

PEPFAR GENDER ANALYSIS IN CAMEROON

SUMMARY OF FINDINGS AND
RECOMMENDATIONS FOR KEY POPULATIONS

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Gender Analysis Overview

In January 2016, a gender analysis was undertaken in Cameroon to identify gender-related barriers and opportunities to successful HIV programming in the country. The gender analysis was broken down into two components. One component, led by the LINKAGES project, focused on key populations (KPs) – specifically men who have sex with men (MSM) and female sex workers (FSW) – and was conducted in partnership with the CHAMP project. The other component, led by the Gender Advisor from USAID/West Africa, focused on adolescent girls and young women and was conducted in partnership with the KIDSS project.

The gender analysis was designed to: 1) assess how gender norms, including those reflected in laws, policies and institutional practices, affect the risk behaviors and uptake of HIV prevention, care and treatment services among KPs, adolescent girls, and young women; and 2) inform strategies that PEPFAR can employ to transform harmful gender norms, reduce gender-related stigma and violence, and enhance the use of HIV services by these priority populations. For both components, the gender analysis consisted of a desk review and field-based interviews and focus group discussions. For the KP component, fieldwork was carried out in Douala, Bamenda and Yaoundé, and information was gathered from 16 MSM, 35 FSW, and 45 CBO representatives and providers serving MSM and FSW.

Epidemiological Context

Cameroon has a mixed HIV epidemic, where both key populations and the general population appear to contribute significantly to transmission. Despite a decrease in HIV prevalence in the general population from 5.6% in 2004 to 4.3% in 2011, Cameroon is one of the highest-prevalence countries in Central Africa (Cameroon National Institute of Statistics, 2012). Prevalence is highest among MSM (37%) and FSW (36%), the majority of whom are not connected to treatment and care (Park, 2013; Tamoufe, 2010). Coverage of ART among KPs is low, with only 13.2% (12/91) of health centers across 7 cities reporting provision of ART services to MSM and FSW compared to 56.5% (52/92) for the general population. Likewise, the proportion of MSM and FSW estimated to be living with HIV but not on treatment ranges from 75-100%, depending on the city (Holland, 2015).

Policy Context

Both sex work and homosexuality are criminalized in the Cameroonian penal code, which has major implications for MSMs' and FSWs' risk of HIV acquisition, experiences of stigma and violence, access to health and other social services, and exposure to human rights violations (Papworth, 2014; Human Rights Watch, 2013; NSWP, 2014). The disproportionate burden of HIV shouldered by MSM and FSW in Cameroon is acknowledged in the country's National HIV/AIDS Strategic Plan (2014-2017), which sets as an output that 80% of key populations know their HIV status. However, the plan offers little in the way of a strategy for reaching that output. In addition, no nationally endorsed published package of services for key populations exists for Cameroon (MacAllister, 2015). Nevertheless, the inclusion of KPs in the national strategic plan offers a critical opportunity to design and deliver HIV services that meet their needs.

Key Findings: FSW and MSM

Gender norms and beliefs

Commonly held beliefs about appropriate roles and behaviors for men and women have far-reaching, harmful consequences for FSW and MSM in Cameroon. Gender norms that affect FSW include the belief

that women should not have multiple sex partners and that women's primary roles are to marry, have children, and take care of the family. Because most sex workers do not conform to these norms, women's participation in sex work is something that society condemns and shames. Participants reported that sex workers are perceived as "lost" and not deserving of respect, and the perpetration of violence against sex workers is considered natural and acceptable. FSWs are also affected by gender norms that harm women in general and are not specific to their participation in sex work. For example, much of the violence perpetrated against sex workers is also a manifestation of gender inequality and discrimination against women more broadly. Participants also reported that it is very stigmatizing for women to have children outside of marriage, and that unintended pregnancies among FSW, especially young sex workers, were common. The criminalization of sex work in Cameroon further marginalizes FSW, preventing them from exercising their rights and exacerbating self-stigma and stigmatization by others.

For MSM in Cameroon, widespread homophobia, defined as a prejudice toward or intense dislike of gay people, and the belief that homosexuality is unnatural and should not exist drives much of the stigma, violence, and health risks experienced by MSM. Most of society perceives MSM to have rejected their masculinity and the traditional and superior gender roles assigned to men and, as a result, they are stigmatized by families, neighbors, and broader society. Perpetration of violence against MSM is common and considered natural and acceptable. Indeed, MSM reported that they are often blamed for the violence perpetrated against them with much of society believing they brought it on themselves "for acting like a woman." The high level of stigma related to homosexuality is directly connected to the criminalization of homosexuality (Papworth, 2014).

Within the MSM community, commonly held gender beliefs for males and females are often applied to MSM partners. Tops (anal-insertive partners), to whom norms for men are applied, are perceived to be the stronger partner, hold the decision-making power (including around condom use), and often have multiple partners. Many tops also have girlfriends and do not identify as gay, making them harder to reach in the MSM community. Some MSM feel obligated to have female partners to protect them from appearing gay and lessen the stigma perpetuated against them by society. Bottoms (anal-receptive partners) are perceived to be the more feminine and weaker partner; they have no voice or power and are more vulnerable to stigma, persecution, and violence. One study has also shown that, in Douala, preferring a receptive sexual role was associated with increased odds of having HIV (Park, 2013). Bottoms also tend to be more economically vulnerable; one participant noted that because they are more effeminate, they are often rejected by their families and turn to sex work to support themselves.

As described below, the pervasive stigma that MSM and FSW experience from family, community members, healthcare providers and society at large for not conforming to traditional gender roles and behaviors for men and women, respectively, deeply affects their risk of violence and HIV acquisition, as well as their desire and ability to access health services, get tested for HIV, and access and adhere to HIV treatment.

Access to healthcare and HIV programming

Stigma and discrimination from healthcare providers is a major obstacle to accessing quality care among MSM and FSW, as reported by gender analysis participants and documented by others (Papworth, 2014). As described below, stigma and discrimination in the healthcare setting affects: (1) whether MSM and FSW seek services; (2) whether they disclose risk behaviors when they do seek services; and (3) availability or provision of KP-friendly services.

Many MSM do not access health services for fear that they will be identified as gay by providers or other health center staff and that this information will be shared with others. They also fear verbal insults, refusal of service, or judgmental counseling that they need to “convert” to heterosexuality. Respondents noted that such past experiences caused them to avoid specific health centers. Even MSM who wish to disclose their sexual practices are reluctant to do so for fear the provider may have them arrested.

Criminalization has also been reported to affect health service provision. A physician in one study noted, “We can’t tell ourselves that we will put structures in place to support them [MSM] because these structures will be the target of police which will be within its purview” (Papworth, 2014). The lack of MSM-friendly services and experiences of being treated poorly by providers and staff and public healthcare facilities has been further documented in a qualitative study with MSM from five regions across Cameroon (Cange, 2015). This study also found that strong feelings of alienation and hopelessness – linked to stigmatization and discrimination – among MSM were a barrier to uptake of clinical HIV services, even when these services were available without a financial or logistical barrier (Cange, 2015).

Most sex workers do not disclose to providers that they are sex workers when they go for services because they fear they will be stigmatized and judged. For those who do not disclose, participants reported “they are treated as any other client” by healthcare providers. However, those who do disclose or are suspected by providers to be sex workers (e.g., because they indicate that they are not married or they present with STI symptoms) are often treated badly and will not return for services there. Because they try to avoid disclosure, most sex workers do not feel that criminalization of sex work affects their access to services. Indeed, even if sex work was legalized, they said they would not disclose they are sex workers because it is so culturally unacceptable. However, criminalization affects access to quality care insofar as sex workers feel they cannot talk openly with providers for fear of how they will be treated and, therefore, providers are unable to accurately assess and address their risks and needs. Providers felt that speed and quality of service provision, as well as clients’ trust/confidence in the provider, greatly influenced their uptake of health services. They also reported that all sex workers who qualify for PMTCT have access to those services through referral to the appropriate health center.

For many FSW and MSM, the drop-in-center (DIC) is the only place they feel safe, supported, and comfortable accessing care. As one MSM said, “it is the only place you can openly talk about yourself.” However, currently the DICs are very HIV-oriented and all FSW and MSM reported that offering a broader integrated package of services at the DIC would make the HIV services more acceptable and convenient and would encourage more FSW and MSM to access services there. All FSW and MSM reported wanting HIV programs to go beyond HIV and address their needs in a more holistic manner.

FSW want the DIC to not only offer HIV testing and counseling and access to free condoms and lubricant, but also STI services, care and treatment (including CD4 and other lab services, which pose financial barriers to sex workers), free medications, vaccinations, family planning, post-abortion care, maternal/PMTCT support for women who are pregnant, PEP for women who are raped, legal support when they experience violence, and nutritional support (especially for those who are just entering treatment). They would also like to integrate life skills training (especially for young sex workers) and income generating activities, as well as fun activities like cooking classes and beauty services. Notably, many of the FSW participants commented that they did not want to be sex workers. Indeed, one woman noted that she would gladly do other lower paying work in order to regain a sense of dignity. Lastly, the ideal program for sex workers would provide support not only to sex workers but also their children (including educational support and medical care).

MSM would like to see the service package that the DIC offers broadened to include nutritional support, lab services, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP). They also reported that the DICs need to have greater volumes of condoms and lubricant onsite as stock outs are common. Several MSM CBO representatives advocated for more onsite testing in the community, greater implementation of test and treat, police involvement in HIV programming, legal support for MSM, MSM-friendly behavior change communication (BCC) materials, and sensitization within the MSM community to improve gender/power dynamics within the couple. Housing support was also a major expressed need of MSM since many MSM, and young MSM in particular, are rejected by their families and kicked out of their homes live on the street. They would also like HIV programs to incorporate more fun activities for MSM (e.g., fashion shows, concerts, potlucks).

Both MSM and FSW reported that peer education and support groups are the best and preferred ways of reaching them with HIV information. Young sex workers and MSM are especially vulnerable and in greatest need of sensitization and education, but are often hidden and hard to reach. It can be difficult to convince them to access services. Young MSM, for example, are especially vulnerable because they live at home, but cannot disclose their status and have to hide their drugs if they are on treatment. MSM-specific DICs work for people who are out, but not for people who are hiding, like most young MSM and MSM who are living with female partners.

HIV Testing and Treatment

The vast majority of MSM and FSW reported that fear that their HIV status will not be kept confidential by providers or others who may learn their status – and the stigmatization that would result from being identified as HIV-positive – is a major barrier to uptake of HIV testing. Many sex workers do not want to get tested for HIV for fear of the stigmatization that will come from other sex workers, family and community members if they test positive. Many MSM are afraid of being diagnosed with HIV because of the stigmatization that will come from within the MSM community, as well as the “double stigma” that would come with being both an MSM and HIV-positive. Many MSM and FSW are also deterred from finding out their HIV status because they still believe that a positive HIV diagnosis is a death sentence. Participants reported that psychosocial counseling and increased availability of onsite testing in MSM and FSW hotspots can make it easier for them to get tested. However, more sensitization is needed in the community that getting diagnosed with HIV does not mean you are going to die (treatment literacy). Sex workers reported that sensitization from peer educators on why it is important to know one’s status, what she can do if she is positive, and other services available to her if she comes for testing encourages many sex workers to seek testing. Assurances that one’s HIV status following testing will remain confidential is critical to encouraging both sex workers and MSM to access testing.

Getting MSM who test positive on treatment is difficult. Some MSM identified economic barriers to seeking treatment. Providers reported that some MSM don’t seek treatment for fear that they will be stigmatized or beaten if observed to be taking regular medications and, therefore, suspected as HIV-positive. Through one-on-one counseling and support groups, peer educators can convince MSM that the best way to reduce stigma is to go on treatment because it will keep them healthy and strong and eliminate physical manifestations of the disease. MSM are also encouraged to seek treatment if there is a package of services available to them, including psychosocial support, nutritional support, treatment of other STIs/OIs, and prevention materials (e.g., free condoms and lubricant).

For sex workers, self-stigmatization and fear of breach of confidentiality by providers discourage them from seeking treatment. Side effects from treatment can also demotivate sex workers to get on treatment if they prevent them from working. Another discouraging factor is the delay between testing and start of

treatment. (Test-and-treat is not currently implemented in Cameroon.) Some sex workers on treatment are lost to follow-up as a result of poor treatment by providers. Arrests from police can keep sex workers from adhering to treatment if they are unable to access their medication while detained. The mobility of sex workers also presents a barrier to treatment adherence since drugs must be obtained from the same healthcare center over time. FSW participants reported that having treatment available at the DIC would improve access and adherence to treatment. Knowledge of the risks of not being treated also encourages sex workers to seek treatment, including understanding that if they become sick, they will have to stop working. Counseling, education, and follow up through home visits by peers can help motivate FSW to seek treatment.

Violence

The perpetration of violence against sex workers and MSM is a violation of their human rights, increases their risk of acquiring HIV, is associated with inconsistent condom use, and affects their access to HIV services and adherence to HIV treatment (Decker, 2015; MSMGF, 2015). Experiences of violence among MSM and FSW in Cameroon are frequent and widespread. Much of this violence appears to be driven by stigma toward FSW and MSM for not conforming to gender and heterosexual norms, and it is enabled by the criminalization of sex work and homosexuality and the resulting lack of law enforcement protection from violence.

In a recent survey of sex workers from seven cities in Cameroon, 60% reported ever having experienced physical or sexual violence (Decker, 2015a). Participants in the gender analysis reported that violence against sex workers takes many forms – physical, sexual, economic, and emotional – and is perpetrated by a variety of actors, including clients, pimps, family members, police officers, and between sex workers themselves. The police were widely acknowledged by participants to be among the worst perpetrators of violence, with several women reporting that police routinely have sex with them and then refuse to pay, or arrest them and then force them to have sex in order to be released. All FSW participants felt it was useless to report violence when it occurred because they risked being exposed as a sex worker, which in turn meant they would be blamed for the violence and possibly even arrested. Because sex workers are perceived as being “outside of the law,” they are not protected by police and have no access to justice. Most sex workers feel they have no place to go for support after experiencing violence, except to a peer sex worker or the DIC. None reported being screened for violence when accessing health services and no providers reported offering screening or messaging on how to deal with violent partners, including for those who test HIV-positive. The high levels of violence described by FSW participants, as well as the reports of victim blaming and a lack of justice or social assistance for sex workers who were raped or experienced other types of intimate violence are consistent with other research findings on violence against sex workers in Cameroon (Decker, 2015a; Lim, 2015; Papworth, 2014).

In a study on violence against MSM in Cameroon, 1 in 4 MSM reported a history of sexual violence and over 1 in 10 reported physical abuse (Decker, 2015b). Perpetrators of violence against MSM include family members (rejection); neighbors (physical violence); classmates (bullying in schools); and the police (arrest and extortion). Intimate partner violence between MSM is also common, as is blackmail within the MSM community (e.g., threatening to out other MSM to their families or employers in exchange for money). When intimate partner violence occurs, the violent partner often threatens to out the other if they report violence perpetrated by them. Another form of violence occurs when MSM are evicted from their residence by landlords or terminated from their employment when they are discovered to be gay. The media also normalize violence against MSM. MSM participants reported they have no place to go if they are experiencing violence, except for the DIC. Moreover, there is a danger for gay men in complaining about/reporting violence; it may require disclosing they are gay which, in turn, could lead to their arrest.

Indeed, despite the fact that 27% of MSM in one study were found to have been detained or physically injured in an altercation, few reported that they would be willing to come forward to lodge a complaint regarding discriminatory acts either in public or in healthcare settings (Papworth, 2014). Another study reported that violence among MSM was associated with denial of health services, mistreatment in the health sector, and with arrest, imprisonment, and the feeling that police fail to protect them (Decker, 2015b). MSM in prison are especially vulnerable to rape and other abuse and an MSM CBO representative reported that 100% of them come out of prison completely dehumanized as a result of beatings, rape, becoming HIV-positive, and lack of visitation from family members.

Participation in Policymaking

Participants could provide no examples of the government successfully partnering with the MSM and sex worker communities, and they are not typically represented in policy discussions. The Global Fund Country Coordinating Mechanisms (CCM) has a seat for KPs, which is occupied by an MSM CBO representative, who speaks on behalf of all KPs. No sex workers are involved in the CCM or were involved in development of the most recent Global Fund concept note. In general, sex workers have difficulty organizing themselves as a group – a struggle mentioned by FSWs as well as NGO representatives – therefore, it is a challenge to engage them in policy discussions.

Recommendations: FSW and MSM

The gender analysis identified a number of structural barriers to HIV service uptake and the overall health and well-being of key populations rooted in gender-based stigma, discrimination, and violence. Addressing these barriers is critical if PEPFAR is to support effective HIV programming for key populations in Cameroon. The following recommendations are specific to the findings from the gender analysis in Cameroon, but consistent with global best practice for implementing HIV programs with sex workers and MSM outlined in the [SWIT](#) and [MSMIT](#), respectively. Moreover, the recommendations are aligned with the 2013 PEPFAR Gender Strategy in that they acknowledge the role that gender plays in the HIV epidemic among key populations and are designed to better enable FSW and MSM to access and utilize HIV prevention, care, and treatment services; practice healthy behaviors; exercise their rights; protect themselves and improve their health outcomes; and live lives free from violence, stigma, and discrimination.

Key recommendations for integrating gender into HIV programming for FSW and MSM in Cameroon include:

- In collaboration with KP-led CBOs, **train/sensitize staff and providers** in public health centers on sexual diversity, human rights (including the right of all people to quality healthcare), the importance of maintaining patient confidentiality, MSM- and FSW-specific risk factors for HIV, clinical skills for treating and addressing medical care needs of MSM and FSW (e.g., treating anal STIs) and how to provide services to MSM and FSW free of stigma, judgement, and discrimination. Ask high level decision-makers at health care facilities where providers have been trained to pledge to offer stigma and discrimination free care.
- **Institute a system through which stigma and discrimination that occur in health care settings, including breaches in confidentiality, can be reported.** Educate providers on the system as part of trainings to be more responsive to KPs' needs so that they recognize they will be held accountable. Have regular meetings of health care facility leadership, government officials, NGOs and KP-serving organizations to discuss reported events and take appropriate action.
- **Support an expanded package of integrated health and non-health services available at the DIC** to FSW and MSM clients so as to increase the attractiveness of the DICs and encourage greater uptake of services at the DIC. The DICs are some of the only safe places FSW and MSM feel they can go to

receive services and support one another and, therefore, they provide a critical entry point for more holistic care that could facilitate uptake of HIV testing and adherence to treatment. Priority services to add to the current package of HIV-oriented services include nutritional support, family planning (for FSW), and violence response services. For sex worker DICs, also explore how linkages can be made with PEPFAR-supported programming for orphans and vulnerable children to increase access to care for the children of sex workers.

- **Continue fostering KP-led outreach by supporting peer educators and peer-led support groups** for FSW and MSM and consider expanding the number of trained peer educators from the communities and the range of information and services they provide. For example, broaden the sensitization that peer educators provide to include information about medical assistance available for rape, other violence-response services and, for FSW, how to access family planning to prevent unintended pregnancies. In addition, strengthen the role that peer educators play in improving treatment literacy in the communities through greater education on HIV as a condition that can be treated. Related, better leverage peer educators and support groups to address stigma against people living with HIV within KP communities through [positive health, dignity, and prevention](#)-related messaging and interventions.
- **Provide more onsite HIV testing** in FSW and MSM communities, and **introduce test-and-treat models** for MSM and FSW to improve treatment uptake for those who test positive. For MSM, accompany onsite testing with BCC campaigns and materials targeting gay men that talk less about sexual orientation and more about sexual practices.
- **Strengthen the links between HIV programming and violence-response services** by placing CBOs at the center of violence response for KPs. Build the capacity of CBOs in Cameroon that serve FSW and MSM to implement the Minimum Package of Services for KP Violence Response developed by the LINKAGES and CHAMP projects and provide support for the implementation, evaluation and, if appropriate, scale up of the package. Support the ability of CBOs providing violence response services to also offer rapid HIV testing, PEP, and other services at the DIC by advocating for changes in the government policies that prohibit these services. (For example, existing policy only authorizes HIV testing at government-accredited test centres, and only one DIC is currently accredited to offer testing - Alternatives Cameroon in Douala.)
- **Work with the police and other stakeholders in the justice system** (e.g., judges, prison guards, lawyers, media, traditional leaders) to promote understanding of the human rights of FSW and MSM, reduce violence and increase protections and access to justice among FSW and MSM, even when sex work and homosexuality are criminalized. Conduct advocacy and trainings with the police and other stakeholders on the rights of FSW and MSM and build a network of KP-friendly police stations with institutional accountability to uphold the rights of sex workers and MSM. Using the [M-friends and M-watchers approach](#) from Ghana as a model, build a community-based rapid-response system to help MSM and FSW access health, legal, and police protection when threatened or abused.
- **Invest in community empowerment approaches with FSW** whereby they are supported to come together as a community to develop internal cohesion and mobilize to articulate and demand their human rights and entitlements and participate in policy discussions and the design and implementation of HIV programs for them. Such approaches have been significantly associated with reductions in HIV and other STIs among sex workers in other settings (Kerrigan, 2015). Moreover, as described in the SWIT, community empowerment is fundamental to addressing HIV among sex workers in a sustainable way. The interventions delivered through a community empowerment approach may include sensitization and training with community members to raise awareness about their rights, the establishment of community-led safe spaces, the formation of collectives that determine the range of services to be provided, outreach, and advocacy.

- **Introduce low capital agricultural income generation activities**, such as mushroom farming, with FSW as a means of nutritional support, as well as economic empowerment for women who wish to have the option of leaving sex work. Support economic empowerment and entrepreneurship of young FSW and MSM through life skills training.
- **Establish youth-friendly services** (that are also KP-friendly) or a youth-friendly clinic in mainstream public health centers as a way to reach young MSM and FSW who do not want to be seen accessing a DIC. The youth-friendly services could also be an entry point for discussions and outreach with young people in Cameroon that are focused on challenging homophobia and other harmful gender norms.
- **Facilitate increased participation of MSM and FSW in relevant policy dialogues.** For example, support the Government and civil society-led KP Network (chaired by Affirmative Action) to build on the already expressed recognition of KPs in the current National HIV/AIDS Strategic Plan (2014-2017) and proactively develop KP-specific input and recommendations for the next Strategic Plan so that it more accurately reflects their needs and elaborates appropriate strategies to meet them. In addition, through the leadership of KP Task Force within NACC, provide support for facilitated discussions between the MOH (where MSM and FSW are recognized) and Ministry of Justice (where MSM and FSW are criminalized) with the long-term goal of forming a KP Task Force that is co-chaired by the two ministries and has meaningful representation and participation from the MSM and FSW communities.
- **Directly identify and seek to transform harmful gender norms that affect MSM and FSW, but also the broader population, throughout a range of KP interventions.** Use peer education, support groups, and other platforms to promote discussion of the ways that gender norms increase HIV risk and limit service seeking, including through damaging individuals' feelings of self-worth. In healthcare worker trainings, discuss the role of gender-norms in stigma against KPs but also the harms caused to the broader population, including providers themselves. Talk about the acceptability of violence against women and the ways in which this belief increases violence against both FSWs and "bottoms" in MSM relationships.
- **Promote greater understanding, acceptance, and tolerance of MSM and FSW in Cameroon by broader society.** For example, advocate for the integration of the rights of FSW and MSM as part of the human rights protection framework of the National Human Rights Commission and/or support a mass media anti-homophobia campaign as ways to achieve greater public awareness about gender and sexual diversity and reduce stigma.

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