\_\_\_\_  
 Position: \_\_\_\_\_  
 NGO/CBO: \_\_\_\_\_

Name/position of each additional interviewee: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Cascade Step	Key Questions
 <b>Test key populations</b>  <b>Diagnose PLHIV</b>	1. How can referrals to HIV testing (from other services) be improved?
	2. Is provider-initiated testing applied for KP members who come in for other services?
	3. Describe the HIV-testing services available for KPs in this area (who and where)?
	4. How long (on average) does a client have to wait for HCT services (from entry to clinic to receiving result)?
	5. Are there opportunities to provide more community-based and rapid HIV testing?
	6. Are same-day test results provided? How long do clients have to wait for results?
	7. What percentage of clients receive their test results? What can be done to reduce the loss of clients between testing and the collection of results?
	8. Do clients have to travel to another location for confirmation of a positive HIV test? If yes, describe the process and time required.
	9. Is client feedback on satisfaction with services documented? If so, how?
	10. How are HIV-negative clients followed for HIV-prevention services?
	11. How are HIV-positive clients linked or referred to care and treatment sites?
 <b>Enroll in care</b>	1. How do you follow up to ensure that diagnosed PLHIV reach and enroll at the care site?
	2. What are the key factors (enablers or barriers) affecting the enrollment in care process?
	3. Do peer navigators, case managers, or others guide or accompany newly diagnosed PLHIV to care and treatment sites?
	4. What process is used to enroll clients in care?
	5. What services are provided during this pre-ART period (including management of OIs)?
	6. What are the main challenges or causes of attrition during pre-ART?
	7. Describe the process used to assess a patient's eligibility for ART.

Cascade Step	Key Questions
	8. What are the reasons for deferring ART for those who are eligible? 9. Describe how a client transitions from enrolment in care to ART initiation.
 <b>Initiate ART</b>	1. What is the time lag between enrollment in care and initiation on ART?
 <b>Sustain on ART</b>	2. What steps are taken to support adherence (adherence counseling sessions, treatment buddy, family adherence supporter)? 3. How do ART providers follow up to monitor adherence (pill count, questions during patient visits)? 4. Where do patients go to pick up their ART pills? How frequently? Do they have a buffer supply on hand? 5. How do you define side effects and how do you manage them? 6. Describe how patients are reminded of their appointments. 7. What system is used to follow up on missed appointments? 8. What community-based support services (e.g., PLHIV support groups) are available? 9. What motivates PLHIV to remain on ART? 10. What are the reasons for attrition during ART care?
 <b>Suppress viral loads</b>	1. Are ART patients routinely monitored using viral load tests? Please describe the criteria for and frequency of viral load testing. 2. Describe the availability of viral load machines, and the process and cost of tests. 3. How do you monitor and report on the viral load data? 4. Is there a plan to scale up viral load testing in the country? 5. What are the challenges in the supply systems for ARV drugs and laboratory reagents?
<b>Crosscutting Issues</b>	1. Are there punitive laws and policies in place against KPs that may affect access to services? 2. Are there reports from KPs on stigma and discrimination in the health care setting? If so, please describe the type of instances that have been reported. 3. How can stigma and discrimination in health care settings be reduced? 4. How are HIV-positive clients tracked across the cascade? 5. Are user-friendly, reliable, and confidential data systems, including the use of unique identifier codes, in place to track clients through the HIV cascade? 6. What data are needed to monitor the HIV CoPCT over time?

### Tool C. Focus Group Discussion — PLHIV


Country: \_\_\_\_\_






Reviewer: \_\_\_\_\_

City/Location: \_\_\_\_\_

Date: \_\_\_\_\_

Number of participants: \_\_\_\_\_



Cascade Step	Key Questions
 <b>Test key populations</b>	1. How were you first connected to HIV counseling and testing services? 2. Was it easy for you to access HIV testing? Please describe what made it easy and what made it difficult.


Cascade Step	Key Questions
 <b>Diagnose PLHIV</b>	3. Did you fully understand your test result? 4. Did you understand your options for follow-on care? 5. How were you linked or referred to a care and treatment site?
 <b>Enroll in care</b>	1. How long did you wait before you visited the referral site? Probe... 2. Did the HIV-testing provider follow up to determine whether you went to the care and treatment site? 3. What factors enabled your enrollment in care? 4. What were the barriers or challenges to enrolling in care? 5. Did a peer navigator, case manager, or other person guide or accompany you to the site? 6. What services did you receive once you were enrolled in care?
 <b>Initiate ART</b>	1. How long did you wait for ART once you were enrolled? 2. What steps do you take to make sure you adhere to your ART?
 <b>Sustain on ART</b>	3. Does anyone help you to adhere to your drugs? Please describe. 4. How frequently do you pick up your ART? Do you experience any challenges with this process? Have you ever run out of drugs? If so, what did you do? 5. What do you do if you have side effects to your treatment? 6. How do you keep track of your clinic appointments? 7. What community-based support services (e.g., PLHIV support groups) do you access? 8. What motivates you to remain on ART? 9. Have you ever stopped taking your ART? Explain why.
 <b>Suppress viral loads</b>	1. Have you ever received a viral load test? If yes, how often? 2. Do you have to pay for this service? If so, how much?
<b>Crosscutting Issues</b>	1. Are there laws and policies that make it challenging for you to access HIV or health services? 2. Have you experienced stigma and discrimination in the health care setting? If so, please describe. 3. How can stigma and discrimination in health care settings be reduced?

## Tool D. Focus Group Discussion — Key Populations

Country: \_\_\_\_\_  
 City/Location: \_\_\_\_\_  
 KP Group: \_\_\_\_\_

Reviewer: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Number of participants: \_\_\_\_\_








Cascade Step	Key Questions
 <b>Reach key populations</b>	1. How were you first connected to HIV-prevention services? 2. How can the prevention services be improved?
 <b>Test key populations</b>	1. How were you first connected to HIV counseling and testing services? 2. Was it easy for you to access HIV testing? Please describe what made it easy and what made it difficult.
<b>Diagnose</b>	3. Did you fully understand your test result?

Cascade Step	Key Questions
 <b>PLHIV</b>	4. How long did you have to wait for HCT services (from entry to clinic to receiving the result)?
	5. Did you understand what you had to do next after receiving your HIV test results?
	6. Are you planning on getting tested for HIV again in the future? Why or why not?
	7. How can HCT services be made more convenient?
<b>Cross-Cutting Issues</b>	1. Are there laws and policies that make it challenging for you to access HIV or health services?
	2. Have you experienced stigma and discrimination in the health care setting? If so, please describe.
	3. How can stigma and discrimination in health care settings be reduced?

### Tool E. Focus Group Discussion — Peer Volunteers

Country: \_\_\_\_\_ Reviewer: \_\_\_\_\_  
City/Location: \_\_\_\_\_ Date: \_\_\_\_\_  
Number of participants: \_\_\_\_\_

Names of peer volunteers participating in FGD: \_\_\_\_\_

Cascade Step	Key Questions
 <b>Identify key populations</b>	1. How do you identify peers who may benefit from HIV-prevention services?
	2. How do you connect them to these services?
 <b>Reach key populations</b>	1. Please describe your outreach strategies.
	2. How do you create demand for HIV services?
	3. How do you encourage clients to get tested?
	4. How do you provide a referral to an HCT site?
 <b>Test key populations</b>	1. How do you follow up on the referral?
	2. What feedback have you received from clients on existing HIV-testing services?
 <b>Diagnose PLHIV</b>	3. How can HCT services be made more convenient?
	4. How do you follow up with HIV-negative clients for HIV-prevention services?
	5. How do you follow up with HIV-positive clients on care and treatment services?
 <b>Enroll in care</b>	1. Have you supported a client as a peer navigator or case manager to guide or accompany someone to a care and treatment site?
	2. What do you think are the key factors (enablers or barriers) affecting the enrollment in care process?
	3. What are the main challenges or causes of attrition during pre-ART?
 <b>Initiate ART</b>	1. Have you provided adherence support to a client on ART? Please describe how.
	2. What do you think motivates PLHIV to remain on ART?
 <b>Sustain on ART</b>	3. What are the reasons for attrition during ART care?

Cascade Step	Key Questions
<b>Crosscutting Issues</b>	1. Are there laws and policies that make it challenging for you or your peers to access HIV services or other health services?
	2. Have you or your peers experienced stigma and discrimination in the health care setting? If so, please describe.
	3. How can stigma and discrimination in health care settings be reduced?

DRAFT