HIV Programming to Meet the Needs of Female Sex Workers and Men Who Have Sex with Men Who Are Survivors of Violence

COMMUNITY-BASED SOLUTIONS IN CAMEROON

APRIL 2018

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This document was made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The contents are the responsibility of the LINKAGES and CHAMP projects and do not necessarily reflect the views of USAID, PEPFAR, or the U.S. Government. LINKAGES, a five-year cooperative agreement (AID-OAA-A-14-00045), is the largest global project dedicated to key populations. LINKAGES is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill. CHAMP, a five-year cooperative agreement (AID-624-A-14-00003), is a large-scale HIV prevention, care, and treatment program for key populations in Cameroon. CHAMP is led by CARE Cameroon in partnership with Johns Hopkins School of Public Health, Global Viral, and MotoAction.

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Acknowledgments

The authors would like to thank Felicia Price, David Anouar Kob Ye Same, and Amelia Peltz of the U.S. Agency for International Development and Hally Mahler, Chris Akolo, Meghan Dicarlo, and Tiffany Lillie of FHI 360 for their feedback on the report. The authors would also like to thank Natasha Mack for copyediting and Jill Vitick for report design.

The authors would like to express gratitude to partner community-based organizations — Alternatives Cameroun, Cameroon Medical Women's Association, Horizons Femmes, and Humanity First Cameroon — for implementing the minimum package of services for gender-based violence response and for sharing their experiences, expertise, and insights throughout the process. Additionally, the gender-based violence program could not have been implemented without support from the following individuals: Iliassou Mfochive Njindam and Stef Baral (Johns Hopkins University), Dan Levitt, and Carrine Angumua.

Recommended citation: Mosenge V, Morales G, Kersten S, Dayton R, Tanyi C, Turpin G, Fouda G, Ndonko F, Abelson A, Lyons C, Decker MR. HIV programming to meet the needs of female sex workers and men who have sex with men who are survivors of violence: community-based solutions in Cameroon. Durham (NC): LINKAGES; 2018.

Acronyms and Abbreviations

AIDS	Acquired immune deficiency syndrome
CAMNAFAW	Cameroon National Planning Association for Family Welfare
CBO	Community-based organization
CHAMP	Continuum for Prevention, Care and Treatment of HIV/AIDS with Most-at-Risk Populations
DIC	Drop-in center
FSW	Female sex worker
GBV	Gender-based violence
HIV	Human immunodeficiency virus
KP	Key population
LINKAGES	Linkages across the Continuum of HIV Services for Key Populations Affected by HIV
MINPROFF	Ministry of Women's Empowerment and the Family
MPS	Minimum package of services
MSM	Men who have sex with men
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SOP	Standard operating procedure
STI	Sexually transmitted infection
USAID	U.S. Agency for International Development
WHO	World Health Organization

Introduction

In 2014, the U.S. Agency for International Development (USAID) launched the five-year Continuum for Prevention, Care and Treatment of HIV/AIDS with Most-at-Risk Populations (CHAMP) project in Cameroon, to be implemented by CARE in collaboration with Johns Hopkins University, Global Viral, and Moto Action. The project aims to improve the technical capacity of government and civil society to implement evidence-based prevention, care, and treatment services with key populations (KPs), notably female sex workers (FSWs) and men who have sex with men (MSM), in Bamenda, Douala, and Yaoundé. CHAMP works in close partnership with community-based organizations (CBOs) serving FSWs and MSM who are central to all that CHAMP does (Box 1).

Box 1. CHAMP partner community-based organizations

- Alternatives Cameroun (Douala)
- Cameroon Medical Women's Association (Bamenda)
- Horizons Femmes (Doula, Yaoundé)
- Humanity First Cameroon (Yaoundé)

CBOs in Cameroon have a long history of serving KPs, and in the case of CBOs working with MSM, are often led by KP members themselves. As a result, they tend to have a complex understanding of the issues, are one of the few trusted sources of information and support, and are key to identifying solutions that work.

Given the high prevalence of violence against KPs in Cameroon and global evidence linking violence to increased HIV risk, decreased HIV testing uptake, and decreased initiation and adherence to antiretroviral therapy among KPs,[2-9] a central strategy to improve outcomes across the HIV prevention, care, and treatment cascade is expanding gender-based violence (GBV) screening and support services for KP members (Box 2).

Box 2. PEPFAR's definition of gender-based violence[1]

Any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender), or behaviors that are not in line with social expectations of what it means to be a man or woman, boy or girl (e.g., men who have sex with men and female sex workers). It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.

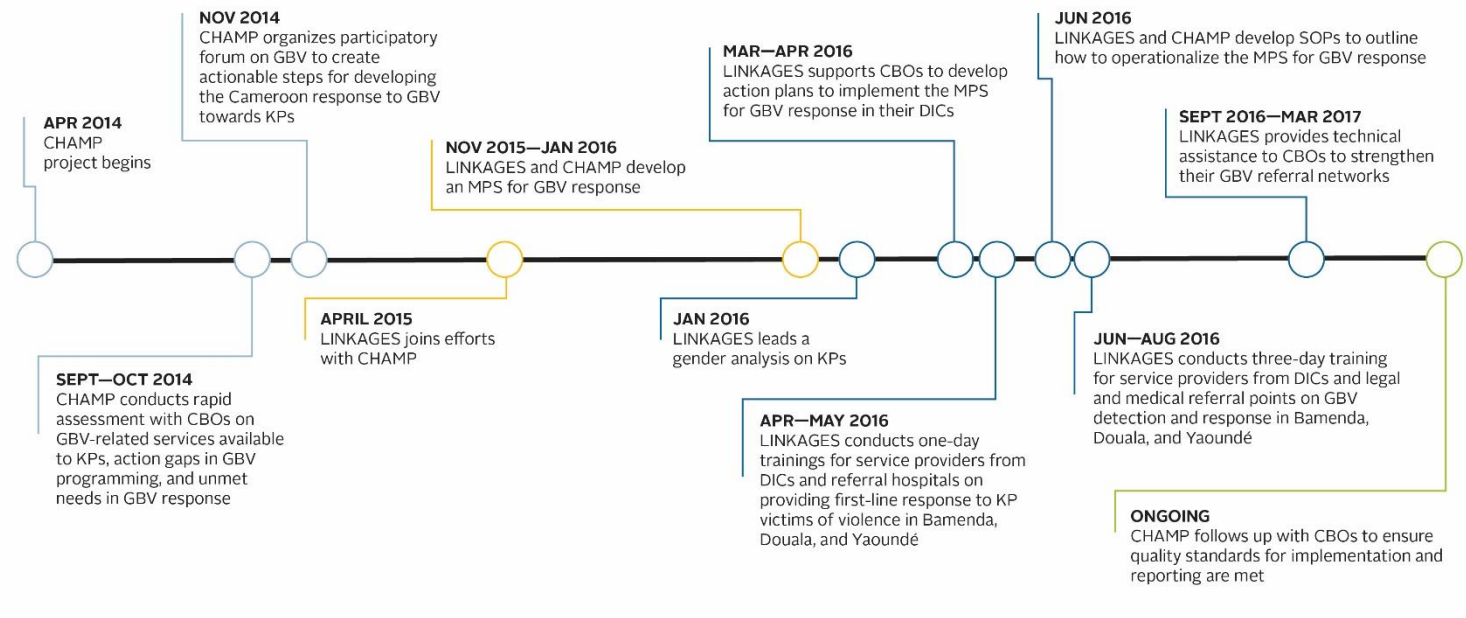
In 2015, the Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) project led by FHI 360 joined efforts with CHAMP to strengthen the ability of CHAMP's partner CBOs to meet the needs of FSWs and MSM who experience violence. As part of this effort, LINKAGES led the development of a minimum package of services (MPS) for GBV response — education and demand generation, first-line response, clinical services, social support, and justice services. LINKAGES also developed standard operating procedures (SOPs) to guide the implementation of the MPS and trained staff and service providers from CBO-run drop-in centers (DICs) and referral points from hospitals to detect violence and provide timely and appropriate GBV response services to KP individuals who experience violence.

Partner CBOs, collaborating with both CHAMP and LINKAGES, played a fundamental role in developing and implementing the MPS through their DICs and peer outreach, in recommending referral points for health, social, and justice services, and in training peer outreach staff and others.

The purpose of this report is to (1) describe the steps taken by CHAMP, LINKAGES, and CBO partners to integrate GBV response into HIV programming with and for KPs in Cameroon and (2) share key lessons learned from this collaborative, community-based process. The steps taken to integrate GBV

and HIV are presented in Figure 1 and discussed in more detail in the body of the report. The report is based on discussions with and feedback from CBOs, health providers, and government representatives in Cameroon, as well as a review of peer-reviewed journal articles, grey literature, and other documents. Although it focuses on GBV response in Cameroon, the steps taken and lessons learned could inform the development of other programs in similar contexts.

Figure 1. Timeline of gender-based violence integration in HIV programming with and for key populations in Cameroon



The Impact of Gender-based Violence on Key Populations in Cameroon

To be responsive to the specific needs of KPs, HIV programs must employ a holistic approach that considers the structural factors driving the HIV epidemic and reducing access to care, in addition to behavioral and biomedical interventions. Results from research and other activities in Cameroon indicate that KPs face violence because of rigidly applied gender norms, pervasive stigma, and legal contexts that criminalize homosexuality and sex work.[4, 5, 10, 11] These factors increase HIV risk while also creating significant barriers to KPs' access to health, justice, and social services.

Recent research with MSM and FSWs in Cameroon confirms high levels of violence against them.[4, 5, 10] A study with 1,606 MSM found that more than one in 10 experienced physical violence and one in four experienced sexual violence in their lifetime.[4] Similarly, in a study with 1,817 FSWs, over half (60 percent) had a history of physical or sexual violence.[5] In a qualitative study, FSWs identified police, intimate partners, and clients as perpetrators of violence.[10]

Violence in turn affects KPs' ability to access health services. For both FSWs and MSM in Cameroon, experiences of violence have been associated with fear of seeking health services, mistreatment at health centers, being refused health services, and lack of police protection.[4, 5]

While the epidemiologic and qualitative data spoke clearly to unmet needs regarding violence prevention and response for KPs, far less was known about the GBV response capacity among CBOs. Thus, CHAMP undertook additional formative research activities on the current GBV prevention and response infrastructure for KPs in Cameroon. From September to October 2014, CHAMP conducted a rapid assessment with CBOs to understand the range and nature of GBV-related services available to KPs, as well as actionable gaps in programming and unmet needs in the GBV response. Gaps identified included the limited access to quality health care for KPs who experienced violence, limitations on the capacity of DICs to provide violence-related support, including a lack of SOPs, and limited access to justice services and lawyers who can intervene in cases of arbitrary arrest. CBOs also noted that their DICs' capacity to respond to GBV survivors was hindered by the fears that providing GBV services would further expose survivors to victimization or could even contribute to stigmatization of the CBOs themselves in the communities where they work.[12]

CHAMP then organized a participatory forum in November 2014 that engaged CBOs, health and policy stakeholders, and leaders in GBV prevention and response in Cameroon. The purpose was to review Cameroon-specific data, results of the rapid assessment, global data on violence towards KPs and violence response, and best practices for GBV prevention and response developed by the World Health Organization (WHO), the U.S. President's Emergency Fund for AIDS Relief (PEPFAR), USAID, and Population Council. Forum participants then created actionable steps for developing the Cameroon response to GBV towards KPs. They prioritized strengthening the following:

- CBO response to GBV to ensure that KPs have the necessary support in place in their DICs
- Systems at the health provider and peer levels to ensure a comprehensive response to violence for KPs
- Connections between CBOs and the health sector

A third formative activity took place in January 2016, when LINKAGES led a gender analysis in Cameroon for PEPFAR.[11] The results of this analysis identified gender-related barriers to and opportunities for successful HIV programming with KPs in Cameroon. As in previous research, the analysis found violence against KPs to be frequent and widespread. Much of this violence was driven by gender inequality and the perception that KP behaviors deviate from traditional gender norms (Box 3). Violence was found to be further enabled by an environment that criminalized behaviors that are perceived as nonconforming (i.e., engaging in same-sex sexual conduct and sex work). For example, MSM feared reporting violence, as suspicion or revelation of sexual behavior could lead to arrest. Likewise, FSWs were afraid that their occupation could be discovered, which could lead to being blamed for the violence they experienced, being denied services, and being arrested. In addition, the participants reported never having been screened for violence, as well as an absence of violence response services. The frequent experiences of violence coupled with the lack of supportive violence response services contributed to KP members themselves often normalizing and minimizing the violence they experienced.

The demonstrated health impact of violence against KPs in Cameroon illustrates the critical need for a coordinated violence response in the country as part of HIV programming. This is particularly the case because KPs often face stigma and criminalization, undermining their ability to obtain health care and access justice in response to violence perpetrated against them.

Box 3. Framing violence against key populations as gender-based violence

While KPs differ in their specific biological and behavioral risks for HIV, they often share social and legal issues, such as stigma and criminalization, that increase their vulnerability to violence. Much of the violence against KPs is rooted in stigma based on rigid gender norms. For example, in Cameroon, FSWs are perceived as deviating from norms that dictate sexual behavior and occupation for women (e.g., having multiple sex partners, engaging in sex work), while MSM are perceived as departing from norms that dictate sexual behavior, and in some cases gender expression, for men (e.g., having sex with men). FSWs and MSM who are perceived as not conforming to rigid gender norms are frequently subjected to discrimination and violence.

Considering violence against KPs as a form of GBV helps to explain the root causes of the violence and explore how to challenge those root causes, including through efforts to challenge gender norms. It also incorporates violence against KPs into advocacy that promotes all forms of GBV as undeserved.

Addressing GBV against KPs also present opportunities for coalition-building — working with others who are already engaged in GBV prevention or response, such as lawyers, police officers, and health providers. These coalitions can benefit both female and male KP individuals, who can then access GBV prevention and response services along with non-KP women who have traditionally been beneficiaries of those services.

Gender-based Violence Response in Cameroon: A Phased Process

This section describes the steps taken by CHAMP, LINKAGES, and partner CBOs during three phases of GBV response activities in Cameroon: design, implementation, and monitoring of the MPS (Figure 2). Using a phased approach provided sufficient time for CBOs to fully develop GBV response services in their DICs and through peer outreach according to the MPS. It also allowed CBO staff and service providers, including peer outreach staff, to progressively build on and hone their skills. While the MPS was being designed and implemented, CHAMP was also conducting broader health sector activities to create an enabling environment (Box 4).

Figure 2. The design, implementation, and monitoring process for the minimum package of services for gender-based violence response

Box 4. Enabling environment: Health sector

Despite the prevalence of violence against KPs and their related HIV and health needs, training in the health sector remained minimal. In the broader effort to build capacity for working with KPs in the health sector, a training-of-trainers curriculum was developed to enhance sensitivity for KPs and build capacity in meeting their unique needs, including those related to GBV. The training of trainers was targeted at health providers, with an aim to create an enabling environment for the effective management of HIV and other sexually transmitted infections (STIs) among KPs. Health sector guidance specific to the GBV response was tailored for KPs and included in the training curriculum (Box 6). GBV awareness, sensitivity, and response were included, including an adaptation of the LIVES response recommended by WHO for front-line health providers.[13] The training of trainers was then validated by the Ministry of Public Health and implemented with health providers (e.g., doctors, nurses, psychosocial counselors).

PHASE 1: DESIGNING THE MINIMUM PACKAGE OF SERVICES FOR GENDER-BASED VIOLENCE RESPONSE

Step 1: Developing the Minimum Package of Services for Gender-based Violence Response (November 2015–January 2016)

KPs who experience violence have multiple needs requiring a corresponding range of services. In designing a responsive MPS, it was essential to identify both the needs of survivors and feasible response approaches.

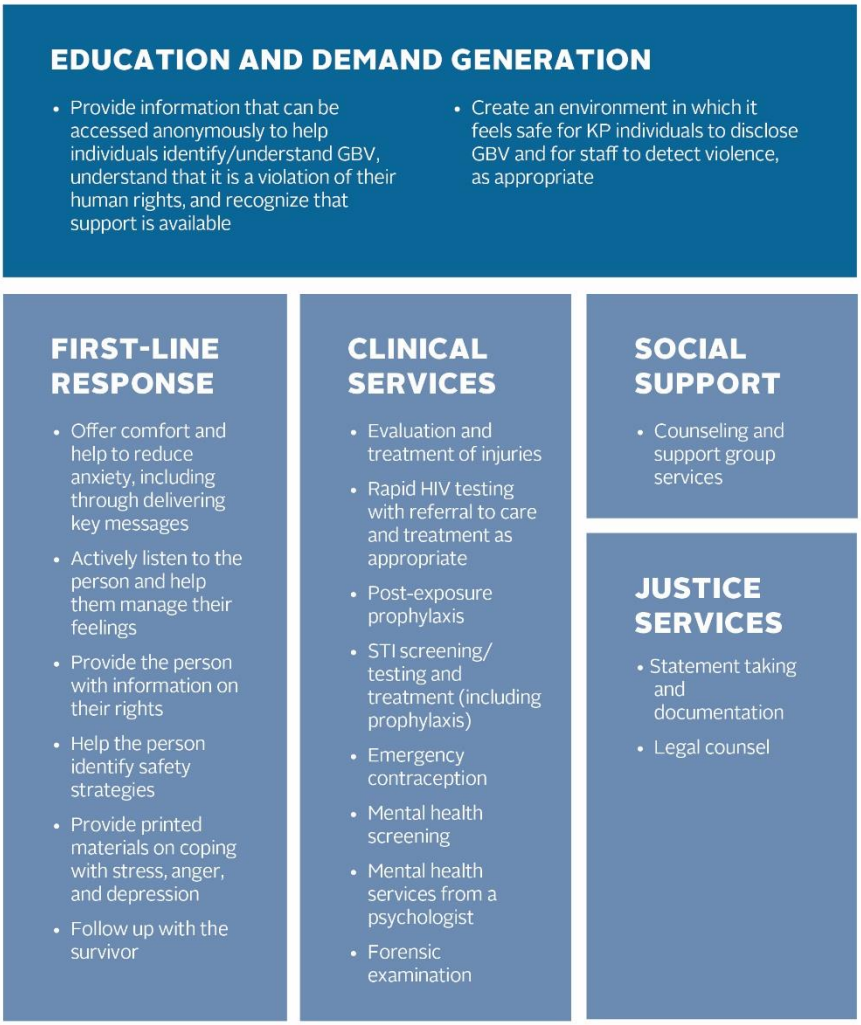
In addition to the formative activities described in the previous section, LINKAGES used global standards and guidance to inform the development of a comprehensive MPS. WHO recommendations for addressing violence within the health sector were consulted to glean global best practices for addressing violence among both the general population and KPs.[14] Insights were also applied from holistic interventions in low-resource settings;[15] KP-specific guidance, including the WHO consolidated guidelines on HIV prevention, diagnosis, and care for KPs, and the MSM and sex worker implementation tools;[16-18] and U.S. Government and PEPFAR expectations, indicators, recommendations, and best practices.[1, 19, 20]

Next, LINKAGES interviewed partner CBOs to determine what services their DICs offered and how, services they considered important to offer, and which services could and could not feasibly be offered by their DICs based on the Cameroon context. These results were used to revise the MPS.

The draft MPS was then presented to partner CBOs and other national and international stakeholders such as government ministries and United Nations agencies for their feedback. Based on the feedback, LINKAGES produced a final version in English and French that is available to all partner CBOs and their DICs.

The MPS includes all features that CBOs and international and national stakeholders considered to be both feasible and important in Cameroon (Figure 3). These features are education and demand generation, trauma-informed first-line response services, clinical services, social support, and justice services. The MPS document also clearly outlines technical quality standards for service providers to follow while providing each service (not pictured below).

Figure 3. Overview of minimum package of services for gender-based violence response in Cameroon*



Step 2: Action Planning (March–April 2016)

The next step in the design phase was action planning to implement the MPS. Action planning was an essential step that enabled CBOs to identify their strengths, opportunities to implement additional services in the MPS, and areas where capacity building was needed to strengthen the skills required to provide first-line response in their DICs. In this step, the MPS served as a checklist for CBOs to identify gaps in their DIC and peer outreach services, as well as any existing services that could meet GBV survivors' needs. For example, two services specified in the MPS — clinical services (e.g., free HIV/STI screening, consultations) and psychosocial counseling — were identified as already being offered in DICs as part of CHAMP's global package of HIV services.

The process of action planning involved LINKAGES conducting site visits at each DIC. During the visit, LINKAGES used the MPS as a checklist to assess existing services and provided DIC staff with a detailed orientation on the MPS. LINKAGES then provided technical assistance to the DICs to create action plans to implement each service in the MPS, including identifying clear indicators to measure the quality of services being offered. As part of their action plans (see action plan template in Annex 1), partner CBOs also developed their own strategies to implement the MPS in their DICs and peer

* Based on the stakeholder interviews and meetings, it was deemed important and feasible to collect forensic evidence through physical exams. However, in Cameroon, these forensic examinations do not regularly include DNA evidence.

outreach. For example, one CBO strategy consisted of increasing sensitization on violence prevention and rights at the community level by integrating these messages into small-group talks led by trained peer outreach staff.

Step 3: Developing Standard Operating Procedures (June 2016)

The last step in the design phase was to develop SOPs for the MPS. Based on global standards and adapted to the Cameroon context, the SOPs were intended to provide detailed information to partner CBOs and direct service providers on how to operationalize the MPS. They outline components that must be in place before and while implementing GBV detection[†] and response. Among other topics, the SOPs outline fundamental principles for GBV response, core GBV messages, and guidelines for developing referral networks. This ensures that essential principles such as "do no harm" are integrated into all aspects of programming (see SOP outline in Annex 2).

PHASE 2: IMPLEMENTING THE MINIMUM PACKAGE OF SERVICES FOR GENDER-BASED VIOLENCE RESPONSE

The ability of service providers to offer the MPS requires the knowledge and skills to detect GBV and provide a response based on the procedures set forth in the SOPs. In the implementation phase, the emphasis was on (1) building the capacity of service providers at the community, DIC, and referral site levels to provide quality GBV response services to KPs and (2) expanding the GBV response referral network for KPs.

Step 1: Building Capacity (June-August 2016)

While the GBV detection and response SOPs were still in development, partner CBOs expressed a need for skills-based training on responding to disclosure of violence. To address this immediate need, LINKAGES developed a one-day training for service providers on offering first-line response to KPs who disclose violence (e.g., actively listening, providing key messages and information on rights, and helping to identify safety strategies). LINKAGES delivered this training to service providers from DICs (e.g., counselors, social workers) and referral points from hospitals in May 2016.

Box 5. Quotes from training participants

Training on GBV response helps us address stigma in relation to violence in the sense that we can help survivors know that violence is not their fault and to speak up. We can also assure survivors of confidentiality and help them feel safe to disclose violence.

- Medical referral point after GBV detection and response training

Violence is prevalent. People don't respect us. Our clients and police violate us. With this training, we know what to say to our peers. We tell our peers to talk about violence because it is very important to our health.

- Peer leader after GBV detection and response training

Once the SOPs were finalized, LINKAGES developed a three-day companion training on GBV detection and response (Box 6). Between June and August 2016, LINKAGES delivered this training to service providers from DICs, as well as legal and medical referral points, to build their capacity to provide quality GBV response services, including detecting GBV using standardized forms, providing first-line response, and using the referral network to ensure KP clients have access to important clinical, social support, and justice services (e.g., HIV testing,

[†] In this report, the term "GBV detection" refers to asking KP members a question or series of questions to determine whether they have experienced violence. Categorizing our GBV detection activities according to WHO definitions, our activities most closely resemble "routine enquiry." Routine enquiry is "sometimes used to refer to investigating intimate partner violence without resorting to the public health criteria of a complete screening program; it can also be used to denote a low threshold for women being routinely asked about abuse in a health care setting, but not necessarily all women."[14]

post-exposure prophylaxis [PEP], emergency contraception, psychosocial counseling, legal counseling). Where possible, training participants included nondirect service providers that may receive disclosures of violence, such as DIC receptionists. This training emphasized appropriate responses to violence to avoid an overemphasis on detection.

As peer outreach staff are often in a position to receive a disclosure of violence, the LINKAGES GBV detection and response training curriculum was also streamlined and adapted for peer leaders and navigators and integrated into existing training curricula on peer outreach and navigation. Navigators were trained on key principles of GBV response and the link between GBV and HIV, including treatment adherence, to inform their work with clients living with HIV. In addition to these topics, peer leaders were trained to detect cases of GBV and to provide first-line response and referrals and accompaniment to DICs as needed, including linking clients to HIV testing, PEP, emergency contraception, and other services in the MPS.

These collective training activities not only fostered ownership of the GBV response, but also the ability of service providers at the community, DIC, and referral site levels to provide and refer KP individuals to appropriate services in the MPS. These multi-sectoral trainings, in which service providers across health, social affairs, and judicial sectors trained together, also created a platform to share experiences and perspectives, find common solutions to problems, and strengthen collaboration between DICs and referral sites. In turn, this made the referral networks more effective and enhanced service provision.

Step 2: Building the Referral Network (September 2016–March 2017)

As the MPS document outlines, KP individuals who experience violence need access to a range of services (i.e., first-line response, clinical services, social support, and justice services). DICs did not provide all the services outlined in the MPS and therefore referred clients to partner hospitals and other social and legal services as needed. Because of the integral role of referrals in the GBV response for KPs, CHAMP, LINKAGES, and partner CBOs sought to build a functional network of professionals and

Box 6. Training content

Health sector training: CHAMP health promotion for key populations
Target audience: Health providers (e.g., doctors, nurses, psychosocial counselors)

This training of trainers covers sexuality and health, enabling environment, violence and professional ethics, mental health promotion, support to KP individuals who use drugs and alcohol, and prevention and management of HIV, AIDS, and STIs. GBV-related content is integrated in this training, including GBV assessment; trauma-informed support; validation; safety promotion; health needs including PEP, HIV testing, and emergency contraception; and links to services. The GBV-related content was rooted in principles of human rights and aligned with guidance for health sector responses to violence against women[13, 21] and for addressing violence and HIV against FSWs[18] and MSM.[17]

CBO training: LINKAGES GBV detection and response
Target audience: Service providers from DICs (e.g., psychosocial counselors, social workers), as well as legal and medical referral points

This training covers core topics, including the rationale for integrating GBV response in HIV programs; concepts related to sex and gender; links between rigid gender norms, stigma, discrimination, and GBV; links between GBV and HIV; and principles of GBV response. This training also provides an overview of the MPS and builds providers' skills in detecting violence, providing first-line response, and linking clients to important services in the MPS (e.g., rapid HIV testing, PEP, emergency contraception, screening and treatment for STIs). This training curriculum draws from global guidance and good practice standards, including recent guidance from WHO and PEPFAR on both violence response services and specific services for KPs.[1, 13, 14, 17-20, 22-25]

All training curricula use a participatory framework to enhance participant learning. Activities include group exercises, role plays, and case studies. This experiential learning approach ensures active participation, allowing participants to draw on their experiences and practice new skills.

community members sensitized on KP issues and trained to support KP individuals who experience violence. Having committed partners in the referral network allowed CBOs to ensure access to services.

Partner CBOs led the process of building the referral network. An important criterion for identifying and selecting individuals as referral points within the network was their sensitivity to KP issues. Referral points also needed technical expertise and a commitment to serve KPs.

Medical referrals in the CHAMP project were most often effected through formal partnerships between CHAMP and select hospitals. Partner CBOs identified KP-friendly health providers to serve as medical referral points during training on health promotion for KPs at these hospitals. CHAMP and LINKAGES then sensitized the selected referral points on the links between GBV and HIV, the importance of addressing KP-specific violence as a key part of the HIV response, and referral and counter-referral processes and tools. As mentioned in Box 6, referral points were also trained using the LINKAGES GBV detection and response training curricula.

Identifying legal referral points has proven more challenging, particularly given the reticence of lawyers and police to be active and consistent service providers for KPs. Lawyers and police alike often reported feeling that their role was futile and that they were hesitant to openly join the referral network. This is because they are bound by the Cameroonian penal code that penalizes homosexuality and sex work, as well as by customary law, which dismisses homosexuality as "unnatural" and against African culture.[26, 27] However, criminalization and custom notwithstanding, several referral points stepped forward to support KPs and provide services, especially after sensitization and trainings. For example, CHAMP and the Cameroon National Planning Association for Family Welfare (CAMNAFAW), a principal recipient for the Global Fund, formed a partnership where CAMNAFAW provided legal services to KP clients referred by CHAMP.

Building and maintaining a functional referral network also requires committed partners at regional and national levels who can serve as key allies to advocate for KPs at higher levels. One-on-one meetings with the range of stakeholders (e.g., government ministries, embassies, United Nations agencies) can be a beneficial advocacy strategy to explain the project and solicit support for KP-specific issues, as well as to determine any roles stakeholders might play.

PHASE 3: MONITORING

Ongoing monitoring and support are critical to ensure that partner CBOs achieve the target outcomes in their MPS action plans. CHAMP and LINKAGES collected information about the services and referrals being provided at the DICs to examine the quality of the services and identify problematic areas. They then arranged to provide any technical assistance that was needed.

With clients' informed consent, CBOs also documented cases of GBV using a screening tool that captured types of violence enacted (emotional, economic, physical, and sexual violence), the perpetrator(s), time period, and type of support needed in each case. However, some clients may prefer that counselors not use the screening tool during their discussions because of concerns about confidentiality. To mitigate this factor, counselors explained the importance of documentation for determining appropriate services and follow-up care for the client and to build evidence to inform future project actions and investments. Counselors also emphasized that declining documentation would not affect the services that clients receive; they were trained to follow the fundamental principles of GBV response, including respecting client choice, above all.

To ensure data security, completed screening and referral forms did not include identifying information such as names or specific locations; were stored in secure, locked spaced; and could only be accessed if a client provided their unique identifier code to a DIC service provider or peer outreach worker.

Key Lessons

Implementing GBV response services as part of CHAMP's HIV response for KPs generated important lessons that could inform the KP-specific GBV response in other country contexts. Lessons learned were compiled based on discussions with CHAMP, LINKAGES, partner CBOs, and other stakeholders who are implementing the MPS to address GBV toward KPs. These lessons illustrate the importance of continuing to support CBOs as they integrate GBV response services across a range of HIV services and activities, including collaborating with service providers and stakeholders at different levels to expand and strengthen the referral network. They also underscore the need to work in inclusive ways with FSWs, MSM, and other KPs for more effective and sustainable interventions.

Lesson 1: **Interdisciplinary GBV response is mutually reinforcing**. The CHAMP/LINKAGES approach of simultaneously training health providers and peer outreach staff in GBV detection and response to meet the needs of survivors, combined with further capacity building through supportive supervision at DICs, represents a true systems-strengthening approach that is greater than the sum of its parts. It is comprehensive in allowing KPs multiple entry points to access the "system" of support, including health sector and DICs. In the CHAMP/LINKAGES approach, by scaling up the GBV response capacity at DICs and in the health sector simultaneously, health providers and peer outreach staff alike can feel confident in the referral network and better able to refer clients for high-quality care.

Lesson 2: STI/HIV and other services available in DICs can be gateways to violence-related assessments and support. Most clients access DICs for services other than those related to GBV. Yet, many have experienced violence, and may not be aware of the violence response services available in DICs. For this reason, DIC staff can use STI and HIV services as entry points to discuss GBV with clients and provide any support the client may need. Seeking GBV services can likewise lead to uptake of related health services, including those related to HIV. For example, people coming in for GBV services can be offered testing for HIV and other STIs, as well as get referred for PEP in cases of sexual violence.

Lesson 3: Sensitizing FSWs and MSM on different types of GBV and their right to live free from violence could help them seek services. The frequent experiences of violence against KPs, coupled with the lack of supportive response structures, contribute to KP individuals themselves often minimizing the violence they experience. Many do not fully understand the complexity and multiple layers of violence, especially emotional and economic violence. DIC staff and service providers, including peer outreach staff, play a critical role in sensitizing KPs about their rights and helping them to identify different types of violence, as well as informing them of the support and services available in the DICs and via referral. Small-group talks facilitated by trained counselors and peer outreach workers can be useful for discussing these issues without people feeling pressured to disclose violence. As discussing violence can potentially lead survivors to recall past trauma or experience vicarious trauma, small-group facilitators must always ensure that service providers trained in first-line response (e.g., counselors, peer outreach workers) are available to provide

support to those who disclose violence or for whom the conversation is difficult and ensure that services are immediately offered to those who disclose violence.

Lesson 4: Strengthening the capacity of a range of community actors can improve GBV response. Violence often occurs in the community (e.g., at brothels, bars, and other hot spots) at hours when peer outreach workers and other staff may not be available to provide support to survivors. CBOs serving FSWs found that involving KP-friendly bar and brothel owners as peer mobilizers was useful for quickly identifying cases of violence as they happened. If peer mobilizers witnessed violence in a hot spot or a KP individual disclosed violence to them, the peer mobilizer could inform them of the services that are available and link them to peer outreach staff, if desired. If available and appropriate, they could also offer to accompany a KP individual to a DIC to receive the desired support. This strategy could be useful to other CBOs; however, it will be important for each CBO to work with KPs and community actors to help identify potential peer mobilizers and discuss realistic expectations for peer mobilizers.

Lesson 5: GBV documentation in DICs can be used as an advocacy tool. GBV is a persistent health and human rights issue. Epidemiological data have begun to demonstrate its prevalence and severity. Community-led documentation can also inform advocacy efforts and validate the experiences of KP individuals. Screening and documenting violence can help ensure detection of cases, as well as linkage to care and support for survivors. However, survivors' needs and concerns regarding confidentiality are paramount. Screening can only be undertaken where staff are trained in a survivor-centered response, and where referral to support services is possible. Supporting survivors must take priority over documentation.

Lesson 6: Confidentiality is essential for KP survivors to disclose violence. Speaking about violence is difficult for many survivors. These concerns can be amplified for KP individuals, who often feel that little help is available to them or that the stigma of being a survivor of violence will be added to the other stigma they already face. Further, issues around confidentiality make KP individuals reluctant to provide information about perpetrators. When screening for violence, service providers should always ensure that the survivor feels secure and reassured that their information will be kept confidential. Any necessary breaches of confidentiality, for example, cases in which the survivor is at risk for self-harm, must be disclosed. The response by the first person the survivor meets at the DIC is pivotal in terms of putting the person at ease and encouraging them to continue seeking services. Therefore, it is critical that KP-specific GBV training include the DIC receptionists, who are often the first point of contact.

Lesson 7: Shared activities — including trainings and meetings — with KP individuals, peer outreach staff, and service providers ensure that referral networks are responsive to the real needs of KPs. Inclusive activities allow KP individuals, peer outreach staff, and service providers to learn each other's perspectives and develop collaborative solutions. Involving a range of actors in training, for example, promotes sharing of experiences and gives each participant the opportunity to learn what is and is not working. Everyone has a role to play and can make important contributions. KP individuals can express their concerns and needs. Peer outreach staff can share firsthand knowledge of the violence that occurs in their communities. Referral points (health providers, lawyers, and others) can clarify what services they offer and describe barriers to service provision. The group can then collaboratively generate potential solutions to problems. Beyond trainings, organizing regular meetings and other activities where CBO and DIC staff, KP members, and referral points jointly participate can further develop the positive partnerships essential for strengthening the referral network.

Lesson 8: Government and international agencies are key players in the response to GBV and HIV services for KPs. The Cameroon national gender policy[28] and national GBV strategy[29] conceptualize GBV as violence against women and girls, but they have yet to address violence specifically against KPs. Integrating KP-specific GBV issues into the national GBV strategy presents several challenges, many of which are linked to sociocultural norms and a prohibitive legal environment. Yet, the involvement of government and other nongovernmental partners in the program's response to violence is crucial for a more inclusive and sustainable approach. In Cameroon, this involves working with the Ministry of Women's Empowerment and the Family (MINPROFF), the principal ministerial agency coordinating GBV interventions in-country, to advocate for including issues specific to KPs in the national GBV strategy. Working with government agencies will also help ensure that the activities and services CHAMP has put in place continue.

Collaboration with government and international organizations also provides networking opportunities, such as when CHAMP and LINKAGES staff participated in the GBV subgroup co-led by MINPROFF and United Nations Population Fund. Although this platform was intended for GBV coordination in the humanitarian context, it provided an opportunity to meet other implementing partners and service providers and have discussions on the feasibility of integrating KP-specific issues into these and other existing GBV platforms. Each meeting with partners was also an opportunity to sensitize them about KP-specific issues, using evidence on the links between HIV prevalence and violence prevalence.

Meetings with local and international partners are also important for including KP-specific issues of violence in national platforms. In these fora, KP-specific needs can be discussed in depth and practical solutions proposed. This may also contribute to moving laws and policies away from homophobia toward a more favorable environment.

Lesson 9: Addressing human rights violations requires broader networks of support ("second-level referrals"). Arbitrary arrests and detention are not uncommon for KPs in Cameroon. This is especially the case for MSM, who are sometimes held at police stations on suspicion of homosexuality without any due process. In situations of human rights violations, international and regional stakeholders — such as international nongovernmental organizations, donors, and embassies — may be able to provide support when local CBOs request support beyond what projects like CHAMP and LINKAGES can offer. For example, when MSM peer leaders were arrested for carrying lubricant and condoms, they received support from Humanity First Cameroon, a partner CBO implementing a project funded by Amnesty International to document human rights abuses against lesbian, gay, bisexual, and transgender people and provide legal support. Collaborating with international and regional stakeholders to address human rights may be particularly useful in advocacy with decision makers in government.

Lesson 10: Collaborating with other CBOs and projects by sharing resources can strengthen the violence response. Financial constraints and issues related to sustainability make it difficult for one organization or program to provide all the necessary services to survivors of GBV. KP-led CBOs have recognized these limitations and are mitigating them by working together. For example, referrals are made among CBOs so that needs and services not provided at one CBO can be provided by another such as legal services through CAMNAFAW

Lesson 11: Tailoring GBV prevention and response tools for KPs is valuable. The GBV-related training elements for health service providers and CBOs were developed iteratively and drew on guidance for GBV response for general populations, as well as recommendations specific to KPs. Foundations of the global GBV response, including the priority on self-determination, survivor-centered care, and linkage to support services are valuable to KPs. Simultaneously, health providers

and CBOs must be aware of the unique risks KPs face for experiencing violence and the challenges they face in disclosing experiences and obtaining support.

Conclusions

Research shows that FSWs and MSM have reported high levels of violence in Cameroon, with significant impact on HIV risk behavior,[4, 5] and global evidence and guidance demonstrate that such violence must be addressed in order for a country to have an effective HIV program.[2, 16-18]

As a result of their collaboration with LINKAGES and CHAMP, staff and service providers from CBO-run DICs and referral points from hospitals are equipped with increased capacity to address GBV toward KPs in HIV programs. They are now more informed about what GBV is and how to detect it, knowledgeable that GBV is not the fault of KP individuals, and better able to offer support such as first-line response and referrals to important GBV response services, such as PEP. Partner CBOs are embracing the training they have received on GBV specific to KPs and are sensitizing their communities about what violence is, what support is available, and what safety strategies to use through screening, counseling, small group talks, and support group activities. KP communities are also responding positively. Early efforts in GBV education and response have led to increased disclosure of violence to peer outreach staff and DIC counselors, which has served as an opportunity to link KP individuals who experience violence to GBV response services. Finally, the integration of GBV response services into CHAMP programming demonstrates that CHAMP recognizes that KPs have needs beyond HIV.

Overall, the implementation process demonstrated partner CBO and health sector capacity to integrate GBV in their HIV programming through a multi-sectoral, community-based approach. This integration is necessary for eliminating the structural drivers of both GBV and HIV and achieving the UNAIDS 90-90-90 goals, including increased HIV testing and increased initiation and adherence to antiretroviral treatment, to end the AIDS epidemic.

Annex 1: Action Plan Template for Gender-based Violence Response in Cameroon

Service from Minimum Package of Services	Community-based Organization (CBO) Activity	LINKAGES/ CHAMP Technical Assistance Needed	CBO Short-term Indicator	CBO Intermediate Indicator	People Responsible	Time Frame				Status of Indicators
						Q1	Q2	Q3	Q4	

Annex 2: Standard Operating Procedure Outline for Gender-based Violence Response in Cameroon

1. **Introduction/Background**
    a. What is gender-based violence (GBV)?
    b. What is the rationale for addressing GBV in the context of HIV programs?
    c. Why is it important to address GBV among key populations along the HIV prevention, care, and treatment cascade in Cameroon?
    d. What key populations do these standard operating procedures (SOPs) focus on in Cameroon?
    e. What is the purpose and scope of the GBV SOPs?
    f. Who is responsible for updating the GBV SOPs and making revisions as needed?
    g. Who are the implementing partners and key stakeholders in Cameroon and what are the roles and responsibilities of each? What are the various "entry points" for key populations?
    h. Who should use these SOPs?
2. **Key definitions and terms**
3. **Fundamental principles for GBV services**
    a. Principle 1: Do no harm
    b. Principle 2: Promote the full protection of key populations' human rights
    c. Principle 3: Use a client-centered approach
    d. Principle 4: Respect clients' right to self-determination
    e. Principle 5: Ensure privacy, confidentiality, and informed consent
4. **GBV program components/supportive structures**
    a. Develop SOPs
    b. Develop core GBV messages
        i. What is the rationale for creating a set of core GBV messages?
        ii. What are the core GBV messages in Cameroon?
        iii. How will core GBV messages be communicated and disseminated?
    c. Develop a referral network
        i. How are organizations selected to be included in the referral network?
        ii. What organizations are involved in the referral network in Cameroon?
        iii. How are focal points at each referral site selected?
        iv. What sensitization and training are provided to focal points at each referral site?
        v. Who is responsible for maintaining and updating the referral network/focal points/referral network?
        vi. How do clients flow through the referral network?

vii. How are referrals tracked?
viii. What makes a referral network effective?

d. Sensitize and train staff and direct service providers
    i. What staff and direct service providers will be trained?
    ii. What topics are included in sensitization and training activities?
    iii. When and how often are staff and direct service providers trained?
    iv. How are sensitization activities and training tracked?
    v. Who provides sensitization and training?
    vi. How are ongoing training needs identified?
e. Develop GBV information, education, and communication (IEC) materials
    i. Who is involved in developing IEC materials?
    ii. What IEC materials will be developed, who are the target audiences, and what content will be included on IEC materials?
    iii. How will IEC materials be disseminated?
    iv. What mechanisms are in place to track dissemination and assess effectiveness of IECs?
f. Provide safe spaces and protect clients from harm or further harm
    i. What are the established/designated safe spaces for key populations in Cameroon?
    ii. How do key populations access these safe spaces?
    iii. What services/activities are available at these safe spaces?
    iv. How are key populations involved in the identification of safe spaces and the development of activities provided through these safe spaces?
g. Maintain provider self-care, support, and personal safety
    i. Why is it important to support providers?
    ii. What are red flags/indicators of stress?
    iii. What are ways direct service providers cope with work-related stresses?
    iv. What mechanisms are in place to provide support to providers?
    v. What mechanisms are in place to keep providers safe?
h. Monitor and evaluate programs
    i. What indicators and outcomes are included in the GBV monitoring and evaluation (M&E) framework? (e.g., PEPFAR indicators)
    ii. What mechanisms are in place to collect data from various sites?
    iii. Who is responsible for compiling data and reporting outcomes?
    iv. What steps are taken to ensure quality of GBV services?
    v. How can staff and other key stakeholders provide feedback about services?
    vi. How are GBV incidence and outcomes shared with key stakeholders?

5. CHAMP Minimum Package of Services (MPS) for GBV response

a. Tier 1 vs. Tier 2 services
    i. Tier 1 services will be offered at the DIC and will be available routinely
    ii. Tier 2 services will be offered at the DIC, through referral, or as a combination of both
b. Encourage uptake of response services
    i. MPS 1: Provide information that can be accessed anonymously to help individuals identify/understand GBV and recognize that support is available (Tier 1)
    ii. MPS 2: Create an environment in which it feels safe to disclose GBV and detect violence as appropriate (Tier 1)

c. Provide compassionate crisis response (first-line response)
    i. Who provides first-line response and when do they provide it?
    ii. MPS 3: Offer comfort and help to reduce anxiety, including through delivering key messages (Tier 1)
    iii. MPS 4: Actively listen to the person and help them manage their feelings (Tier 1)
    iv. MPS 5: Provide the person with information on their rights (Tier 1)
    v. MPS 6: Help the person identify safety strategies (Tier 1)
    vi. MPS 7: Provide printed materials on coping with stress, anger, and depression (Tier 1)
    vii. MPS 8: Follow up with the survivor (Tier 1)
d. Provide/refer to clinical post-GBV services
    i. Who provides clinical post-GBV services?
    ii. Required conditions for providing clinical post-GBV services at the facility level
    iii. Clinical post-GBV services
    iv. MPS 9: Evaluation and treatment of injuries (Tier 2)
    v. MPS 10: Rapid HIV testing with referral to care and treatment as appropriate (Tier 1)
    vi. MPS 11: HIV post-exposure prophylaxis (PEP) (within 72 hours of sexual assault) (Tier 2)
    vii. MPS 12: STI screening/testing and treatment (including prophylaxis) (Tier 2)
    viii. MPS 13: Emergency contraception (EC) (within five days of sexual assault) (Tier 2)
    ix. MPS 14: Mental health screening (Tier 1)
    x. MPS 15: Mental health services from a psychologist (Tier 2)
    xi. MPS 16: Forensic examination (Tier 2)
e. Provide social support services
    i. MPS 17: Counseling and support group services (Tier 1)
f. Provide judicial services
    i. MPS 18: Statement taking and documentation (Tier 1)
    ii. MPS 19: Legal counsel (Tier 1)

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