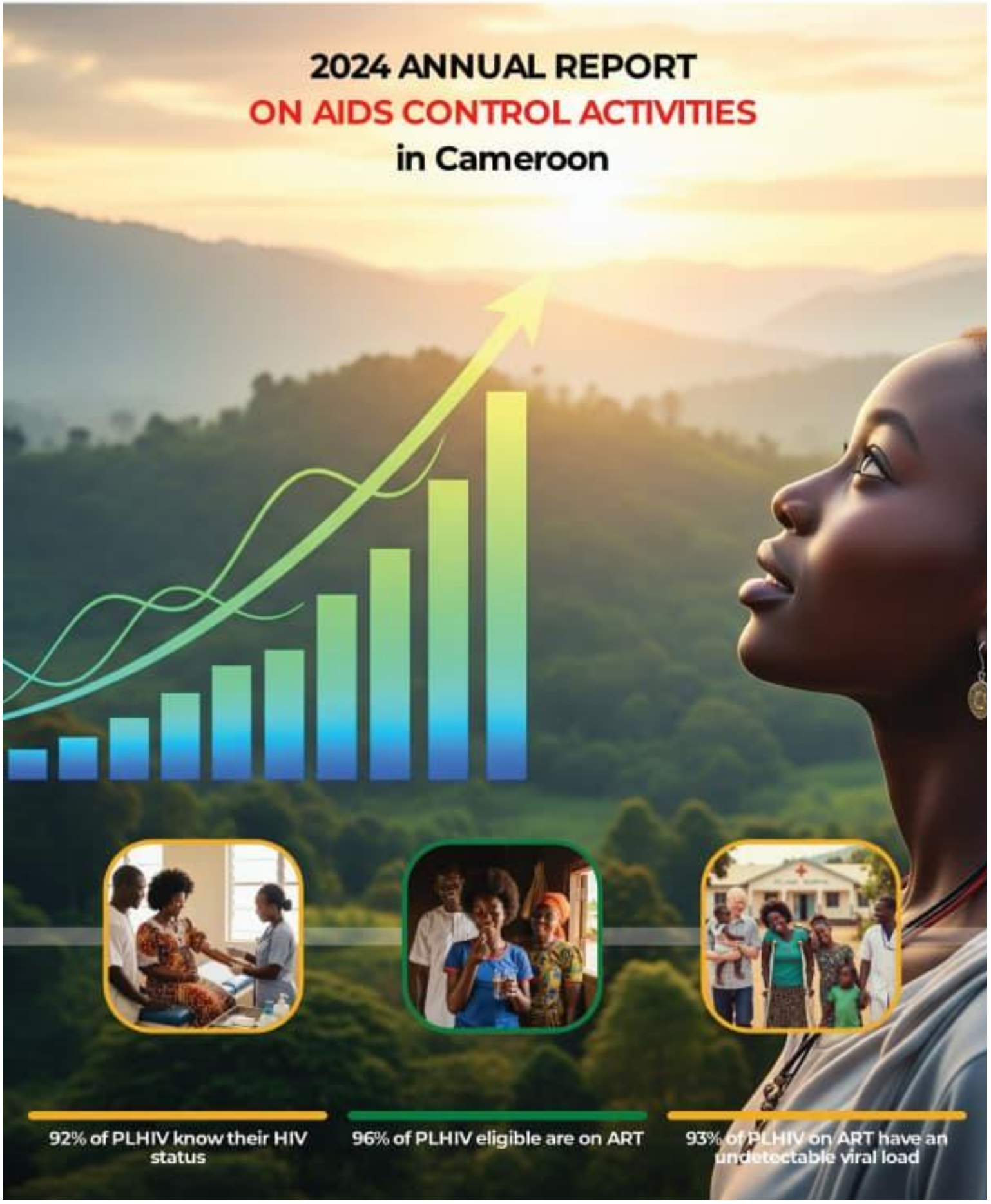
2024 ANNUAL REPORT
ON AIDS CONTROL ACTIVITIES
in Cameroon



Mes 3 réflexes pour une vie positive

Si je fais mon test de dépistage, je connais mon statut sérologique.

Si je suis séropositif (ve), je prends mon traitement et je reste en bonne santé.

Si je prends mon traitement en continue, le virus est neutralisé.

Les antirétroviraux maintiennent en vie

MINISTERE DE LA SANTE PUBLIQUE

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LIST OF ABBREVIATIONS

ACMS: Cameroon Association for Social Marketing
ACRR: Data Clerck
AHD: Advanced HIV Disease
ANC: Antenatal care
ARC: Community Relay Agent
ART: Antiretroviral Treatment
ARV: Antiretroviral drugs
BFW: Breastfeeding Women
CAA: Autonomous Sinking Fund
CBO : Community-based Organisation
CDIP: Provider-initiated screening advice
CENAME: National Procurement Centre for Essential Drugs and Medical Devices
CF: Counterpart Funds
CPCG : Centre Pasteur du Cameroun annexe de Garoua
CSO: Civil Society Organisation
DBS: Dried Blood Spot
DHIS2: District Health Information System
DHS: Demographic Health Survey
DIC: Drop In Center
DQA: Data Quality Assessment
DR/LR : Delivery Room/Labour room
EGPAF: Elizabeth Glaser Pediatric AIDS Foundation
HEI: Exposed Infants
FA: Active File
FSW: Female Sex worker
GBV : Gender Based Violence
GF: Global Fund
HD: Health District
HF: Health Facility
AFH : HIV Free Holidays
HIV : Human Immunodeficiency Virus
HRP: High risk population
HT: Health Talk
ICD: Intervention under Community Directives
IDB: Islamic Development Bank
IRCCB: Chantal Biya International Reference
MINAS: Ministry of Social Affairs
MINEDUB: Ministry of Basic Education
MINJEC: Ministry of Youth and Civic Education
MINPROFF: Ministry of Women Empowerment and the Family
MOH: Ministry of Public Health
MSM: Men who have sex with Men
MU: Mobile Unit
NACC: National Aids Control Committee
NOSO: North West, South West
NSP: National Strategic Plan
OTC: Outpatient Treatment Centre
OVC: Orphans and Vulnerable Children
OVP: Other Vulnerable Populations
PC: Paediatric Care
PCHW: Polyvalent Community Health Workers
PCR : Polymérase Chain Réaction
PE : Peer Educator
PEPFAR: Presidents Emergency Plan for Aids Relief
PLHIV: People living with HIV
PMTCT: Prevention of Mother-to-Child Transmission
PNC: Post Natal Care
POC: Point of Care
PODIC: Community dispensing point
PR: Principal Recipient
PSA: Psychosocial Support Agent
PW: Pregnant Women
RFHP: Regional Fund for Health Promotion
RTG: Regional Technical Group
SBC: Social and behavioural changes
SR: Sub Recipient
SRH: Sexual and Reproductive Health
STI: Sexually Transmitted Infections
TB: Tuberculosis
TFP: Technical and Financial Partners
UNAIDS: United Nations Programme for HIV/AIDS
UNFPA: United Nations Population Fund
UNICEF: United Nations Children's Fund
UPEC: Care Unit
USAID: U.S. Agency for International Development

VCT: Voluntary Counselling and Testing
VL: Viral Load
WHO: World Health Organization
YTBNS: Young and teenage Boys not attending School
YTGNS: Young and Teenage Girls not attending School

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Introduction

The year 2024 marked an important milestone in the implementation of the national HIV response in Cameroon. Committed to the UNAIDS 95-95-95 targets and the elimination of AIDS as a public health threat by 2030, the country continued its efforts through strategic, multisectoral and community interventions.

This annual report presents key achievements, progress and challenges in the areas of prevention, testing, management, viral suppression, governance and coordination. It reflects the ongoing commitment of national authorities, technical and financial partners, civil society organizations and communities to strengthen the response to HIV, improve access to care, reduce new infections and ensure a better quality of life for people living with HIV.

In a context of limited resources, but of strong political will and notable programmatic innovations, the year 2024 has made it possible to consolidate the achievements while mapping out the prospects for accelerating the response in the coming years.

Summary of programmatic performance in 2024

Number of people living with HIV in Cameroon

Table 1: Estimated number of PLHIV

	2020	2021	2022	2023	2024	Trends
PLHIV (total)	488 640	484 869	480 228	474 764	510 000	↗
Children < 15 years	33 475	31 280	29 168	26 182	20 450	↘
Adolescents (15-19 years)	18 351	17 632	16 719	15 751	13 340	↘
Youths (20-24 ans)	31 152	29 560	27 796	26 001	24 272	↘
Adults (15-49 ans)	376 163	368 826	359 988	350 477	368 175	↗
Women	322 598	321 509	319 583	317 108	330 000	↗

Source : Report on HIV 2024 estimates and projections

Reduction in new infections

Table 2: Number of new HIV infections

	2020	2021	2022	2023	2024	Trends
New HIV infections (total)	14 074	12 221	9 898	7 297	13 000	↘
Children < 15 years	4 411	3 793	3 414	1 702	2 722	↘
Adolescents (15-19 years)	1 797	1 577	1 218	1 052	1 087	↘
Youths (20-24 years)	2 031	1 766	1 359	1 176	2 308	↘
Adults (15-49 years)	9 015	7 862	6 047	5 217	9 638	↘
Women	8 949	7 799	6 256	4 792	8 000	↘

Source : Report on HIV 2024 estimates and projections

HIV-related deaths:

Table 3: Number of HIV-related deaths

	2020	2021	2022	2023	2024	Trends
HIV related deaths (total)	13 330	11 569	10 198	8 561	9 400	↘
Children < 15 years	3 414	3 177	2 795	2 160	1 873	↘
Adolescents (15-19 years)	412	389	376	323	268	↘
Youths (20-24 years)	481	459	453	311	385	↘
Adults (15-49 years)	7 508	6 314	5 531	4 715	5 287	↘
Women	7 012	6 154	5 484	4 636	4 700	↘

Source : Report on HIV 2024 estimates and projections

Preventive measures against HIV infection .

Distribution of condoms, lubricant and prevention products:

Table 4: Number of condoms and lubricants distributed

	2020	2021	2022	2023	2024	Trends
Female condoms	2 918 908	2 660 738	2 846 635	1 005 380	349 506	↘
Male condoms	41 057 011	33 111 351	29 122 272	28 180 438	24 027 837	↘
Lubricants	912 714	14 059 136	12 347 440	5 615 620	2 202 014	↘
Prep among MSM	1 064	1 376	1 853	2 020	3 989	↗
Prep among FSW	688	1082	2984	3 789	7 443	↗

Source : CARE and CHP 2024 activity report and NACC 2024 annual report

HIV Screening and Testing

Table 5: Number of people tested for HIV.

	2020	2021	2022	2023	2024	Trends
Number of people tested (fixed and community strategies)						
Nb of people tested	2 984 346	3 479 989	2 948 355	2 638 708	**1 996 138**	↘
Nb. of people tested HIV+	99 273	92 829	70 206	54 916	**46 025**	↘
Seropositivity rate	3,3%	2,7%	2,4%	2,1%	**2,3%**	→

Source : Monthly activity reports from health facilities in 2024 and NACC 2023 annual report

Table 6: Prevention and screening for key and vulnerable populations.

	2020	2021	2022	2023	2024	Trends
Number of people benefiting from HIV prevention programmes						
Female Sex Workers (FSW)	69 361	46 841	83 344	60 964	**91 188**	↗
MSM	38 291	18 801	39 963	45 388	**38 899**	↗
DU	1 252	6 019	6 393	3 172	**6 873**	↗
TG	1 963	466	1 627	1 285	**1 191**	↘
Clients of FSW	141 378	18 965	12 927	11 758	**7 208**	↘
YTGNS	49 201	29 800	12 326	12 079		
YTBNS	55 182	12 634				
Seropositivity rate						
Female Sex Workers (FSW)	11,6%	5,6%	5,2%	4,3%	**3,3%**	↘
MSM	13,0%	10,4%	6,3%	6,2%	**4,3%**	↘
DU	8,2%	3,8%	3,1%	4,9%	**3,3%**	↘
TG	12,7%	10,1%	11,2%	12,0%	**8,5%**	↘
Clients of FSW	2,4%	3,0%	3,9%	3,3%	**6,7%**	↗
YTGNS	1,2%	1,2%	1,1%	1,1%		
YTBNS	0,7%	1,0%	1,1%	1,0%		

Source : CARE and CHP 2024 activity report and 2023 NACC annual report.

Prevention of Mother to child Transmission

Table 7: Prevention of mother-to-child transmission of HIV.

	2020	2021	2022	2023	2024	Trends
Number of PW received at ANC	785 253	869 313	853 399	826 115	**758 346**	↘
ANC Attendance rate	83,2%	86 ,7%	83,2%	78,7%	**69,7%**	↘
Proportion of PW screened who knew their status	89,6%	94,8%	99,7%	99,8%	**98,8%**	↘
Number of HIV+ PW identified	20 852	19 081	17 587	15 378	**12 057**	↘
Seropositivity rate among PW	2,9%	2,3%	2,1%	1,9%	**1,8%**	↘
Proportion of PW already known to be HIV+	49,1%	55,8%	57,9%	58,9%	**59,3%**	↗
Number of PW HIV+ on ART	16 731	17 304	15 950	13 899	**10 937**	↘
Proportion of HIV+ PW initiating ART	80,2%	90,7%	90,7%	90,1%	**90,7%**	→
Ratio of PW partners screened	0,04%	0,04%	0,04	0,04	**0,04**	→
Seropositivity rate in male partners of PW	2,8%	1,5%	1,3%	1,4%	**2,7%**	↗↘
Number of HEI identified	14 137	13 807	13 414	12 957	**9 889**	↘
Number of HEI who carried out PCR exam	13 777	12 160	13 381	12 538	**8 615**	↘
Proportion of HEI receiving PCR services	97,4%	88,2%	99,4%	96,8%	**87,1%**	↘
Proportion of HEIs on ARV prophylaxis	85,2%	91,5%	94,3%	94,9%	**94,5%**	↗
Positivity rate among HEI	4,3%	4,0%	3,6%	3,3%	**2,3%**	↘
% of HEI with PCR+ who initiated ART	62,3%	72,6%	80,4%	78,4%	**93,4%**	↗

Source: Monthly activity reports from health facilities in 2024 and 2023 NACC annual report

Care and treatment of PLHIV

- Linkage to ART

Table 8: Link to ART among key and vulnerable populations

	2020	2021	2022	2023	2024	Trends
Link to ART (%)						
Female Sex Workers	64,1%	75,1%	78,9%	72,6%	**99,6%**	↗
MSM	42,2%	80,7%	95,1%	88,6%	**92,9%**	↗
IDU	68,9%	75,9%	82,2%	77,6%	**82,1%**	↗
TG	54,0%	85,1%	85,6%	81,0%	**90,1%**	↗
Clients of FSW	71,3%	60,6%	65,1%	69,7%	**98,5%**	↗
YTGNS	67,9%	66,3%	67,3%	74,3%		
YTBNS	67,6%	70,1%	69,1%	79,8%		

Source: CARE and CHP Activity Report 2024 and 2023 NACC Annual Report

Table 9: Monitoring PLHIV on ART

	2020	2021	2022	2023	2024	Trends
Identified PLHIV	413 188	469 783	460 088	481 147	468 449	↗
% Awareness of HIV+ status	83,2%	94,1%	95,8%	98,1%	92%	↗
Active file	350 818	388 358	424 771	448 818	449 290	↗
% link to ART	84,9%	82,7%	93,3%	96,2%	96%	↗
Number of VL test performed	203 905	241 613	265 019	203 134	308 861	↘
% VL test done	58,1%	62,2%	62,4%	45,3%	68,7%	↘
VL suppression	172 212	227 429	236 493	174 593	282 328	↘
% VL suppression	84,5%	94,1%	89,2%	85,9%	93%	↘
Retention at 12 months	75,7%	ND	85%	87%	88,8%	↗

Source : 2024 reference laboratories database and 2023 NACC annual report

TABLE 10: SUMMARY OF REGIONAL PROGRAMMATIC RESULTS

	Adamawa	Centre	East	Far-north	Littoral	North	North-west	West	South	South-west	National
Prevalence (EDS 2018)	4,10%	3,5%(without Ydé)	5,60%	1,10%	2,4%(without Dla)	1,70%	4,00%	1,60%	5,80%	3,20%	2,70%
		Yaoundé : 2,4			Douala : 2,4						
Women	4,70%	4,30%	7,30%	1,10%	3,90%	2,50%	5,80%	1,80%	5,50%	3,70%	3,40%
Men	3,40%	2,70%	3,40%	1,10%	1,10%	0,70%	1,60%	1,30%	6,10%	2,60%	1,90%
Seropositivity rate											
General population											
Pregnant women	1,9%	2,8%	2,9%	0,5%	2,5%	0,9%	2,7%	1,5%	3,1%	240,0%	1,8%
Partners of PW	3,3%	3,3%	5,0%	5,3%	3,3%	3,4%	1,5%	0,8%	2,1%	1,3%	2,7%
Exposed Infants	1,4%	1,7%	2,9%	2,5%	3,0%	2,7%	1,4%	0,8%	2,0%	1,3%	2,3%
Prevention of mother-to-child transmission											
ANC coverage	83,8%	70,1%	94,9%	73,0%	64,4%	69,0%	51,8%	71,1%	76,7%	42;2%	69,7%
Syphilis screening rate on PW	50,5%	36,3%	51,7%	31,4%	50,6%	38,7%	76,9%	61,9%	51,3%	79,0%	45,5%
ART coverage in PW	97,6%	80,7%	95,2%	92,9%	92,0%	93,6%	95,8%	91,1%	99,3%	90,4%	90,7%
Prophylactic ARV coverage in HEIs	98,9%	86,6%	96,9%	94,9%	97,1%	94,4%	95,7%	98,1%	99,8%	95,6%	94,5%
Screening on HEIs	73,0%	93,3%	75,9%	96,4%	86,1%	79,7%	71,9%	97,5%	88,1%	103,0%	87,1%
Care and treatment											
Linkage to care	93,4%	87,7%	94,3%	93,6%	82,6%	91,5%	84,5%	91,2%	94,6%	89,5%	89,4%
VL carried out	43,3%	50,5%	49,7%	91,5%	83,1%	68,2%	87,5%	90,0%	81,0%	68,3%	68,7%
Viral Load suppression	92,8%	88,6%	85,7%	92,5%	92,1%	89,4%	93,9%	94,7%	91,9%	92,2%	91,4%
Retention to care at 12 months	87,5%	86,0%	87,2%	87,9%	83,6%	91,8%	86,1%	92,2%	92,9%	91,2%	88,8%
Active file	25 723	115 372	38 996	29 309	70 051	28 776	43 332	34 119	25 859	37 753	449 290
CBO's active file	1224	10474	2445	1254	5670	1019	1419	1344	909	1755	27 513

Source : 2018 DHS survey, DHIS 2 and reference laboratories database

SUMMARY OF THE 2024 HIGHLIGHTS IN THE FIGHT AGAINST HIV IN CAMEROON

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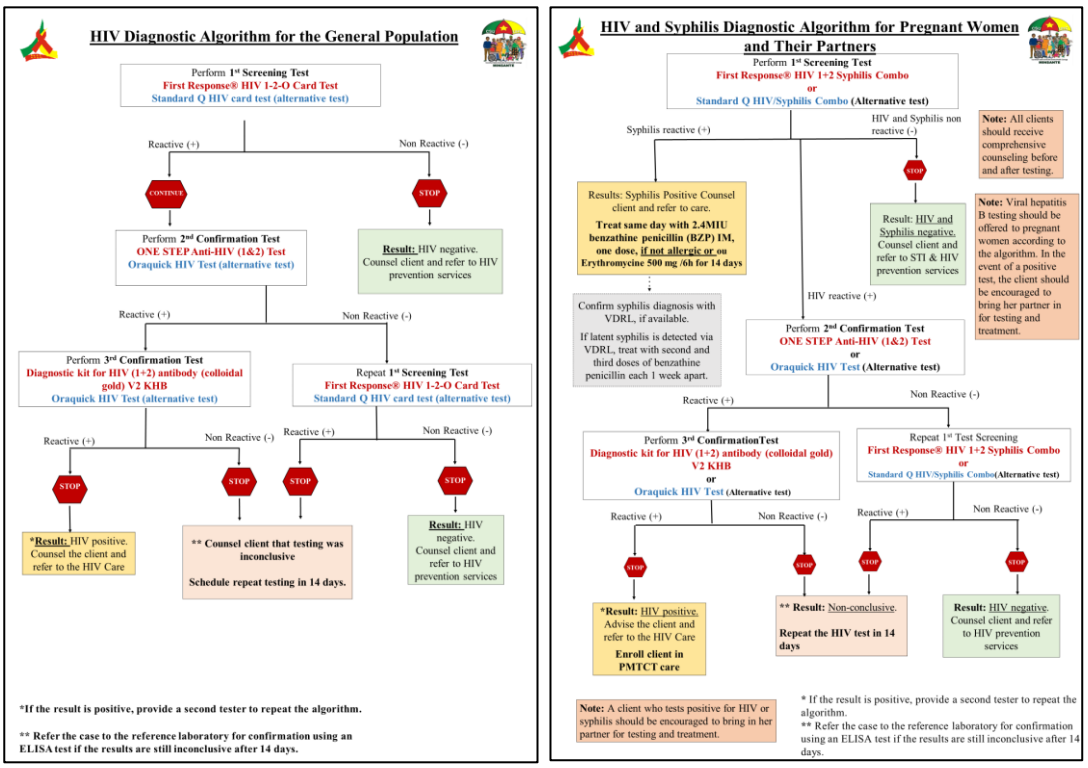
1. Transition from the 2-test algorithm to the 3-Test algorithm

Following the recommendations of the World Health Organization (WHO) for countries with low HIV seropositivity (less than 5%), Cameroon (with its national prevalence of 2.7% since DHS 2018) opted for the implementation of the three-test algorithm for HIV screening and diagnosis. This initiative is transitioning the 2-test algorithm to a 3-test algorithm in order to preserve the positive predictive value of testing for anyone who has tested HIV positive. To achieve this objective, a technical working group was set up by decision N/1403 of the MINSANTE on March 19, 2024, composed among others of representatives from the NACC, technical departments of the Ministry of Public Health (DPML, DLMEP, DSF), reference laboratories (CIRCB, LNSP and CPC), technical and financial partners (UNAIDS, WHO, UNICEF, Evidence Action, CDC, USAID, Care-Cameroon) and other experts. The work within the working group resulted in the development of a budgeted transition plan to the three-test algorithm that describes the process, strategies and interventions to be implemented for an effective and successful transition, also taking into account all the needs in terms of supply chain and tools for reporting test results and monitoring-evaluation indicators of implementation.

In its implementation, the transition was planned in two phases: the first phase (A), which concerns only pregnant women and key populations, is subdivided into two sub-phases (A1 and A2), the first of which (A1) concerns only 4 regions (Centre, Littoral, South, and West) for a duration of 3 months starting from July 2024; the second (A2) was an extension to the remaining 6 regions. Testing in these targets is coupled with the syphilis and hepatitis B test. The second phase (B) which focusses on the general population, began on January 2025, and aims to achieve nationwide coverage of all the targets.



Three-test HIV screening algorithm according to target populations in Cameroon.

2. The scaling up of the enrolment of PLHIV to Universal Health Coverage (UHC)

The World Health Organisation defines Universal Health Coverage (UHC) as an initiative aimed at guaranteeing that the entire population has access to essential preventive, curative, and palliative services, as well as rehabilitation and health promotion. It emphasises that these services must meet adequate quality standards to be effective, while also ensuring that their costs do not create financial barriers to accessing available health services. In pursuit of enhanced accessibility to health services for everyone, Cameroon inaugurated the UHC initiative, marked by the official commencement of phase I on April 12, 2023, led by the Minister of Public Health, Dr. Manaouda Malachie, in Mandjou, in the East region of Cameroon. HIV-positive individuals are prioritised during this phase, with the assurance that all Cameroonian citizens will receive free HIV screening and diagnosis, care for all individuals with HIV+ status free of charge (user fee) for clinical consultation services, antiretroviral treatment, viral load test monitoring of treatment efficacy, advanced disease management, psychosocial support, therapeutic education, and other services in health units and affiliated community-based organisations.

In order to make this vision of the Head of State effective, Cameroon has implemented a system of gradual enrolment of the population in the UHC through a platform administered by the National Technical Unit of the UHC. This helps in the monitoring of the effectiveness of authorized care within the framework of UHC, including all service offerings related to HIV/AIDS. At the end of 2023, 56.3% (252 633/448 818) of PLHIV were enrolled in UHC. By the end of the year 2024, this enrolment is moved from 56.3% to 86.8% (390 118/449 290). This result stems from the strong involvement of the NACC through the training of providers and field actors at all levels of the health pyramid, the focus on enrolment levels at each occasion of an activity in the field (including CAMPHIA), the extension of communication around the benefits of UHC, the monitoring with health training providers of the systematic enrolment of PLHIV at UHC during routine ARV dispensations, as well as the good collaboration between the NTC-UHC and the CTG/NACC through joint coordination and joint field work.

Régions	PvVS				
	Cible	Obectif 70%	PVVS Enrôlés	performance 70%	performance globale
Adamaoua	24 301	17 011	21 617	127%	89%
Centre	114 141	79 899	84 670	106%	74%
Est	35 498	24 849	34 329	138%	97%
Extrême Nord	25 283	17 698	24 965	141%	99%
Littoral	71 579	50 105	75 696	151%	106%
Nord	29 150	20 405	29 539	145%	101%
Nord Ouest	43 154	30 208	33 923	112%	79%
Ouest	32 081	22 457	25 087	112%	78%
Sud	23 390	16 373	26 608	163%	114%
Sud Ouest	36 419	25 493	34 951	137%	96%
Total	**434 996**	**304 497**	**391 385**	**129%**	**90%**

Updated performance of UHC among PLHIV in April 2025

2. Implementation of the CAMPHIA 2024 survey

Cameroon conducted during the year 2024 a survey to evaluate the impact of HIV on the Cameroonian population (CAMPHIA) thanks to the support of PEPFAR funding. It was a cross-sectional HIV-focused household survey conducted from a nationally representative sample of people aged 15 and above. This survey comes in a need to:

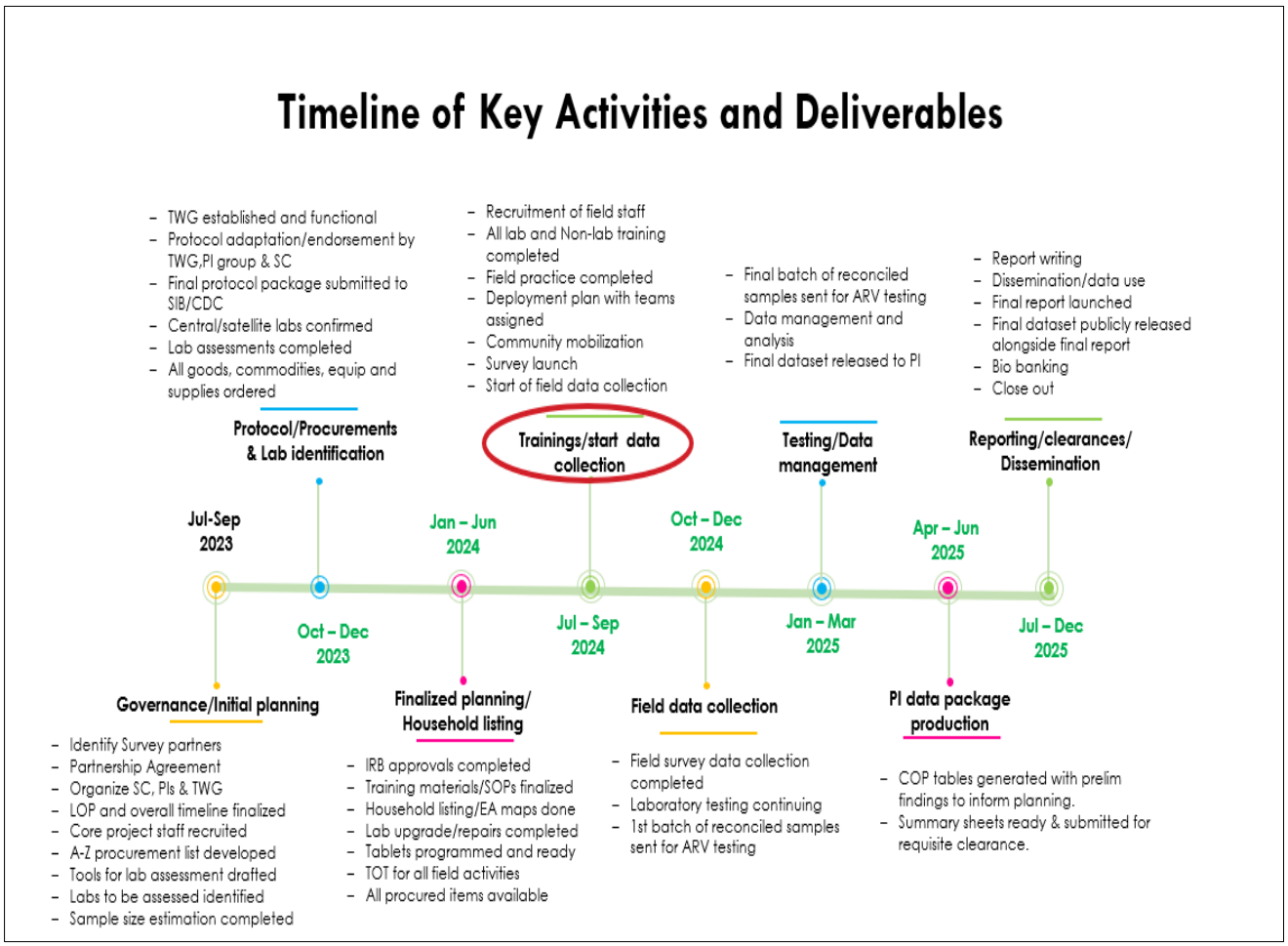
- Assess the prevalence and incidence of HIV in the population of Cameroon.
- Assess the coverage and impact of HIV services at the population level.
- Characterize HIV risk behaviours associated with contracting and/or transmission of HIV.
- Estimate the prevalence of key HIV indicators - viral load suppression, pharmaco-resistance and ARV plasma presence.
- Obtain data to estimate the UNAIDS 95-95-95 targets.
- Exploring the evolution of the epidemic and the impact of HIV efforts since CAMPHIA 2017.

The CAMPHIA 2024 survey was led by the Ministry of Public Health following a participatory approach through multi-partner collaboration in all phases. A technical working group was set up for better monitoring and evaluation. It was composed of representatives from the Ministry of Public Health (DROS, DPML, DLMEP, LNSP, CIRCB), the NACC, CDC, INS, CBCHB, ICAP, United Nations agencies, CBOs and other international NGOs. Among the key actors, INS and ICAP were responsible for ensuring the technical aspects of the survey in relation to data production (sampling, training of field actors, organization of collection, data clearance, analysis and data storage); CBCHB ensured the community mobilization, CRIHSS Foundation ensured the laboratory aspects in collaboration with CBCHB, the DROS ensured the technical coordination of the investigation, the NACC as beneficiary ensured the programmatic coordination through the monitoring of survey results, the identification of cases and the link to treatment as well as enrolment on the UHC for free care.

From a methodological point of view, the CAMPHIA survey covered a national sample of 22 strata comprising the 10 administrative regions subdivided into urban and rural areas as well as the major cities of Yaoundé and Douala, for a total of 512 enumeration zones to be selected. For a 2-tier draw, 15,360 households were randomly selected for an estimated participation of 12,240 households. These households will cover approximately 30,212 people aged 15 and above for about 26,719 people to be sampled for laboratory examinations. The collection of data and blood samples in households was subjected to the consent/assent of eligible participants. In the case of blood samples, a rapid HIV screening test following the national algorithm was carried out, then a sample was sent to the identified reference laboratories for further biological analyses. (confirmation of HIV status, viral load, resistance test, plasma dosage of ARV, etc).

As a prelude to the actual start of the survey, community mobilization was carried out according to the context of each zone. These field works were aimed at obtaining community support and participation from the different stakeholders. The local mobilization teams were thus composed of well-known and respected people within the community, such as community health workers. Globally, the timeframe for implementing the survey was set during the working group sessions and

planned for the end of the sampling in the first half of the year, the beginning of training during the 3rd quarter and the data collection in the 4th quarter of 2024. The post-field investigation phases are planned in 2025 according to the figure below.



2. Development of the NACC coordination framework

The year 2024 marks the first year of implementation of the new national strategic plan to fight HIV (NSP 2024-2030). This strategy, which aims to lead the country towards the elimination of HIV by 2030, places great emphasis on the coordination of all actors involved in the implementation of the strategy and the leadership of the country. The NSP in its Impact 4, "By 2030, governance and management are strengthened to ensure the acceleration, efficiency, accountability and sustainability of the national response to HIV/AIDS" outlines all interventions that should contribute to effective coordination. In order to make these interventions proposed in this impact more operational, the NACC identified ten priority interventions for achieving elimination and the WHO has accompanied the NACC in developing a response coordination framework. This instrument is a tool made up of 5 pillars (planning, coordination, monitoring and evaluation, human resources management and financial management) each of which is divided into a set of activities planned over time and allowing the actors to come together for effective monitoring of the major axes of the response.

Conerstones		Critical interventions	Accountable parties	
Planification		Organize an annual orientation and strategic programme planning meeting on the priorities and coordination mechanism of the NACC with the stakeholders (health sector, sectoral, CSOs/NGOs, TFPs).	SG -MINSANTE	CSRLSP
		Organize an annual strategic discussion meeting on funding and opportunities for integrating funding (sustainability) with all donors	SG -MINSANTE	CSRLSP
		Organize quarterly meetings to monitor the anchoring of interventions carried out/planned in the NSP by the partners and sectors according to the approach by area and/or by sector of activity.	NACC	CSRLSP
		Organize an annual mid-term performance review meeting for all strategic and operational actors in the response.	SG -MINSANTE	CSRLSP - M&E head of department
		Develop/update and validate a national planning and reporting tool (DASHBORD) for the activities of all stakeholders and roll it out	NACC	CSRLSP - M&E head of department
Coordination		Annually update the database and documents relating to the partnership/collaboration/financing agreements of the various actors (MOH, TFPs and the CSOs/NGOs concerned, sectoral)	NACC	CSRLSP
		Organise quarterly technical meetings to coordinate activities between the CTG-NACC/RTG and MOH's Technical Directorates and RDPHs, on the one hand, and with the TFPs, on the other.	SP/NACC	M&E head of department - SRLSP
		Every six months, ensure that the activity reports sent to the CTG-NACC by partners and sectors at all levels are complete.	TFP	CSRLSP
Monitoring and evaluation		Make an inventory of all the MOUs available from the DCOOP and carry out a triangulation with the TFPs in the field in order to complete the missing MOUs.	DCOOP/FTP	CSRLSP - M&E head of department
		Systematically integrate the CTG/NACC into the development of micro plans for TFPs, sectors and CSOs.	SP/NACC	CSRLSP - M&E head of department
		Define/update annually the indicators, performance targets and data collection tool for monitoring coordination deliverables at the NACC strategic programmatic planning and orientation meeting on priorities and the coordination mechanism.	M&E CTG/NACC	M&E head of department
		Organize quarterly sessions to fill in and validate the national reporting tool (DASHBORD) for the activities of all stakeholders according to the approach by area and/or by sector of activity.	M&E CTG/NACC	M&E head of department
Human Resources management		Conduct a bi-annual HR situational analysis and performance evaluation	UCS-FMP	RH-NACC
		Draw up an annual capacity-building plan for the CTG-NACC's human resources, to be incorporated into the resource mobilisation plan	SP/NACC	RH-NACC
Financial management		Annually update the map of all actors involved in the HIV response	NACC	CSAF
		Organize an annual strategic exchange meeting on funding and funding integration opportunities (Sustainability) with all actual or potential donors (All Donor meeting) to better monitor the funding landscape.	NACC	CSAF
		Strengthen quarterly coordination between the DCOOP, the DRFP and partners	NACC	SRLSP

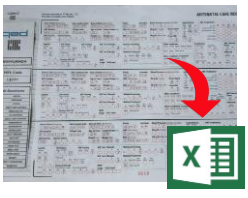
	Organize an annual advocacy and resource mobilisation meeting at local level with the strategic and operational bodies of decentralised local authorities and the private sector	NACC	SRLSP

3. Digitalisation of HIV programme tools.

The challenges in the fight against HIV in Cameroon are manifested by the intensification of differentiated interventions marked by patient-centered approaches to control the epidemic. This implies a continual and consistent need for high-quality, detailed strategic information as reflected in the granular data collection of a larger set of disaggregated indicators observed during the last revision of the program tools in 2022. Based on this observation and given the significant delays in the reprography and distribution of tools in the field, the program has undertaken the process of digitalizing data collection tools. The development of the GC7 grant allowed the country to benefit from financial support from the Global Fund to accompany this process. In the implementation, the program benefits from the technical support of the Health Information Unit (CIS). It is mainly a question of developing and deploying the tracker modules of DHIS 2. The first phase was aimed at ensuring interoperability between the DHIS 2 tracker and existing IT solutions in the field. While the second phase will be an extension to health facilities with no application for monitoring patients. At the start of the first phase, a situational analysis of the existing was performed to identify all the current working IT solutions and the HFs that had them. This step enables to upgrade the DHIS 2 Tracker as well as all these applications compared to the updated indicators of standard physical tools in the field. Following this step, the Health Information Unit (CIS) continued the development of the DHIS 2 tracker by setting up the different program rules and the necessary notifications.

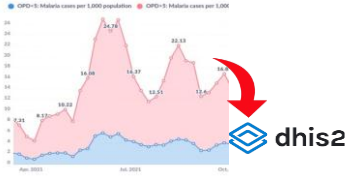
The NACC has implemented two major innovations in digitalizing program management tools. The development of a dashboard for the digital management of supply and inventory of program commodities: this tool has helped reduce the risks of stock outs and mitigate overstocking, which is a source of potential expiries. The year 2024 saw the introduction of **artificial intelligence** in data management through the implementation of the scanForm for active research of children and adolescents living with HIV in the ten regions of Cameroon during the pediatric surge. This innovation was made possible thanks to the active collaboration between the NACC and CDC/PEPFAR, the technical departments of MOH (CIS, DLMEP, DSF, DOSTS, DPML, DCOOP, DRFP). The scanForm works on a smartphone with transcription of the image/photo into digital data, without using the computer/scanner tool.

Timeliness, accuracy, availability of data for evidence-based decision-making.



STEP 3

Recover data



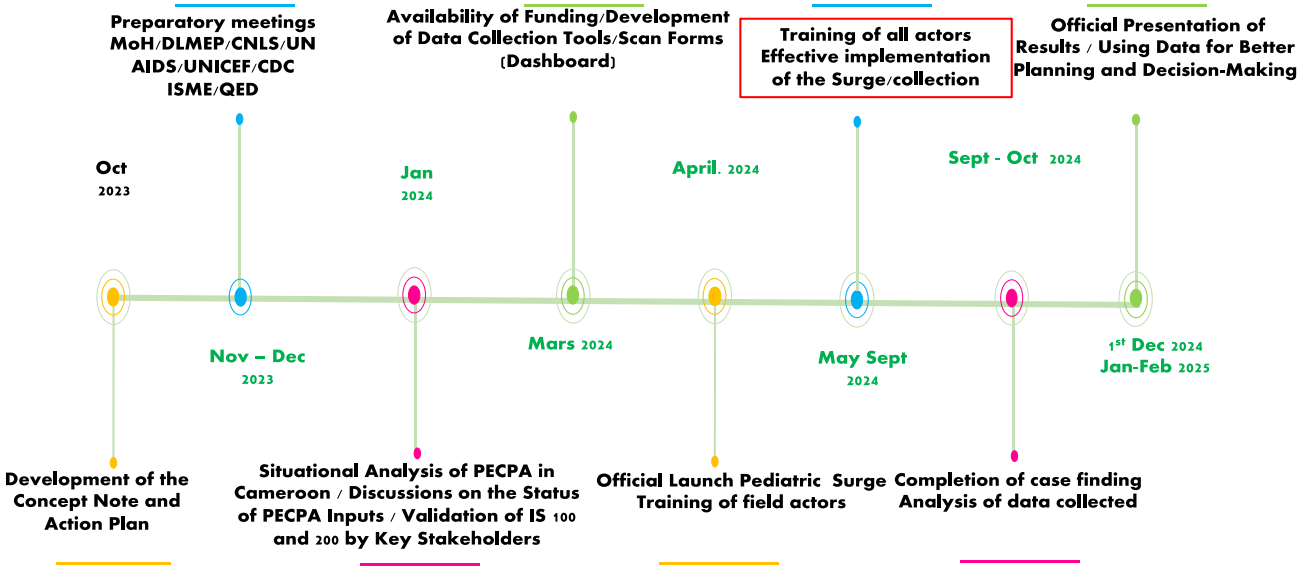
Step4

Use data

Computers or scanners not required.

4. Implementation of the pediatric surge

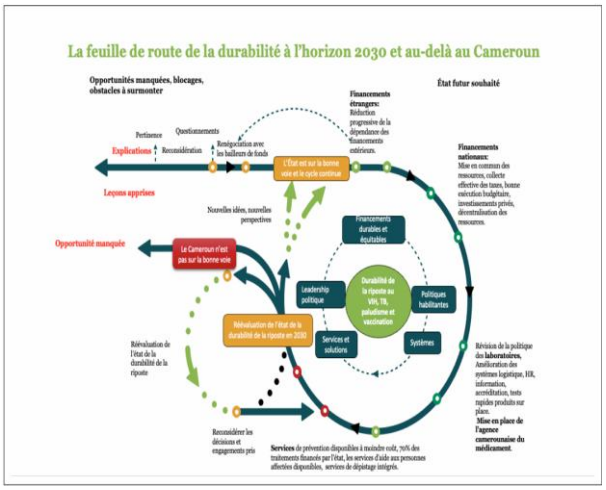
Among the priority targets identified in the NSP 2024 – 2030 are the group of children and adolescents. In the particular case of children under 15 years, HIV infections are mainly due to vertical transmission. Despite the efforts made to prevent mother-to-child transmission of HIV and to monitor infected children and adolescents, the country continues to face many challenges that are reflected in the gaps observed in the identification and placement of children on ART. This situation is likely to compromise the achievement of the elimination of paediatric AIDS by 2030. This observation led the country to implement the "pediatric surge" whose objective was to actively find all children infected or exposed to HIV not captured by the health system for an improvement of the treatment cascade. This initiative based on a multi-strategic approach was used in the 10 regions of Cameroon between July and September 2024. It was about intensive research in community and HF. This research targeted 3,172 children under 15 years in 203 health districts and 1,012 health areas. It was facilitated by the use of a scan form via smartphones. The results collected as of December 31, 2024 (P-Surge dashboard) report that 740 children living with HIV were found in the community and brought back into the health care system for treatment, which represents 23.8% achievement of the target. In addition, the initiative mobilized 16,036 mothers/guardians of unknown status in the community, which allowed for the identification through testing of 1,345 HIV-positive cases among whom 1,031 were put on ARV treatment (77%). In addition to these cases, the initiative made it possible to find 776 mothers/guardians lost to follow up for an effective return of 376 cases to treatment (48.5%). Other contributions of P-surge were marked in the triple elimination with the identification of women infected with syphilis (1 9072/30 251) and women infected with hepatitis B (19 127/30 108). This initiative yielded numerous benefits, namely the intensification of the commitment of all stakeholders, the effective involvement of actors at all levels of the health pyramid, the integration of services and the strong engagement of the community.



Major phases of paediatric surgery in Cameroon in 2024

5. Sustainability Roadmap for the fight against HIV in Cameroon.

Sustainability of the response to HIV, tuberculosis (TB), malaria and immunization by 2030 and beyond refers to the capacity of systems, structures and interventions put in place to address these health issues, to sustain their positive outcomes over the long term, while adapting to the evolving needs and resources of the targeted populations. The development of the Sustainable Response Roadmap is intended to be a holistic, people-centred approach, focusing on five areas needed to achieve the goals of eliminating the threat to public health from these diseases by 2030 and beyond: (a) a political commitment to effective, inclusive and participatory shared responsibility and multisectoral governance with the community at its centre; (b) prevention programmes and evidence-based care, effective and high impact; (c) management systems that build on local capacities and strong institutions, with people-centred interventions; (d) enabling policies that support equitable services, accessible and of high quality that leaves no one behind; and (e) adequate, sustainable and equitable national and international financing that includes a gradual increase in national resources, and an integration of these resources into public budgets. The schedule for the iterative process of sustainability analysis in Cameroon started at the beginning of 2024 with the support of UNAIDS, WHO, GF, PEPFAR, USAID, and GIZ. This process of evaluation of the sustainability of the response, which was based on a multisectoral technical working group set up by the Country Coordination Mechanism (CCM) under the leadership of the Prime Ministry. The aim was to contribute to a better understanding of the current state of the response and thus engage in reflections and a strategic and concrete commitment with the view of consolidating the achievements, and sustain the response through mobilization of resources within the Cameroonian context. Challenges were identified and a way forward reflecting transformations that can accelerate progress towards a sustainable impact of the response by 2030 and beyond were proposed.



- Thus, for Cameroon, sustainability will ensure the continued existence of gains and the possibility of meeting global health targets (particularly the sustainable development goal - SDG 3.3, 3.8, 3.11, 3.12, 3.13), while relying on local, innovative, and adaptable approaches to ensure the continuation of efforts to prevent, treat, take care of, and control diseases even in the event of changes in economic, political, or social contexts

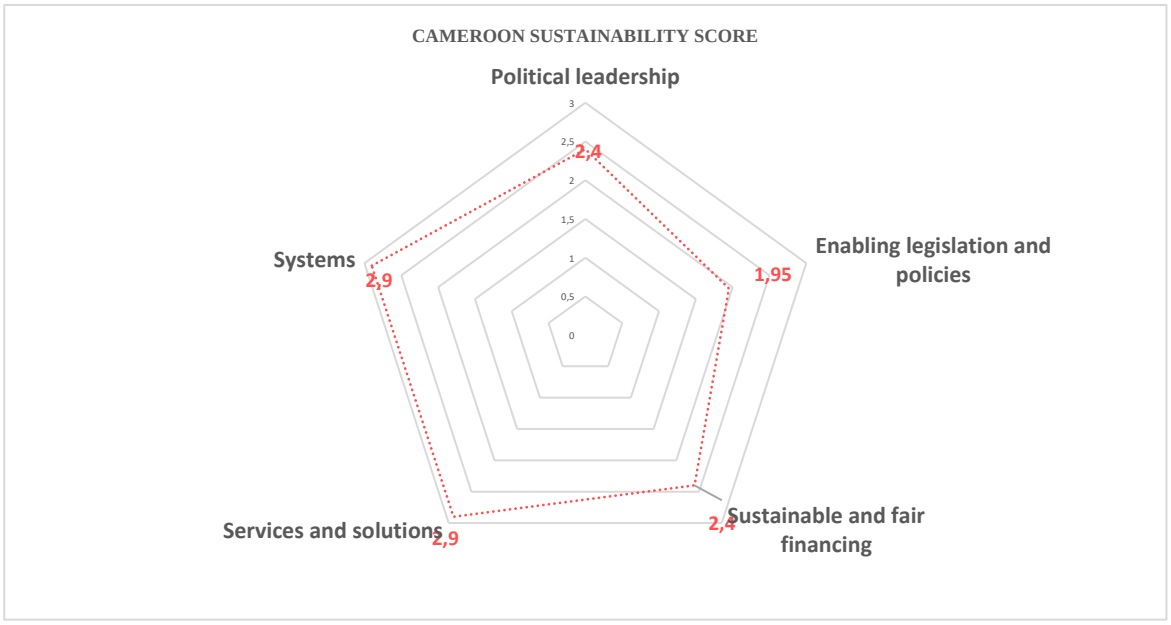
- **Institutional framework:** (resilience of health systems): strengthening national health systems, integration of HIV, TB, malaria and EPI pr ogrammes into public structures, strengthening local capacities for diagnosis, treatment and prevention of these diseases, national leadership and effective governance.
- **Financial framework:** diversification of funding sources (international donations, strengthening of domestic resources, public-private partnerships), reduction of dependence on external financing, innovative financing mechanisms (health insurance, targeted taxation, etc.)

- **Technical and operational framework:** Continuous training of healthcare personnel, approaches based on evidence and aligned with international standards, development and adoption of adapted and innovative health technologies.

- **Social and community framework:** Community appropriation of programs, active participation of key populations and vulnerable groups, awareness raising and fight against stigmatization.

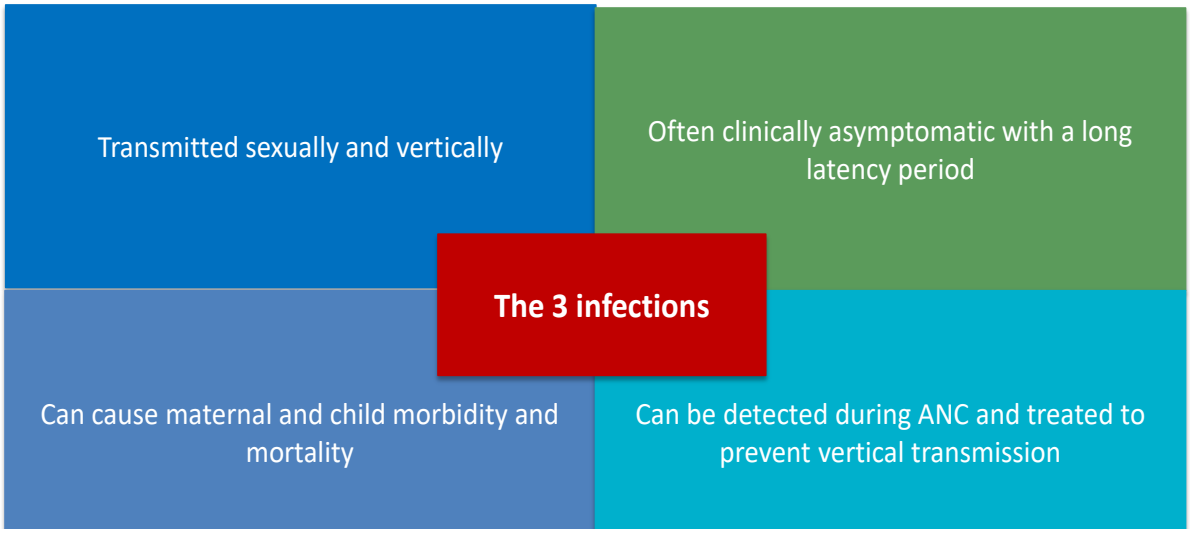
- **Environmental aspect:** Evaluation of the environmental impact of interventions (e.g., management of biomedical waste in vaccination campaigns).

Following the technical working group's work, the evaluation's findings are displayed in a spider chart, with scores by domain ranging from 0 to 3, from lowest to highest. These findings served as a framework for defining the top sustainability goals, which are (i) systems, (ii) financing and macroeconomic settings, (iii) political leadership, enabling laws and regulations, and (iv) services and solutions



6. Triple elimination of vertical transmission of HIV, syphilis and hepatitis

Cameroon's health landscape is characterized by a high prevalence of sexually transmitted infections (STIs) within the general population, with a particularly significant burden among pregnant women. During the year 2024, the multiple screenings conducted in the HF reported 2% positivity rate for HIV and syphilis among pregnant women. In addition, co-infections are 7.6% for HIV and syphilis and 6.7% for HIV and viral hepatitis B. These results show a need for strengthening interventions aimed at pregnant women to continue mitigating the risks of vertical transmission. The country has therefore revised its operational plan for the elimination of vertical transmission of HIV 2021-2023.



This review resulted in the development of a national strategic plan for the triple elimination of HIV, syphilis and hepatitis. The development of this plan was led by the Ministry of Public Health through the Family Health Department (DSF), the National AIDS Control Committee (NACC), and the other Directorates of MoH with the technical and financial support of the Technical Secretariat of the Sectoral Health Strategy (ST/SSS) alongside the partner ABBOTT. It aligns with the e-TME guidelines and criteria (WHO, 2021) and takes into account the results of the analysis of main failures and bottlenecks. The expected results are consistent with those of the 2024-2030 national strategy to combat HIV. The vision of the plan is that by 2030, no infants will be infected with HIV, syphilis or viral hepatitis B (HVB) in Cameroon.

7. First Edition of the NACC Scientific days

- With the aim of better visibility of information on scientific and organizational advances on the one hand, and on the results of scientific research related to the response to the HIV epidemic in Cameroon on the other hand, NACC held its first scientific day on December 3-4th, 2024. This day, under the theme 'IMPLEMENTING PRIORITY INTERVENTIONS FOR THE ELIMINATION OF AIDS IN CAMEROON'' brought together researchers and experts from the national scientific community, technical and implementation partners, decision-makers in the health sector and beneficiaries. It was launched by the Minister of Public Health and moderated by the members of the scientific council. The activities were organized in the form of plenary sessions and exchanges in the form of panel discussions. This event was animated by four major sessions:
- **Session 1:** programmatic interventions for HIV elimination: It highlighted lessons learned, issues and persistent challenges in achieving the elimination targets. The discussions focused in particular on strategies for preventing mother-to-child transmission of HIV, with a particular focus on sentinel HIV surveillance in prenatal consultations and active search for exposed children as part of the "surge" approach. Regarding adults, the session explored the impact of the epidemic in terms of mortality and continuity or interruptions of care, highlighting the importance of strengthening retention in care to achieve national goals.
- **Session 2:** Pharmacovigilance for optimizing care in the Cameroonian context: Three major themes of interest were discussed. Firstly, the non-adherence to antiretroviral treatment (ART) with emphasis of its association with the occurrence of resistance. An analysis of the results of resistance tests carried out leads to therapeutic recommendations for achieving viral suppression in at least 80% of patients under DTG in 03 months of ART. Secondly, the use of therapeutic protocols based on integrase inhibitors is subject to close monitoring in order to ensure their efficacy and prevent the emergence of resistance. Attention was paid to common side effects weight gain and arterial hypertension in patients after 192 weeks of ART with DTG. Thirdly 15% of PLHIV under ART have a high risk of developing chronic noncommunicable diseases, risk related to a combination of factors such as the effects of HIV on the immune system, ageing, classic risk factors, and side effects associated with ARVs.
- **Session 3:** Innovative strategies in the HIV response towards elimination by 2030. Among the strategies presented and discussed is the implementation of the new three-test HIV algorithm coupled with syphilis testing in pregnant women through the Duo test. Key populations community screening approaches in hotspots and the deployment of the national strategy for community initiation to ART was also discussed.
- **Session 4:** Interventions for elimination and sustainability of the HIV response. This session addressed the update of major assessments in the HIV response. A report was made based on the CAMPHIA 2 preliminary results, on the results of the IBBS survey and those of the study on the Stigma Index 2.0 for PLHIV. Also, was discussed innovative and community-based, intersectoral and differentiated approaches, people living with disability and other vulnerable populations under the lead of the Ministry of Social Affairs.

Official Launch of the first Edition of the NACC Scientific Days (November 2024)

CHAPTER I: ORGANISATION OF THE FIGHT AGAINST HIV

1. General guidelines and strategies for the HIV response.

The creation of the National AIDS Control Committee (NACC) in 1999 responded to a need for coordination of interventions taken within the framework of the fight against HIV. The establishment of this body has made it possible to organize the fight against HIV in accordance with the three principles of the United Nations Organization for the Fight against AIDS (UNAIDS) which are: (i) the establishment of a common national framework for the fight against AIDS whose vision is supported by the National Strategic Plan (NSP), (ii) the organization of the fight around a broad-based and multisectoral representative coordination body (NACC), (iii) the use of a single monitoring and evaluation system at the national level.

Since its creation, NACC has experienced the implementation of five NSPs, each of which responded to a reorientation of the strategy. The NSP (2024-2030), which is at its first year of implementation, has as goal the reduction in HIV incidence, morbidity and mortality related to HIV, as well as the mitigation of the socio-economic burden of the disease on the country's development.

2. Mapping of the main stakeholders involved in implementation.

NACC in its national coordination role is the supreme organ for strategic guidance of the HIV response in Cameroon. It relies on its Central Technical Group (CTG) and its Regional Technical Groups (RTG), which supervise the interventions while ensuring their alignment with the national strategy. Depending on the multisectoral nature of the fight, implementation actors come from the public sector, the private sector and the community (associations and networks of PLHIV, associations of the most exposed population groups, NGOs and networks involved in the national response to HIV, etc.). Equally, there are Technical and Financial Partners (FTP) as well as their various implementation partners. Activities are implemented at all levels of the health system, national, regional, district, and peripheral levels —encompassing both health facilities and community settings.

3. Coordination of the response

Cameroon's vision for the response to HIV/AIDS, as set out in the National Strategic Plan (NSP), is based on three major objectives: preventing new infections, providing access to treatment and reducing the impact of the epidemic. To achieve these objectives and ensure effective monitoring of interventions, emphasis is placed on the overall coordination of the programme. Alongside the major objectives, a plethora of actors intervene in the implementation of activities.

4. Difficulties encountered in coordination, mitigation strategies and challenges

TABLEAU 11 : DIFFICULTIES ENCOUNTERED IN IMPLEMENTING COORDINATION IN 2023 AND MITIGATION STRATEGIES

OUTPUTS	COORDINATION ACTIVITIES	DIFFICULTIES	STRATEGY HIGHLIGHTS	RECOMMANDATIONS
At both national and regional levels, response coordination bodies are 100% functional, with strengthened multisectorality	Biannual PR coordination meeting (TB/HIV)	No major difficulties	Harmonising and complementing the work of the various PRs in the field	Sustaining the activity
	Coordination meeting with the community PR (CARE-Cameroon)	No major difficulties	Harmonisation of the vision and integrated monitoring of the implementation of activities by CARE	Quarterly coordination with this community PR
	Quarterly coordination meeting with CSOs (Associations of PLHIV, coalition, KPCLM of HEDECS)	Low involvement of PLHIV organisations in the meetings held. Reorganisation of the coalition under way.	Enables greater involvement and ownership of the response by beneficiaries	Involvement of all PLHIV organisations Mobilisation of internal resources
	Quarterly coordination meeting for monitoring community and humanitarian SRs under the Global Fund grant	Lack of funding for the production and dissemination of tools	Allows better visibility of the contribution of SRs to PR results and objectives	Make tools available and prepare and transmit SR reports on time
Supply chain	Monthly meeting of the Regional Task Force	Lack of funding	Timely availability of commodities at all levels Simplification of the online ordering process	commodities acquired by the BID fund must be taken into account when drawing up the commodities allocation plan
	Quarterly supply chain evaluation meetings	Absence of commodities supply chain evaluation meetings IDB/UNICEF	Identification of supply chain problems in the previous quarter	Evaluating the IDB's supply chain

Source : National Strategic Plan (NSP) 2024–2030 and Coordination Framework for Stakeholders in the HIV Response in Cameroon

CHAPTER 2: INTENSIFYING THE PREVENTION OF NEW HIV INFECTIONS

1. Sensitisation

The fight against HIV/AIDS requires effective communication to promote positive social and behavioural change. Recognizing this, NACC and its partners have implemented a wide range of communication strategies tailored to specific audiences and using various channels. These efforts have played a decisive role during the year 2024 which has just ended, in raising awareness, promoting understanding and encouraging positive behaviors at the individual, environmental and social levels.

It is about reporting on multifaceted communication efforts, highlighting key initiatives that have contributed significantly to the national response to HIV/AIDS. Also, an illustration is made about the commitment of actors to harness the power of communication to stimulate social change and promote individual and community well-being...

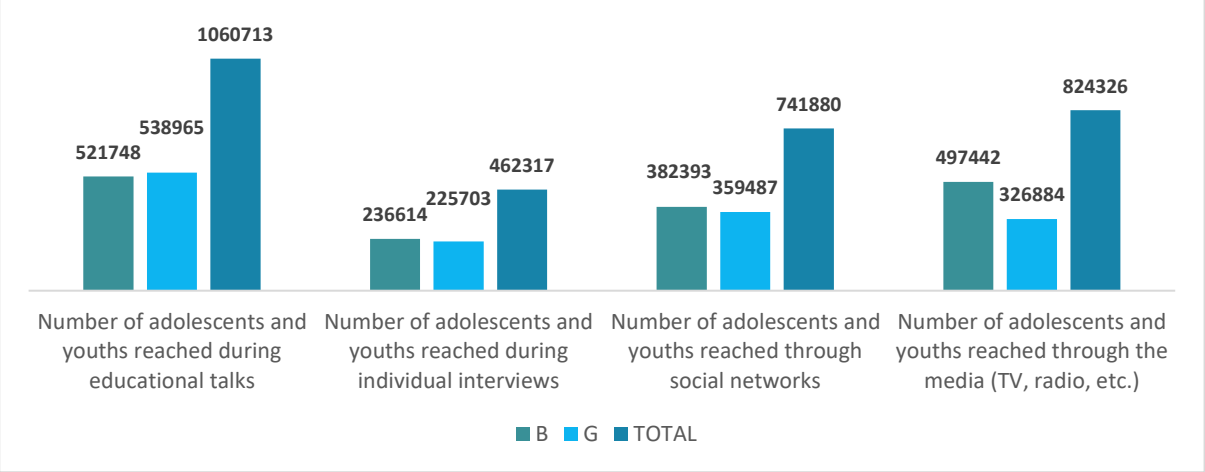
1.1. Sensitisation campaign using posters and social networks

Several campaigns of this type and addressing various themes were conducted during the year. In the particular case of the fight against stigma and discrimination related to HIV/AIDS, the NACC has deployed awareness-raising posters in several regions, including a large number in the Centre and Littoral regions. Through Facebook, Twitter and TikTok, the NACC has regularly disseminated information on HIV/AIDS prevention to Internet users to increase their awareness. These sensitizations were also done in person during the youth's fortnight with young people, both in and out of school, through educational talks and the distribution of awareness-raising materials.

1.2. Sensitization campaign during the 21st edition of "Holidays Without AIDS"

In addition to the field actions detailed above, it should be pointed out that, in accordance with the broad guidelines resulting from the preparatory meetings, it was requested to promote strategic and targeted initiatives, given the limited resources. It is in this sense that certain indicators have been chosen, notably 04, with the aim of optimally monitoring sensitisation activities. Graph 1 presents the awareness situation of the Aids free holidays Without AIDS activity for the year 2024.

Figure 1 *: Sensitization among youths during Aids free Holidays 2024.*

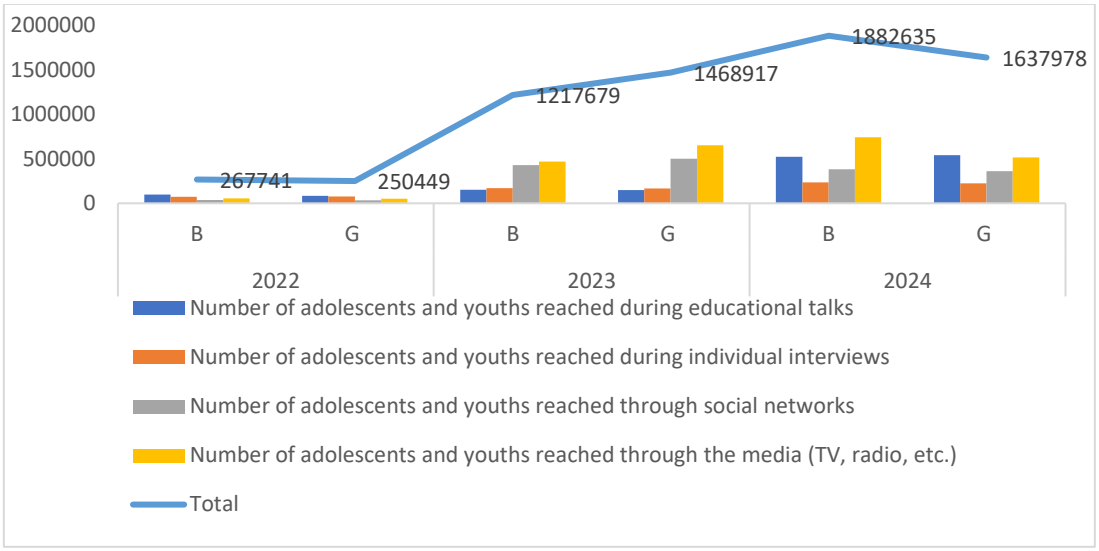


Source : National report, Aids free holidays 2024.

Out of the 3,089,236 people sensitized through the different channels identified for the mobilization of youths and adolescents, educational talks reached the largest number of people with 34% (1,060,713/3,089,236) followed by awareness through other media with 27% (824 326/3 089 236). Moreover, it should be noted that male adolescents and youths were somewhat more aware than their female counterparts (53% against 47%).

Graph 2 illustrates the evolution of sensitization indicators for the last three years of implementation of the AIDS free holiday activity.

Figure 2 *: Comparative analysis of Aids-free Holidays sensitization activities (2022-2023-2024)*



Source : Cameroon Aids free Holidays reports 2022, 2023,2024

More youths were reached between 2022 and 2024, thanks to greater participation from both boys and girls in 2024 and the growing number of peer educators. The AIDS-Free Holidays campaign has clearly succeeded in raising HIV/AIDS awareness among youths. The sharp rise in young people reached with prevention messages shows that the strategies used are working well.

It is particularly noteworthy that social networks played a crucial role in amplifying the campaign's reach, reaching a record number of youths. This trend highlights the importance of integrating digital platforms into public health communication strategies to reach the youths and connected populations. Increased awareness among girls is also a positive element to highlight, as it contributes to reducing gender disparities in access to information and HIV/AIDS prevention services.

1.3. sensitization campaign during the 8th edition of Cameroon Month and the 36th World AIDS Day

Table 11 presents a summary of data on the people sensitized according to the actors involved in the implementation of the activities of the Cameroonian month of fight against HIV (RTG, Sector, NGOs and CSOs, private companies, health facilities) and their distribution by gender.

TABLE 12 : SYNTHESIS OF DATA ON SENSITIZATION

Designation	*Men*	*Women*	*Total*
CTG	4213	2809	7 022
RTG	67 312	105 983	173 295
Sectors	107 611	108 202	215 813
NGOs ans Associations	121 313	145 396	266 709
Private sector	12 230	10 501	22 731
Health Facilities	80 134	109 884	190 018
Social Networks and Media	1 145 387	881 109	2 026 496
TOTAL	**1 538 200**	**1 363 884**	**2 902 084**

Source : *report of Cameroonian month 2024 of the RTGs*

It is noted that the total number of people sensitized amounts to 2,902,084. Men represent a higher proportion than women, or 53% with a total of 1,538,200 men sensitized against 1,363,884 women, or 47%.

It is also highlighted a predominance of awareness through social networks and media with about 70% of people affected via these media. The contribution of NGOs/CSOs and the FOSA is remarkable with respectively 266,709 and 190,018 people sensitized.

2. Strengthening the supply of condoms and PreP for the prevention of HIV/AIDS and STIs

The availability and distribution of male and female condoms, as well as lubricants, play a crucial role in preventing HIV/AIDS transmission and STIs. The NACC, in collaboration with its partners, implements strategies to ensure adequate access to condoms and promote their optimal use.

2.1. General situation regarding the distribution of condoms

During the year 2024, approximately 24,027,837 male condoms, 349,506 female condoms and 2,513,164 lubricant gels were distributed. The populations most at risk of HIV infection were the main

beneficiaries. The distribution of these products was mainly done during HIV awareness activities and campaigns.

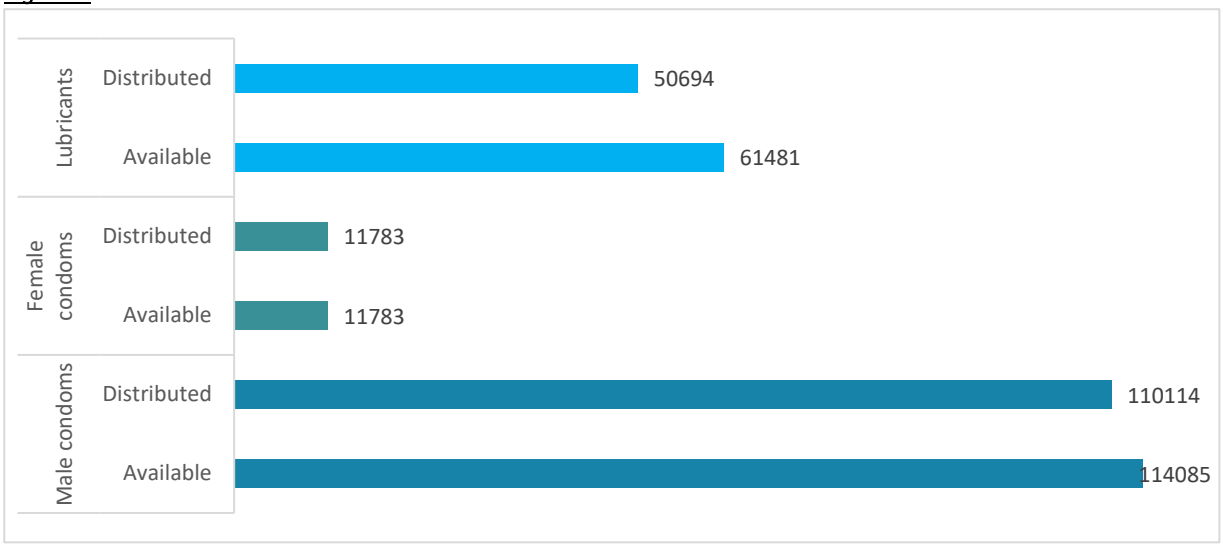
TABLE 13: SUMMARY OF CONDOM DISTRIBUTION IN 2024

Distribution structures	Products shared in 2024			
	Male condoms	Female condoms	Lubricants (Sachets)	Lubricants (tubes)
CENAME	1 291 616	-	-	-
ACMS	7 019 760	-	-	-
DKT	10 591 662	0	-	3 264
CHP	4 277 129	65 683	1 651 328	295 386
HORIZONS FEMMES	828 670	283 823	550 686	12 500
ONG JAPSSO	19 000	-	-	-
TOTAL	**24 027 837**	**349 506**	**2 202 014**	**311 150**

Source : NACC 2024 communication section report

Condom distribution campaigns were organized during special events such as " AIDS Free Holidays " and the "Cameroonian Month of Fight against HIV/AIDS". These initiatives have raised public awareness and facilitated access to condoms, thus helping to reduce risky behaviours.

Figure 3 : Distribution of Condoms and Lubricants under AFH



Source : National AFH Report 2024

Chart 3 shows that of the 114,085 male condoms available, 110 114 were distributed, representing a distribution rate of 97%. For female condoms, the 11,783 available were all distributed. In addition, 50,694 lubricants were distributed out of the 61,481 available. Despite the persistence of stock shortages, the available condoms and lubricants were distributed by the various actors during the Cameroonian month of fight against HIV/AIDS. The distribution was generally associated with HIV awareness and testing sessions.
Table 13 presents the distribution of male condoms, female condoms and lubricants in the 10 regions.

Table 14 : Condom and lubricant distribution by region

Régions	Male condoms	Female condoms	TOTAL condoms	Lubricants
Adamawa	49212	0	49212	0
Centre	10391	714	11105	2264
East	69594	3294	72888	20025
Far-north	31335	158	31493	0
Littoral	165713	8651	174364	21158
North	12993	363	13356	0
North-west	52566	4216	56782	7970
West	18000	0	18000	0
South	22565	0	22565	0
South-west	56756	0	56756	0
Total	**489 125**	**17 396**	**506 521**	**51 417**

Source : 2024 Cameroon regional monthly report

At the regional level, the Littoral region reported the highest distribution of male condoms, with 165,713 units. In contrast, the Northern (12,993) and Central (10,391) regions recorded the lowest figures. These results may be attributed to inventory shortages observed in nearly all regions, as well as the implementation of pre-exposure prophylaxis (PrEP).

For female condoms, the Littoral region recorded the highest distribution (8,651), followed by the Northwest (4,216) and the East (3,294). All other regions distributed fewer than 2,000 units. With respect to lubricants, the Littoral also reported the highest distribution, with 21,158 units. Overall, condom and lubricant distribution across the 10 regions was effective, reaching a total of 557,938 units—comprising 489,125 male condoms, 17,396 female condoms, and 51,417 lubricants.

2.1. Pre-Exposure prophylaxis (PrEP)

Pre-Exposure Prophylaxis (PrEP) is a complementary HIV biomedical prevention strategy that involves giving ARVs to uninfected (seronegative) individuals before exposure to HIV, in the context of high-risk sexual relationships. During the year 2024, PrEP delivery activities were carried out by several partners including CARE and CHP. The results reported in Table 14 were obtained along the cascade of preventive care offered to key populations (MSM and TS).

TABLE 15: OVERVIEW OF PREP RESULTS IN 2024

Indicator	Values
Number of FSW on PrEP	7 443
Number of MSM on PrEP	3 989

Source : CHILL & Care data base 2024

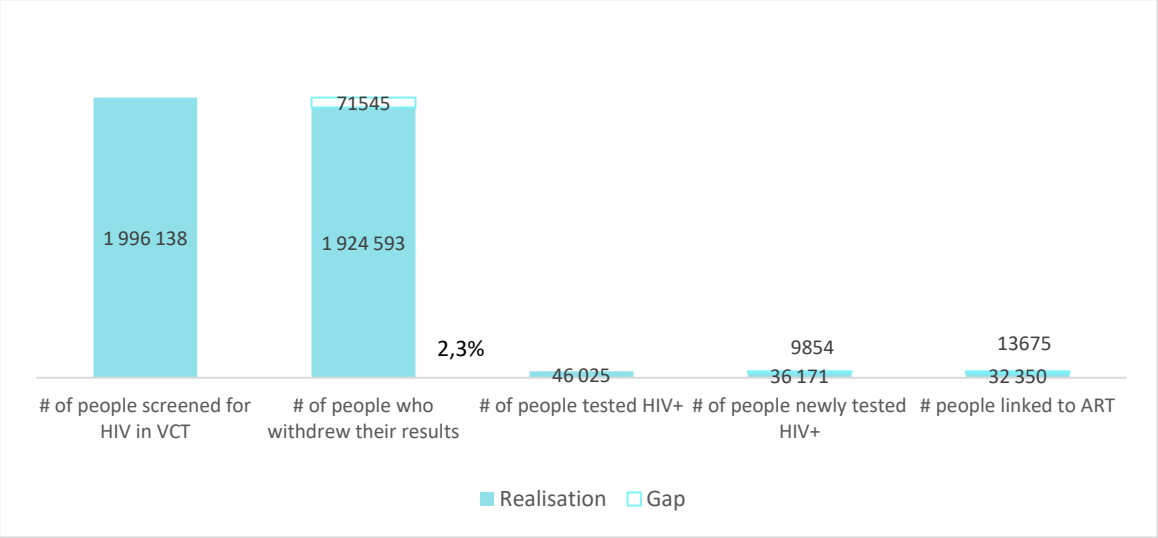
3. Strengthening screening services

3.1. Routine screening in health facilities

HIV screening and awareness of serostatus remain the cornerstone of any prevention policy against the pandemic. In 2024, a total of 1,996,138 screening tests were conducted across all health facilities registered in the national health information system. Of these, 46,025 tests were positive, corresponding to a seropositivity rate of 2.3%. Among the positive cases, 36,171 were newly

diagnosed (78.6%), while 9,854 were already known. Of the newly identified cases, 32,350 were initiated on antiretroviral therapy (ARV), yielding a direct linkage-to-care rate of 89.4%.

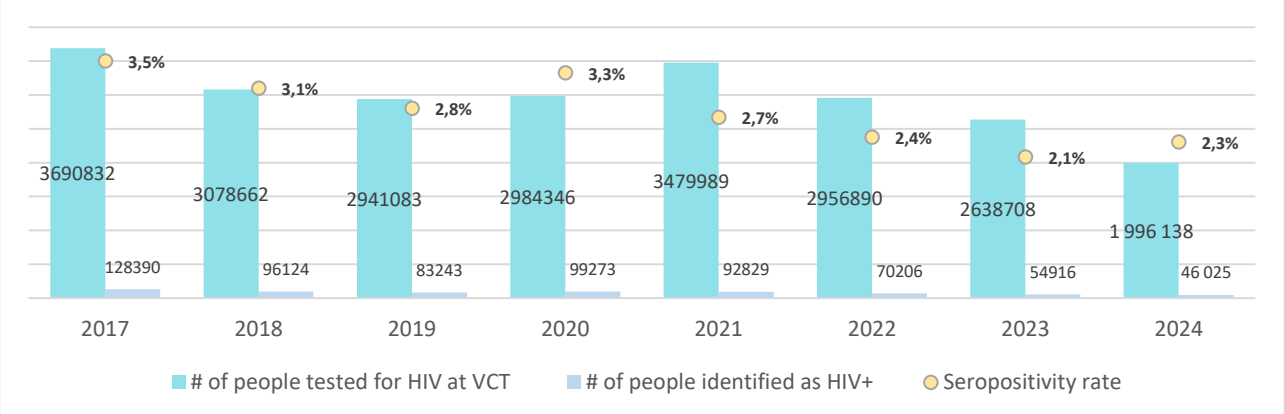
FIGURE 4: fixed strategy screening cascade



Source : 2024 DHIS2 Database *(26/02/2025)*

The routine seropositivity rate has decreased by 1.2 points since 2017, ranging from 3.5% to 2.3% in 2024. The number of tests routinely performed tends to decrease over time. This trend is attributed to targeted screening. It is particularly lower in 2024 due certainly to the problems with test availability that the country has experienced and the non-systematization of routine testing during this year.

FIGURE 5: TRENDS IN HIV TESTING RESULTS IN THE GENERAL POPULATION SINCE 2017.



Source : *NACC annual reports 2017 to 2023 + 2024 DHIS 2 database.*

During the year 2024, seropositivity experienced variabilities from one region to another. The highest seropositivity rates were recorded in the Eastern and Southern regions (4%), while the Far-North, Northwest and West regions recorded the lowest seropositivity rates (see table 15). Analysis of new

infections reveals that newly reported HIV positive cases represent 78.6% of the HIV positive cases identified at the national level. This weight differs from one region to another.

TABLE 16 : NUMBER OF PEOPLE TESTED; WITHDRAWAL OF RESULTS AND SEROPOSITIVITY RATES BY REGION

	People screened	Withdrawal of results	% results returned	Cases tested positive	Newly tested positive cases	% of positive cases	Weight of newly positive cases
Adamawa	120 036	119 138	99,3%	3 323	2 870	2,8%	86,4%
Centre	363 605	360 541	99,2%	10 813	8 601	3,0%	79,5%
East	135 386	133 969	99,0%	5 389	4 159	**4,0%**	77,2%
Far North	241 210	238 952	99,1%	3 408	2 948	1,4%	86,5%
Littoral	337 601	334 969	99,2%	8 408	6 105	2,5%	72,6%
North	157 412	155 959	99,1%	2 741	2 287	1,8%	83,4%
North-west	190 044	188 739	99,3%	2 669	1 861	1,4%	69,7%
West	226 010	225 451	99,8%	3 049	2 169	1,4%	71,1%
South	76 970	76 566	99,5%	3 092	2 641	**4,0%**	85,4%
South-west	147 864	146 840	99,3%	3 133	2 530	2,1%	80,8%
National	**1 996 138**	**1 981 124**	**99,2%**	**46 025**	**36 171**	**2,3%**	**78,6%**

Source : Base DHIS2 2024 from 11/03/2025

Regardless of the age group (Chart 6), the number of tests performed is higher among women. The main reason being the systematic offer of HIV testing to pregnant women as part of prenatal consultations and in the delivery room for those with an unknown serological status. The 25 – 49 and 20 – 24 age groups benefited most from HIV testing. However, the highest rates of positivity are recorded in the 25 – 49-year-old brackets (3% for men and 2.7% for women) and 50+ (2.7% for men and 3.1% for women).

FIGURE 7 : AGE PYRAMID OF HIV+ CASES

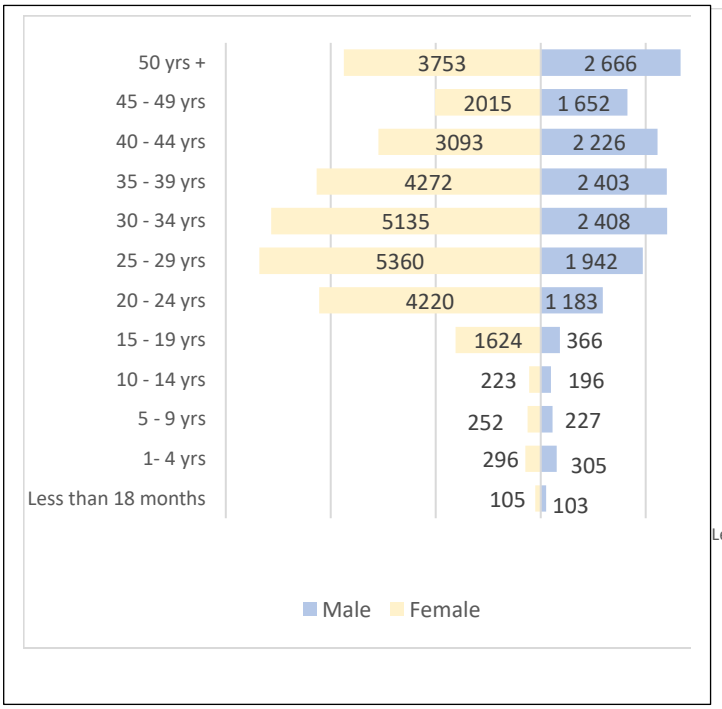
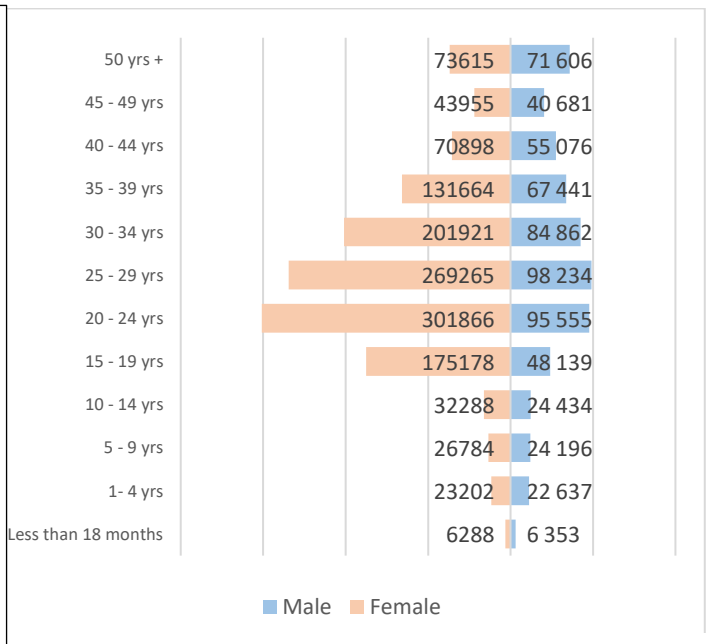


FIGURE 6 : AGE PYRAMID FOR TESTING IN 2024



Source : Base DHIS2 2024 du 07/02/2025

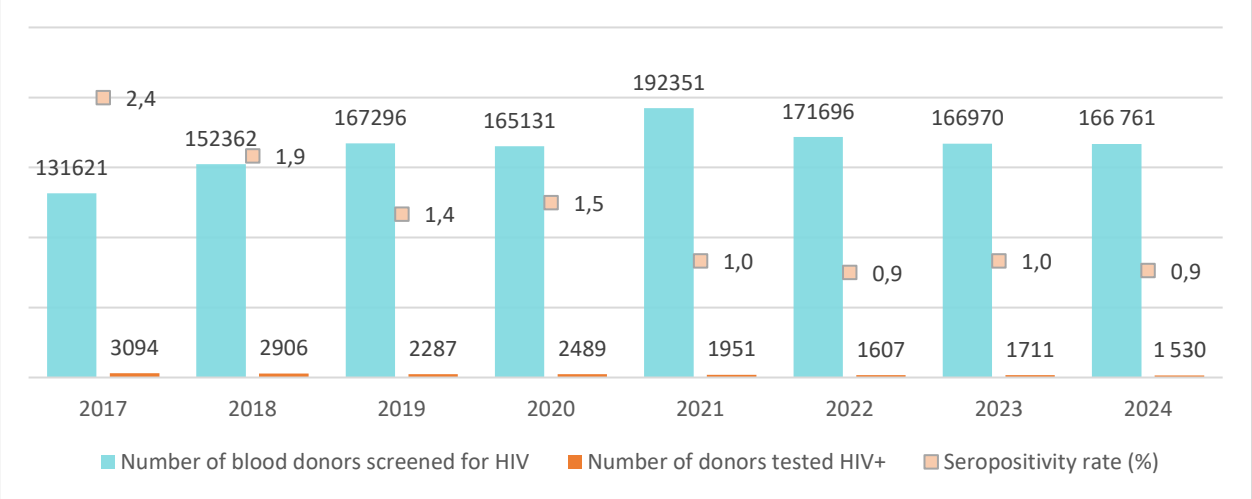
3.2. Sécurisation de la transfusion sanguine

Screening of blood donors identified a considerable burden of blood-borne infections, including 1,711 cases of HIV, 7,568 cases of hepatitis B, and 2,978 cases of syphilis.

3.2.1. Blood transfusion HIV testing

In 2024, 166,761 blood donors were tested, revealing 1,530 cases of HIV, representing a seropositivity rate of 0.9%, slightly down compared to 1.02% in 2023. This rate varies from 0.72% to 2.1% depending on the region. The evolution of seropositivity in blood transfusion is illustrated in graph 8.

Figure 8 : *Trend of the seropositivity rate in blood transfusions from 2017 to 2024.*



Source : *NACC annual reports (2017 – 2023) and DHIS2 database (2024).*

3.2.2. Screening for syphilis in blood transfusions

Sexually transmitted infections (STIs) are a major risk factor for HIV infection. This is why early screening and treatment are essential components of an effective and comprehensive response to HIV. In 2024, 164 247 blood donors were tested for syphilis, revealing 2 634 positive syphilis cases, representing a national positivity rate of 1.6%, down slightly by 0.2 points compared to 2023. This rate remains however high in the regions of the Littoral (2.2%) and the South-West (2.3%).

3.2.3. Screening for viral hepatitis B in blood transfusion

In 2024, 168,219 blood donors were tested for hepatitis B as part of the blood transfusion. Among them, 5,464 were tested positive, representing a seropositivity rate of 3.2% in continuous decline compared to previous years 2023 (4.4%), 2022 (5.1%) and 2021 (5.7%). The Far North and North regions recorded the highest positivity rates, with 5.4% and 9.3% respectively in 2024.

3.3. Testing by population groups at high risk of HIV infection

Populations at high risk of HIV infection are prioritized for the implementation of HIV response activities. High-risk populations are classified into two categories: vulnerable populations and key populations.

3.3.1. Testing in vulnerable populations

According to the National Strategic Plan (NSP), adolescents and youth, drug users (DUs), clients of female sex workers, and orphans and vulnerable children (OVCs) are classified as HIV-vulnerable populations. In 2024, a total of 14,081 individuals from these groups were screened for HIV, including 6,873 DUs and 7,208 clients of female sex workers. Of those tested, 707 (5.0%) were HIV positive, and 650 (92.0%) of them were successfully linked to ART.

TABLE 17 : SCREENING AND LINKAGE TO ART AMONG VULNERABLE POPULATIONS IN 2024.

Vulnerable populations	*People screened*	*People who tested positive*	*Seropositivity rate*	*Tested positive and put on ARVs*	*ART link rate*
DU	6 873	225	3,3%	172	76,4%
Clients of FSW	7 208	482	6,7%	478	98,5%
Total	**14 081**	**707**	**5,0%**	**650**	**92,0%**

Source : *Care 2024 database*

3.3.2. Screening key populations.

In 2024, screening among key populations involved 135,771 people including 91,188 FSW, 38,899 MSM, 1,191 TG, and 4,493 IDU (Table 17). Among these key populations, 4,939 were identified positive, representing an overall seropositivity rate of 3.6%. Disparities are observed between subgroups: the seropositivity rate is 8.5% in TG, 4.3% in MSM; 3.9% in IDU and 3.3% in FSW.

TABLE 18 : TESTING AND LINKAGE TO ANTIRETROVIRAL THERAPY (ART) FOR KEY POPULATIONS – 2024.

Key populations	*Number of KPs screened*	*Number of KP tested positive*	*Seropositivity rate*	*Tested positive and put on ARVs*	*ART link rate*
FSW	91 188	3 006	3,3%	2 993	99,6%
MSM	38 899	1 653	4,3%	1 537	92,9%
TG	1 191	101	8,5%	91	90,1%
IDU	4 493	179	3,9%	147	82,1%
Total	**135 771**	**4 939**	**3,6%**	**4 768**	**96,5%**

Source : *CHP and Care 2024 Database*

3.3.3. Testing at special events

- ***Aids free holidays***

In terms of promoting testing, 290,152 people were counselled on HIV during the GBV campaign. Among the counselled people, only 24,225 were tested for HIV and 24,021 withdrew their results for a withdrawal rate of 99.2%. A total of 159 positive cases were recorded, among which 59 were newly screened for HIV+. This makes the seropositivity rate 0.7% slightly lower than that of the 2023 edition

(0.9%). At the end of the campaign, 95% (56/59) of newly tested positive people were enrolled in treatment.

Table 19 : Regional screening stunt during Aids free holidays 2024 edition.

Region	No. of people counselled	Number of people screened	Number of results withdrawn	Number of positive cases	Number of new positive cases	Seropositivity rate	Number of positive cases linked to ART	% Link to ART
Adamawa	70670	944	927	23	12	2,5 %	12	100 %
Centre	4928	4902	4894	38	14	0,8 %	13	93 %
East	6373	5963	5953	24	9	0,4 %	7	78 %
Far-north	869	869	869	4	0	0,5 %	0	-
Littoral	186900	5068	5068	26	9	0,5 %	9	100 %
North	1784	1784	1745	9	7	0,5 %	7	100 %
North-west	1305	1305	1305	16	1	1,2 %	1	100 %
West	1064	1064	1064	4	1	0,4 %	1	100 %
South	1291	1000	992	10	6	1,0 %	6	100 %
South-west	14968	1326	1204	4	0	0,3 %	0	-
National	**290152**	**24225**	**24021**	**158**	**59**	**0,7 %**	**56**	**95 %**

Source : DHIS2 Database 2024 (as of February 26, 2025)

- ***Cameroon HIV/AIDS Month***

During Cameroon HIV/AIDS Month, 373,465 people were counselled for HIV. Among the recommended people, 147,786 were screened, a screening acceptance rate 39.6% lower than that obtained in 2023 (78%). Among the people screened, 146,386 withdrew their result and know their status, a withdrawal rate 99% higher than that of 2023 (95.8%). Among the people who were tested, 1,828 (1.24%) were tested positive and 1,715 were put on antiretroviral treatment (ART), an ART binding rate of 93.82%. The advanced strategy allowed for screening a larger number of people but with very few positive cases compared to the fixed strategy during this event.

Table 20: Cascade of screening by type of strategy during Cameroon Month

Actors	*Number of people counselled*	*Number of people screened ées*	*Number of people tested who withdrew their results*	*Number of people testing positive*	*Seropositivity rate (%)*	*Number of people tested positive and put on treatment*	*ART linkage rate*
Fixed strategy	143959	57714	57481	1016	1,77%	934	91,93%
Advanced strategy	229506	90072	88905	812	0,91%	781	96,18%
TOTAL	**373465**	**147786**	**146386**	**1828**	**1,24**	**1715**	**93,82**

Source : RTG Monthly Report, Cameroon 2024

Table 20 presents disaggregated data on screening by region during the Cameroonian month. It appears that the regions of South (26,547), Littoral (24,495) and Northwest (23,812) are those having conducted more screening. East (3.2%), Adamawa (2.19%) and Far North regions (1.56%) are those with the highest rates of HIV infection compared to the national average. Finally, Far-North, North, and West regions show a 100% link to treatment.

Table 21 : Breakdown of advanced and fixed-strategy screening by region during the Cameroonian month.

Regions	No. of people counseled	Number of people screened	Number of withdrawals of resultsts	Number of positive cases	Seropositivity rate	Number of positive cases linked to ART	% Link to ART
Adamawa	16 505	16 505	16 424	361	2,19	352	97,5
Centre	12 626	12 447	12 077	87	0,70	82	94,3
East	19 316	11 312	11 200	362	3,20	306	84,5
Far-north	78 142	4 880	4 860	76	1,56	76	100,0
Littoral	165 969	24 495	24 387	216	0,88	212	98,1
North	4 364	3 956	3 889	31	0,78	31	100,0
North-west	23 812	23 812	23 349	268	1,13	250	93,3
West	8 393	8 393	8 325	7	0,08	7	100,0
South	27 549	26 547	26 547	243	0,92	231	95,1
South-west	16 789	15 439	15 328	177	1,15	168	94,9
National	**373 465**	**147 786**	**146 386**	**1 828**	**1,24**	**1 715**	**93,8**

Source : RTG Monthly Report, Cameroon 2024

3.4. Differentiated HIV screening

Optimizing the provision of differentiated HIV testing in Cameroon involves taking into account the Who? What? Where? and When? for the mobilization, testing, and linkage during the implementation of each strategy.

The implementation of differentiated HIV testing strategies (such as index case testing, self-testing or screening via social networks) in connection with prevention or treatment services improves testing coverage for people at high risk of HIV infection.

3.4.1. Screening by entrance door

Table 21 summarizes screening results by strategy and gateway. The index case strategy reached more than twice as many people as targeted community strategies. But the seropositivity rate is higher in this latter (9%) as well as the link to TARV of positive cases (94%). Regarding the entry doors, hospitalization records the highest number of cases screened (35 834 tests) followed by the blood bank (31,604). The tuberculosis screening service recorded the small number of screenings but the highest seropositivity rate (4.4%).

TABLE 22 : BREAKDOWN OF THE NUMBER OF PEOPLE TESTED BY ENTRY POINT AND SCREENING STRATEGIES.

		Number of tests done	Number of positive tests	% of positive cases	Starting ART	% link to Treatment
Screening strategy	Self-testing	15 128	490	3,0	335	68
	Index Case Testing (ICT)	27 063	1 372	5,0	1209	88
	Targeted community screening	12 346	1 208	9,0	1 135	94
Entrance door	Emergency	20 554	588	2,8	534	91
	Hospitalisation	35 834	949	2,6	784	83
	Blood bank	31 604	107	0,3	17	16
	TB	3 460	155	4,4	86	55

Source : DHIS2 2024 updated on February 26, 2025.

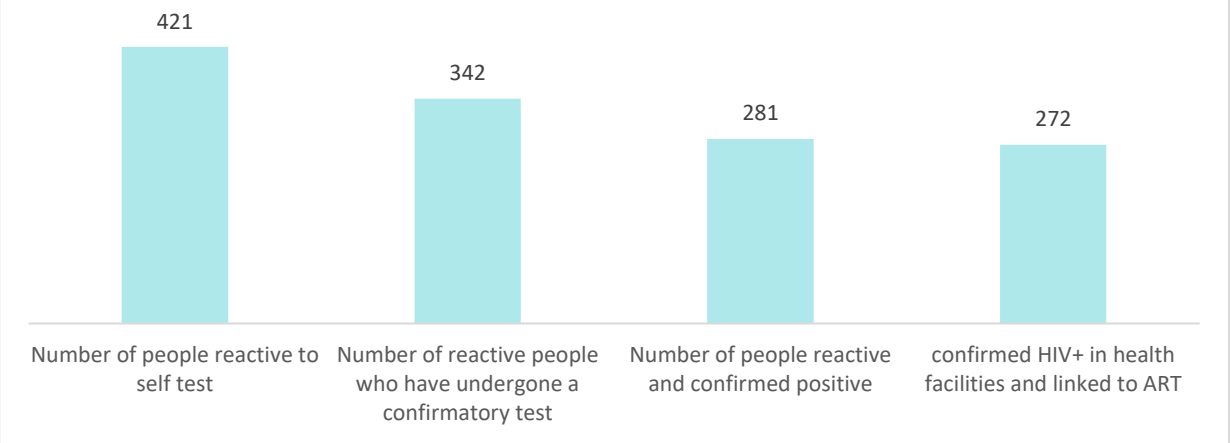
3.4.1. HIV self-testing

HIV self-testing as an orientation test is an opportunity to improve the coverage of screening among difficult-to-access targets by conventional approaches to HIV testing. In Cameroon, the populations benefiting from this strategy are:

- Key populations: MSM, TS, Transgender, drug users and injecting drug users;
- Partners and clients of key populations;
- Partners of PLHIV;
- The partners of pregnant women;
- Youths aged 18-24 in vulnerable situations;
- Men in vulnerable situations.

Mobilization to create demand is carried out by peer educators in the community, in health training by health providers for index cases and partners of pregnant women. During the year 2024 after distribution of 17 911 self-test kits, 421 people were reactive. Approximately 73% (342/421) of these had a confirmation test, 59% (281/342) of which were confirmed positive for HIV, 272 of which were linked to ART.

Figure 9: Global cascade of HIV self-testing reactivity results.



Source : Base de données Care 2024

Table 22 shows that the regions with the most distribution of ADVIH testing are, the Centre (28.1%), Littoral (19%) and the East (10%) during the year. Of the 421 people reactive to HIV self-testing, 78% took a confirmation test. The regions with the highest confirmation rate are Northwest, West and South with a performance of 100%. Finally, regarding the link to treatment, the regions of the East, North, Northwest and South have good results (100%).

Table 23: Results of the implementation of self-testing in the regions

Region	Number of self-test kits distributed	Number of results returned	Number of cases reactive to the self-test	Number of reactive cases with a confirmatory test	%	Nbre de cas réactifs confirmés VIH+	Nbre de cas confirmés liés au TARV	%
Adamawa	1 345	1 335	26	21	80,7	20	18	90,0
Centre	5 037	4 740	119	86	72,3	71	68	95,8
East	1 869	1 812	42	37	88,1	31	31	100,0
Far-north	868	587	53	42	79,3	14	13	92,9
Littoral	3 550	3 168	65	63	96,9	57	56	98,2
North	665	856	51	29	56,8	21	21	100,0
North-west	627	620	2	2	100,	2	2	100,0
West	992	926	16	16	100,	15	14	93,3
South	1 546	1 546	19	19	100,	19	19	100,0
South-west	1 412	1 093	28	27	96,4	27	26	96,3
TOTAL	**17 911**	**16 683**	**421**	**342**	**81,2**	**277**	**268**	96,8

Source : Care 2024 database

3.4.2. Screening of index cases in health facilities

The strategy aims at offering HIV testing to the environment and sexual contacts of PLHIV. It is about offering HIV testing to all sexual contacts of a PLWHIV and also partners of injecting drug users. The mobilization for this strategy is done from an identified person living with HIV, through community raids, by phone call or anonymously.

Social network testing is an approach to HIV testing that builds on social networks among key populations and as part of a comprehensive package of care and prevention services. It involves HIV-positive and HIV-negative people at high risk of HIV infection (recruiters) to identify and mobilize people in their social, sexual and substance abuse networks (members of the network) for testing. Key Populations tested negative are directed towards prevention services, but documentation of HIV prevention services remains insufficient.

4. SWOT analysis to improve prevention measures

After reviewing results, strategies, and interventions in HIV prevention and case identification, the major elements that can guide better decision-making must be identified.

Strengths	Weaknesses
• Strong political engagement • Effective use of media and social networks to raise awareness about HIV/AIDS issues. • High HIV testing coverage. • Lower HIV seropositivity rate. • Targeted efforts for HIV testing among key and vulnerable populations. • Implementation of differentiated screening including self-testing • Availability of a national prevention roadmap.	• Strong political engagement • Effective use of media and social networks to raise awareness about HIV/AIDS issues. • High HIV testing coverage. • Lower HIV seropositivity rate. • Targeted efforts for HIV testing among key and vulnerable populations. • Implementation of differentiated screening including self-testing • Availability of a national prevention roadmap.
Opportunities	**Threats**
• Integration of information and communication technology (ICT) into HIV/AIDS programmes. • Increased engagement of the community and civil society actors.	• Lack of financial resources • Disinformation and misinformation regarding HIV/AIDS.

CHAPTER 3: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

In Cameroon, mother-to-child transmission remains the main vector of HIV infection among children under 15. The e-MTCT initiative aims to reduce this transmission to less than 2% at 6 weeks and less than 5% at 18 months. Significant progress has been made through strategies such as the integration of SRMNIA/HIV/PMTCT services, decentralization of care and task delegation, thus enhancing the effectiveness of prevention and monitoring.

1. Results vs. NSP 2024-2030 programmatic targets

Table 23 illustrates the crucial impact of PMTCT in the fight against HIV in Cameroon. It shows insufficient mobilization of pregnant women for screening, with 69.7% tested, and low ARV initiation (57.9%). The monitoring of exposed children is strengthened: 87.1% benefited from a PCR examination and 94.5% received an ARV prophylaxis. For children tested HIV+, 93.4% were put on antiretroviral treatment, improving their care. These results show notable progress, but the gap between targets and performance highlights the need to continue efforts to strengthen accessibility and awareness.

Table 24 : *Results of PMTCT indicators in relation to targets*

Indicators	Target	Performance	
Number of pregnant women seen for ANC and Labour room	1 088 041	758 346	69,7%
Number of PW tested for HIV in ANC and LR	758 346	677 159	89,3%
Number of identified HIV+ PW put on ARVs	18 894	10 937	57,9%
Number of exposed children (EI) who received a PCR test	9 889	8 615	87,1%
Number of exposed children (EI) receiving ARV prophylaxis	9 889	9 346	94,5%
Number of HIV+ EIs started on ART	197	186	93,4%

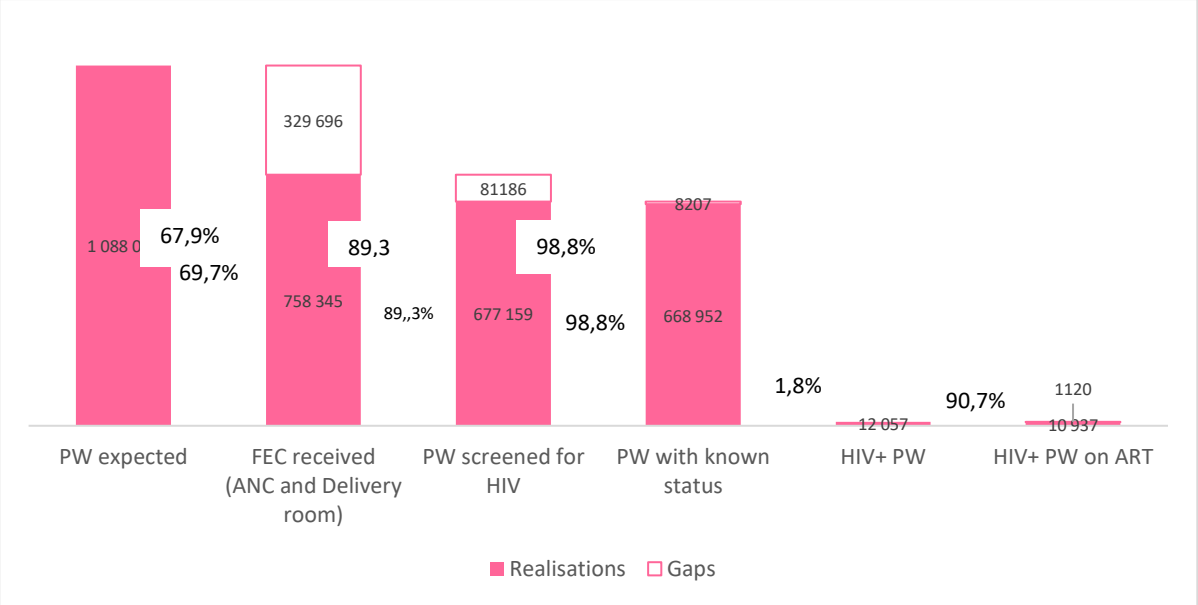
Source : *NSP 2024-2030 and DHIS2 2024, CIS data.*

The pregnant woman's cascade

Prevention of mother-to-child transmission (PMTCT) is based on a cascade of services aimed at reducing neonatal infections during pregnancy, childbirth and breastfeeding. In 2024, 1,088,041 pregnant women were expected in Cameroon, but only 69.7% of them were actually received in prenatal consultation (ANC) and delivery room (DR), revealing a lack of access to maternal monitoring services. Among these, 677,159 (89.3%) were screened for HIV, which indicates insufficient coverage, with 10.7% of women followed escaping HIV screening. Of the 12,057 pregnant women diagnosed with HIV, 90.7 were placed on antiretroviral treatment (ART), leaving a difference of 9.3% that requires rapid management to limit vertical transmission.

This cascade highlights the progress made in PMTCT but also the gaps to be filled, notably the improvement of the monitoring of untested pregnant women and the initiation of treatment for all HIV+PW. More effective integration of women in prenatal consultations would increase screening coverage and ensure universal access to care. By optimizing testing and treatment, Cameroon could significantly reduce mother-to-child transmission of HIV and strengthen its efforts towards an HIV-free generation.

Figure 10: 2024 Mother cascade



Source : CIS and Dhis2/MOH 2024 databases.

A disaggregated analysis of the PMTCT mother cascade shows some particularities according to age groups. During the year, 2476 PW of less than 15 years old, 108 619 PW of 15-19 years old, 201 388 PW of 20-24 years old and 364 676 PW of 25 years and above were received and tested in ANC and LR. Regarding to seropositivity, it is 1.8% at the national level but disparate according to age groups. Thus, while it is respectively 1.2% and 1.1% in those under 15 years and 20-24 years, among PW over 25 years, there is a seropositivity of 2.5%.

The most striking element of this analysis is certainly the rate of use of ART. It is 90.7% at the national level but particularly low in PW aged less than 15 years (53.8%) and relatively better for other age groups (87.3% for 15 to 19 years 86.5% for 20-24 years and 92.2% for over 25 years).

It would therefore be appropriate to define approaches for linking care more adapted to this particularly vulnerable age group. For example, it would be a question of setting up age-appropriate educational programs to inform young people about HIV; to strengthen the capacities of medical staff on the specific needs of young PW while ensuring that they are sensitive to psychosocial issues and communication with adolescent girls; and to promote support groups for PW by age group.

TABLE 25: PERFORMANCE OF THE PMTCT MOTHER CASCADE BY AGE GROUP

Indicators	Performances			
	Less than 15 years	15-19 years	20-24 years	Plus de 25 years
Pw tested for HIV	92,6%	88,1%	89,0%	89,8%
PW with known status	98,3%	98,8%	98,6%	98,9%
HIV+ PW	1,1%	0,7%	1,2%	2,5%
HIV+ PW on ART	53,8%	87,3%	86,5%	92,2%

Source : CIS and Dhis2/MOH 2024 databases

2. PMTCT services

2.1. Geographical coverage of PMTCT sites

Table 25 presents the PMTCT site coverage by region in Cameroon in 2024, highlighting regional disparities that influence access to services for the prevention of mother-to-child transmission of HIV.

The coverage of PMTCT sites at the national level is 71.9%, indicating that nearly a quarter of health facilities (HFs) were not PMTCT sites in 2024. However, some regions have coverage levels lower than the national average, notably the Littoral (58.5%), the Southwest (61.6%) and the Centre (62.3%), which could limit the care of HIV-positive pregnant women in these areas. Conversely, regions such as the Far North (84.9%), the North (88.2%), and the East (86.5%) show high coverage, reflecting a better territorial meshing of PMTCT services. Thus, the absence of PMTCT sites in some regions could be partly explained by the low attendance to ANC, as some pregnant women did not have access to health facilities to ensure adequate monitoring of their pregnancy. It is necessary to strengthen community interventions in favour of sensitization for the ANC attendance and thus improve the coverage of PMTCT sites.

Table 26: *coverage of PMTCT sites 2024.*

Regions	HD	Number of Health facilities	PMTCT sites	Coverage
Adamawa	11	231	198	85,7%
Centre	32	2 171	1364	62,8%
East	15	312	270	86,5%
Far - North	33	497	422	84,9%
Littoral	24	1 207	706	58,5%
North	15	347	306	88,2%
North -West	21	438	375	85,6%
West	20	1008	839	83,2%
South	13	344	275	79,9%
South-west	21	388	239	61,6%
National	205	6 943	4994	71,9%

Source : *Base DHIS2 2024*

2. 2. Early HIV screening for children born to HIV+ mothers

Since 2016, early diagnosis for children born to HIV-positive mothers has been provided through PCR/DNA testing on dried blood spots (DBS) in conventional laboratories, or via point-of-care (POC) devices. This approach has reduced turnaround time for results and improved early initiation of treatment for infected children. The national early diagnosis system currently includes 110 POC/IED devices and 5 reference laboratories performing early HIV diagnostics. The Central region hosts the highest number of POCs, with 20 devices in operation.

Table 27: *Breakdown of DBS and EID/POC sites by region*

Regions	PMTCT sites	Reference laboratory	POC/EID
Adamawa	198	0	9
Centre	1364	1	20
East	270	0	10
Far-north	422	0	14
Littoral	706	1	13
North	306	0	10
North-west	375	1	11
West	839	1	11
South	275	0	7

South-west	239	1	5
National	**4994**	**5**	**110**

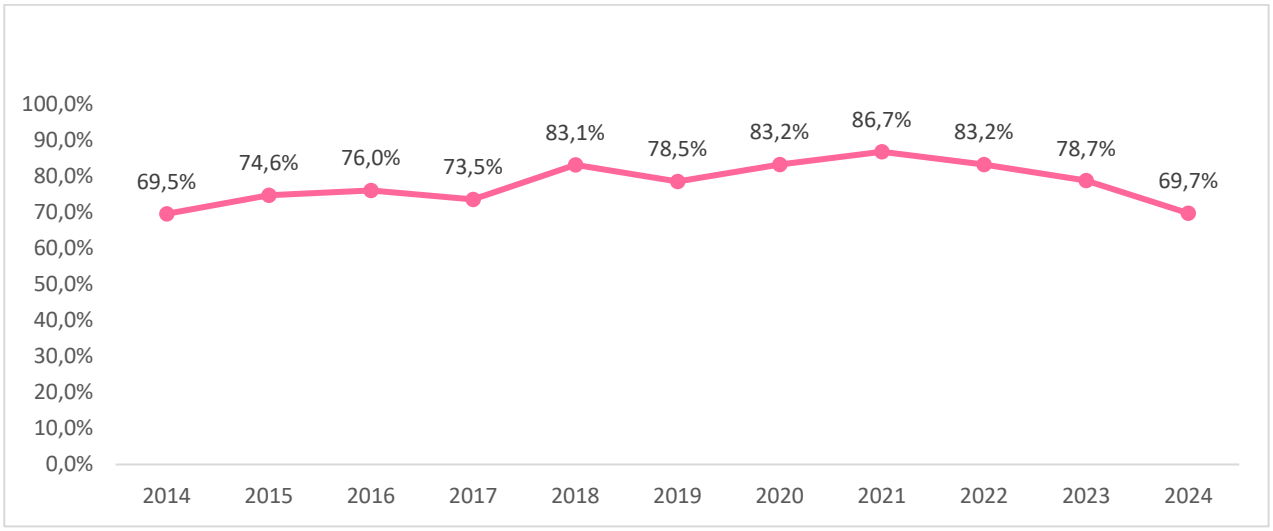
Source : *Base DHIS2 2024*

3. Request for PMTCT services

3.1 Pregnant women Attendance at antenatal clinics and knowledge of their status

Prenatal consultation is the main entry point for PMTCT interventions. The attendance rate corresponds to the proportion of pregnant women who have received at least one ANC and allows measuring the coverage of services in relation to the target. This curve shows the evolution of the attendance rate for prenatal consultations (ANC) between 2014 and 2024, highlighting fluctuating trends with periods of progression and decline.

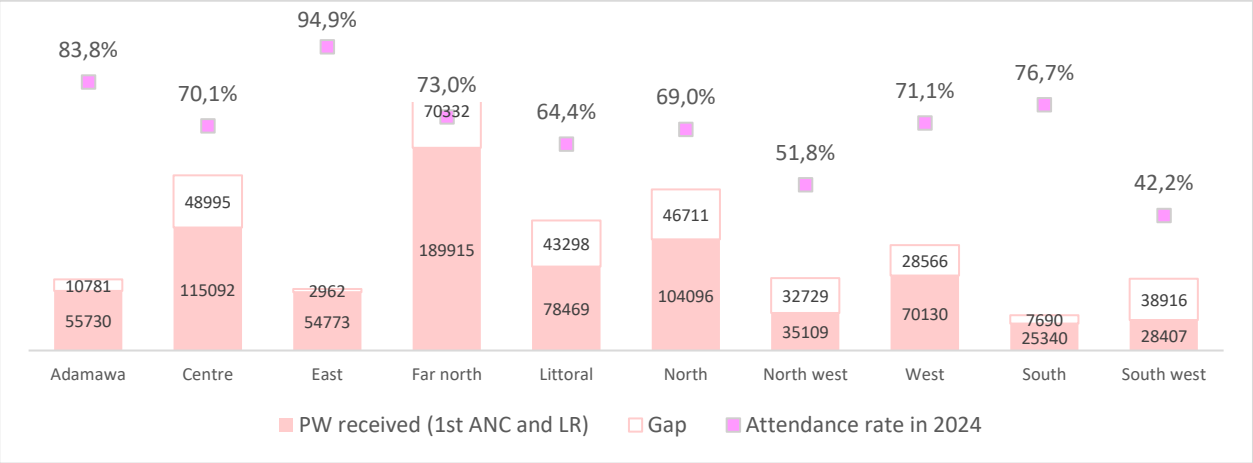
Figure 11: Trend in ANC attendance between 2014 and 2024



Source : *Base DHIS2 2024*

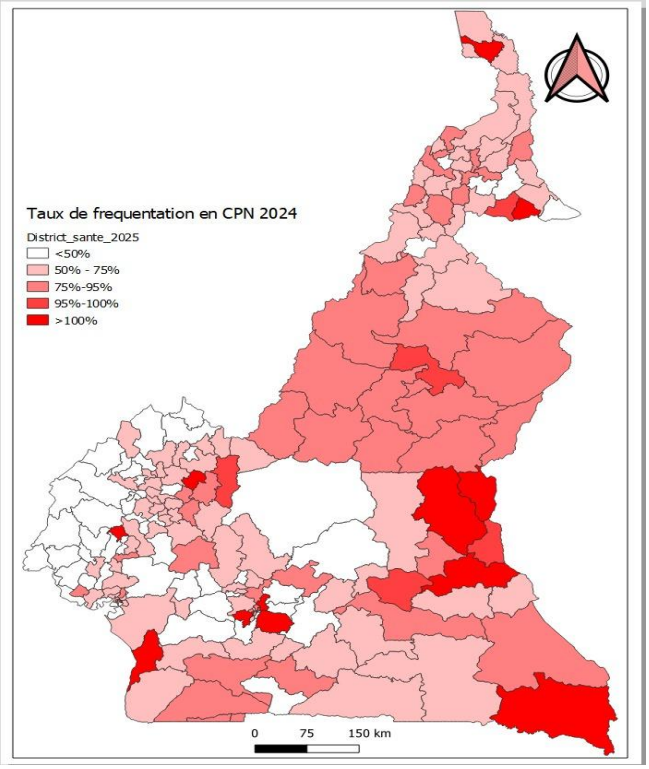
The analysis of attendance at prenatal consultations (ANC) in 2024 highlights significant regional disparities, influencing access to maternal care and the prevention of mother-child transmission of HIV. Indeed, in addition to the overestimation of the targets, several factors can explain this decrease. Among them, we note the use of matrons' services, attendance at non-conventional health structures that are not recorded in the DHIS2, insufficient communication regarding the health voucher in the north region, as well as the inaccessibility of certain health facilities in regions affected by the security crisis. Certain regions such as the North-West (51.8%) and the South-West (42.2%) show particularly low rates, certainly due to population displacements due to the security crisis. On the other hand, relatively high performances are observed in the East (94.8%) and Adamawa (83.8%) regions. Beyond these regional disparities, a closer examination of the reported data suggests an under-reporting of program data.

Figure 12: *Performance of the 1st ANC attendance at regional level*



Source : *DHIS 2, 2024*

FIGURE 13: ANC ATTENDANCE RATES BY HEALTH DISTRICT IN 2024 IN CAMEROON



Analysis of the ANC attendance rate in 2024.

Graph 13 highlights big differences in ANC attendance. Some regions (East, South, Centre, Far North) have excellent rates above 95%, while others (West, Northwest, Southwest) fall below 50%. Low attendance means pregnant women and babies face greater health risks.

General Findings :

1. Marked regional inequalities

o The East, South, Centre and Far North districts have high visitation rates (>95%, even >100%).

o Several districts in the West, North-West and South-West have low rates, some even < 50%.

2. Districts in outperformance

o Some districts (in bright red) exceed 100%, indicating a high affluence or an overestimation of the target population. This may also reflect an influx of patients outside the area.

3. Districts in critical underperformance

o The white areas show large deficits in ANC attendance, which represents a high risk for maternal and neonatal health in these regions.

4. National trend

o A majority of the districts are between 75% and 100%, which shows an overall satisfactory level of attendance, but still insufficient to achieve Finally, the high performances observed in certain districts could serve as models to guide good practices at the national level.

Some details at regional level:

Adamawa : the regional attendance rate is 83.8%. All HDs except for the Djohong HD experienced a decrease in attendance during the year in ANC. The first investigations of this situation indicate that 43 clandestine high-volume health facilities do not report their data in the DHIS2.

Centre: the attendance rate in the region is 70.5%. The HDs that had the lowest attendance rates were: Akonolinga (29.5%), Yoko (36.7%), Awaé (49.5%), Eseka (11.7%), Nanga Eboko (27%), Ngog Mapubi (37.4%), Ngoumou (36.9%), Nkolndongo (40.9%) and Odza (49.5%). It should be noted here that some of these HDs saw their target number of expected pregnant women literally double between 2023 and 2024.

East: the performance remains good (94.8%) but however there is a decrease compared to previous years. The HDs of Nguelemendouka (57.5%) and Ndelele (58.0%) are the weakest performers while Betare Oya (106.8%), Moloundou (130.0%), Batouri (139.3%) and Garoua Boulai (142.4%) are outperforming. This great difference can be explained by the movements and preferences of populations for certain health structures but also by the presence of refugees (Garoua Boulai).

Far North: the regional performance is 73.0%. In general, the reasons mentioned to justify this performance are: an overestimation of the expected PW target, the weakness of the purchasing power of populations who struggle to pay for health vouchers, the distance and authority of the PW partners. The HD with the lowest performance are Mindif (17.3%), Moulvoudaye (32.1%), Guere (38.7%), Roua (48.2%), Gazawa (53.7%), Fotokol (55.2%) and Hina (56.1%).

Littoral : The coverage in ANC is 64.9% in 2024 compared to 84% in 2023. We observe a quasi-generalized gradual decline over the last 4 years. This decrease varies from 45.4 points in the Bonassama HD to 4.5 points in the Manoka HD. Only the HDs of Logbaba (101.7%) and Newbell (93.5%) show encouraging performances. Several hypotheses have been put forward to explain this decrease. Among others, we have: an overestimation of the target, a socio-anthropological phenomenon, the under-reporting of observed data from the PMTCT sheet or even the proliferation of clandestine health facilities.

North: between 2023 and 2024, a decrease in attendance of 5 points is observed from 74% in 2023 to 69.0% in 2024. The districts in which this decrease is more pronounced are: Garoua 2 (42.3%), Garoua I (56.1%) and Figuil (57.3%). The factors underlying this poor performance include constraints linked to obtaining the required health voucher (cheque santé) prior to managing pregnant women, as well as under-reporting of data.

Northwest: the regional performance is 51.8%. Only the HD of Batibo (62.5%) and Kumbo East (60.8%) present an acceptable performance. The reasons for these performances are among others the security crisis that has been raging for several years in the region, leading to population displacements and the closure of many health facilities.

West: there is a decrease of 4 points between the performance recorded in 2023 and that of 2024. The HD of Galim (33.1%), Kekem (37.5%), Bandja (41.1%), Santchou (49.1%) record the lowest performances while Bangourain (102.0%) and Malantouen (95.4%) have the best performances.

South : the regional performance is 76.4%, down 2.9 points compared to 2023. The HDs of Mvangan (34.0%), Zoetele (50.2%) and Niete (50.5%) have the lowest performances while Kribi (121.7%) and Sangmelima (89.7%) have the best performances.

Southwest: the national performance is down 5.2 points compared to 2023 when it was 47.4%. Only the HDs of Banzon (115.8%), Buea (79.6%), South Kumba (74.9%) stand out.

Recommandations

- Strengthen community interventions in districts with CPN coverage below 80%;
- Analyze the structural causes of low rates (geographical barriers, cost, service offer);
- Valuing practices of district with 100% performance to inspire the others;
- Intensify communication around the health check and universal health coverage on free CPN;
- Set up a system for data collection and mentoring unconventional health training;
- Strengthen the capacities of matrons on referral against referral from FEC to health facilities;
- • Organize advanced strategies for the offer of ANC (including PMTCT) in community;
- • Disseminate awareness messages for the attendance of the CPN through social networks.

3.2. Testing and treatment of syphilis in Pregnant women.

Cameroon revised the operational plan e-MTCT HIV and developed the operational plan for eliminating vertical transmission of HIV, syphilis and viral hepatitis B 2024-2030 which aligns with the commitments and main orientations of the national response in the fight against HIV, syphilis and viral hepatitis B and aims to achieve the target 95-95-95 in Cameroon.

As part of the implementation of this plan, the provision of services for the fight against syphilis has allowed 343 676 pregnant women to be screened during ANC1, which represents 45.5% of the PW present at this ANC. This coverage remains insufficient but may improve with the transition to 3-test HIV screening which integrates the dual test (HIV/Syphilis) and which is free. Among the PW detected for syphilis, the positivity rate is 2.0%, down from 2023 (8.5%). In addition, only 35.3% of diagnosed syphilis cases have been treated, highlighting a major challenge in the management of positive cases and prevention of congenital syphilis. The issue of treatment will also be taken into account as part of the transition to the 3-test algorithm, which could increase the number of cases being managed among the positive PW identified.

Table 28 : Regional screening for syphilis in pregnant women 2024

Regions	Number of PW registered	Number of PW screened for syphilis	Syphilis testing rate among PW	Number of cases of syphilis diagnosed in pregnant women	Syphilis positivity rate among PW	Number of cases of syphilis treated in pregnant women	Treatment rate for syphilis in PW
Adamawa	55 730	28 129	50,5%	350	1,2%	189	54,0
Centre	115 092	41 721	36,3%	1 379	3,3%	351	25,5
East	54 773	28 323	51,7%	1 128	4,0%	514	45,6
Far- North	189 915	59 615	31,4%	566	0,9%	86	15,2
Littoral	78 469	39 725	50,6%	688	1,7%	355	51,6
North	104 096	40 295	38,7%	363	0,9%	90	24,8
North-west	35 109	27 002	76,9%	717	2,7%	230	32,1
West	70 130	43 432	61,9%	781	1,8%	217	27,8
South	25 340	12 992	51,3%	339	2,6%	204	60,2
South-west	28 407	22 442	79,0%	581	2,6%	196	33,7
Total	**757 061**	**343 676**	**45,5%**	**6 892**	**2,0%**	**2 432**	**35,3**

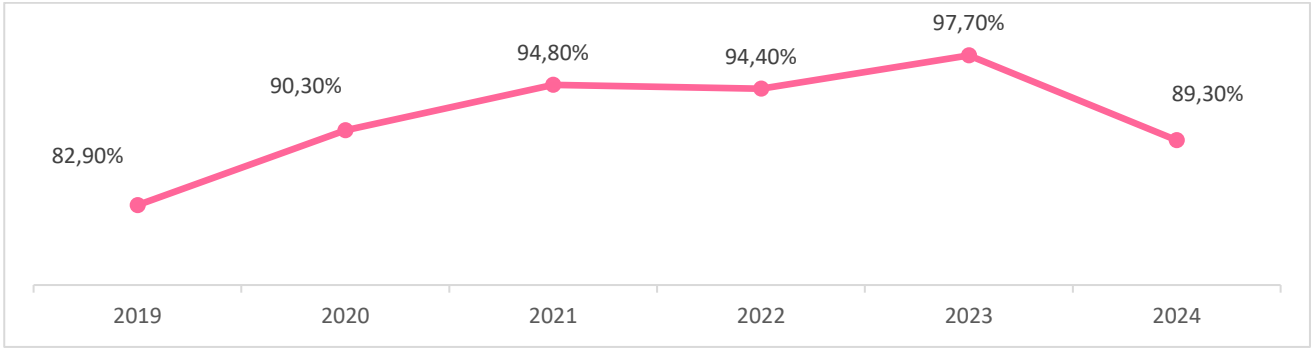
Source : Base DHIS2 2024

3.3. HIV screening in pregnant women

3.3.1. Trends in screening over time

In 2024, HIV testing was offered to pregnant women in attending ANC or LR/DR. This offer resulted in 89.3% coverage of pregnant women received and tested in ANC and LR at the national level, down from 2023 (97.7%). However, a significant decrease in 2024 raises concerns about screening accessibility and uptake. This regression could be linked to screening commodities issues. The North Region (71.4%) is the one with the lowest HIV test completion rate.

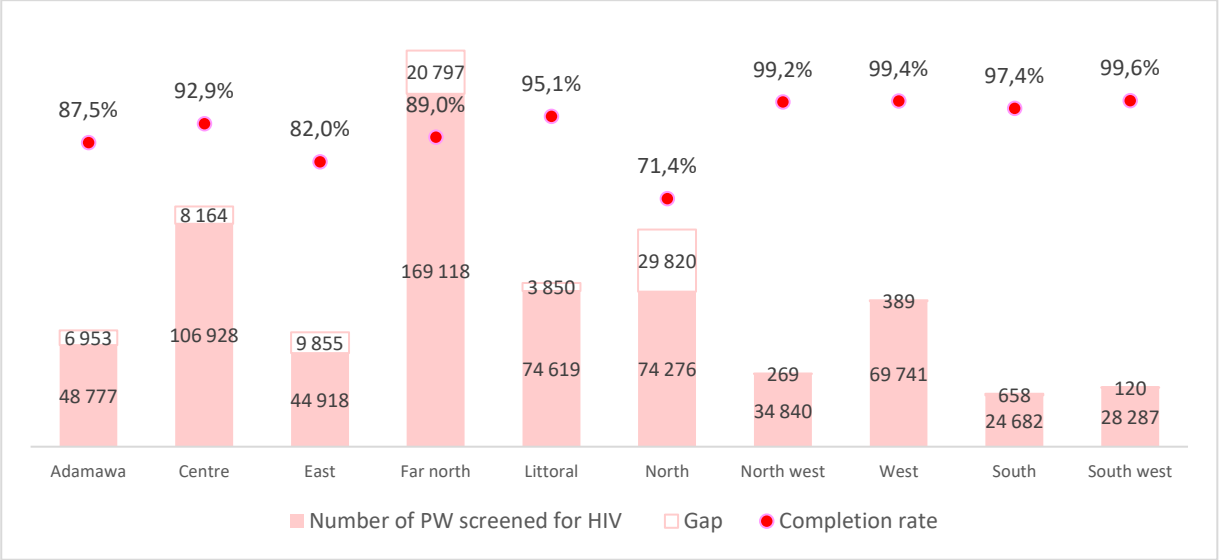
Figure 14: Trends in the rate of HIV testing among PW between 2019 and 2024.



Source : DHIS2/MOH 2024

The regional analysis of HIV testing reveals that it varies between 71.4% in the North region and 99.6% in the Southwest region.

Figure 15 : *HIV testing at regional level*

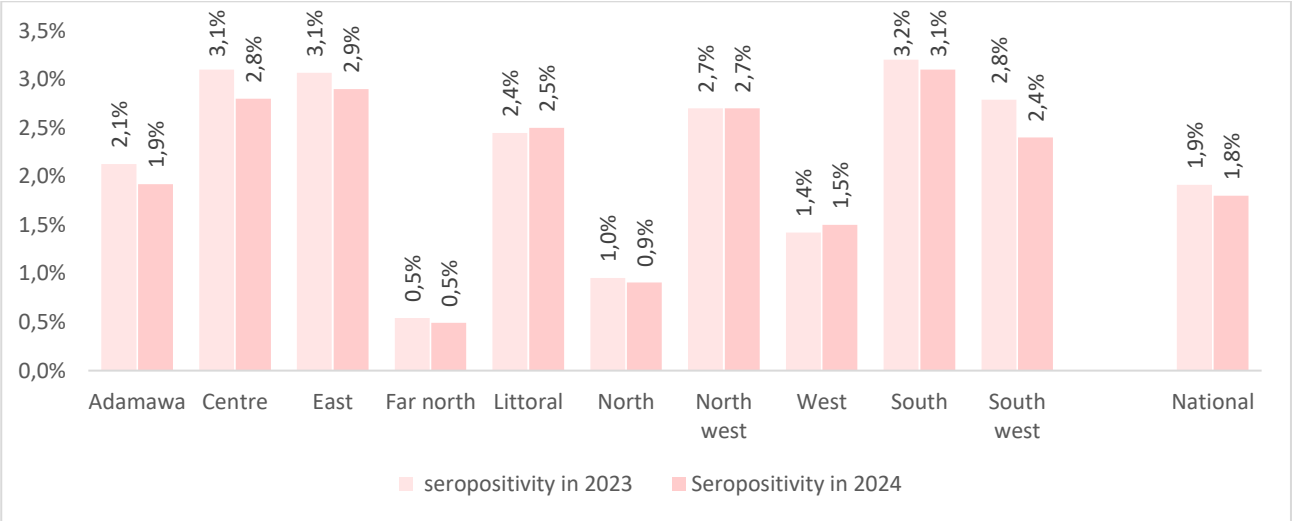


Source : *Dhis2 Data base/MoH2024*

3.3.2. Analysis of HIV seropositivity rates in Pregnant women

In 2024, 89.3% of pregnant women accepted HIV testing, with 12,057 identified as HIV-positive, including 7,431 who were already aware of their HIV status prior to the current pregnancy. The observed seropositivity rate was 1.8%, slightly lower than the 1.9% recorded in 2023. *Graph 16* illustrates the seropositivity rate among pregnant women by region in 2024. Notably, the rate decreased in 7 out of the country's 10 regions, while it remained unchanged in the Far North and the Northwest regions.

Figure 16 : *Comparison of regional seropositivity rates among PW between 2023 and 2024.*



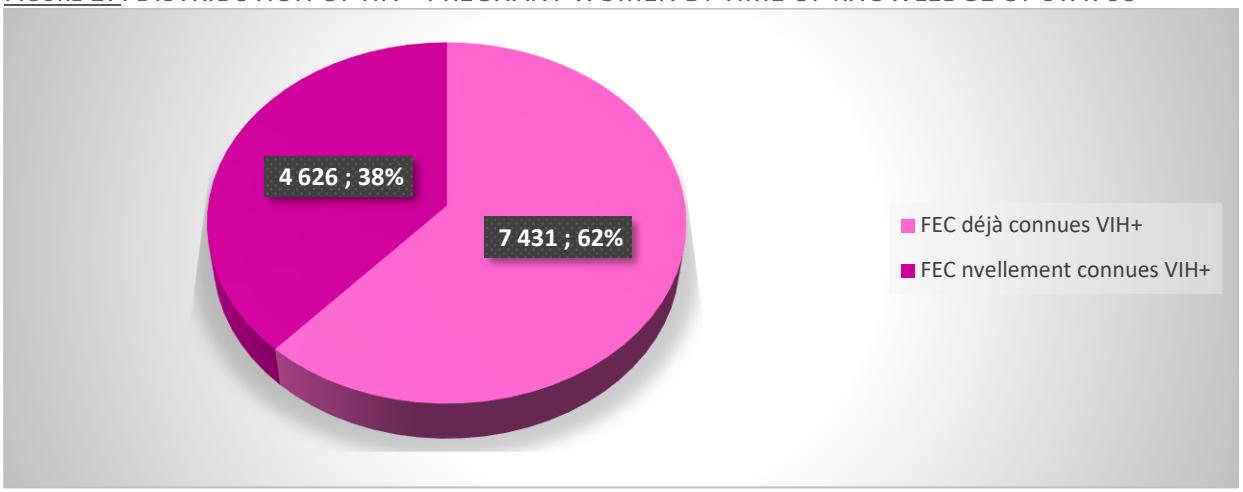
Source : *2023 annual report and 2024 Dhis2/MOH database.*

An in-depth analysis of HIV-positive pregnant women shows a distribution into two subgroups:

1. Women newly diagnosed as HIV-positive during antenatal consultations (ANC and labor/delivery rooms).
2. Women who were already aware of their HIV-positive status before the current pregnancy.

Graph 17 illustrates this distribution, highlighting that the number of already known HIV-positive pregnant women is higher (62%) than that of newly diagnosed cases (38%).

FIGURE 17: DISTRIBUTION OF HIV+ PREGNANT WOMEN BY TIME OF KNOWLEDGE OF STATUS



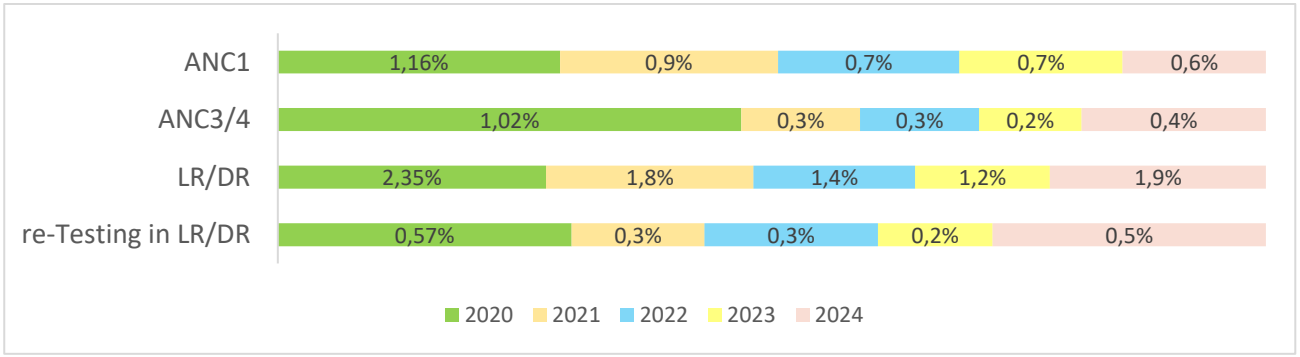
Source : *Dhis2/Minsanté 2024*

Over the past five years, the seropositivity rates among pregnant women (PW) identified across different stages of antenatal care (ANC) have shown a general decline—whether at ANC1, intermediate ANC visits (ANC3 or 4), or in the delivery room. However, between 2023 and 2024, there appears to be a new increase in these rates (*see Graph 18*).

The most striking finding is the seropositivity rate in the delivery room, which is generally more than twice as high as the rate observed at earlier ANC stages, and in 2024, it even reached three times the level of the other stages. This situation can be explained by the fact that the majority of screenings carried out in the delivery room involve pregnant women presenting for the first time to a health facility during pregnancy, which puts their children at considerable risk of HIV infection.

This highlights the urgent need to develop targeted strategies for this subgroup of women, not only to significantly reduce such cases but also to ensure that appropriate prophylaxis (e.g., dual therapy with AZT and 3TC) is systematically provided to their newborns, thereby markedly reducing the risk of HIV transmission.

Figure 18 : *Breakdown of HIV+ pregnant women by time of screening.*

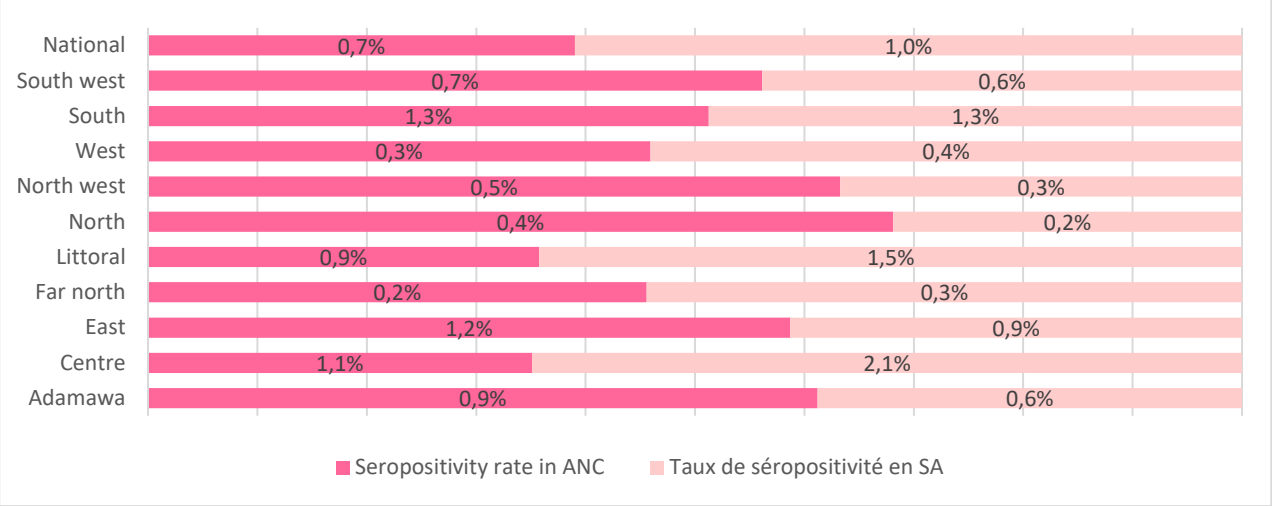


Source : *Dhis2/MoH 2024 database.*

Graph 19 highlights the regional variations in the HIV seropositivity rate among pregnant women according to the gateway: Prenatal Consultations (ANC) and Delivery Room (DR). There are marked disparities, with rates ranging from 0.2% to 1.3% in CPN and from 0.2% to 2.1% in LR/DR, indicating

that some regions detect infections later. The Centre has the highest rate in LR/DR (2.1%), while the Far North records the lowest rates in ANC (0.2%) and DR (0.3%). This distribution highlights the importance of early detection and equitable access to PMTCT services in limiting mother-to-child transmission of HIV.

Figure 19 : *Regional breakdown of the seropositivity rate by entry point.*



Source : Dhis2/MoH 2024 database.

In the very particular case of re-testing pregnant women, it is about the screening carried out either in ANC3/4 or in LR thus allowing to catch up with those who had a negative test in ANC1 and who would have been infected during the period until the other ANC or in the delivery room. In 2024, 86,762 pregnant women benefited from a re-testing in LR. The HIV seropositivity rate obtained during the re-testing in LR was 0.5%. The re-testing allowed capturing additional 454 HIV+ PW.

3.4. Screening in male partners of pregnant women

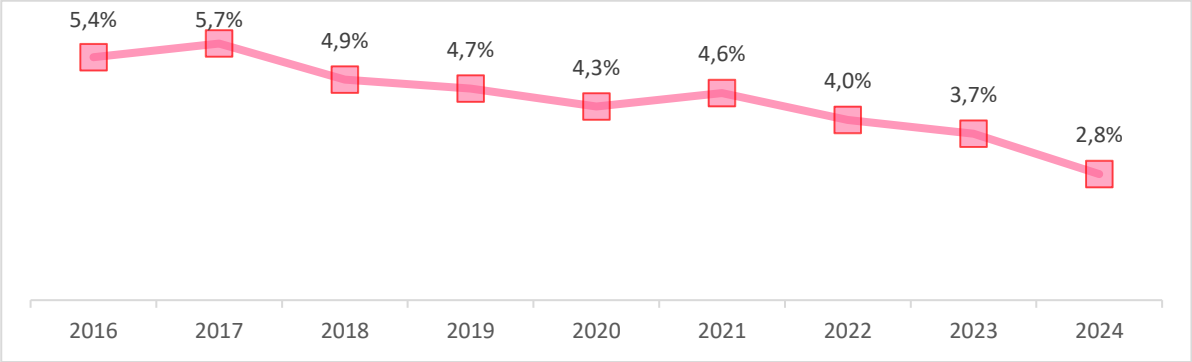
The family approach encourages pregnant women to be accompanied by their male partners during antenatal consultations, allowing both to benefit from HIV testing. However, screening of male partners of pregnant women has shown a steady decline between 2016 and 2024, dropping from 5.4% in 2016 to only 2.8% in 2024 (*see Graph 20*)—a decrease of nearly 50%.

This regression compromises HIV prevention within couples and limits opportunities for the early management of HIV-positive cases. To reverse this trend, it is crucial to :

- Raise awareness among male partners on the importance of testing.
- Increase accessibility to HIV testing services.
- Identify and address barriers that hinder male engagement.

Strengthening interventions such as the effective implementation of index case testing, ensuring the constant availability of test kits, and promoting HIV self-testing for partners of pregnant or breastfeeding women through the ANC-father strategy could significantly improve this indicator and contribute to more effective HIV prevention and control.

Figure 20 : *Change in screening coverage among male partners of PW between 2016 and 2024.*



Source : Annual reports from 2016 to 2023 and DHIS2 2024 database.

The ratio of tested male partners to tested pregnant women has remained stagnant at 0.03%, corresponding to approximately 1 partner tested for every 26 pregnant women tested. Through this strategy, a total of 474 PLHIV were identified among male partners, with the highest number recorded in the Centre region (101 cases).

As shown in Table 28, the seropositivity rate among male partners of pregnant women tested was 2.7% (474/17,364) in 2024, which represents an increase compared to 2023 (1.4%) and is also higher than the seropositivity rate among pregnant women themselves (1.8%) for the same year.

At the regional level, notable variations were observed, ranging from 0.8% in the West region to 5.3% in the Far North region.

Table 29 : *HIV screening among PW male partners.*

Regions	Number of PW received (ANC &DR))	Number of PW screened for HIV (ANC &DR)	Nombres de FEC testées VIH+ (SA&CPN)	Number of PW male partners screened for HIV	Ratio of partners tested to PW screened	Number of PW male partners tested HIV+	HIV+ partners (%)	Ratio of HIV+ tested partner to Regions HIV+ PW
Adamawa	55 724	48 771	920	1411	0,03	47	3,3%	0,05
Centre	115 655	107 240	3 009	3058	0,03	101	3,3%	0,03
East	54 722	44 867	1 282	1288	0,03	64	5,0%	0,05
Far-north	189 751	168 959	826	1020	0,01	54	5,3%	0,07
Littoral	78 967	74 863	1 851	2552	0,03	83	3,3%	0,04
North	103 803	74 077	668	1039	0,01	35	3,4%	0,05
North-west	35 134	34 860	938	1143	0,03	17	1,5%	0,02
West	70 062	69 669	1 070	2732	0,04	23	0,8%	0,02
South	26 115	25 563	804	1105	0,04	23	2,1%	0,03
South-west	28 412	28 290	689	2052	0,07	27	1,3%	0,04
National	**758 345**	**677 159**	**12 057**	**17400**	**0,03**	**474**	**2,7%**	**0,04**

Source : *DHIS2 Data base/MoH 2024*

3.5. ARV coverage among HIV+ PW

In 2024, among registered HIV-positive pregnant women, 10,937 were initiated on ART, representing a coverage of 90.7%. Conversely, 1,120 HIV-positive pregnant women were not placed on ART, reflecting missed opportunities to prevent mother-to-child transmission (MTCT) of HIV. The main reasons for these missed opportunities include:

- Refusal of ART by HIV-positive pregnant women.
- Non-compliance with national “Test and Treat” guidelines.

- Poor management of ARV stocks.

Overall, ART coverage among newly identified HIV-positive pregnant women (84%) was lower compared to those already aware of their HIV-positive status (94.9%).
At the regional level, disparities are significant (see Table 29). While high performance is observed in the South (99.3%), Adamawa (97.6%), and the Northwest (95.8%), lower coverage is reported in regions such as the Centre (80.7%). Similarly, treatment initiation among newly detected HIV-positive pregnant women remains more effective in the South (99.2%) and Adamawa (97.2%), but lags behind in the Centre (68.6%) and the West (79.6%).
These disparities underscore the urgent need to:

- Strengthen access to care in underserved regions.
- Accelerate ART coverage among newly identified cases.
- Harmonize resource allocation to improve equity and ensure more effective prevention of MTCT.

Table 30 : *Regional ART coverage for HIV+ FPW in 2024.*

Regions	Number of PW known HIV+ PW	Pregnant women with known HIV+ status on ART	ART coverage in known HIV+ PW	Number of newly identified HIV+ PW (ANC&DR)	newly identified HIV+ PW initiated on ART (ANC&DR)	ART coverage among Pw newly screened for HIV+	Overall ART coverage among PW screened HIV+.
Adamawa	494	484	98,0%	426	414	97,2%	97,6%
Centre	1777	1584	89,1%	1232	845	68,6%	80,7%
East	694	681	98,1%	588	540	91,8%	95,2%
Far-north	387	375	96,9%	439	392	89,3%	92,9%
Littoral	1238	1198	96,8%	613	504	82,2%	92,0%
North	368	353	95,9%	300	272	90,7%	93,6%
North-west	744	722	97,0%	194	177	91,2%	95,8%
West	810	768	94,8%	260	207	79,6%	91,1%
South	441	438	99,3%	363	360	99,2%	99,3%
South-west	478	449	93,9%	211	174	82,5%	90,4%
National	**7431**	**7052**	**94,9%**	**4626**	**3885**	**84,0%**	**90,7%**

Source : Base DHIS2 2024

➢ *ART in newly screened HIV+ PW*

The coverage of antiretroviral treatment (ART) among newly detected pregnant women declined from 89.1% in 2023 to 84% in 2024. At the regional level, the Centre (68.6%) and West (79.6%) recorded the lowest ART coverage rates among newly screened HIV-positive pregnant women.

This situation may be explained by:

- Insufficient number of health personnel trained in PMTCT.
- Suboptimal management of ARV supplies, which does not adequately account for population mobility and service delivery needs.

To address these gaps, it is essential to:

- Strengthen the capacity of health providers on the importance of timely ART initiation and best practices for follow-up of newly diagnosed women.

- Intensify the implementation of support groups and psychosocial support to improve adherence and retention in care.

ART in already known HIV+ PW

The Centre Region (89.1%) recorded the lowest ART coverage rate, highlighting challenges not only with the retention of women on ART, but also with the initiation of newly identified pregnant women.

To address these gaps, priority actions should include:

Deployment of mentor mothers and pediatric psychosocial agents (PSAs) across all regions to strengthen adherence and follow-up.

Implementation of the "Reach Every District" (RED) approach, supported by tailored interventions, to improve ART initiation and retention.

3.6. Analysis of TB/HIV Co-infection Screening and Management Among HIV+ Pregnant and Breastfeeding Women in 2024

In 2024, data analysis on TB/HIV co-infection screening and management among HIV-positive pregnant and breastfeeding women (PW/BFW) revealed that only 70.9% (9,483/13,384) of HIV+ PW were investigated for signs suggestive of tuberculosis (TB), with some regions reporting rates below this national average.

The TB/HIV co-infection rate stands at 1.6%, with higher prevalence observed in the East (2.3%) and Centre (2.1%), highlighting the need to strengthen TB screening efforts in these regions.

TB treatment initiation remains low at the national level, with only 32% of co-infected cases receiving treatment. Particularly low coverage was recorded in the Littoral (24.6%) and the Far North (19.8%) regions. These findings underscore the urgent need to enhance screening, optimize case management, and better integrate TB/HIV co-infection management into PMTCT services to reduce the impact of this dual infection on maternal and child health.

Several inconsistencies in the reported rates indicate that data quality still requires improvement. To better understand the current situation, it is essential to consider the negative screening results of newly screened pregnant and breastfeeding women. Incorporating this dimension into the analysis can refine statistics and guide targeted interventions more effectively.

Integrating TB and HIV services is crucial not only for improving testing and case management but also for ensuring consistency of data between the two diseases. Strengthening simultaneous screening of pregnant women for HIV and TB allows for more effective detection of co-infection cases and timely initiation of treatment.

3.7. HIV/Syphilis and HIV Hepatitis B co-infections

In 2024, syphilis screening among HIV-positive pregnant women tested 7,819 women, revealing a co-infection rate of 7.6%, an increase compared to 4.2% in 2023. Certain regions reported notably high prevalence rates, such as the Centre (22.3%) and the North-West (8.3%), indicating a need for enhanced care and increased awareness. Strengthening screening strategies and improving access to care remain critical priorities to reduce maternal-fetal risks associated with syphilis/HIV co-infection.

For hepatitis B (HBV), 8,267 HIV-positive pregnant women were tested, showing a co-infection rate of 6.7%. Some regions, such as the South (9.6%), exhibited higher prevalence, while others, like the Coast (4.7%), reported lower rates. Preventing HBV/HIV co-infection requires systematic screening, timely management of positive cases, and integration of care into mother-child prevention strategies.

Overall, syphilis/HIV co-infection (7.6%) is slightly more frequent than HBV/HIV co-infection (6.7%) among HIV-positive pregnant women, although the clinical implications of these co-infections differ.

Table 31: *Syphilis and Hepatitis B Screening for Triple Elimination – 2024.*

Regions	Number of HIV+ PW tested for syphilis	Number of HIV+ PW Syphilis+	Rate of co-infection with HIV/Syphilis	Number of HIV+ PW tested for HVB	Number of HIV+ PWtesting positive for HBV	HIV/HBV co-infection rate
Adamawa	677	27	4,0%	907	31	3,4%
Centre	1 410	315	22,3%	1364	118	8,7%
East	851	58	6,8%	658	38	5,8%
Far North	335	23	6,9%	329	28	8,5%
Littoral	1 514	43	2,8%	1716	80	4,7%
North	241	20	8,3%	404	39	9,7%
North-west	965	34	3,5%	1149	49	4,3%
West	748	16	2,1%	663	30	4,5%
South	443	30	6,8%	418	40	9,6%
South-west	635	27	4,3%	659	28	4,2%
Total	**7 819**	**593**	**7,6%**	**8267**	**556**	**6,7%**

Source : *DHIS2, 2024*

3.8. Care for exposed children.

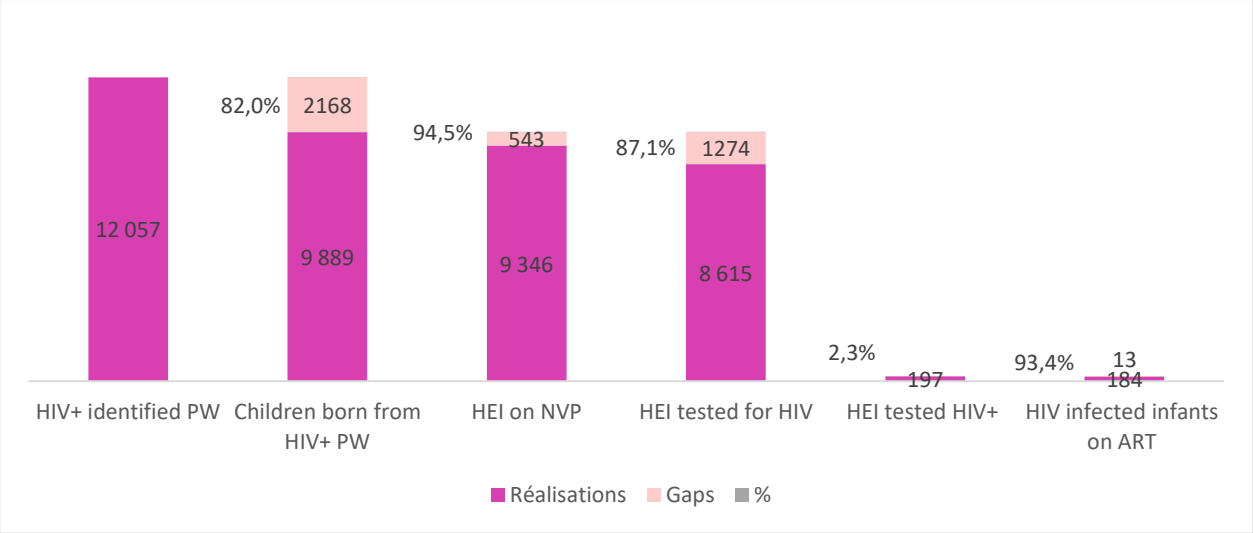
The follow-up of HEI from birth to 24 months of life includes (i) the administration of Nevirapine, (ii) the completion of various early diagnoses of HIV and (iii) the administration of Cotrimoxazole.

3.8.1. Cascade of care for the child exposed to HIV

Analysis of the cascade of care for HIV-exposed children (see Graph 21) shows that 9,889 children were identified, of whom 9,346 (94.5%) were initiated on Nevirapine syrup. The performance of Early Infant Diagnosis (EID) in 2024 remained high and comparable to 2023 (94.9%). A total of 8,615 HEIs were screened using PCR among 9,889 identified infants (87.0%), resulting in 197 positive cases (2.3%). Of these, 184 infants were initiated on ARV treatment, representing a treatment initiation rate of 93.4%, an improvement from 78.4% in 2023. This increase is likely attributable to better availability of paediatric ARVs and the establishment of centres of excellence for paediatric care.

According to programmatic targets, PCR positivity between 6 and 8 weeks is set at 1%, indicating that elimination targets are being approached or achieved within hospital settings.

Figure 21 : *2024 PMTCT-child cascade*



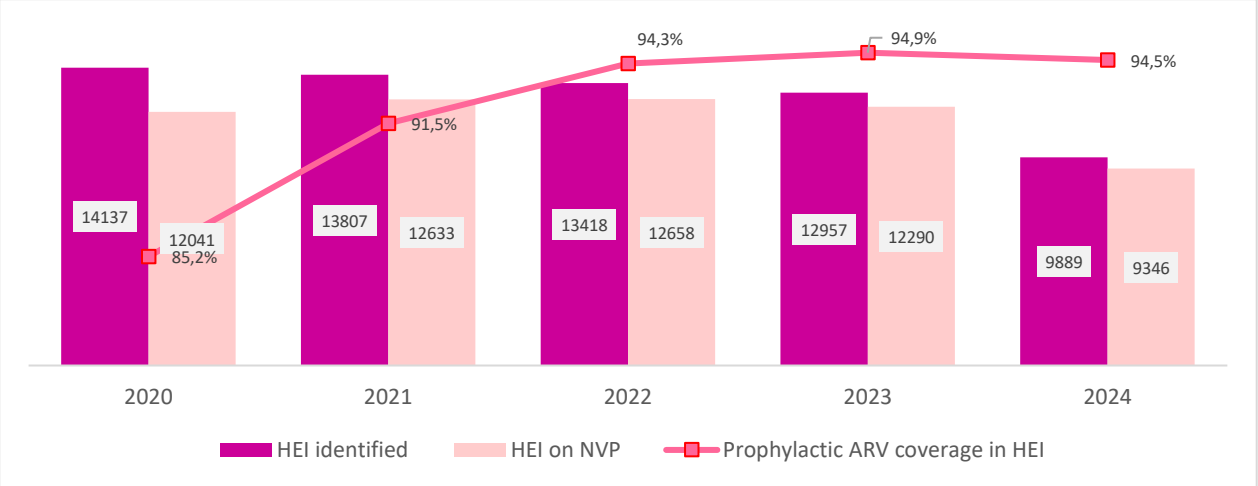
Source: *Base DHIS2 2024*

3.8.2. Prophylactic ARV coverage in exposed children

Prophylactic antiretroviral treatment (ARVs) for HIV-exposed infants is recommended within 72 hours of birth to reduce the risk of HIV transmission. Over the past five years, the coverage of prophylactic ARVs has increased by approximately 10 percentage points**,** reflecting improved access and adherence to early interventions.

However, this positive trend is contrasted by a decline in the number of HIV-exposed infants identified over the same period, highlighting the need to strengthen early identification and follow-up of exposed children to ensure that all at-risk infants benefit from timely prophylaxis.

Figure 22 : *Trend of NVP coverage among HEIs between 2020 and 2024.*



Source : *Annual reports NACC/ DHIS2 database 2024.*

The regional analysis of prophylactic ARV coverage among HIV-exposed infants (HEIs) shows rates generally similar to the national average, except in the Centre region, where coverage is the lowest at 86.6%. Several factors may explain this lower performance, including:

- Remoteness of certain districts, which limits delivery to the last mile and causes intermittent stock shortages.
- Frequent movement of trained health personnel, affecting continuity of service provision.
- Challenges in data quality, which may lead to underreporting or inaccuracies.

Conversely, better performances in some regions have been achieved through specific strategies, such as:

- Provision of NVP boxes to all HIV-exposed children (HEIs) in the third trimester of pregnancy.
- Dynamic redeployment of NVP syrup boxes from sites with surplus to sites with greater need, ensuring timely availability of prophylaxis.

These targeted interventions highlight the importance of logistics, human resource stability, and proactive stock management in improving prophylactic ARV coverage.

Table 32 : *Regional coverage of prophylactic ARVs for EI in 2024*

Regions	Number of HEI identified	Number of HEI on NVP	Prophylactic ARV coverage in HEI
Adamawa	786	778	98,9%
Centre	2304	1994	86,6%
East	1067	1034	96,9%
Far-north	528	501	94,9%
Littoral	1607	1561	97,1%
North	566	534	94,4%
North-west	1007	964	95,7%
West	888	871	98,1%
South	541	540	99,8%
South-west	595	569	95,6%
National	**9889**	**9346**	**94,5%**

Source : *DHIS2 Database 2024*

3.8.3. Early diagnosis of HIV and initiation of ART in infected children

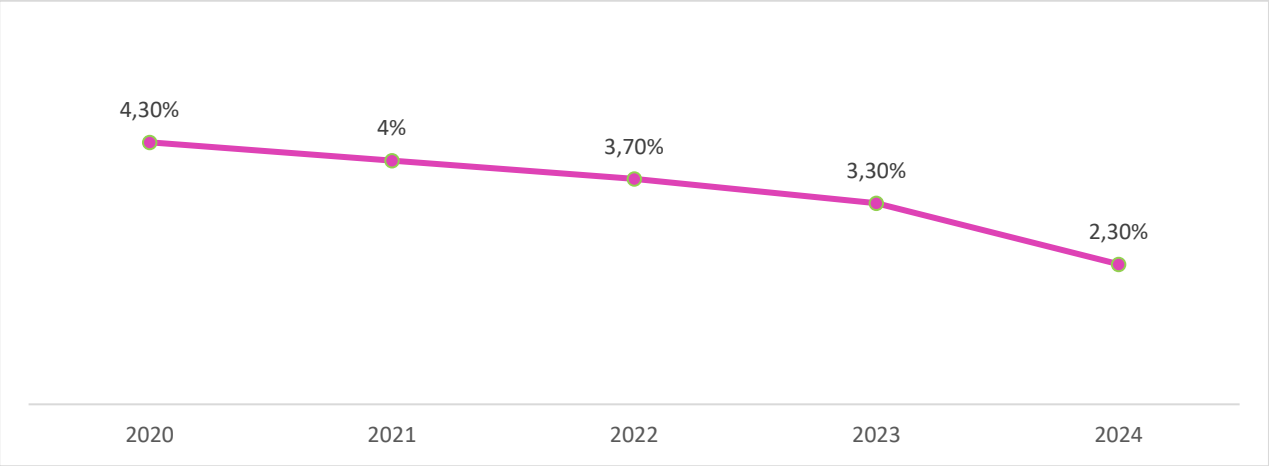
HIV-exposed babies need two main types of tests: PCR tests in the first 2 months and at 9 months, then a blood test at 18 months to confirm their HIV status. Early diagnosis has been improved with more POC machines in health centres.

➢ PCR exam offering

In 2024, a total of 9,889 HIV-exposed children were identified, of whom 8,615 (87.1%) received early diagnosis (EID). This represents a slight decrease from 96.8% in 2023, largely attributable to disruptions in supplies and platform maintenance issues.

The HIV positivity rate before 18 months was 2.3%, down from 3.3% in 2023, indicating progress in preventing mother-to-child transmission. Among children testing positive by PCR, 94.5% were initiated on antiretroviral treatment (ART), reflecting strong linkage to care for diagnosed infants.

Figure 23 : *Taux de positivité au VIH des EE entre 2020 et 2024*



Source : *DHIS2 database 2024*

Over the past five years, the seropositivity rate among children has shown a downward trend, decreasing by 2 percentage points (Graph 23). This decline reflects the positive impact of interventions aimed at eliminating mother-to-child transmission (MTCT) in hospital settings.

In 2024, regional disparities in screening were observed (Table 32), with higher seropositivity rates reported in the Littoral (3%) and the East (2.9%) regions. These elevated rates may be attributed to intensified screening of HIV-exposed children and active community follow-up of children whose mothers have not been initiated on ART.

Table 33: *EID and ART coverage in 2024 by region*

Regions	Number of HEI identified	No. of HEI with PCR-positive	PCR positivity rate	HEI initiated on ART	ARV coverage for PCR+ HEI
Adamawa	786	11	1,4%	9	81,8%
Centre	2304	39	1,7%	41	105,1%
East	1067	31	2,9%	30	96,8%
Far-north	528	13	2,5%	13	100,0%
Littoral	1607	48	3,0%	45	93,8%
North	566	15	2,7%	14	93,3%
North-west	1007	14	1,4%	12	85,7%
West	888	7	0,8%	5	71,4%
South	541	11	2,0%	10	90,9%
South-west	595	8	1,3%	5	62,5%
National	9889	197	2,0%	184	93,4%

Source : 2024 *DHIS2 Database*

- *Serology services.*

In 2024, 5,330 children exposed to HIV were tested at 18-month serology and 97 were tested positive at 18 months for an HIV positivity rate of 1.8%. Only 83.5% of children who tested positive were put on treatment.

TABLE 34: *Provision of serology to HEI in 2024 in Cameroon.*

HEIs tested for serology at 18 months	5 330	(%)
HEIs tested HIV+ at 18 months	97	1,8%
HEI tested HIV+ at 18 months on ART	81	83,5%

Source : *DHIS 2, 2024*

3.9. Community interventions in favour of PMTCT

Improving the quality of governance in the national HIV response requires active contribution from the community system, which is targeted to reach 30% involvement in the strategic and operational plan by 2030. To achieve this goal, multiple strategies and interventions are being implemented across various areas of the response, including PMTCT, with a specific focus on eliminating mother-to-child transmission of HIV.

This section presents the results of community-led activities in PMTCT in 2024, organized around four key axes: Presentation of strategies and community interventions implemented in PMTCT, Matrix of stakeholders and community actors involved in the response. And the results of activities carried out by community actors in 2024.

3.9.1. Contribution of the CHWs in the research of HIV+ PW in the community

Table 34 highlights the critical role of Community Health Workers (CHWs) in reaching pregnant women (PW) at the community level. In 2024, CHWs referred a total of 20,201 PW to health facilities for services. Among these, 80.3% were screened for HIV, yielding a seropositivity rate of 1.7%.

Notably, the Central region recorded a seropositivity rate six times higher than the national average, underscoring the importance of targeted interventions and intensified follow-up in regions with elevated HIV prevalence.

Table 35: *contribution of CHWs in the search for HIV+ PW in the community.*

Region	PW referred by CHWs and received in the health facility	PW referred by CHWs and tested for HIV in the health facility	HIV testing coverage among PW referred by CHWs	PW referred by CHWs and tested HIV+ in the health facility	Seropositivity rate among PW referred by CHWs
Adamawa	1 755	1 417	80,7%	13	0,9%
Centre	577	465	80,6%	34	7,3%
East	1 274	902	70,8%	19	2,1%
Far-north	6 030	5 064	84,0%	51	1,0%
Littoral	498	457	91,8%	16	3,5%
North	5 334	3 677	68,9%	11	0,3%
North-west	1 499	1 375	91,7%	67	4,9%
West	1 269	1 040	82,0%	10	1,0%
South	624	541	86,7%	24	4,4%
South-west	1 341	1 281	95,5%	30	2,3%
National	20 201	16 219	80,3%	275	1,7%

Source : *DHIS 2, 2024*

3.9.2. Contribution of CBOs in the search for HIV+ PW in the community

Table 35 highlights the role of Community-Based Organizations (CBOs) in identifying HIV-exposed pregnant women (PW) within the community. At the national level, CBOs identified 275 HIV-positive PW, corresponding to a seropositivity rate of 1.7%. Regional analysis reveals significant disparities: the Northwest, East, and Southwest regions reported the highest numbers of HIV-positive PW referred by CBOs. The screening rates for referred PW also varied widely, ranging from 46% in the North to 102.8% in Adamawa, reflecting differences in follow-up efficiency and possibly in data reporting practices.

Table 36: *CBO's contribution to the search for HIV+ PW in the community.*

Region	PW referred by CBOs and received in the health facility	PW referred by CBOs and tested for HIV in the health facility	Coverage of HIV testing among PW referred by CBOs	PW referred by CBOs and tested HIV+ in the health facility	Seropositivity rate among HIV+ PW referred by CBOs
Adamawa	71	73	102,8%	3	4,1%
Centre	70	53	75,7%	4	7,5%
East	50	41	82,0%	10	24,4%
Far-north	137	93	67,9%		
Littoral	35	19	54,3%	4	21,1%
North	107	50	46,7%	3	6,0%
North-west	520	496	95,4%	45	9,1%
West	265	248	93,6%		
South	24	24	100,0%	5	20,8%
South-west	404	391	96,8%	10	2,6%
National	**1 683**	**1 488**	**88,4%**	**84**	**5,6%**

3.10. SWOT analysis

STRENGHTS	WEAKNESSES
• Routine HIV screening offered to pregnant women in ANC and delivery rooms. • Adoption of differentiated approaches for pregnant and breastfeeding women and exposed children • - Re-testing pregnant women in ANC 3&4 and in LR/DR. • Prophylaxis for exposed children available to pregnant women from the 3rd trimester of pregnancy. • Strengthening the technical platform for early diagnosis of HIV with an increase in the number of POCs. • Active search by PCHWs and referral to health facilities of PW/BFW not enrolled in ANC/Post natal care services and newborns born in the community. • Sensitization of pregnant women in the community about the use of ANC services.	• Sub-optimal ANC coverage • Low coverage of partner screening for HIV+ pregnant women • Low linkage rate for newly diagnosed HIV+ pregnant women • Low INH coverage of newly diagnosed HIV+ pregnant women • Low proportion of PMTCT sites
OPPORTUNITIES	**THREATS**
• PETVISIDAME Project • Reaching every district" approach • COSMO Project • CSU • Health voucher	• No free screening for syphilis and viral hepatitis B in pregnant women • Security crisis in the NOSO • Cross-border population flows • Staff turnover in the care of exposed pregnant women and children

4. Considérations and Perspectives

DOMAIN	PERSPECTIVES
Coordination	Hold biannual coordination meetings with the actors involved in community activities in the response to HIV (GTR/DRSP, FTPs, OSC/OSC, Districts, Health facility, etc.) in the regions. Organise a meeting with all CBOs and PTFs to identify community PMTCT activities planned at all levels; Strengthen collaboration between HF/HD and community players;
Planning, Monitoring & Evaluation	To draw up and implement a roadmap for community PMTCT interventions in each region; Disseminate harmonised tools for collecting community PMTCT monitoring data to all community and institutional players;
Services on offer	Build the capacity of health staff in PMTCT and DBS/POC sampling. Mobilise resources for the regional transport of PCR and CV samples Making POC inputs and DBS kits available. Intensify the introduction and scaling up of differentiated care models
Service Requests	Build the capacity of health providers and community players in PMTCT; Build the capacity of health facility providers in the management of medicines, inputs and laboratory consumables at all levels; Provide community players with information and communication materials for community mobilisation.; Lobby PTFs for financial support for CBOs to carry out community PMTCT activities; Disseminate information on active search for VDPs and those absent from ART in the Health Districts (PW/BFW HIV and HEI) Prioritise communication actions in routine activities; Implement the transition to the 3-test algorithm, taking into account triple elimination, in order to guarantee free screening and treatment for syphilis and viral hepatitis B among PW. Optimise the community PMTCT approach by integrating the COSAs.

Key Observations on PMTCT Implementation in 2024

The implementation of PMTCT interventions during 2024 was carried out with the support of health facilities, implementing partners, and community actors. Despite these efforts, several challenges were identified:

- Insufficient ANC Coverage: ANC coverage remains inadequate nationwide. A decline in the number of pregnant women (PW) attending ANC has been observed over the past two years in the North and is now affecting other regions. A thorough investigation is needed to identify the underlying causes.
- Insufficient Screening Coverage: The coverage of PW HIV screening was reduced due to prolonged stock-outs of rapid diagnostic tests (TDR) during the first semester. The country

has initiated the transition to a 3-test HIV screening algorithm, prioritizing PW. Mobilization of all supply chain actors is essential to prevent interruptions during this transition.

- High Seropositivity at Delivery: Seropositivity rates are higher in delivery rooms compared to other PMTCT entry points. Many PW detected at this stage are at their first contact with health facilities during pregnancy, increasing the risk of HIV transmission to the child. Adapted prophylaxis (e.g., dual therapy with AZT and 3TC) should be implemented for these cases.
- Declining Male Partner Testing: Continuous decline in testing coverage of male partners of pregnant women calls for intensified index-case based screening.
- High Syphilis/HIV Co-infection Rates: Rates of syphilis/HIV co-infection remain high, despite the country's engagement in the triple elimination initiative. Contributing factors include: Absence of harmonized pre-qualified tests for HFs, lack of a national syphilis screening algorithm, uncertain quality assurance of tests and testing procedures at health sites.
- Insufficient ART Coverage for Newly Identified PW: ART initiation remains suboptimal among newly diagnosed HIV+ PW during pregnancy.
- Suboptimal TB Screening and Management: Clinical screening for TB in HIV+ PW is not yet systematic across all ASFOs offering PMTCT services.
- Management of TB+ cases in HIV+ PW remains very low, requiring targeted interventions.
- HIV Positivity Among Exposed Infants: the positivity rate among tested HIV-exposed infants (HEIs) is lower than the hospital-based strategy target but remains a concern in the community.

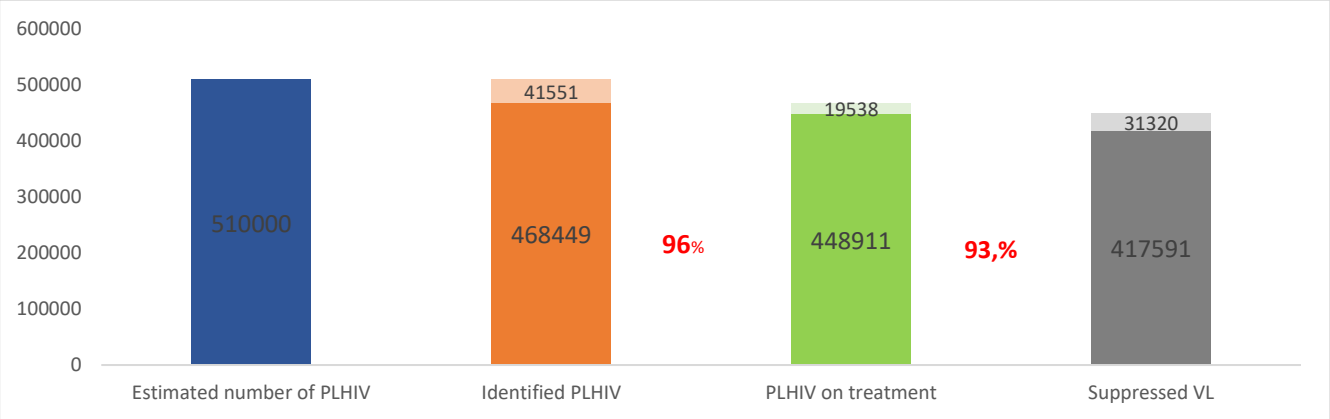
CHAPTER 4: IMPROVING THE QUALITY OF LIFE OF PLHIV THROUGH IMPROVED CARE AND TREATMENT.

Cameroon has made remarkable progress in HIV care through initiatives that have expanded access to treatment and support. The country has adopted several strategies to strengthen the management of people living with HIV (PLHIV) on antiretroviral therapy (ART). These include the "test and treat" approach, the decentralization of HIV services, continuous training of healthcare providers to enhance their expertise in managing PLHIV, and regular patient follow-up. Additionally, Cameroon ensures the provision of free antiretroviral drugs (ARVs), offers psychosocial support, promotes community involvement, and implements differentiated service delivery models for ART. Biological monitoring, particularly through viral load testing, further enhances care. Together, these measures aim to improve the quality of life for PLHIV on ART while also reducing HIV transmission within the wider population.

HIV Cascade and Progress Toward the 95-95-95 Targets in Cameroon

Based on estimates generated using programmatic data and survey inputs in the EPP SPECTRUM model, Cameroon has approximately 510,000 people living with HIV (PLHIV). Of these, an estimated 468,449 PLHIV know their HIV status as identified through programmatic activities. According to these estimates: 448,911 PLHIV should be on antiretroviral treatment (ART) and 417,591 PLHIV are expected to have achieved viral suppression.
This corresponds to an estimated cascade of 92%-96%-93%, based on the UNAIDS 95-95-95 targets (see Graph 24). These results indicate good progress toward achieving the 2025 targets, reflecting the effectiveness of identification, treatment, and viral load monitoring efforts in the country.

FIGURE 24: ESTIMATED HIV CASCADE REGARDING THE 3*95



Source : *EPP Spectrum 2025*

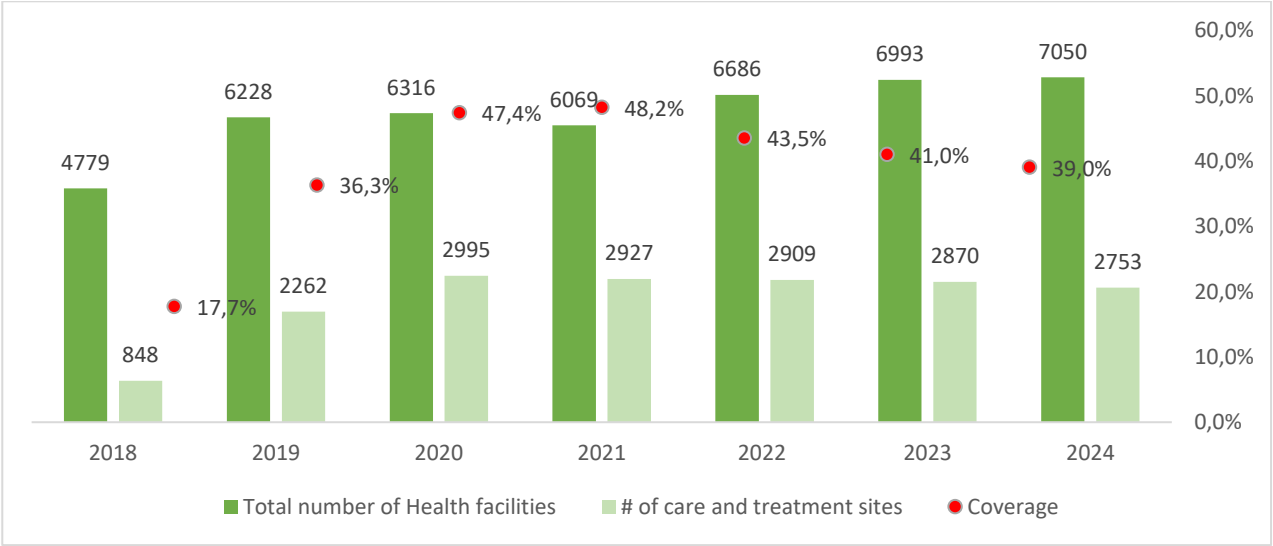
1. Care and treatment services

1. 1. Trend in annual coverage of HIV services

Since the decentralization of HIV care, there has been a clear increase in the coverage rate in treatment sites. The proportion of care unit sites has increased significantly for more than 5 years.

This rate has more than doubled from 17.7% in 2018 to 39.0% in 2024 even though we have observed a decrease since 2022 when this rate dropped by 4.5 points.

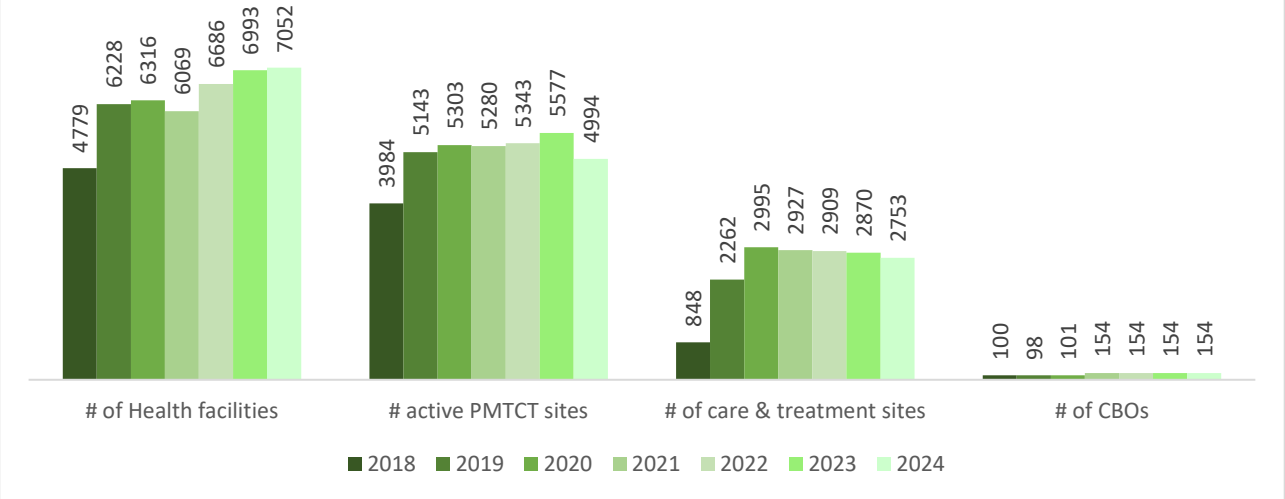
FIGURE 25: EVOLUTION OF THE NUMBER OF ARV TREATMENT SITES COMPARED TO THE NUMBER OF HEALTHCARE FACILITIES IN THE COUNTRY



Source : *2024 DHIS2 database (26/03/2025)*

Although the proportion of care and treatment sites has been rising overall, the number of active ARV treatment sites has declined, dropping from 2,995 in 2020 to 2,753 in 2024. Similarly, the number of active sites providing PMTCT (Prevention of Mother-to-Child Transmission) services has also decreased over the same period, from 5,303 in 2020 to 4,993 in 2024, despite a temporary increase in 2023 when the figure reached 5,577. This decline is largely attributed to the closure of sites in the North-West and South-West regions of the country.

FIGURE 26: EVOLUTION DES SITES DE PECG, PTME ET OBC EN 2024



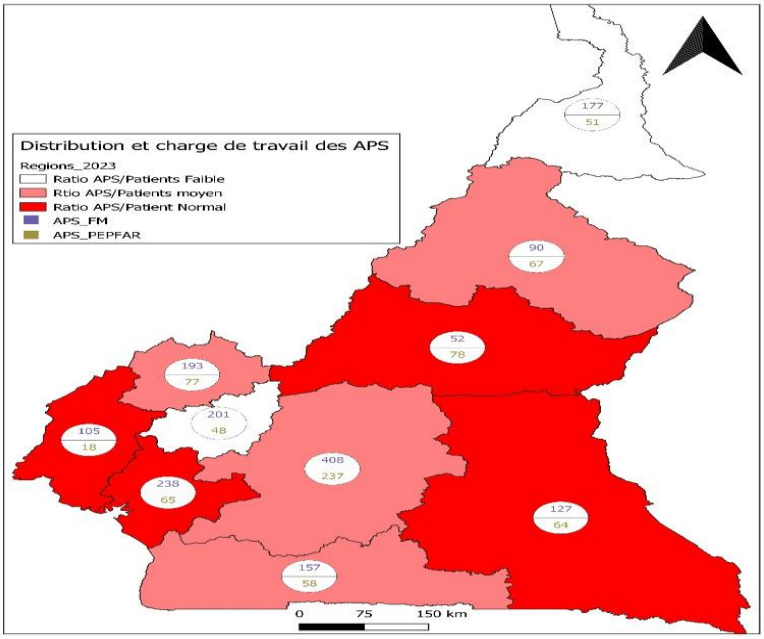
Source : *2024 DHIS2 database*

1. 2 PSA distribution at the national level

The program, with support from the Global Fund and PEPFAR, benefits from the contribution of psychosocial agents (PSA) who operate under service contracts to ensure the well-being of people living with HIV (PLHIV). These agents, who are actively engaged in multiple aspect of the HIV response — including testing, linkage to treatment, maternal follow-up, and patient support — are deployed across all regions of the country. In total, 2,511 PSA are currently engaged, with 1,748 supported by the Global Fund and 763 by PEPFAR. Based on the recommended APS-to-patient ratio of 1 PSA per

250 patients (1:250), the overall national coverage appears satisfactory. However, the actual distribution of APS across sites does not always align with the required ratio. As a result, some facilities experience work overload, depending on the size of their active patient cohort (Active file) within the Health Facility.

FIGURE 27 : MAPPING OF PSA AT NATIONAL LEVEL



Source : *Epidemiological report from the regions*

2. Request for care and treatment services

2.1. Direct linkage from testing to treatment

2.1. 1 Direct link to treatment for newly diagnosed PLHIV

Testing and Treatment implementation guidelines prescribe the initiation of treatment for people who test positive for HIV no later than 7 days after their identification. In 2024, 36,171 people were newly tested positive; and among them, 32,350 were put on ART, representing a direct link rate of 89.4%. Overall, the linkage is good in all regions (see table 36). Moreover, the South region recorded the highest performance (94.6%) and that of the Littoral the lowest (82.6%).

TABLE 37: DIRECT LINK TO TREATMENT FOR PEOPLE NEWLY TESTED HIV6POSITIVE IN 2024.

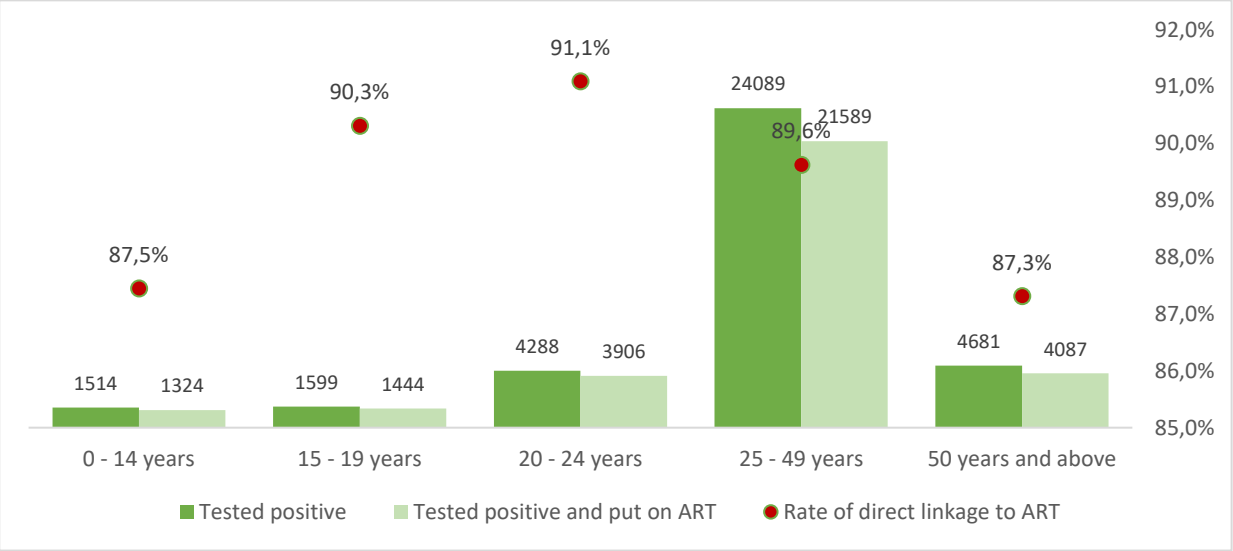
Region	Number of people newly tested HIV positive	Number of people newly tested positive put on ART	Direct linkage
Adamawa	2 870	2681	93,4%
Centre	8 601	7542	87,7%
East	4 159	3920	94,3%
Far-north	2 948	2759	93,6%
Littoral	6 105	5041	82,6%
North	2 287	2093	91,5%
North-west	1 861	1573	84,5%
West	2 169	1978	91,2%
South	2 641	2499	94,6%
South-west	2 530	2264	89,5%
National	**36171**	**32350**	**89,4%**

Source : *2024 DHIS2 Database dated 26/03/2025*

2.1. 2 2.1. 2 Direct link to treatment among newly diagnosed HIV-positive patients, by age group.

Graph 28 presents the direct link to TARV by age. Overall, this link is better for all age groups. An inter-group comparison shows that the lowest performances are those of the group of people aged 50 years and over and children (0-14 years), respectively 87.3% and 87.5%. On the other hand, adults aged 25-49 years and adolescents aged 15-19 years (77, 4%) present the highest performances, namely 91.1% and 90.3%.

FIGURE 28: DIRECT LINK TO ART IN NEWLY DIAGNOSED HIV-POSITIVE PEOPLE BY AGE GROUP

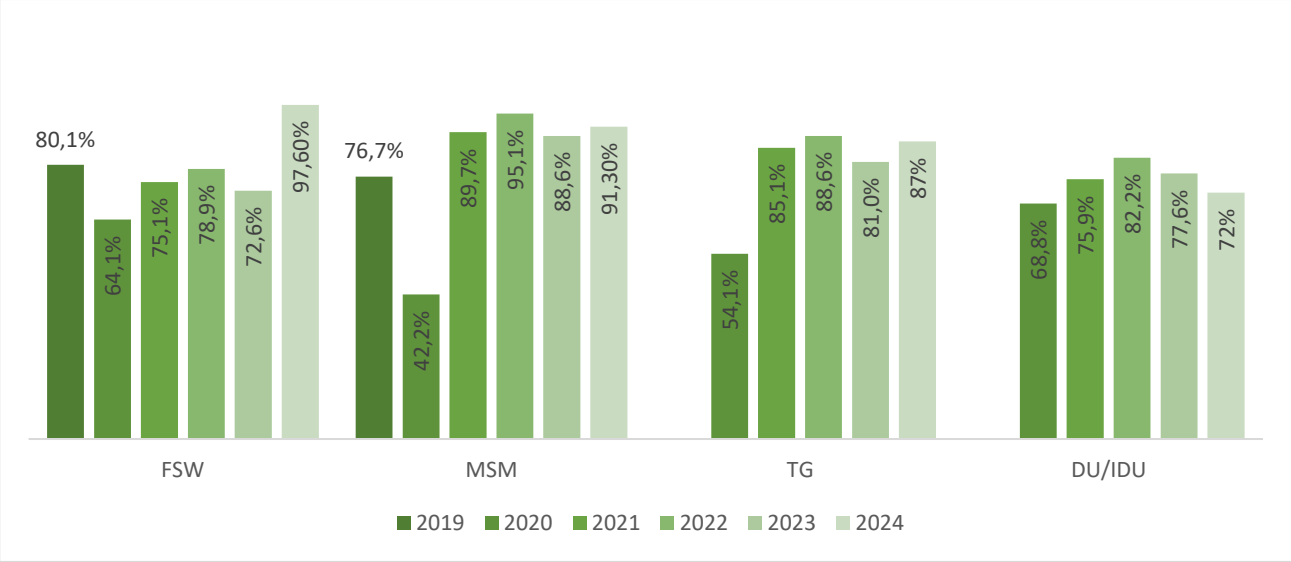


Source : *2024 DHIS2 Database dated 26/03/2025*

2.1. 3 Direct link to ART among key population

Graph 29 shows the evolution of the link to ART among key populations between 2017 and 2024.

FIGURE 29: LINK TO ART AMONG KEY POPULATION.



SOURCE : *2024 CARE/CHP REPORTS*

Among female sex workers men who have sex with men and transgender people there has been a notable increase in direct linkage to ART between 2019 and 2024. For sex workers, the rate rose sharply from 72.6% in 2023 to 97.6% in 2024, representing a 25-point increase. For MSM, the

increase was 2.7 points, while for TG it was 6 points. In contrast, among drug users/injecting drug users the direct linkage rate declined, dropping from 77.6% in 2023 to 72% in 2024.

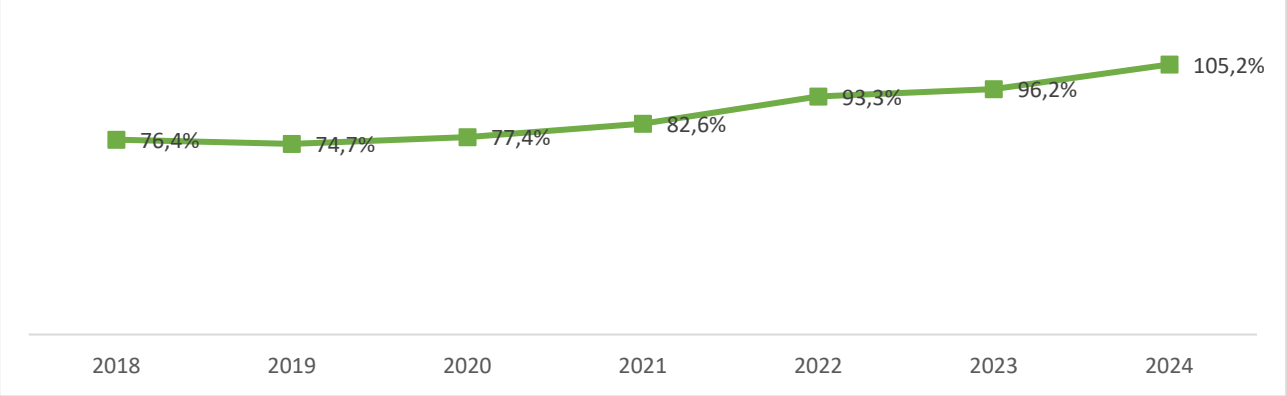
2.2. Indirect link to ART in PLHIV

2.2. 1 Evolution of the national rate of indirect link to treatment in PLHIV

The Testing and Treatment implementation guidelines recommend that people testing positive for HIV be initiated on treatment within 7 days of diagnosis. According to programmatic data, Graph 30 illustrates a growing trend in indirect linkage to ART, increasing from 76.4% in 2018 to 105.2% in 2024. Since 2020, there has been a consistent improvement in the proportion of HIV-positive individuals linked to ART.

In 2024, 105.2% of PLHIV who know their HIV status were linked to ART, compared to 96.2% in 2023. This figure, which exceeds 100%, represents the indirect linkage rate—it includes not only individuals newly diagnosed in 2024, but also those identified in previous years who have then been initiated on ART.

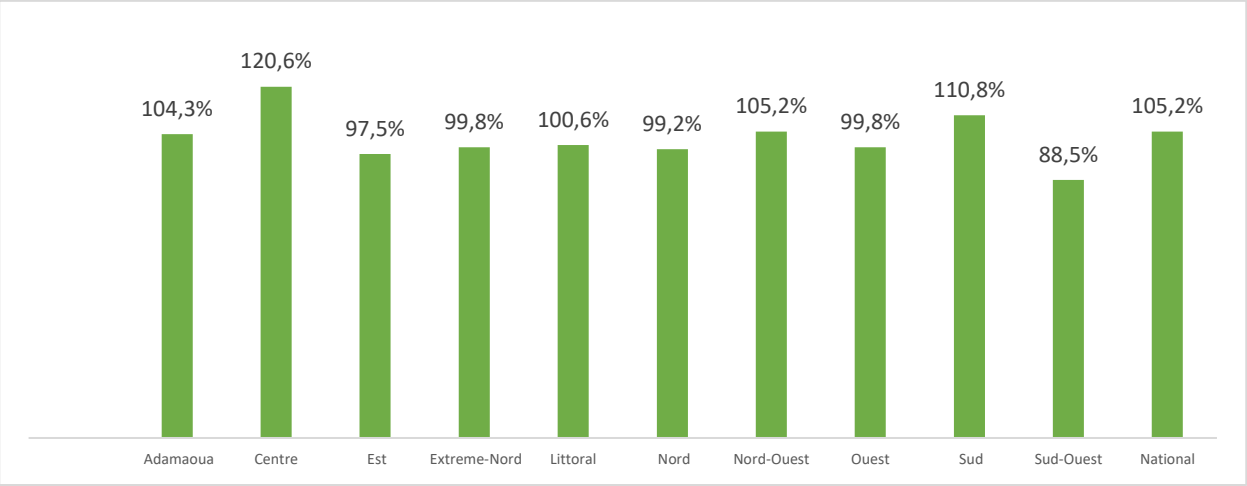
FIGURE 30: EVOLUTION OF INDIRECT LINKS AMONG PLHIV UNDER ART FROM 2018 TO 2024



Source : 2024 DHIS2 Data base dated 26/03/2025

The disaggregation of the indirect linkage to ART, as presented in Chart 31, indicates overall good performance across all regions. However, the Southwest region records the lowest rate at 88.5%. Both the Central and Southern regions also fall below the national average of 105.2%).

FIGURE 31: INDIRECT LINK TO ART AMONG PLHIV BY REGION IN 2024. .

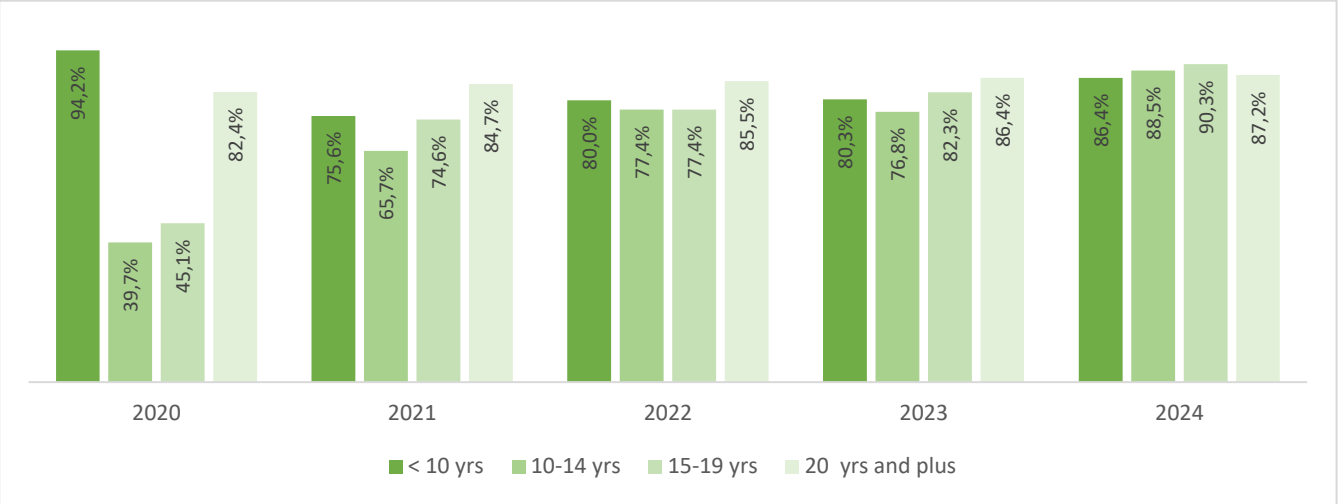


Source : Base DHIS2 2024 du 26/03/2025

2.2. 1 *Changes in the national rate of indirect links to treatment by age group*

Graph 32 illustrates the evolution of the indirect linkage to ART by age group between 2020 and 2024. The lowest rates are observed among children (10–14 years) and adolescents (15–19 years). The poor performance in these age groups can be explained primarily by the difficulty of ensuring consistent follow-up without the presence of an adult (parent or guardian). In addition, challenges include the limited geographical coverage of paediatric HIV care sites and the shortage of providers trained in both disclosure osf HIV status and the clinical management of children and adolescents.

FIGURE 32: CHANGES IN THE INDIRECT LINK TO THE TARV BY AGE FROM 2020 TO 2024

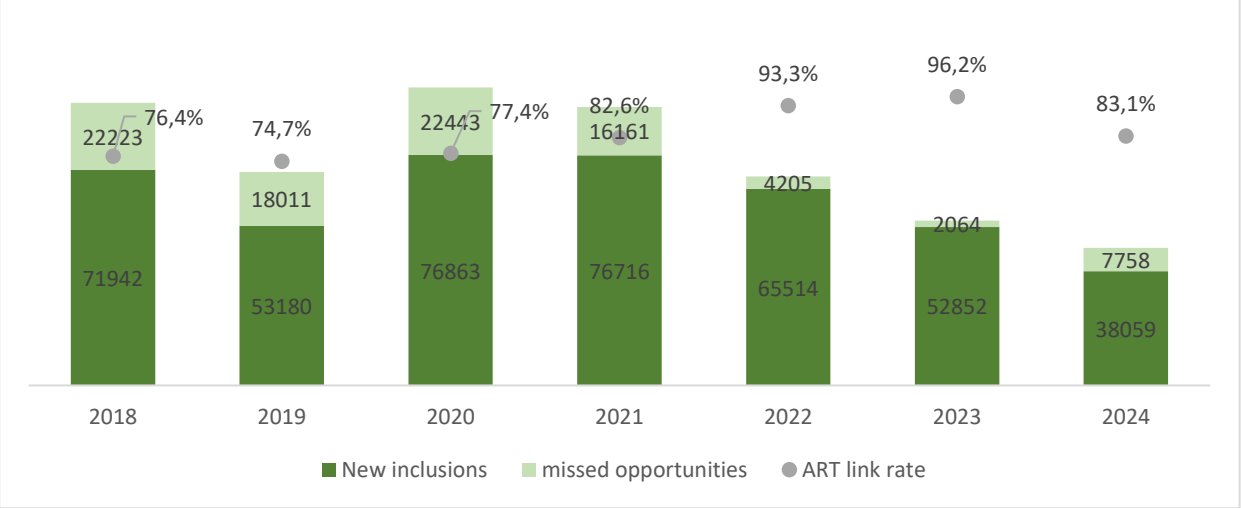


Source : Base DHIS2 2024 du 26/03/2025

2.2. New inclusions in ARV treatment

The number of new inclusions has significantly declined since 2020, dropping from 76,863 to 38,059 in 2024. At the same time, there has been a sharp increase in missed opportunities, rising from 2,064 in 2023 to 7,758 in 2024. Several factors contributed to this situation in 2024, including: Poor reporting of data, the termination of PSA contracts previously supported by the CDC Cameroon's clinical implementation partners, and insecurity in certain areas (such as Touboro), which hindered community-based activities like home visits.

FIGURE 33 : CHANGES IN NEW INCLUSIONS IN THE NATIONAL ACTIVE FILE FROM 2018 TO 2024



Source : 2024 DHIS2 data base dated 26/03/2025

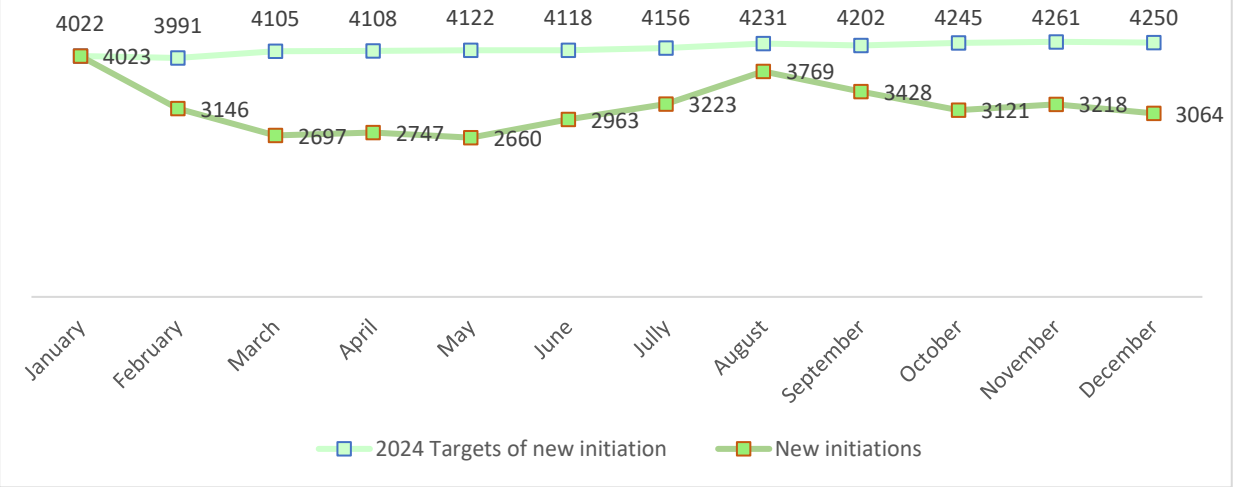
- Initiation of patient on ART in the community

One of the key aspects of the community's contribution to patient care in 2024 was the enrolment of new PLHIV at the community level. Through community case-finding activities, 410 individuals were identified, of whom 381 were eligible for ART initiation within the community. Among these eligible individuals, 287 were actually initiated on ART, representing a community-level direct linkage rate of 75.3% (287/381).

2.3.1. Trend in the monthly evolution of the number of new inclusions in ART

The observation of the monthly evolution of new inclusions over the year shows a trend below the level of national targets. Treatment initiations first fall during the first six months of the year, then increase over the next two months before falling again until the end of the year. The maximum inclusion number is observed in the month of January (4,023) and the minimum in May (2,660) with an annual average of 3,171 inclusions per month.

FIGURE 34 : MONTHLY CHANGE IN THE PLHIV INITIATION TO CARE FROM JANUARY TO DECEMBER 2024.

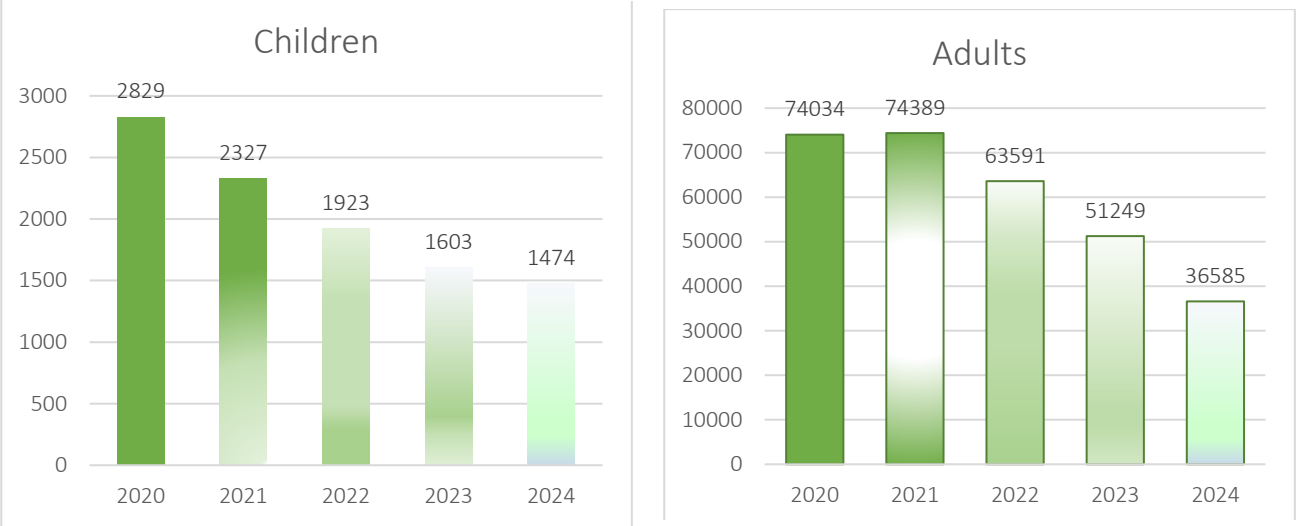


Source : 2024 DHIS2 data base dated 26/03/2025

2.3.2. Trends in the annual change in the number of new inclusions to ART by age group

The subdivision by age group according to children aged under 15 and adults for ages over 15 shows a similar trend over the last 05 years.

FIGURE 35 CHANGES IN NEW INCLUSIONS AMONG CHILDREN (UNDER 15) AND ADULTS (15 AND OVER) FROM 2020 TO 2024



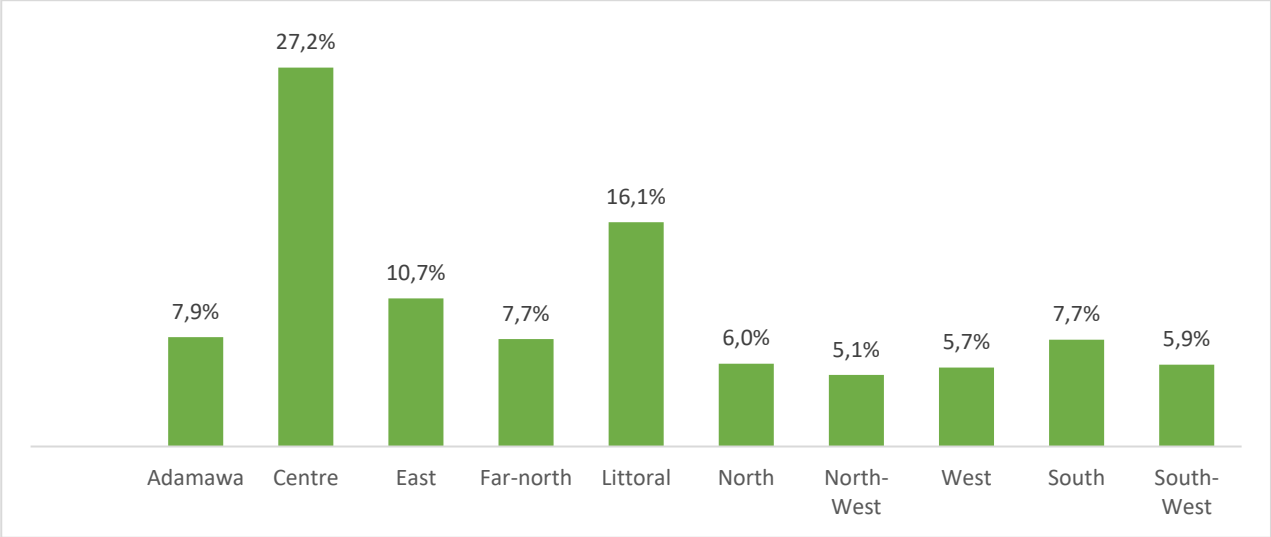
Source : 2024 DHIS2 data base dated 26/03/2025

A continuous decline in ART initiations has been observed since 2020 among both children and adults. This reduction in new enrolments may be partly explained by the decrease in new HIV infections, reflecting the progress achieved in the national response to HIV/AIDS. In 2024, children represented 3.9% of new initiations, while adults accounted for 96.1%.

2.3.3 Distribution of new inclusions in treatment by region

The distribution of new treatment initiations over the year shows that the largest shares are concentrated in the Centre (27.2%),Littoral (16.1%), and East (10.7%) regions. Together, these three regions account for more than half of all new inclusions nationwide. In contrast, the Northwest (5.1%), West (5.7%), Southwest (5.9%), and North (6.0%) regions record the lowest rates of new inclusions.

Figure 36 : Breakdown of new inclusions by region in 2024

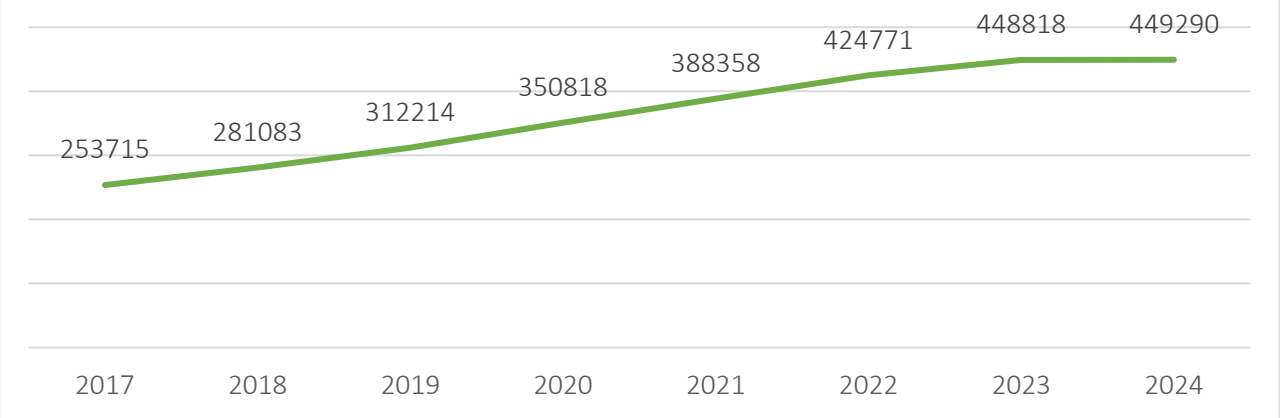


Source : 2024 DHIS 2 Data Base dated 26/03/2025

2.3. Overview of patient's cohorts on ARV treatment (active file)

2.4.1. Annual trend of the national active file of patients on ART.

FIGURE 37: CHANGES IN THE NATIONAL ACTIVE FILE FROM 2017 TO 2024



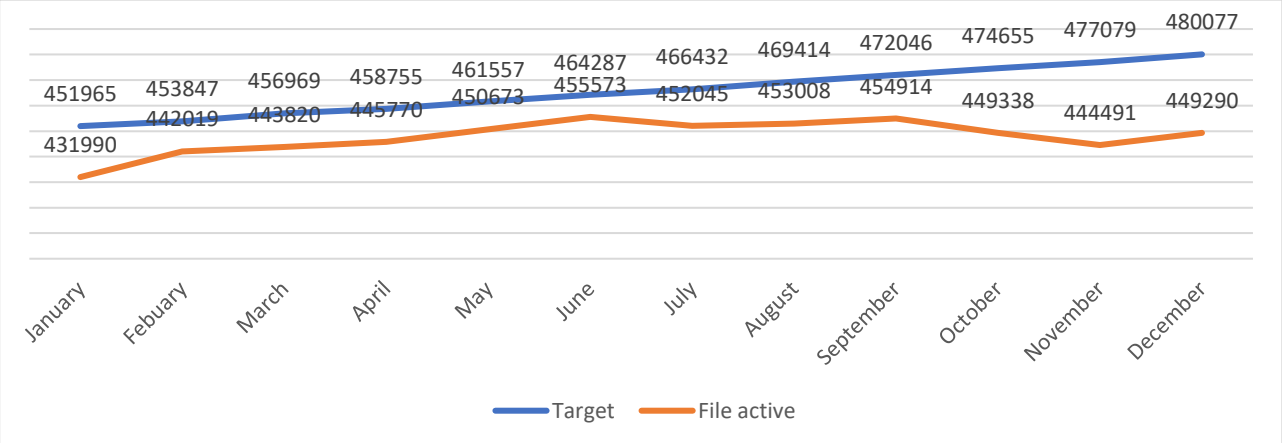
Source : *2024 DHIS2 data base (26/03/2025)*

Graph 37 illustrates the evolution of the active cohort of people on ART between 2017 and 2024. The number of patients increased from 253,715 in 2017 to 449,290 in 2024, representing a 77.1% growth. However, the increase between 2023 (448,818) and 2024 (449,290) was marginal, falling well below the national target of 480,077 PLHIV on treatment by December 31, 2024.

The progression trend of the active cohort slowed after 2023, due to several combined factors:

1. Data quality interventions: The program undertook efforts to clean poor-quality data reported by certain HF. Routine data audits revealed discrepancies between medication dispensation data and cohort records, highlighting weaknesses in filling out primary monitoring tools and managing drug stock information.
2. Reduction in partner support staff: Many HF experienced reduced staff from implementing partners, alongside transitions between partners in some regions (e.g., ACMS and ICAP, SHWARI and GU). This negatively affected continuity of support and supervision.
3. Challenges with remote patients: A proportion of patients living in hard-to-reach areas were not consistently followed up at HF level, contributing to gaps in the active patient file.

FIGURE 38: MONTHLY CHANGE IN THE ACTIVE FILE OVER 2024



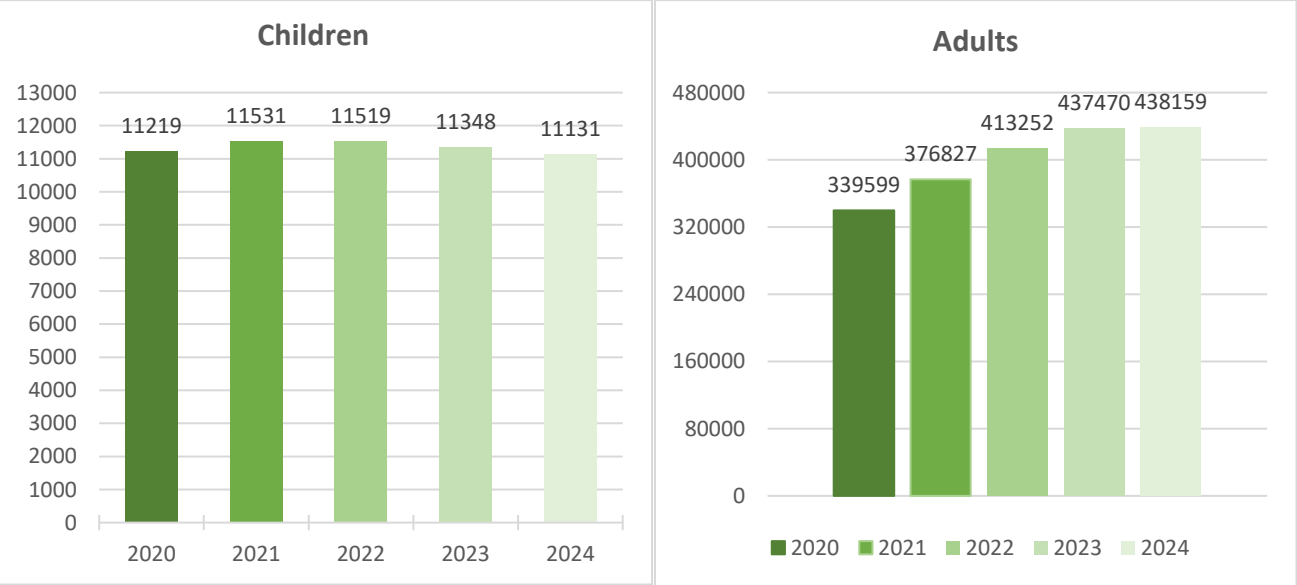
Source : *2024 DHIS2 Data base (26/03/2025),and 2024 Performance Framework.*

Graph 38 confirms the sharp decline in the active cohort, which remained below the national target throughout 2024. Despite this, the active file showed an upward trend in the first half of the year, increasing from 431,990 patients in January 2024 to 455,573 in June 2024. However, this gain was not sustained, as the number declined to 449,290 patients by December 2024.

2.4.2. Annual evolution of the national active file among children and adults

The adult active cohort recorded an average annual growth rate of 29.0% between 2020 and 2024, increasing from 339,599 to 438,159 patients. This growth is largely attributable to the reduction in LTFU (patients lost to follow-up), achieved through strengthened strategies for tracking both LTFU patients and treatment absentees. In addition, the implementation of differentiated ARV dispensation strategies has supported retention and expansion of the adult cohort. In contrast, the pediatric active cohort experienced a slight decline of 0.8% over the same period, with the number of children on ART decreasing from 11,219 in 2020 to 11,131 in 2024. This reduction can be explained by two main factors: the transition of 14-year-old patients into the adult cohort, and the decline in new pediatric HIV infections as a result of prevention efforts.

Figure 39 : Change in the active file for children and adults from 2020 to 2024.



Source : Base DHIS2 2025 du 26/03/2025

2.4.3. Répartition de la file active par région, par sexe et âge

The analysis of the active cohort distribution presented in Table 37 shows that the largest share remains concentrated in the Centre (25.7%) and Littoral (15.6%) regions. In contrast, the Adamawa (5.7%) and South (5.8%) regions record the lowest proportions. At the national level, children under 15 years represent 2.5% of the active cohort. The regions with the highest proportions of children are the Far North (4.1%), Northwest (3.2%), and Adamawa (3.1%), while the Littoral region reports the lowest proportion (1.9%).

TABLE 38: BREAKDOWN OF THE ACTIVE FILE BY REGION IN 2024

Region	Women	Men	Total	Enfants	% enfants	Poids région
Adamawa	17 377	8346	25723	792	3,1%	5,7%
Centre	77 639	37733	115372	2321	2,0%	25,7%
East	26 523	12473	38996	1104	2,8%	8,7%
Far-north	19 081	10228	29309	1202	4,1%	6,5%
Littoral	48 932	21119	70051	1365	1,9%	15,6%
North	19 559	9217	28776	830	2,9%	6,4%
North-west	30 817	12515	43332	1375	3,2%	9,6%
West	23 728	10391	34119	821	2,4%	7,6%
South	17 354	8505	25859	593	2,3%	5,8%
South-west	26 120	11633	37753	728	1,9%	8,4%
National	**307130**	**142160**	**449290**	**11131**	**2,5%**	**100,0%**

Source : 2024 DHIS2 Data base (26/03/2025)

Table 38 presents the distribution of the national active cohort as of December 31, 2024, disaggregated by gender and age. Women account for 68,3% of the national active file. By age group, patients aged 50 years and above represent the largest share (26.9%), highlighting an aging treatment cohort. This reflects the success of ART in prolonging life expectancy, but also underscores the need for specialized monitoring of older patients to prevent and manage opportunistic co-morbidities and co-infections. At the other end of the spectrum, children under one year old make up only 0.03% of the active file, corresponding to 136 children.

Table 39: Breakdown of the active file by sex and age in 2024

Age group	Female	Male	Total	Weight (%)
<1 yr	64	72	136	0,03
1 - 2 yrs	359	339	698	0,2
3 - 4yrs	578	646	1224	0,3
5-9 yrs	1980	1880	3860	0,9
10-14 yrs	2723	2490	5213	1,2
15-19 yrs	5146	2626	7772	1,7
20-24 yrs	16587	5123	21710	4,8
25-29 yrs	27303	10280	37583	8,4
30 - 34 yrs	41328	13839	55167	12,3
35 -39 yrs	47755	17623	65378	14,6
40 - 44 yrs	47892	21376	69268	15,4
45 - 49 yrs	39745	20652	60397	13,4
50 yrs and above	75670	45214	120884	26,9
Total	**307130**	**142160**	**449290**	**100,0**

Source : 2024 DHIS2 database (26/03/2025)

2.4.4. Breakdown of the active file by treatment protocol

The vast majority of patients in Cameroon remain on first-line ART, predominantly under the Tenofovir/Lamivudine/Dolutegravir (TLD) regimen. In 2024, 97% of patients were on a first-line

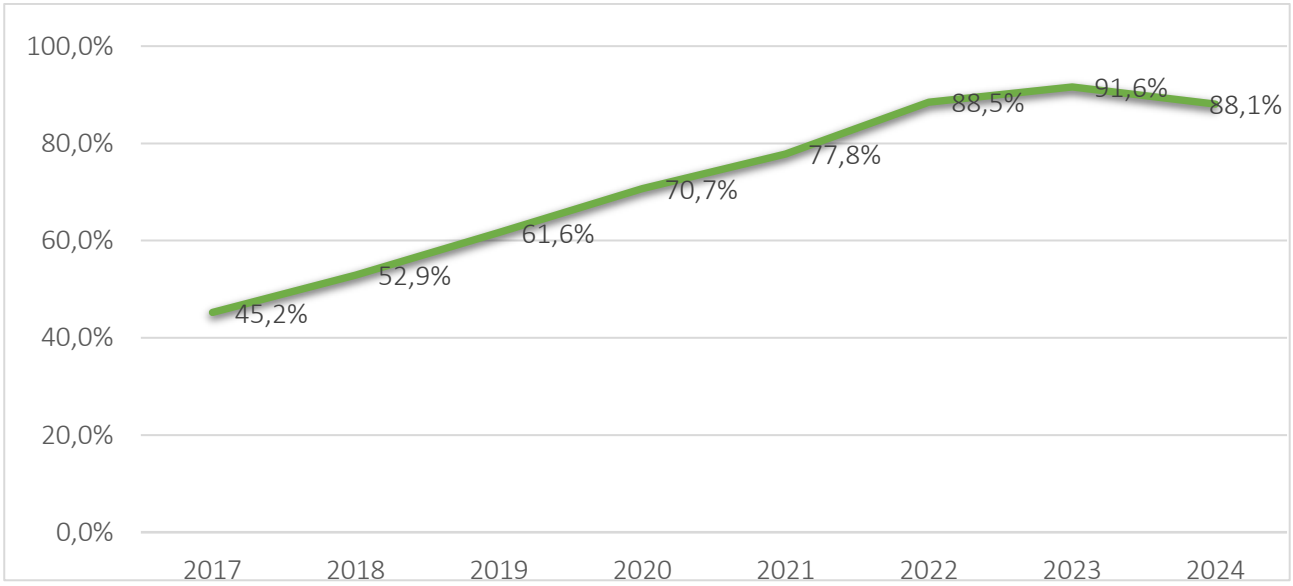
protocol, compared to 2.9% on second-line and 0.1% on third-line treatment. The transition to TLD has been largely successful, with 92.4% of patients on TLD in 2024, up from 75.8% in 2023. However, a challenge persists regarding pharmacovigilance, as cases of side effects associated with TLD have been reported in certain regions, underscoring the need for strengthened monitoring and reporting systems.

2.4. ARV Population coverage

2.5.1. Trend in annual ARV population coverage

Graph 39 shows the evolution of ARV coverage at the national level from 2017 to 2024. Overall, ARV coverage followed an upward trend during this period, rising from 45.2% in 2017 to 88.1% in 2024, representing a 94.9% increase. This improvement reflects the program's sustained efforts in identifying and initiating patients on treatment. However, a decline of 3.5 percentage points was noted between 2023 and 2024. This drop is explained by the increase in the estimated number of PLHIV in 2024, following updates to certain parameters of the EPP-SPECTRUM model.

Figure 40 : Trend in ARV population coverage at national level from 2017 to 2024



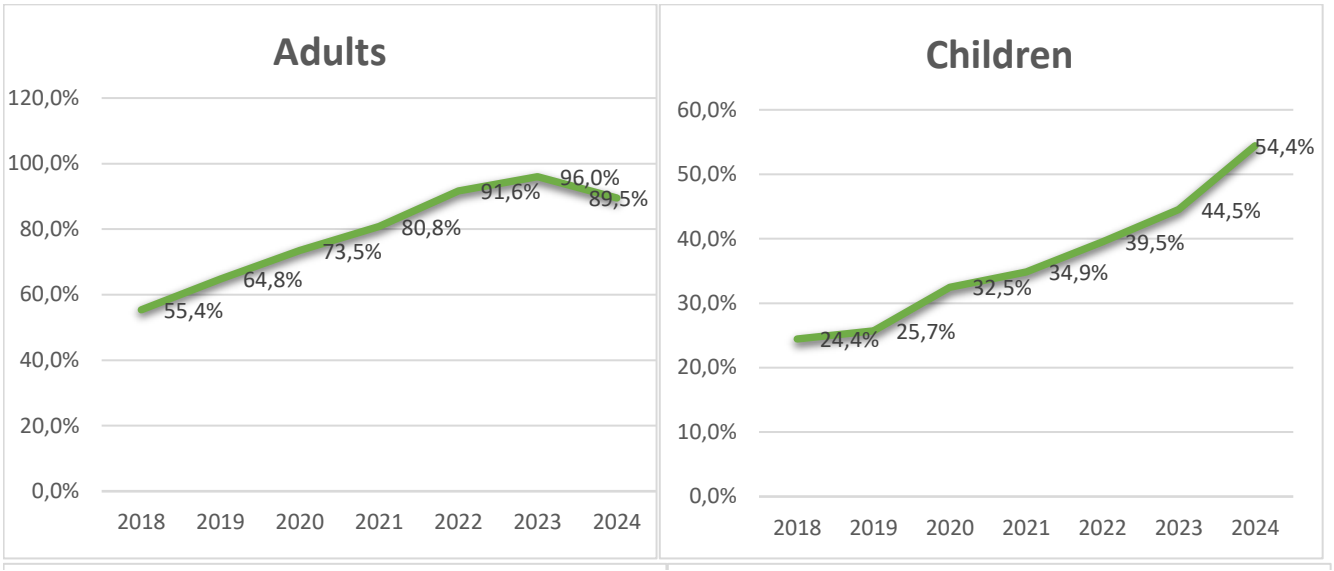
Source : *2024 DHIS2 database (26/03/2025), EPP SPECTRUM 2025*

2.5.2. Trend in annual population ARV coverage in children and adults

ARV coverage among adults shows a steady upward trend. Between 2018 and 2024, it increased by 61.5%, moving from 55.4% to 89.5%. Similar to the national level, a slight decline in 2024 is observed, explained by the increase in the estimated number of PLHIV following updated parameters in the estimation models.

In contrast, ARV coverage among children remained relatively stable from 2018 to 2023, before recording a significant increase of 22.2% between 2023 and 2024. This improvement is linked to a decrease in the estimated number of children living with HIV, which dropped from 27,960 in 2023 to 20,450 in 2024. Despite this progress, the denominator remains high considering the programmatic efforts deployed. For example, under the PEDIATRIC SURGE initiative, which aimed to identify 3,204 children living with HIV who were not yet on treatment, 740 children (23.8%) were successfully traced and re-integrated into care. These findings reinforce the hypothesis of a possible overestimation of the number of children infected with HIV in the country.

Figure 41 : Trends in ARV coverage for adults and children from 2018 to 2023



Source : 2024 DHIS2 database (26/03/2025)

2.5.3. Population ARV coverage by sex and age

Analysis of population-based ARV coverage (Chart 42) highlights disparities across age groups and between genders. Overall, women consistently show better coverage than men across all age groups. Coverage is lowest among children and adolescents and highest among young people (20–24 years) and adults (25 years and older).

Children under 10 years: Coverage is 43.1%, with no major gender difference.

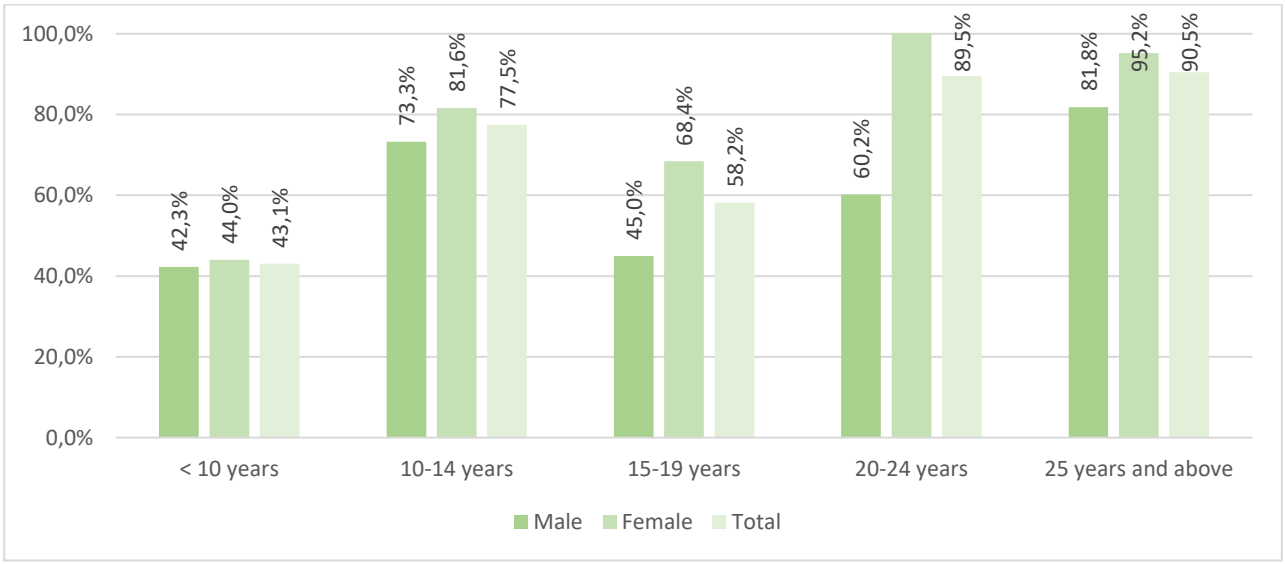
Children aged 10–14 years: Coverage rises to 77.5%, higher among girls (81.6%) than boys (73.3%).

Adolescents aged 15–19 years: Coverage drops to 58.2%, but remains much higher among girls (68.4%) compared to boys (45.0%), a gap of 23.4 points.

Young people aged 20–24 years: Coverage is relatively high at 89.5%, but with a stark contrast: women exceed 100% (105.3%), while men are much lower (60.2%).

Adults aged 25 years and older: Coverage remains strong at 90.5% overall, but is again higher among women (95.2%) than men (81.8%).

Figure 42 : ARV coverage by sex and age group in 2024



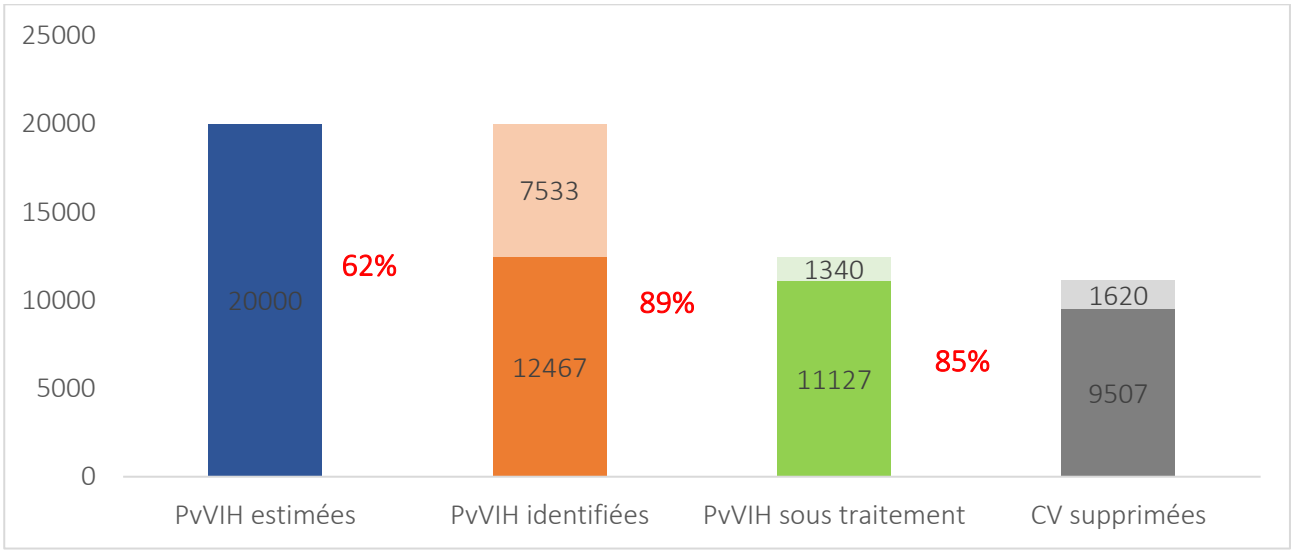
Source : 2024 DHIS2 database (26/03/2025)

2.4 Synthesis of care and treatment cascades for children aged 0-14 years

The analysis of the 3*95 cascade in children reveals a substantial gap compared to the general population. The first 95 (HIV diagnosis), although showing an improvement compared to the previous year, remains low at 62%, highlighting persistent challenges in identifying children living with HIV. By contrast, the second 95 (treatment initiation) and third 95 (viral suppression) are relatively strong, at 89% and 85%, respectively.

To address these gaps, efforts in pediatric HIV care have been reinforced. In 2024, the PEDIATRIC SURGE initiative contributed significantly by identifying and reintegrating 740 children living with HIV into the healthcare system. This progress demonstrates the program's commitment to improving pediatric indicators, though further work is still needed to close the diagnosis gap.

Figure 43 : Cascade estimée des 3*95 chez les enfants 0-14 ans, 2024



Source : *EPP Spectrum 2025*

2.4. Suivi psycho-social et continuum de soins des PvVIH sous traitement ARV

Psychosocial care for people living with HIV/AIDS (PLHIV) is a crucial determinant of their overall health and well-being. The needs of PLHIV go beyond access to medicines and clinical care—they also require psychological and social support to reduce the perception of an inevitable link between HIV infection and death. Such support helps foster better adherence to treatment while promoting social integration.

This component is delivered by psychosocial support workers (PSAs) for both children and adults, who play a central role in daily patient follow-up. Their responsibilities include:

(i) Monitoring the mother–child pair throughout the PMTCT process until its completion.
(ii) Tracking patient appointments within the cohort to ensure continuity of care.
(iii) Documenting patient outcomes in the cohort through the ACRR.
(iv) Facilitating individual and group education/therapy sessions (ETP), such as discussion groups and adherence support, for both newly initiated and long-term ARV patients.

2.6.1 Situation of the retention in care of PLHIV under ART

As part of the follow-up of patients enrolled in treatment, it is essential to ensure both the continuous availability of ARV drugs at treatment sites and the regular uptake of medication by patients according to prescriptions. These elements are key to improving treatment retention and guaranteeing a better quality of life for people living with HIV. In this process, the support of psychosocial support workers (PSAs) is crucial. On a routine (monthly) basis, they:

- Monitor patient attendance at appointments for ARV refills,
- Actively follow up with patients, and
- Trace those who miss visits, helping to bring them back into care.

The evaluation of retention in care was conducted using 12-month follow-up data from the April, May, and June 2023 cohorts. Data were drawn from ART registers in health facilities and validated during review sessions organized by the Health Districts.

Table 40: Regional retention in care rates among PLHIV 12 months after initiation

Regions	Eligibles	Transfered	Deaths	LTFU	Retention rate	Performance (95% threshold)
Adamawa	673	35	32	48	87,5%	92,1%
Centre	1233	32	55	113	86,0%	90,5%
East	1165	41	50	94	87,2%	91,8%
Far-north	1191	65	47	89	87,9%	92,5%
Littoral	1083	113	33	126	83,6%	88,0%
North	1398	38	51	60	91,8%	96,7%
North-west	439	30	31	26	86,1%	90,6%
West	508	9	15	24	92,2%	97,0%
South	804	32	27	28	92,9%	97,8%
South-west	456	12	8	31	91,2%	96,0%
Nationale	**8307**	**381**	**321**	**563**	**88,8%**	**93,5%**

Source : ART registers for health facilities.

Legend :

	≥95% (Good)
	[75 - 95% [(Average)

<75% (Bad)

Table 39 presents the retention rates of patients on ARVs. Based on the WHO performance threshold, national retention is considered average, as is the case for most regions. However, the North, West, South, and Southwest regions are performing strongly, having already surpassed the 95% benchmark.

To further improve overall performance, program-level efforts remain necessary. In particular, strengthening adherence support by providers and building capacity in the implementation of differentiated service delivery (DSD) models could help consolidate gains and address gaps in regions still below target.

2.6.3 Monitoring of ARV Dispensation through Differentiated Service Delivery Models

The differentiated provision of ART refers to adapting HIV treatment to the specific needs of PLHIV. This approach enhances treatment adherence, client satisfaction, patient empowerment, and contributes to decongesting care units.

Differentiated models can be classified into intensive and less intensive approaches:

1. Intensive models
    - Require close clinical monitoring with monthly consultations, regular biological assessments, frequent ARV dispensing, and sometimes hospitalization.
    - Examples: Advanced disease management and the standard model.
2. Less intensive models
    - Designed for stable patients with fewer clinical needs.
    - Two main approaches:
        - Health facility–based models
            - *Individual model*: patient follow-up and ARV refills at the facility.
            - *Group model*: patients organized in groups within the facility for ARV refills and support.
        - Community–based models
            - *Individual model*: ARV refills and follow-up provided directly in the community.
            - *Group model*: patients organized into community groups for ARV distribution and adherence support.

classification of less intensive models of differentiated ART adopted in Cameroon

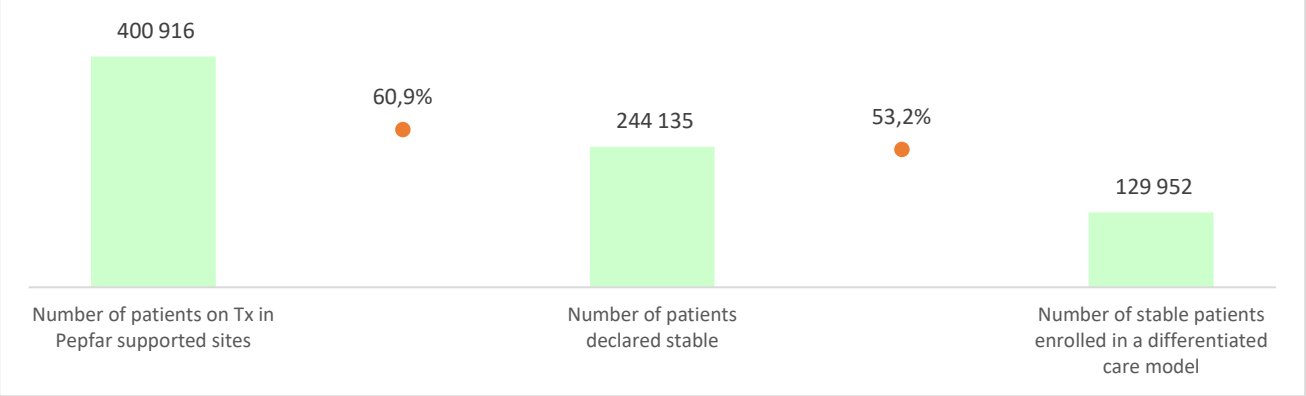
	Health facility	Community
Individual	- Fast dispensing circuit - Accelerated visit - Multi-month dispensing - Dispensation outside working hours/days - Dispensing by dispatch	- Dispensing at home - Dispensing in PODICs (CBO) - Dispensing in pharmacies
Group	- Support group (compliance club)	- Family dispensing - Support group - ART Community Group

Source : *Operational guide to the delivery of differentiated services 2023.*

Most of the information on the various differentiated treatment models was collected from HFs supported by the PEPFAR partner. Of the 2,753 active treatment sites in 2024, 348 sites supported

by implementation partners are implementing and reporting data on differentiated treatment, an increase of 46 sites compared to 2023.

FIGURE 44: ENROLMENT OF PATIENTS IN DIFFERENT CARE MODELS.

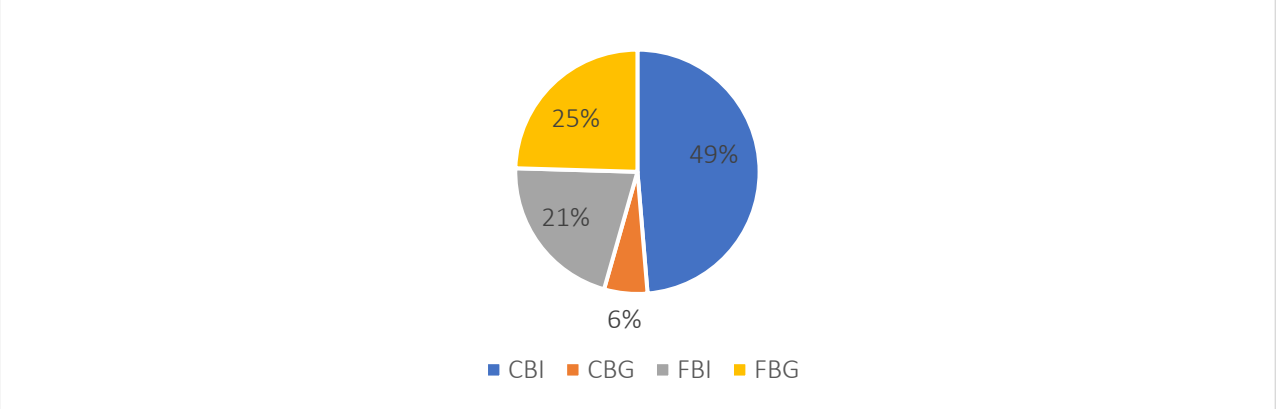


Source : *DAMA /EMR*

The analysis of the distribution of patients enrolled in Differentiated Service Delivery (DSD) models across sites shows that:

- 49% were enrolled in an individual community model (dispensation in OBC/PODIC, home delivery, or third-party dispensation);
- 25% in a group FOSA-based model (support groups, family dispensation);
- 21% in an individual facility-based model (dispensation within health facilities);
- and only 6% in a community group model.

FIGURE 45: COMMUNITY DISPENSATION OF ARVS THROUGH LESS INTENSIVE DIFFERENTIATED SERVICE DELIVERY MODELS

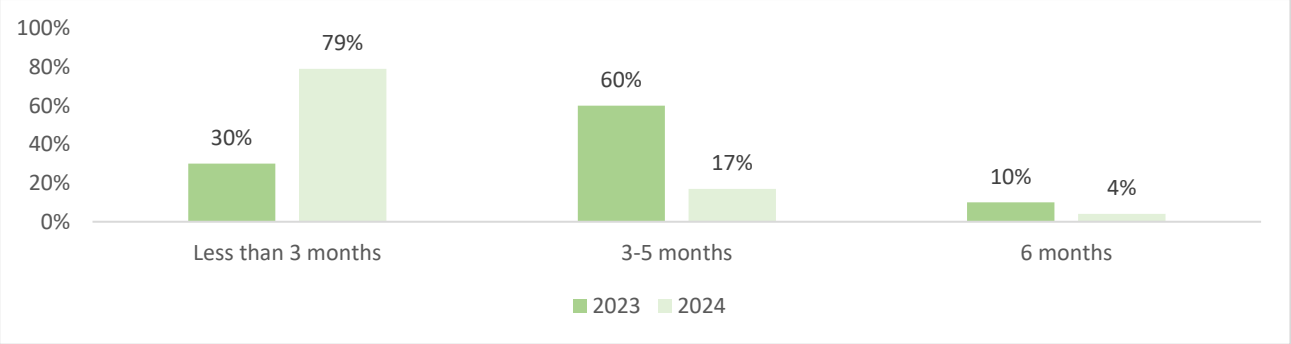


Source : *Dama /EMR*

2.6.3 Multi-month dispensing of ARVs

The dispensation of ARVs for less than 3 months increased to 74% in 2024, compared to 30% in 2023, reflecting a 44-point rise in line with the country's 2024 target of 30% for short-term dispensation. Conversely, the 3–5-m onth dispensation declined sharply, from 60% in 2023 to 17% in 2024, and the 6-month dispensation also decreased relative to 2023. These reductions in multi-month dispensing are attributed to ARV stock shortages observed in 2024.

Figure 46: Change in multi-month dispensing of ARVs between Q4 2023 and Q4 2024

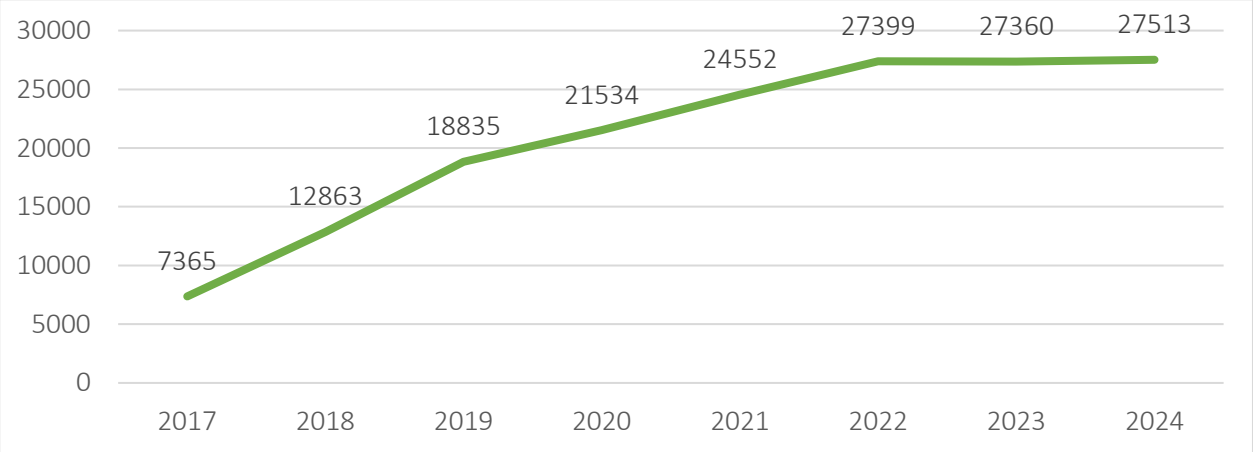


Source : *ART register data from sites supported by CDC implementation partners*

2.6.4 Community dispensation of ARVs by CBOs

As part of the scaling up of community contribution in the fight against HIV in Cameroon and especially to unclog the HFs and reduce the number of patients enrolled in more intensive models, the community dispensation of ARV by CBOs has been chosen as one of the advanced dispensation strategies. Chart 47 provides an overview of the evolving trend in the active queue of patients referred to CBOs for community dispensation. Thus, since the launch of this strategy, there has been a growing trend from 7,635 patients in 2017 to 27,513 patients in 2024. The strategy which benefited from extensive communication on the ground now seems to be in a slowdown situation given the data recorded from the year 2022.

Figure 47 : Trends in the active file for community dispensing in Cameroon



Source : *2024 Community data*

The situation at the regional level for the year 2024 is reflected in table 41. From the results collected, it emerges a gradual evolution in the regions of Centre, Littoral and East which recorded a high rate of enrolment in community ARV dispensation activity during the year. Which differs for other regions.

TABLE 41: QUARTERLY CHANGES IN THE REGIONAL ACTIVE FILE OF THE DC DURING THE YEAR 2024

Regions	CBO's active file				
	T4 2023	T1 2024	T2 2024	T3 2024	T4 2025
Adamawa	1 224	1 218	1 218	1 211	1224
Centre	10 574	10 534	10 478	10 489	10474
East	1 788	2 346	2 393	2 445	2445
Far-north	1 290	1 317	1 312	1 256	1254
Littoral	6 045	6 144	6 071	5 738	5670
North	954	1 033	1 016	1 026	1019
North-west	1 411	1 452	1 455	1 484	1419
West	1 323	1 323	1 334	1 348	1344
South	1 013	1 001	833	1 111	909
South-west	1 738	1 837	1 851	1 864	1755
TOTAL	**27 360**	**28 205**	**27 961**	**27 972**	**27513**

Source : *ART registers of HFs*

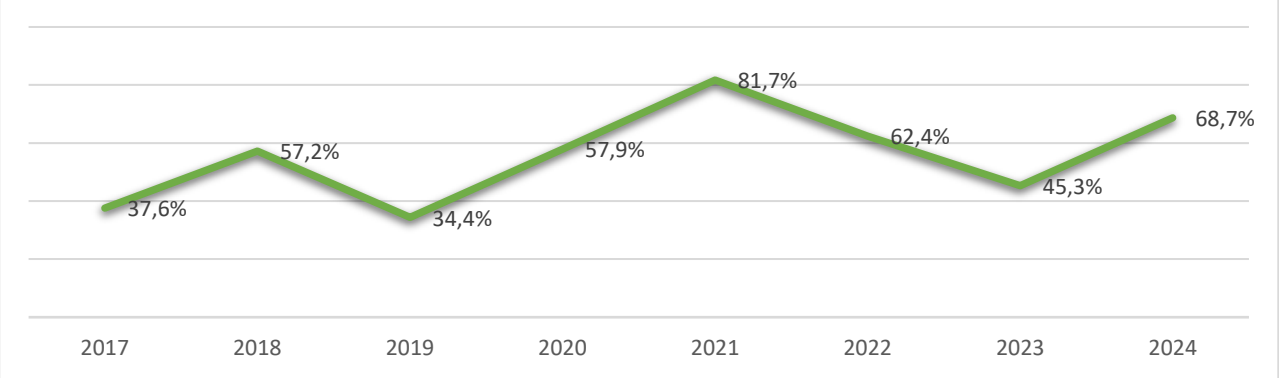
2.7 Biological monitoring of PLHIV on ART

As part of the biological monitoring of patients on ART, the WHO recommends viral load measurement as the gold standard. Viral load testing is essential for assessing treatment effectiveness and identifying treatment success or failure.

Chart 48 presents the national trend in viral load coverage. It shows a declining trend over the past two years, from 81.7% in 2021 to 62.4% in 2022 and 45.3% in 2023, followed by a rebound to 68.7% in 2024. This improvement in 2024 is attributed to:

- The availability of testing commodities, which allowed for the analysis of previously untested samples from 2023.
- The implementation of contingency plans in regions with non-functional testing platforms.

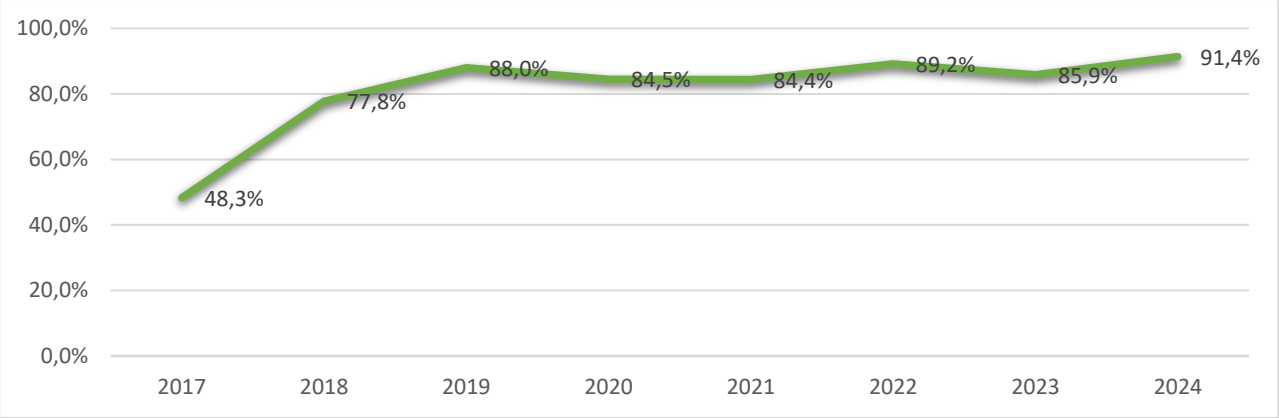
Figure 48 : Change in the VL completion rate from 2017 to 2024



Source : *Données de laboratoires de référence et des POC 2024*

Regarding the results of the viral load review, the national suppression rate has seen a slight increase since 2018 as shown in Chart 49 with a rate maintained above 80% and reaching 91.4% in 2024.

Figure 49 : Change in the rate of VJ suppression from 2017 to 2024.



Source : *Data from reference laboratories and POC 2024*

The regional disaggregation of viral load data (Table 42) highlights significant disparities across the country. Five regions recorded achievement rates below the national average: Adamawa (43.3%), East (49.7%), Centre (50.5%), North (68.2%), and Southwest (68.3%).
Regarding viral suppression, the East (85.7%), Centre (88.6%), and North (89.4%) regions had the lowest performance, falling below the national average of 91.4%. In contrast, the West region achieved the highest viral suppression rate at 94.7%

TABLE 42: COVERAGE AND SUPPRESSION OF VL BY REGION IN 2024.

Region	Active file	No. of PLHIV who perform a vL exam	VL coverage	No. of PLHIV with a suppressed VL	Suppression rate (%)
Adamawa	25723	11 136	43,3%	10 337	92,8%
Centre	115372	58 310	50,5%	51 655	88,6%
East	38996	19 373	49,7%	16 602	85,7%
Far-north	29309	26 804	91,5%	24 798	92,5%
Littoral	70051	58 230	83,1%	53 652	92,1%
North	28776	19 635	68,2%	17 563	89,4%
North-west	43332	37 937	87,5%	35 619	93,9%
West	34119	30 701	90,0%	29 075	94,7%
South	25859	20 945	81,0%	19 252	91,9%
South-west	37753	25 790	68,3%	23 775	92,2%
National	**449 290**	**308 861**	**68,7%**	**282 328**	**91,4%**

Source : Données de laboratoires de référence et des POC 2024

2.8 Monitoring and management of TB/HIV co-infection

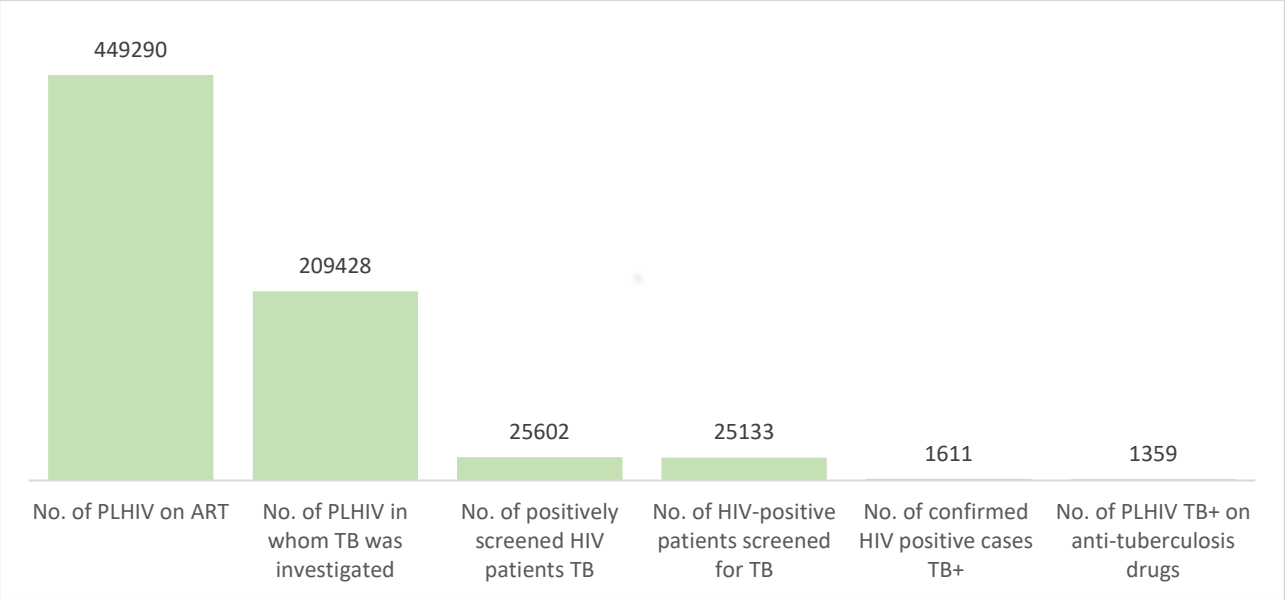
Surveillance of TB/HIV co-infections in HIV patients is carried out through the routine investigation of the clinical signs of TB in these patients. For positive cases in this investigation, a reference is made to the TB CDT for diagnosis and management in case of a positive result. On the other hand, negative cases are initiated into Preventive Tuberculosis Therapy (TPT).

2.8.1 Clinical research of tuberculosis in PLHIV

By the end of 2024, 449,290 PLHIV were receiving ARV treatment. TB clinical screening was conducted in 209,428 patients (46.6%). The relatively low screening coverage is likely due to the absence of TB screening for patients enrolled in differentiated service models or receiving multi-month ARV dispensation.

Among those screened, 25,602 patients (12.2%) showed at least one positive TB symptom, an increase from 19,597 (10%) in 2023. During the year, 25,133 PLHIV underwent confirmatory TB testing, resulting in 1,611 positive cases (6.4%). Of these, 1,359 patients were initiated on anti-tuberculosis treatment, corresponding to an anti-TB treatment coverage rate of 84.3%.

FIGURE 50: TB SCREENING CASCADE FOR PLHIV ON ART IN 2024



Source : 2024 DHIS2 database (26/03/2025)

n the specific case of TB screening among HIV-positive pregnant women on ART, 86.3% (9,435/10,927) underwent this investigation in 2024, showing a notable increase compared to 67.4% (10,359/15,378) in 2023. Among those screened, 136 pregnant women were diagnosed with TB, but only 43 were initiated on anti-tuberculosis treatment, representing a coverage of 31.6%.

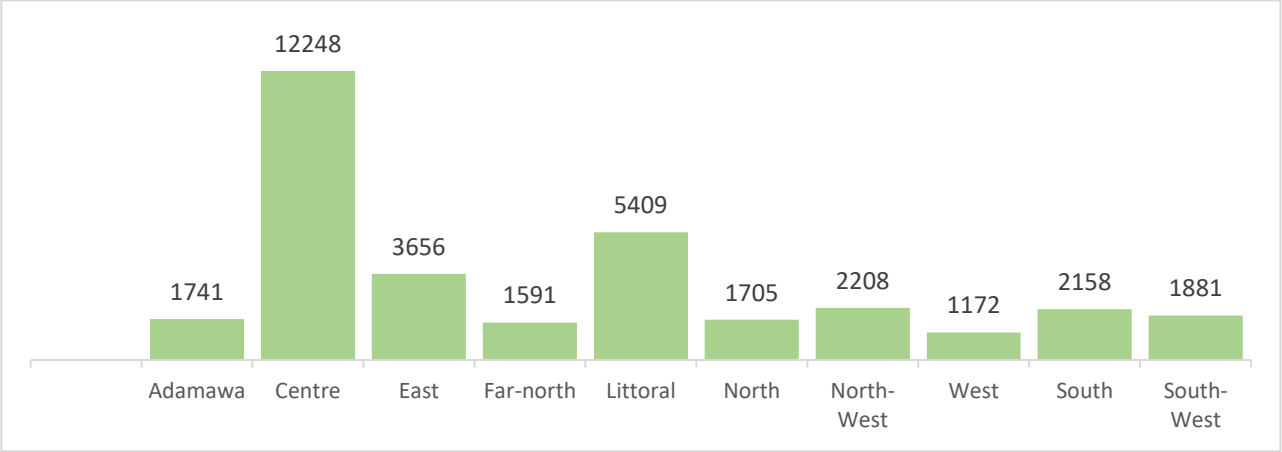
Regarding tuberculosis preventive therapy (TPT), it was provided to 1,533 of the 3,884 newly enrolled pregnant women on ART, corresponding to a coverage rate of 39.5%.

2.8.2 Preventive treatment of tuberculosis

In 2024, of the 38,059 patients newly initiated on ART, 33,769 patients received tuberculosis preventive therapy (TPT), representing a coverage of 88.7%. The shortfall in coverage is largely attributed to INH stock shortages experienced across the country during the year.

Graph 51 presents the regional distribution of TPT initiation among new ART patients. The Central Region recorded the highest number of patients placed on INH, while the West Region had the lowest, with only 1,172 patients initiated on TPT.

Figure 51: Répartition du nombre de PvVIH ayant pris l'INH par région en 2024



Source : *Base DHIS2 2024 du 26/03/2025*

2.9 Procurement and Supply Chain Management

In Cameroon, the national response to HIV/AIDS relies on pooled funding mobilized by all stakeholders, with the goal of ensuring the continuous availability and free accessibility of HIV-related health commodities. This collaborative approach secures the supply chain for essential products, which are critical for the effective implementation of interventions. The provision of free HIV services and commodities nationwide underscores the strategic importance of regular and uninterrupted supply, an indispensable condition for the proper functioning of the program. For the year 2024, an overall budget of €41,919,284.6 was allocated for the acquisition of pharmaceutical and medical products, covering:

- Antiretrovirals (ARVs) ;
- Rapid Diagnostic Tests (RDTs) ;
- Laboratory reagents and consumables ;
- Biomedical and laboratory equipment.

2.9.1. Procurement of HIV health products

In 2024, the procurement of commodities for the HIV/AIDS response was fully financed by major donors, namely the Global Fund, PEPFAR, UNICEF, and the counterpart funds of the State of Cameroon. As part of the dedicated grant implementation, a tripartite memorandum of understanding (MoU) was formalized between the National AIDS Control Committee (NACC), the National Supply Centre for Essential Drugs and Medical Consumables (CENAME), and the Regional Funds for Health Promotion (RFHP). This agreement clearly defines the technical and logistical responsibilities of each actor, covering the reception, secure storage, and efficient distribution of HIV commodities (ARVs, RTKs, reagents, etc.) down to the service delivery points (SDP). This institutional synergy reinforces the national supply chain and guarantees the continuity of HIV/AIDS care across the country.

TABLE 43: ARV STOCKS AND RDTs IN 2024.

Product designation	Quantities received in 2024	Quantities available at 31 Dec 2024
ARVs		
ABC+3TC 120/60 mg Bte 30 Cp	102 300	23 326
AZT+3TC 60/30 mg Bte 30 Cp 60	7 871	2 991
DTG 10mg Bte 90 Cp	39 410	0
TDF+3TC+DTG (300/300/50) mg Bte 30 Cp	1 720 250	606 118
TDF+3TC+DTG (300/300/50) mg Bte 90 Cp	1 002 000	420 330
LPV/r 100/25mg tab 60	1 472	1 472
NVP 10mg/ml oral susp 100ml	19 142	37 432
ABC/3TC 600+300 mg Bte 30 Cp	0	5 851
TDF/3TC 300+300 mg Bte 30 Cp	24 900	0
AZT/3TC 150+300 mg Bte 60 Cp	94 448	25 758
ATV/r 300+100 mg Bte 30 Cp	143 289	111 099
RTV 100 mg Cp Bte de 30	3 618	2 268
DRV 600 mg Cp Bte de 60	2 062	1 475
DTG 50 mg Cp Bte de 30	75 160	29 212
Cotrimoxazole 240mg/5ml,100 ml Susp Bte de 100	300	300
Cotrimoxazole 400 mg/ 80 mg Cp Bte de 1000	2 400	0
Cotrimoxazole 800 mg/160 mg Cp Bte de 1000	4 150	0
RDT		
HIV-1/2, Determine, Tests K/100	1 092 000	322 000
Test de confirmation (KHB,) K/50	220 700	48 950
Anti-HIV (1&2) test colloidal gold (whole Blood/Serum/Plama) K/40	24 800	24 800
Syphilis combo test 1+2 K/50	450 000	450 000

2.9.2. Implementation of GAS activities

During 2024, a series of strategic activities were implemented to ensure the uninterrupted supply of drugs and inputs used in HIV care. These actions mobilized all stakeholders in the supply chain and contributed to improving the planning, coordination, and performance of the national HIV commodities management system. Key activities included:

- National quantification workshop for HIV health products, organized under the GC7 grant, which brought together major supply chain actors (DPML, DLMEP, NACC, NTCP, PEPFAR, CDC, USAID, UNICEF, etc.). This technical exercise enabled the definition of national consumption needs, mapping of available funding, and optimization of supply forecasts.
- Multi-sectoral technical coordination meetings, held at central level, which strengthened governance by facilitating the systematic sharing of information on commodity flows, stock levels, and forecast breakdowns across the logistics circuit.
- Supervision missions on logistics data quality, conducted across several sites in different regions, which assessed the reliability and completeness of data from stock sheets, monthly logistics reports, and tracking forms. These contributed to strengthening the logistics information system (ILS). In addition, regional reviews of commodities management data with decentralized actors provided a framework for dialogue, performance monitoring, and correction of shortcomings in the use of management tools.

- Targeted supervision of health facilities (HF) by regional teams, focusing on compliance with stock management practices, use of standardized tools, and proper product storage conditions.
- Expansion of the network of reference laboratories for viral load testing and early infant diagnosis, with the inclusion of five new laboratories.

All these activities are part of ongoing efforts to strengthen the national HIV logistics system, ensuring the continuous availability of essential products and improving the quality of services provided to target populations.

2.9.3. Supply chain coordination

Regular coordination meetings—held on a weekly, monthly, and quarterly basis with all supply chain stakeholders—played a crucial role in ensuring the continuous availability of HIV commodities at every level of the logistics system.

The implementation of the Last Mile Distribution (LMD) model, led by the GHSC-PSM project, has significantly enhanced logistical performance by reducing delivery times between the Regional Funds for Health Promotion (RFHP) and the Health Facilities (HF).

These consultation frameworks also enabled the rollout of several structural initiatives, including:

- The establishment of inter-HF decentralized stock management platforms, which facilitate both intra- and inter-regional redistribution of inputs;
- The centralized validation of purchase orders issued by HF, improving traceability and equity in product distribution;
- The monthly preparation of regional distribution plans, offering greater visibility of stock levels at the periphery.

2.9.4. Contribution of the ISAHC and ESCAPE projects to strengthening the HIV supply chain

In view of the activities and initiatives undertaken to ensure efficient management of HIV commodities in Cameroon, it is relevant to highlight the specific contributions of the ISAHC (Increasing Site-Level Availability of Health Commodities) and ESCAPE (Efficient Supply Chain Advance Patient Engagement) projects. Funded by the U.S. Government and supported by PEPFAR through USAID, these projects have provided significant added value in several critical dimensions of the national supply and distribution system:

1. Logistical Capacity Building

- Training of staff involved in commodity management, including stock management, use of logistics tools, quantification, and consumption monitoring.
- Deployment of technical human resources within coordination structures (NACC, CENAME, FRPS), contributing to improved logistics performance.

2. Improving the Availability of Commodities

- Support for the supply of strategic health commodities (ARVs, TDRs, laboratory reagents, etc.) during critical periods, thereby reducing the risk of stock shortages.
- Contribution to Last Mile Distribution, ensuring the transport of commodities to even the most remote FOSA.

3. Digitalization and Logistics Information Management

- Support for the implementation and deployment of digital inventory tracking and logistics reporting tools (e-LIS).
- Monitoring of performance indicators to enhance visibility and enable data-driven decision making.

  Development of the DASHBOARD GAS inventory monitoring tool for CENAME, FRPS, and health facility stores, designed to provide real-time information for timely and appropriate decision-making.

Multi-sector coordination

Active participation in national coordination meetings and strategic planning workshops has helped to support the coherence of interventions carried out by different partners.

2.9.5. Persistent challenges in managing HIV inputs

The National AIDS Control Committee (NACC) has generally achieved its objectives in monitoring the treatment of care recipients, largely thanks to rigorous stock management and the functionality of logistical arrangements at central, regional, and peripheral levels.

However, several bottlenecks persist:

- Logistical constraints, particularly regarding the transportation of commodities to isolated or hard-to-reach areas;
- A short-term risk of underfunding, driven by the constant growth of the active cohort and the inadequacy of planned financing for the 2024–2028 cycle, despite ongoing support from the Global Fund and other technical and financial partners.

In light of these challenges, it is essential to anticipate complementary resource mobilization and to strengthen operational capacities in order to sustain progress and ensure equitable and sustainable access to HIV health commodities.

SWOT Analysis

Strengths	Weaknesses
Achievement of 95% coverage in the general population Initiation of ARV treatment in the community Effective delegation of tasks Dispensing of ARVs in pharmacies Decentralisation of paediatric care through the implementation of Pediatric centres of excellence Intensification of diferenciated service delivery Rapid transition to DTG-based	Pediatric care with poor performance accross all axes Lack of pharmacovigilance data
Opportunities	**Threats**
Involvement of TFPs and community stakeholders in the response UHC E-learning Plateform	Instability in certain conflict zones (NW and SW) VL commodities shortage Instability in border areas Delays in commodities deliveries Risk of cold chain breakdown HR insufficient in quality and quantity

Ultimately, the interventions related to the management of PLHIV in 2024 led to several key observations:

- Low progression of the active cohort of PLHIV on ART compared to previous years, resulting in a decline in population coverage for ARVs.
- Retention rates remain insufficient, with only 4 out of 10 regions reaching or surpassing the expected threshold of 95%.
- Increase in the proportion of patients in the intensive model compared to those in the less intensive model, reflecting a decline in multi-month dispensing practices.
- Aging treatment cohort: patients aged 50 years and older account for 26.9% of the national active file, highlighting the need for regular monitoring to reduce comorbidities and adverse events in this group.
- Stagnation of the active cohort under community ART dispensation, limiting the expansion of differentiated service delivery.
- Low viral load testing coverage, affecting the quality of biological monitoring of PLHIV on ART.
- Insufficient TB drug coverage among HIV-positive pregnant women with tuberculosis, with only 31.6% receiving appropriate treatment

CHAPTER 5: DATA MANAGEMENT, RESEARCH AND MONITORING

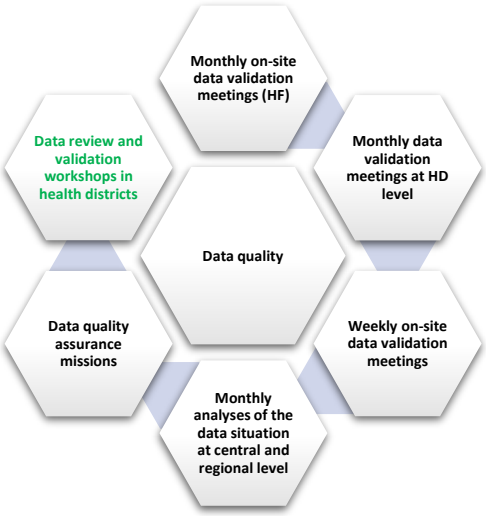
1. Data collection process

The data collection process on the HIV response is guided by the monitoring and evaluation plan of the National HIV Strategic Plan 2024-2030. It is integrated into the national health information system of the Ministry of Public Health and includes two components: primary data collection and secondary data collection. Primary data are collected at the point of care by providers during care, and recorded in medical records (physical or electronic). They cover all areas of intervention: management, screening, prevention and biological monitoring. The secondary data come from monthly reports extracted from the primary tools. Regarding the health sector, these reports are entered into DHIS2 between the 5th and 15th of the following month, either by the staff of the health facilities or by that of the district. Community data are transmitted by partners such as Care and CHP via Excel files, including information on prevention, screening, linkage to treatment and human rights of key populations. To strengthen the continuous availability of this data, a community DHIS2 is being developed, with test instances already operational.

In 2024, the data collected reveals relatively high completion rates for most areas: 95.8% for care and treatment, 95.3% for dispensation, 96.5% for PMTCT, 100% for blood transfusion. However, concerns remain regarding the completeness of screening forms (76.25%), differentiated dispensation (58%) and viral load (93.74%), which show insufficient performance. These shortcomings are partly explained by a problem of updating the health map in certain regions: several closed or non-functional health facilities continue to be wrongly included in the calculation of indicators. Overall, there is a slight decrease in completion rates compared to 2023, with an estimated average decline of about 2%.

2. Data quality assurance

Quality data is essential for decision making. Several activities have been routinely carried out at all levels of the health system to ensure data quality.



- In the specific case of data review and validation workshops at health district level, this is the new format adopted by the programme during the year as part of the district approach and the transfer of responsibility to the health district. This new workshop format was adopted

during Q3 2024 through the training of district teams involved in data management followed directly by a pilot phase within 51 priority health districts. The process involved recounting the active queue by gender, age, and protocol; assessing retention at 12 months; correcting inconsistencies in DHIS2; combing through and entering missing reports in DHIS 2.

The fourth quarter marked the extension phase in the other health districts of the 10 regions of the country. The same exercise was maintained but by adding the count of TB screening in new patients enrolled in TARV; the count of old patients and new patients placed on TPT; and the count of patients who withdrew at least 03 months of treatment.

In view of the supervision of the implementation of this activity at the national level, a set of challenges must be addressed:

- The lack of financial resources leading to a reduction in the frequency and duration of the activity as well as the number of participants;
- The difficult appropriation by stakeholders in the Health District (mastery of tools is a major concern in most health districts);
- The instability of the DHIS 2 application (access difficulties during data review sessions);
- Problems of scheduling and timely implementation by the Health Districts.

2.1. Data Quality Assessment (DQA)

2.1.1. Organising DQA :

During the year 2024, several data quality missions were organized, notably 02 DQA on global support data and a DQA on PMTCT data. Regarding the support data, the quality of the data was organized in the first and fourth quarters with different objectives. The DQA of the PMTCT data was organized in Q3 2024 and the main objective was to evaluate the quality of the data in the PMTCT sites that are not supported by the implementation partners. This operation, which involved 75 HFs, mainly focused on:

- The availability and quality of filling primary and secondary tools of PMTCT;
- The quality of the data provided (accuracy, consistency between tools and consistency between indicators within the same tool);
- The assessment of the level of retention in care in pregnant/breastfeeding women on ART.

As for the QA on global support data, it allowed to visit 51 HFs and aimed to:

- Evaluate the quality of filling in patient reporting tools and medication inventory;
- To compare data on drug discharges and patients dispensed;
- To compare drug output data between the different HIV input data management tools.

For the particular case of the DQA held in the 4th quarter with the support of the CDC Cameroon team, it focused on all the HF supported by the PEPFAR funds (347 HFs) and essentially aimed at an audit of cohort data crossed with medication dispensation data. Two steps guided its implementation. The first consisted of a field phase with the joint regional teams of the regional delegation and implementation partners (SHWARI, ACMS, CBCHB, ICAP, EGPAF). Their field visit made it possible to collect the data via a tool validated beforehand and allowing the identification of inconsistencies and outliers following the recount of the data both in the different monitoring registers and in the electronic tools.

The second phase, on the other hand, was a verification phase of the central level made up of CTG/NACC, CDC and DoD personnel. This counterchecking operation involved 25% of the Health

facilities randomly drawn from among the HFs visited during the first phase in order to compare the results.

2.1.2. DQA Results

From the various data quality assessments conducted during the year, a set of major results emerge namely: Mission Results DQA PECG Q1 2024:

• Absence of standard tools (primary and secondary) for data collection and reporting;
• Absence and misuse/retention of HIV health product data collection and tracking tools;
• Low completeness in filling key variables (dispensing location, dispensing pattern and TPT taking);
• Low concordance between cross-data from patient cohort tracking tools and medication dispensing tracking tools (ART registry, patient files, and dispensation registry);
• Low consistency between active file data and ARV dispensation data.

Following these findings, actions were taken to improve the data quality of the targeted sites. A monitoring for the improvement of the completeness of the variables highlighted above was done, an optimization of the active file consistency and dispensation of ARVs was done, a particular investigation on patient data was done during the entire second semester and led to a gradual decrease in the active file following the cleansing of data.

The results of the CDC-supported DQA have led to similar results to the one above with an emphasis on other results:

• Better agreement (99%) between the field phase and the counterchecking phase confirming the results obtained;
• Discordance between cohort follow-up data and ARV medication dispensation data (8% ranging from 6% to 13% regionally);
• Discrepancy between cohort follow-up data and ARV medication dispensation data in adults 15 years of age and above (8%) and children under 15 years of age (15%).

Regarding the discrepancies, the teams noted in the field a divergence in the methodology for filling out the different tools. According to the dispensing circuit, some HFs fill at a single entrance gate while others do it in two gates (UPEC service and pharmacy). The challenge of the availability of human resources is also a reason that leads to filling by one or more people causing omissions in the filling of certain data. These elements are exacerbated by the problems of availability of standard tools and compliance space for the dispensation of ARV in several HFs visited. In the case of PMTCT data, some results are consistent with those of the overall management data. Overall, the major results were:

• Lack of monitoring tools in the context of PMTCT (cohort registers for mother and child monitoring, register for screening children exposed by PCR);
• Low completeness in filling the major variables of the registers (ANC and delivery room) for monitoring pregnant women (HIV and syphilis status, and entrance door);
• Problem with the accuracy of the data reported from the ANC and delivery room records (20% discrepancy between the reported data and the data counted in the record during supervision);
• Low concordance between the data from the monitoring tools in PMTCT (patient file & L/DR registry & ART registry);
• Good retention in ART for pregnant women (already known HIV+ 98.09% and newly identified HIV+ 84.6%) and breastfeeding (96.66%).

These findings followed up on a monitoring plan for attention HFs for evaluation during the raids of the year 2025. For the very particular case of data collection tools, the mobilization of IPs in the production of tools is effective in all regions of the country.

3. Research and Surveillance in the Context of HIV Control

Several studies and research activities were carried out in 2024 on HIV in Cameroon. Some were carried out by the program and others by researchers, students. The major studies carried out by the program were: HIV sentinel surveillance of syphilis and hepatitis B in pregnant women, the continuity and interruption of ARV treatment in PLHIV under ART, the integrated bio-behavioral survey – among key populations in Cameroon and mapping places of vulnerability to HIV, of services and programs aimed at key populations (IBBS), the national survey on the stigma index among people living with HIV in Cameroon (the stigma index).

3.1. Summary of the HIV, Syphilis and Hepatitis B sentinel surveillance study in PW

Data on the magnitude of the epidemic show that HIV prevalence among the working population dropped significantly between 2004 and 2018, from 4.3% according to the EDS IV Demographic and Health Survey to 2,7% according to EDS V. The monitoring of the dynamics of infection is based on the EDS performed every 5 years and on the conduct every 2 years of a sero-surveillance study in sentinel sites with subpopulations including that of pregnant women (PW) in prenatal consultation. In this wake, the HIV sentinel surveillance survey among the PW received in ANC was conducted by the GTC/NACC in 2023 with the support of technical and financial partners. It aimed to update the existing data of sentinel surveillance of HIV and hepatitis B in PW, to evaluate the feasibility of using PTME data for epidemiological surveillance of HIV in Cameroon. The peculiarity of this survey is the first monitoring of the occurrence of hepatitis B in PW. To achieve the objectives set, a cross-sectional, analytical study with an evaluative aim was conducted in the 10 regions (60 sites) of Cameroon targeting 7000 PW in first ANC (4000 in urban areas and 3000 in rural areas). The HIV test was done according to the national algorithm, and that of hepatitis B by Hightop AgHBs. The sensitivities, specificities, positive (VPP) and negative (VPN) predictive values of the HIV test by the sites were calculated using the results of the National Reference Laboratory (NRL) as a reference. Out of a total of 7283 PW (sampling coverage: 104.0%), the acceptability rate of the HIV test was 99.5% (6890/6922). Based on NRL data, the national HIV seropositivity was 4.6% (332/7283), or 4.4% in urban areas and 4.8% in rural areas. The epidemic records a significant decrease, of 7.6%, 7.8%, 5.7%, 4.3% and 4.6% respectively from 2009, 2012, 2016, 2019 and 2023. At the level of the sites, this positivity was 4.6%, or 4.5% in urban and 4.8% in rural areas. The multivariate analysis reveals four (04) factors associated with HIV risk among pregnant women, including region of residence, age groups, marital status and parity. The ability of PMTCT sites to return a truly positive result (sensitivity) was 78% (259/330) and a truly negative result (specificity) was 99% (6307/6355). At the site level, the probability that a woman declared positive (VPP) was actually infected was 84% (253/307) and the probability that a woman declared negative (VPN) was HIV-free was 99% (6307/6378). The seropositivity for hepatitis B was 6.5% (ranging from 4.1% in the West to 10.6% in the Far North) with a multivariate analysis reporting four (04) factors associated with the risk of hepatitis B infection among pregnant women, namely the region of residence, the environment of residence, the age, and the level of education.

3.2. Summary of the ART continuity and interruption study in PLHIV on ART

As part of this study on the understanding of ART continuity and interruption in PLHIV, the main objective was to identify factors associated with ART interruption in PLHIV. Specifically in this study, it was a question of identifying the clinical, individual, organizational factors related to ART interruption as well as ART adherence in PLHIV. To achieve these objectives, the interruption was considered as any cessation of ARV use for two consecutive days over the last 03 months. Adherence to treatment, on the other hand, is measured according to the prescriptions of national guidelines which illustrate 03 methods including the patient's declarative approach on the number of remaining doses during his visit. In the operationalization of the study, we used a cross-sectional study with descriptive and analytical aim on a sample of 2720 recruited according to the inclusion criteria and during their prescription renewal visit or examination in the care structures drawn for the study. This sample of patients observed was a representation of the national active file with 68% women and 32% men under TARV. The results obtained regarding the objectives reveal that the rate of interruption of treatment is 11.7% in the country and varies from one region to another, the regions with the highest rates of interruption (above the national average) were the Northwest 16,8% the Southwest (14.2%), Centre (14.8%), Adamawa (14.2%). In terms of age groups, those aged 21-24 were the most likely to interrupt treatment (14.3% higher than the national interruption rate). According to marital status, singles were more prone to interruption compared to others (13.1%). Patients with revival churches as their religion interrupted more compared to others and waiting time was also subject to interruption. In the explanatory analysis, two types of factors were identified as determinants for the interruption of the ART. The use of alternative treatment before the start of ART is the individual factor, while taking ARV treatment in a HF supported by a partner and being dispensed in a more intensive dispensing model constitute the organizational and clinical factors with the adoption of the TLD protocol as a protective factor for ART interruption.

The adherence rate of patients on ART, was measured according to different time sections as in national guidelines (04, 07, 30 days) and according to different modalities good, moderate and mediocre.

At 30 days, the adherence rate to ART was 80.5% for the good adherence, 18.1% for the moderate adherence, and 1.4% for the low adherence. At 07 days, the adherence rate was 86.4% for good adherence, 4.7% for moderate adherence and 8.9% for low adherence. At 04 days, the adherence rate was 89.3% for good adherence, 3.8% for moderate adherence and 6.9% for low adherence. As for the interruption, the identification of factors associated with good adherence was also done, and at the end of this exercise, we came to the conclusion that good adherence is mainly explained by variables such as patient income, the means of travel used to go to health centres to get their medication, the dispensing model on which the patient is particularly less intensive models

3.3. Summary of IBBS survey

In 2023-2024, the integrated bio-behavioral survey (IBBS) was conducted among MSM, TS, UDI and TG. Its main objective was to update the biological, behavioral and environmental indicators influencing HIV transmission among key populations (FSW, MSM, TG, IDU) in 13 cities of Cameroon,

in order to inform programmatic interventions and policies aimed at reducing the prevalence and incidence of HIV in these populations. The method used was that of a cross-sectional study conducted in the study population group enrolled in 30 sites of the 10 regional capitals and 3 satellite cities (Dschang, Kribi, Limbé). This enrollment was done through the chain recruitment method (RDS) adapted to difficult to reach population groups. In the implementation of the study, a behavioral questionnaire was administered while laboratory technicians performed rapid HIV tests.

With regard to the results, 6218 participants were surveyed across all sites on the expected minimum size of 5702, which represents an achievement rate of 109.1%. Among the respondents, 2899 (46.7%) are FSW, 2667 (42.9%) are MSM, 273 (4.4%) are TG and 379 (6.1%) are IDU.

Among men who have sex with men, adjusted prevalence values are 28.0% [27.5%-28.3%] in all 13 sites, 17.4% [16.8%-18.0%] in Douala and 48.2% [46.1%-50.2%] in Yaounde. In the field of prevention among MSM, systematic condom use over the past 6 months ranges from 39% during sex with regular partners to 49% during sex with casual partners. Only 16% of MSM in general have already taken pre-exposure prophylaxis (PrEP) to prevent HIV infection, with proportions exceeding 25% in the cities of Bamenda (35%) and Douala (27%). In the other cities, these proportions are between 1% of MSM (Garoua) and 24% (Bafoussam). The assessment of global targets for HIV elimination by 2030 (95-95-95 cascade) gives, for MSM, adjusted values of 77%-98%-85%. The size estimates of MSM in the main cities give: Douala 5296 (95% CI, 4757 – 5836), Yaoundé 5147 (95% CI, 4430 – 5965), Bamenda 1386 (95% CI, 784 – 1977), Ngaoundere 1354 (95% CI, 1250 – 1457) and Dschang 1312 (95% CI, 1240 – 1384). The comparison of prevalence results with those from IBBS 2016 shows that prevalence trends were increasing in all survey cities, except for the site of Douala where the trend is decreasing, with 17.4% in 2023 compared to 25.9% in 2016. The largest increase was recorded in Bertoua with 9.2% in 2016 and 16.6% in 2023. Regarding sex workers (FSW): The adjusted values of HIV prevalence are 14.9% [14.6%-15.2%] in all 13 sites, 15.8% [9.4%-21.4%] in Douala and 12.8% [8.1%-17.6%] in Yaounde. They reported different types of sexual partners, including regular male partners (74%), casual male partners (56%), unpaid male partners (26%) or paid male partners (14%). Exposure to unprotected sex in the past 6 months is higher with paid male sexual partners (49%), followed by regular male sexual partners (35%) and casual male sexual partners (22%). The use of condoms during the last sex is lower with the regular non-paying partner (44%) and higher with a new client (91%). The assessment of global HIV elimination targets by 2030 (95-95-95 cascade) gives, for SCs, adjusted values of 79%-94%-85%. The comparison of prevalence results with those from the IBBS-2016 study shows that trends in prevalence were decreasing in all survey cities. The largest decrease is observed in Bamenda with 33.8% in 2016 and 20.8% in 2023.

For injecting drug users: Due to selection bias, only 92 IDUs from Douala were eligible for analysis. The gross value of prevalence is 18.5% [17.0%-19.9%]. About 11% of IDUs in Yaoundé say they have shared their needle with someone else or used someone else's used needle to inject drugs in the last 6 months, compared to 8% of IDUs in Douala. However, almost all IDUs in Yaounde (98%) reported using a new needle or syringe during the last injection in the past month, compared to only 50% of IDUs in Douala. The assessment of global targets for HIV elimination by 2030 (95-95-95 cascade) gives values for IDUs of 47%-100%-88%.

Regarding transgender people: The adjusted estimates of prevalence by RDS are 37.7% (95% CI, 28.9-46.6), including 38.8% (95% CI, 27.6 - 50.0) in Yaoundé and 36.3% (95% CI, 22.0 - 50.6) in Douala. The proportion of respondents reporting having used a condom during the last sexual intercourse in the past 6 months is high for all types of partners, reaching 88% of respondents in Douala with paid male sexual partners and 69% with paid male sexual partners. In Yaoundé, these proportions were low with paid male partners, with only a quarter of the respondents (26%), compared to 66% for paid male sexual partners. The systematic use of condoms with paid sexual partners over the past 6 months is quite low with a proportion of 38% of TG in Yaounde compared to 18% of TG in Douala. The assessment of global HIV elimination targets by 2030 (95-95-95 cascade) gives adjusted values for TG of 73%-100%-79%. The estimates of TG size give: Douala 1449 (95% CI, 1328 – 1571), Yaounde 1087 (95% CI, 1008 – 1167).

Despite a significant decline in recent years, HIV prevalence remains high among key populations in Cameroon. Nearly two-thirds of the positive cases among IDUs were undiagnosed by programs, and for other targets, the number of undiagnosed cases accounted for half of the positive cases. Disparities between cities were significant for biological and behavioural indicators and should be taken into account in the design, development and implementation of HIV prevention and treatment programmes. Combined packages of prevention and treatment interventions will need to be strengthened to overcome the barriers faced by key populations in accessing care that have been widely reported in this sample, including strategies aimed at reducing stigma, discrimination and gender-based violence.

3.4. Summary of the Index stigma 2.0 survey

Stigma is one of the main barriers preventing PLHIV from accessing health care. HIV-related stigma and discrimination result in poor mental health, low uptake of services and low adherence to antiretroviral (ARV) drugs. The pilot survey "PLHIV Stigma Index 2.0" from 2017 showed that 14.75% of PHAs chose not to seek healthcare because of their serological status. This stigmatization was due to the health staff on one hand and the PLHIVs themselves on other parts. To update this situation, a joint initiative under the lead of the national network of PLHIVs (RéCAP+) in partnership with the Global Network of People Living with HIV (GNP+), the International Community of Women Living with HIV (ICW), the International Planned Parenthood Association (IPPF), and UNAIDS was conducted during the year.

In this approach, the objective was to estimate the prevalence and nature of HIV-related stigma and discrimination among people living with HIV (PLHIV). Ultimately, the aim of this approach was to develop an evidence base and a broader understanding to inform the response to HIV in Cameroon.

To do this, the approach was based on a descriptive cross-sectional study based on the methodology of "HIV Stigma Index 2.0" developed by the Global Network of People Living with HIV (GNP+), ICW and UNAIDS (http://www.stigmaindex.org/). This nationwide survey targeted PLHIV aged 18 and over including key populations (FSW, MSM, TG, IDU). The sample size method of which is based on the online Sample Size Calculator of the Stigma Index for People Living with HIV (https://hall.shinyapps.io/PLHIV_Stigma_Sample_Size_Calculator/) reported 2,400 people to be reached.

Thus, a total of 2 104 PLHIV General population (1 606) Key populations were enrolled in the survey and the following results were observed:

• Sites: all 10 regions, 41.6% of respondents are in the sites of Douala and Yaounde - Median age of participants: 36 years, [18,86]

• Age distribution: The group of [25.29] less represented with 14.8% and the most represented is that of [30.39] with 27.9%

• Gender identity: high feminization of male sex with +3.6%; This high feminization of male sex is concentrated in the age group [18,29]

• Average duration of knowledge of seropositivity: 7.6 years - 7.8% of participants live with a disability (hearing, mobility, intellectual or developmental)

• Profession and Education: 31.8% of the respondents are unemployed with a high female dominance (77.8%); 14.6% have no formal education and 15.3% have finished university/higher education.

• Disclosure: 48.0% state that their seropositivity is known by spouses/partners and 17.0% of them state that this disclosure was made without their consent

• Experience of stigmatization: 3.7% have been victims of physical violence over the past year - Internal stigma: 12.5% have isolated themselves from their loved ones; 13.1% no longer want to have sex; self-stigmatization is inversely proportional to the duration of knowledge of the status

• 8.2% avoided a health centre and/or the hospital when they needed one due to anticipated stigmatization. 17.2% of the participants in the study reported having already interrupted or stopped their antiretroviral treatments (ART).

CHAPTER 6 : OWNERSHIP OF THE FIGHT BY THE STAKEHOLDERS

In Cameroon, the response to HIV is based on a multisectoral approach involving a wide range of actors at all levels, both in the health sector and related sectors. This response is ensured by public sector structures (central administration, decentralized services, health training), private sector providers, national and international technical and financial partners, as well as civil society. The latter includes non-governmental organizations, community-based organizations, and networks of people living with or affected by HIV. This diversity of actors ensures a coordinated, inclusive response adapted to local realities, while strengthening national and community ownership in the fight against HIV.

1. Strengthening the commitment and involvement of new community actors

Community actors are central to the national response to HIV, providing a vital link between vulnerable populations and health services. Thanks to their proximity to the communities, they strengthen awareness, prevention, psychosocial support, and promote equitable access to care, including in isolated areas.

In this context, the association ALECO-PROSACO (Association of Community Leaders for the Promotion of Community Health) illustrated itself through its field action in 2024:

- Sensitization of 2,004 people through campaigns and educational talks;
- Voluntary screening of 331 people;
- Community dispensation of ARV at 349 PLHIV;
- Distribution of condoms to 781 people;
- Completing 157 home visits.

Under the coordination of DOSTS, Plan International Cameroon contributed to the organization of the 1st National Forum on Primary Health Care and the Institutionalization of Community Health in Cameroon. Under the theme "Primary health care and community health, a key pillar of the Cameroonian health system to achieve the SDGs", this event mobilized stakeholders around key topics:

- Funding of primary health care;
- Empowerment of community health workers;
- Mobilization of traditional and religious leaders;
- Local ownership of health interventions.

The 'Matrone' project, launched in 2022, also strengthened the community-based approach to the response: 219 pregnant women benefited from NPC and 231 were screened for HIV, with a marked improvement in the completeness of reports.

The organization “Synergies Africaines”, in collaboration with MINSANTE (DPS, NACC), reached 808,000 young people through media campaigns, school activities, educational tournaments, and talks. She also mobilized 241 students as part of the Cameroon Month and conducted several advocacy days.

Finally, ENTRAIDE MÉDICALE, in partnership with MINEDUB and the technical departments of MINSANTE, conducted awareness campaigns on International Women’s Day, offering free HIV, malaria and hepatitis B screening to educational staff. The organization UNIVERSAL HELP also conducted community campaigns with the distribution of prevention kits made up of condoms, lubricants, posters and educational materials.

2. Main achievements of the implementation partners (IPs) in 2024

➢ Summary of the activities carried out by the EGPAF Project in the Littoral and South Cameroon regions in 2024

1. General context

The report presents the activities carried out by EGPAF in Cameroon in 2024 as part of the fight against HIV/AIDS, with the support of the Global Fund. The focus is on screening, management, PMTCT, viral suppression and reducing the socio-economic impact of HIV.

2. Coordination

EGPAF has strengthened coordination with stakeholders in the HIV response through technical meetings, joint supervision and training sessions.

3. Screening

- 187 896 patients tested in total (overall seropositivity rate: 3%)
- Community screening: 15,839 tests with a positivity rate of 9.4% (35.3% of positive cases identified)
- Screening by index case: low contribution (16% of positive cases)

4. PMTCT (Prevention of mother-to-child transmission)

- Screening rate in ANC 1: 95%
- ARV initiation rate: 95%
- Challenges: disparities between districts, awareness and support still insufficient

5. Care of PLHIV

- Overall ARV treatment initiation rate: 93%
- Total active file in 2024 : 81,822 patients (a decrease of -2.5% over the year)
- Still high rates of loss to follow-up, transfers and deaths

6. Viral suppression

- Viral suppression rate not explicitly indicated, but regular monitoring of PLHIV in progress

7. Children and adolescents

- 41,968 children and teenagers tested (<15 years and 15-19 years)
- Seropositivity rate: 1%
- Initiation of treatment for 94% of positive cases

8. Community and multi-month dispensation (MMD)

- 70% of patients under multimonth dispensation
- 15% of patients dispensed in community

9. TB/HIV co-infection

- 399 TB+ patients placed on anti-TB treatment

10. Major challenges

- Input shortages (tests, ARVs)
- Denial of screening in some families
- Difficulties in tracking mobile patients or in isolated areas

11. Outlook 2025

- Intensification of targeted screening
- Strengthening of pediatric and community care

• Improved active queue tracking and patient retention

• Increased integration of HIV services with primary health care

➢ **Summary of activities carried out by the CoSMO Project:** Community-based Support for Orphans and Vulnerable Children

During the year 2024, the CoSMO project (Community-based Support for Orphans and Vulnerable Children) continued its commitment to the protection, well-being, and empowerment of orphaned and vulnerable children as well as families affected by HIV. Through a community-based, family-centered and needs-driven approach, CoSMO implemented various interventions aimed at improving access to health, education, protection and economic support services.

This report highlights the main achievements of the project throughout the year, illustrating its positive impact on thousands of beneficiaries across the regions of intervention. The activities implemented within the framework of the project covered: prevention of HIV infection, PMTCT, comprehensive care, etc.

1. Prevention of HIV infection:

- Community sensitization

• Participation in the 22nd program "Vacation without AIDS", in partnership with the Ministry of Public Health.

• Training of young mentors, adolescent champions and peer educators, including some adolescents living with HIV, to share their experiences and raise awareness about HIV prevention.

• During the 16 Days of Activism Against Violence, CoSMO conducted awareness campaigns:

o Link between sexual violence and HIV

o Encouragement to denounce abuses and avoid amicable settlements

o Targeting of local authorities to promote early care for survivors

- Strengthening HIV testing

• Objective: to contribute to UNAIDS 95 (95% of people living with HIV know their status).

• 582 OEV <18 years old with unknown status were screened for HIV risk:

o 442 identified at risk

o 345 tested, 243 negative, 0 positive

• Forces:

o Risk-based screening effective targeting

• Challenges:

o Stock shortages of rapid tests

o Refusal of some parents (especially newly enrolled) to have their children tested

2- Prévention primaire du VIH

• Ongoing prevention activities with OVEs, including adolescents (10–17 years old):
o Monthly group sessions in community
o Safe spaces in sexual and reproductive health (SRH)
o Use of validated curricula for life skills development and the

3- Prevention of mother-to-child transmission

- Provision of PMTCT services: they mainly consisted of referencing beneficiaries tohealth facilities to access PMTCT services.
- Community interventions for PMTCT
• Monthly home monitoring of:
o 158 pregnant/breastfeeding adolescents living with HIV
1,660 children exposed to HIV (HEI)
• Services rendered in 2024:
o 158 teenagers received support for adherence to ARV treatment
o 7 received the ARV at home
1 pregnant woman not followed was referred for prenatal care
o 1 261 HEI of 6–8 weeks were supported for the PCR1 test
o 357 HEI aged 9 months and over have accessed the PCR2 test
o 133 18-month-old HEI were referred for an HIV serological test
Approaches used:

- Individualized, family-centered and needs-based case management.

Main challenges :

- Instability/inaccessibility of certain families
- Product shortages (notably for EID tests)
- Irregular supply of certain services in health facilities

As part of the Ministry of Health's Paediatric Surge:

- 3,257 HEI identified by the clinical structures were followed up by CoSMO
- Among them, 24 children from the project benefited from a final HIV test
- 8 PCR1
- 4 PCR2
- 12 other serological tests
- As part of improving the quality of life for vulnerable people, the CoSMO project strengthened the capacities of households affected by HIV to meet their basic needs and ensure the well-being of their children. In 2024:
- Training and economic empowerment:
- 29 parents/guardians and 104 out-of-school adolescents received vocational training.

- o 26 parents/guardians and 103 teenagers received financial support to create an income-generating activity.
- 1 282 beneficiaries were connected to savings and credit services, of which 117 underwent financial education training.
- 802 very vulnerable households received cash transfers to cover their basic needs.
- 220 households benefited from food distributions for malnourished children.
- Education of orphans and vulnerable children (OVC):
- 1 530 children were supported.
- 892 received school materials (including 723 children living with HIV).
- 638 have received the payment of tuition fees (including 468 HII).
- 59 have obtained a school placement (including 27 HII), thanks to the support of MINESEC, MINEDUB, MINAS and other partners.
- Prevention and response to violence:
- 56 284 participants (including 9 695 HII) were sensitized to gender-based violence (GBV), child abuse (ACV), harmful gender norms and the importance of seeking help.
- 93 cases of violence have been identified and treated, including 20 cases of sexual violence.
- Rapid interventions and appropriate referencing have been ensured to limit the consequences.

Major challenge: the insufficiency of financial resources limits the coverage of all the needs of the beneficiaries.

- Summary of the activities of the Military Program for the Fight against HIV in 2024

In 2024, the Military HIV Program continued its commitment to align with the UNAIDS 95-95-95 targets, thus contributing to the national response to the epidemic. A total of 26,509 people were tested for HIV, including 4,752 active military personnel, with an overall positivity rate of 3.0%. The index screening reached 1,580 contacts for a positivity rate of 6.8%, reflecting moderate effectiveness in actively seeking cases.

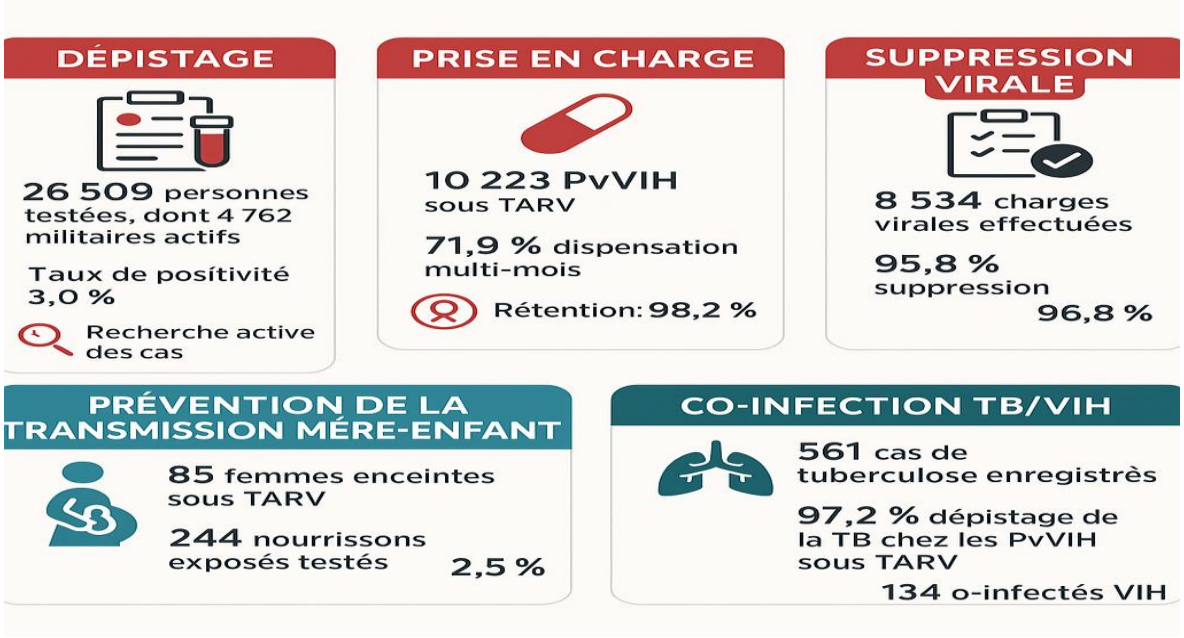
Regarding management, 10,223 people living with HIV (PLHIV) were on antiretroviral therapy (ART) at the end of 2024, with a retention of 98.2%. Furthermore, 71.9% of patients benefited from a multi-month dispensation, contributing to improved adherence.

In terms of viral suppression, 8,534 viral loads were carried out, with 95.8% suppression, thus reaching the third 95. Among active military personnel, viral suppression reached 96.8%. However, some regions such as RSM4 and a few FOSASs still perform below targets.

As part of the prevention of mother-to-child transmission, 85 pregnant women living with HIV were treated under ARV, and 244 exposed infants were tested, with a positivity rate of 2.5%. All positive cases were put on treatment.

In terms of TB/HIV co-infection, 561 cases of tuberculosis were recorded, including 134 HIV co-infected, with 97.2% of symptomatic TB screening among PLHIVs on ART.

Finally, innovative initiatives marked the year, notably the implementation of the SABERS study on seroprevalence in the Defence Forces, and the launch of the ECHO MINDEF Cameroon project, aimed at strengthening the capacities of providers through tele-education platforms.



3. Main achievements of NGOs and associations

- World Health Organisation (WHO)

  In 2024, the WHO contributed technically and financially to strengthening the fight against HIV, hepatitis, tuberculosis (TB) and STIs in Cameroon, through:

  • the strengthening of the health system,
  • the improvement of the quality of care,
  • data-based monitoring,
  • resource mobilization.

  Main areas of intervention

  1- Prevention of new HIV infections

  • Awareness: 207 people sensitized, 110 screened, 2 positives put on treatment.
  • Strengthening of screening: transition to a 3-test HIV algorithm, deployment of 528 sites, increase in hepatitis B (+200%) and syphilis (+144%) screening in NPC.
  • Combined screening: 672 people tested on World Hepatitis Day, with treatment-related positive results.
  • Promotion of PreP and condom use.

  2- Prevention of mother-to-child transmission (PMTCT)

  • Support for the implementation of the district approach to triple elimination HIV, hepatitis B and syphilis.
  • Training of 48 PTME focal points in the use of the duo-test.
  • Strengthening of pediatric care in centres of excellence.

• Reinforced monitoring of the mother-child couple, catch-up of exposed children lost to sight.

Care and treatment (PECG)

• Training of 181 health personnel on Care and treatment/PMTCT/PECPA in the Littoral.
• 15% increase in PLHIV put on ART at supported sites.
• Support for the deployment of Task Delegation with production of guides.
• Strengthening and decentralization of differentiated service delivery (DSD).
1- Supply management
• Reinforcement of inventory management skills in 17 HFs.
• Persistent difficulties: frequent breaks, insufficient collection tools.
2- Data management, research and monitoring
• Support for improving data collection, completeness, timeliness and analysis.
• Strengthening of case-based surveillance in 16 pilot sites (Centre, Littoral and, West regions).
• Production of guides, capacity building, configuration of DAMA alerts.
• Active participation in national coordination and relaunch of the Global Alliance to End Paediatric AIDS.
3- Resource mobilization
• Funds mobilized in 2024: 233,722 USD (internal funding + UNAIDS, USAID, CDC).
• Projection 2025: 286,299 USD.
4- Program Strengths
• Integrated and multisectoral approach.
• Effective training and in situ mentoring.
• Implementation and operationalization of new tools (algorithm 3 tests, DSD guides, task delegation).
• Strengthened community engagement via CBOs
5- Weaknesses and challenges
• Frequent stock-outs of health products.
• Insufficient supervision.
• Lack of PCR and viral load equipment.
• Limited extension of case-based surveillance due to lack of funding

Perspectives 2025

Extension of case-based surveillance.
Increased deployment of differentiated approaches.
Strengthening stockpile management.
Support for the sustainability of funding.
Strengthening of biological monitoring of PLHIV.

- **Summary of the 2024 activities of the Syphilis Free Start Cameroon programme – Evidence Action .**

In 2024, Evidence Action actively supported the Ministry of Public Health (MINSANTE) in implementing the dual elimination program for HIV and congenital syphilis. Despite an effective start in the second half of the year, significant progress has been made thanks to direct technical and financial support totalling CFA116.7 million.

Among the main interventions are:

• The development and validation of the new operational plan for double elimination.

• The training of trainers (national, regional and district) and on-site training for 2,179 health workers in 260 health facilities covering approximately 21% of pregnant women followed in CPN.

• Organising introductory meetings in the regions and supporting national coordination through monthly task force meetings.

• The validation and printing of 600 new registers integrating syphilis indicators for monitoring in health facilities.

• The acquisition of an implementation vehicle, and the signing of an agreement with a local investigative firm for data tracking.

• The technical advocacy that allowed UNICEF to donate 1.6 million HIV/syphilis tests and the mobilization of 50,000 USD by WHO for the training cascade.

In parallel, Evidence Action has strengthened its local presence with the opening of an independent office, the creation of local bank accounts, and the expansion of its team (M&E, operations, driver), while continuing administrative procedures with MINSANTE.

- Cameroonian Network of Adolescents and Positive Youth (RéCAJ+)

1. Context and objectives

In a context of persistent HIV prevalence in Cameroon, particularly among young people, the RéCAJ+ continued in 2024 its mission to raise awareness, advocate, provide psychosocial support and improve access to care for adolescents and young people living with HIV (AJvVIH).

2. Sensitization and prevention activities

- • 9,465 youths sensitized on HIV, STIs, GBV and SRH.
- • 1,623 youths affected by the educational talks (PETVISIDAME project).
- • 1,145 youths sensitized via the U-Test pilot program (West), 198 referred for screening.
- • Digital campaigns: 82,468 people reached, 12,771 interactions (Facebook, Instagram, etc.).
- 3. Community screening
- • 853 youths tested for HIV (2 positive cases, put on treatment).

• Activities carried out in the Central, South and West regions.

4. Community care

• Community dispensation of ARV at 30 AJvVIH.

• 103 young people participated in discussion groups.
• 257 AJvVIH benefited from therapeutic education.
• Psychosocial support (VAD, mentoring, art therapy).
5. Human rights interventions
• Community Legal Clinic (CJC) operational in 5 southern cities.
• 320 people sensitized, 52 received psychological support, 7 legal.
6. Advocacy and community engagement
• Organization of community General States with 67 participants.
• Contribution to the creation of the AOC Regional Observatory on HIV/AIDS (Dakar).
• Multiple training and capacity building of young people and community actors.
7. Stock management

• 1,000 Oraquick kits received (706 used), 200 HIV/Hepatitis tests received (147 used).

8. Challenges and recommendations

• Challenges: lack of funding, limited community mobilization, input shortages.

• Recommendations: strengthen regional branches, advocate for more financial support, improve monitoring tools and documentation.

- Synergies Africaines contre le Sida et les Souffrances

1. Sensitization among youths

In 2024, Synergies Africaines conducted several awareness-raising activities for young people:
• The national campaign "Holidays Without AIDS" has allowed a broad mobilization in the targeted regions.
• The television show "Jeunesse, Parlons-en" has raised awareness among about 300,000 young people via CRTV.
• An awareness documentary was produced and broadcast, reaching nearly 500,000 young people.
• The peace tournament, organized in collaboration with the town hall of Douala 2nd, reached about 3,000 young people.
• An SMS campaign reached 5,000 people with prevention messages.
2. Capacity building of associations, OBCs and schools
• Awareness kits were distributed to 25 associations and schools.
• Six associations received support to strengthen their community activities.
• During the Cameroonian month of fight against HIV/AIDS, 80 structures benefited from awareness materials and 241 participants took part in educational talks.
3. Mobilization and advocacy
• The organization took part in AFRAVIH 2024 with a booth and advocacy interventions.
• She also participated in the Mobilization and Advocacy Day (JOMP), and in the organization of World AIDS Day (JMS), helping to raise awareness among several hundred people.

4. Care for people living with HIV (PLHIV)

- Synergies Africaines" provided one-off financial support to PLHIV identified as vulnerable.

- Word Food Programme (WFP)

The World Food Programme (WFP) has contributed to improving the well-being of more than 2,000 vulnerable households living with HIV by implementing a combined economic strengthening approach. This initiative has included their grouping within Village Savings and Credit Associations (VZC), training provided by the sectoral services of MINADER and MINEPIA, as well as the provision of starter kits for income-generating activities. In addition, these households were integrated into food assistance programmes, benefiting either from cash assistance totalling US$235,606 or from in-kind food assistance amounting to about 20 tonnes of foodstuffs (cereals, pulses, oil and salt).

In addition, WFP has strengthened nutritional education for people living with HIV (PLHIV) in the care units of the East, Adamawa and South-West regions through the training of 54 health professionals and psychosocial workers. This training focused on infant and young child feeding in the context of HIV, to improve the quality of advice given to patients.

Moreover, nearly 800 people living with HIV on antiretroviral treatment (ART), screened for moderate acute malignancies in three care units in Adamawa, received nutritional support, with a recovery rate of up to 92%.

- **Affrimative Action**

1. Prevention and Awareness

Affirmative Action has conducted awareness campaigns aimed at key populations: MSM (Men who have sex with men), TG (Transgender), UD (Drug users), UDI (Injection drug users).

• Total sensitized: 39,596 people

• Activities carried out in the 10 regions of Cameroon in partnership with 33 OBCs and 96 peer educators.

• Special activities during the Cameroonian Month and World AIDS Day: 21,364 people sensitized.

• Difficulties: administrative delays and late mobilization of funds.

2. Condoms and PrEP

• Male condoms: 967 667 distributed

• Female condoms: 8 349

• Lubricant gels: 465 437

• Initiation to PrEP: 730 people (MSM)

o Yaoundé: 380 | Douala: 221 | Ngaoundéré: 50 | Bamenda: 79

3. HIV, hepatitis B and STI screening

• HIV (routine activities):

o 25 778 people screened

o 1 004 positive

o 901 put on ARV

• Hepatitis B:

o 8 073 screened, 400 positive, 324 supported

• STI (syndromic management):

o 1 646 cases supported (MSM: 923, UD: 566, UDI: 132, TG: 25)

• Special events (Cameroonian month, Screening Week):

HIV: 1,623 tested, 22 positive, 20 put on treatment

o Hepatitis: 120 tested, 7 positive, all taken care of

4. Strength and Challenges

- **Strengths**: national coverage, strong community mobilization, multi-stakeholder partnership
- **Challenges**: administrative delays, irregular mobilization of funds, structural barriers in certain areas

➢ **CAMCOCHE contribution to community interventions in the response to HIV in 2024**

In 2024, CAMCOCHE actively contributed to the community response to HIV by targeting young people and adolescents as a priority through awareness-raising activities, screening, and linking to treatment, in collaboration with religious leaders.

As part of its interventions, the organization conducted 6 awareness campaigns among pastors from various congregations, in order to strengthen their involvement in HIV prevention among young faithful. Although the initial target planned for 8 campaigns, partial achievement is mainly related to the absence of external financing and an exclusive use of the association's own funds.

CAMCOCHE also organized targeted screening sessions, which tested 300 teenagers and young people. People diagnosed with HIV were systematically referred to health facilities for treatment, with a total of 12 positive cases referred during the year.

These activities helped to strengthen community-based screening and improve the continuum of care within targeted religious communities. However, several challenges remain to be addressed, notably the need to mobilize sustainable funding, improve planning for better compliance with the schedule, and strengthen monitoring of the effectiveness of the link to treatment.

For 2025, CAMCOCHE plans to consolidate its action by strengthening the partnership with health structures, by expanding the geographical coverage of its interventions, and by actively seeking technical and financial support to ensure the sustainability and impact of its community activities.

4. Achievements of the sectors during 2024.

SECTORS	KEY RESULTS
MINAS	• 33,847 people reached during Cameroon Month • 571 people reached during sensitization campaigns • 6,675 people reached during educational talks • 1,234 people tested for HIV • 288 condoms distributed • 33 junior MPs and leaders of organisations trained (15 men and 18 women)
MINJUSTICE	• 03 training workshops for prison health workers on the human rights-based approach to HIV and tuberculosis (37 health workers trained) • 288 condoms distributed to Ministry staff, 15 T-shirts distributed, 55 posters distributed and 278 leaflets distributed • 9271 Men sensitised, 2479 Men screened, 11 cases tested HIV+ and put on ART • 596 Women reached, 337 tested, 00 HIV+ cases
MINTOUL	• Sensitization and distribution of prevention materials in 63 hotel structures in the town of Kribi • Sensitization and screening for HIV/AIDS, Syphilis and Hepatitis for players in the tourism and leisure sector in the town of Ntui (14 hotel structures, 73 staff made aware and 17 people screened)
MINPROFF	• Capacity-building workshop on SRH and HIV/AIDS for MINPROFF social workers and other HIV/AIDS stakeholders • Implementation of combined HIV prevention in CPFFs and delegations in 8 priority health districts in the South region • Community mobilisation in favour of PMTCT • Distribution of condoms (male and female)
MINEFOP	• Strengthening regional focal points on the concepts of the right to health and information on HIV care procedures in the regions. • Sensitization among managers of decentralised structures about sex education and the avoidance of drug use within vocational training structures • Sensitization among central services staff about the harmful effects of vertical transmission and HIV prevention measures in the workplace. • Sensitization among MINEFOP central services staff about vertical transmission, prevention, treatment methods and HIV treatment and care: 318 central services staff raised awareness and 43 learners from the CFPREB-YDE (Centre de Formation Professionnel Rapide d'Employés de Bureau de Yaoundé)
MINAC	• - HIV/AIDS and hepatitis B screening campaign to mark Cameroon Month: 62 people tested (24 men and 38 women), 4 cases positive for viral hepatitis B.
MINDDEVEL	• Sensitization and screening during Cameroon Month
MINCOMMERCE	• Sensitization and communication campaign for staff in central and decentralised departments • Round table organised for members of the "bayam-selam" association (partner association of MINCOMMERCE) on the theme: let's be careful, AIDS is still decimating us • Meetings of the Central AIDS Supervision Commission • Sensitization and screening during Cameroon Month
MINSEP	• Distribution of communication materials (150 leaflets, 25 posters, 10 T-shirts, 3 polo shirts) • Distribution of male condoms (864) and lubricant gels (100) • Awareness-raising (207 local educational talks and 2,500 people reached via social networks)

5. Mapping of technical and financial partners for the implementation of HIV interventions

Table 44 : Mapping of stakeholders and areas of intervention.

Implementation agencies	Implementation partners	Intervention domains	Intervention areas	Target population	Financements
NACC	Directions techniques MOH RTG	- Prevention - Care - Support - Supply chain	All regions	- General population - Pregnant women - Children, teenagers and youths	- State of Cameroon - Global Fund - PEPFAR
CDC	ICAP, EGPAF, SHWARI, CBCHB, ACMS, GHSS, CRIHSS Foundation	- Prevention - Care - Support	All regions (155 HDs)	- Gerenal population	PEPFAR
DoD	HAEDA	Prevention	All regions / military hospitals	Military	PEPFAR
USAID	CHP-CHILL, CENC ISAHC, GHSC-PSM Chemonics-PSM	- Prevention - Supply chain	All regions	- General population - KPs - Vulnerable populations (children and orphans)	PEPFAR
Peace Corps	Volunteers	Prevention	All the regions	Children, adolescents and teenage mothers	PEPFAR
PETVISIDAME	DRSP	- Primary prevention of HIV in youths and adolescents - Care for children and adolescents living with HIV. - PMTCT	Adamawa, East, Far North, North, West, South in 65 HDs	PW/BFW HIV+, HEI, Children and adolescents HIV+	State of Cameroon (IDB loan)
CARE	CHP, PJD, ACT, GIZ, FESADE	- Prevention - Human rights	All the regions	FSW, HSH, Clients of FSW, YTGNS, YTBNS, IDU et TG	Global Funds
PNLP	REACH OUT, PLAN INTERNATIONAL	Care TB/VIH	All the regions	General population	Global Funds
HCR	CTD	Prevention	Far-north Adamawa, Est	PLHIV General Population, Displaced populations in remote areas	

Implementation agencies	Implementation partners	Intervention domains	Intervention areas	Target population	Financements
ONUSIDA	NACC RECAP+	- Prévention - Prise en charge - CLM	All the regions	PLHIV	
OMS		- Prévention - care	National	General population	ONUSIDA PEPFAR
ONU WOMEN		Prévention	National	Women and Adolescents	
CSCC-Santé		Building the capacity of civil society organisations to make an effective contribution to the national response to AIDS, tuberculosis, malaria and hepatitis.		General population	
ACMS	RECAJ+	Implementation of the Star project (HIV SELF TESTING AFRICA INITIATIE)		Adolescents and youths not attending school	
Evidence action	NACC	- Prevention		Pregnant women and partners	

CHAPTER 7 : MOBILISATION AND MANAGEMENT OF HIV-RELATED FINANCIAL RESSOURCES

In addition to the contribution of the State of Cameroon, the national response to HIV includes contributions from several donors, the main ones being: The Global Fund and the American Government through PEPFAR funds.
The funds allocated to the annual HIV response budget for the 2024 financial year meet the needs presented in the national strategic plan 2024-2030 by impact results. Interventions supported by these donors must be sufficiently specific to be integrated into overall planning and budgeting procedures.

1. Estimated of financial resource requirements

The national need for financial resources for the 2024 exercise as planned by the PSN Operational Plan for the year 2024 amounts to 96°147°872°522 CFA francs. Impact result 2 on mortality reduction represents 44% of this budget.

TABLE 45: 2024 BUDGET ESTIMATE BY IMPACT RESULT

Impact indicator	Total 2024
Impact 1: By 2030, new HIV infections are reduced by at least 70%.	41 496 632 826
Impact 2: By 2030, HIV/AIDS-related mortality is reduced by at least 50%.	42 315 533 867
Impact 3: By 2030, reduction of stigma and discrimination, respect for human rights and promotion of equity in access to care and services.	2 685 741 952
Impact 4: By 2030 Governance and management are strengthened to ensure the acceleration, efficiency, accountability and sustainability of the national response to HIV/AIDS.	9 649 963 877
TOTAL	**96 147 872 522**

Sources : PTA NACC 2024

2. Mobilisation of funds for the HIV response in 2024 at CTG/NACC level.

All the resources mobilized for the implementation of the PSN in 2024 are not yet available, however the budget estimates were estimated at 45°567°201°174 CFA francs representing the contributions pledged by the implementing actors and the PTFs.

TABLE 46: BREAKDOWN OF BUDGET ENTRIES BY DONOR

SOURCES DE FINANCEMENTS	FUNDING AVAILABLE IN 2024
GLOBAL FUND	35 172 978 165
NACC_CDC_PEPFAR	916 050 000
BIP	2 873 071 114
UNICEF_MINJEC_MINAS	125 101 900
WHO	265 000 000
FCP	6 480 000 000
TOTAL GENERAL	**45 567 201 179**

Overall, the funding actually mobilized for the 2024 exercise as part of the implementation of activities to combat HIV/AIDS by the NACC amounts to FCFA 45,567,201,179 representing 47.40% of the budget.

2. Execution of the budget mobilized at the GTC/NACC level in 2024

3.1. Global Fund budget execution

As part of the implementation of activities under Global Fund funding (GC7), recorded expenditures and broken down by cost category are presented in table 47. Thus, it should be noted that the achievements for the 2024 financial year related to activities and services amount to 21,609,364,952 FCFA. These expenses only concern the funds managed at the GTC/NACC level.

TABLE 47: EXPENDITURE RECORDED ON BEHALF OF GC7 FINANCING IN 2024

By cost group	FY 2024	2024 achievement	% completed
1.0 Human Resources (HR)	2 730 427 286	2 627 212 809	96,22
2.0 Travel related costs (TRC)	2 263 035 984	978 873 470	43,25
3.0 External Professional services (EPS)	1 460 012 316	74 366 552	5,09
4.0 Health Products - Pharmaceutical Products (HPPP)	15 077 380 616	11 793 770 355	78,22
5.0 Health Products - Non-Pharmaceuticals (HPNP)	3 492 261 018	1 623 920 168	46,50
6.0 Health Products - Equipment (HPE)	-	-	0,00
7.0 Procurement and Supply-Chain Management costs (PSM)	5 524 714 988	3 867 451 706	70,00
8.0 Infrastructure (INF)	3 300 000	2 260 450	68,50
9.0 Non-health equipment (NHP)	746 946 086	31 038 466	4,16
10.0 Communication Material and Publications (CMP)	128 966 000	3 360 000	2,61
11.0 Indirect and Overhead Costs	508 465 517	436 642 686	85,87
12.0 Living support to client/ target population (LSCTP)	160 000 000	-	0,00
13.0 Payment for results	219 492 000	170 468 290	77,66
Total	**32 315 001 813**	**21 609 364 952**	**66,87**

Source : *TOMWEB accounting data*

Several reasons justify the different achievement rates observed during the 2024 exercise, notably:

- The late start of activities due to the change in the funding cycle;
- The instability of contract staff due to the recruitment procedure during the first six months;
- The non-validation of program vehicle orders and the capacity building plan for program staff;
- Health products ordered but not yet received;

3.1. Execution of the 2024 counterpart funds budget

TABLE 48: BREAKDOWN OF COUNTERPART FUND EXPENDITURE BY ITEM

ITEM OF EXPENDITURE	INSCRIPTIONS BUDGETAIRES (A)	MONTANTS EXECUTES (B)	TAUX	AVAILABLE (C)=(A-B)
GROUP 1 : CURRENT EXPENDITURE				
ITEM. 1: Purchase of reagents and consumables for screening for HIV and other STIs (syphilis, viral hepatitis, EID, etc.).)	418 868 251	0	0,00%	418 868 251
ITEM No. 2: Purchase of reagents and consumables for viral load testing	656 783 582	0	0,00%	656 783 582
ITEM 3: Procurement of 1st, 2nd and 3rd line ARVs	4 102 139 084	0	0,00%	
ITEM 4: Staff bonuses not covered by the Global Fund	783 486 000	587 256 955	74,95%	196 229 045
ITEM 5: Social security charges and employers' contributions	188 723 083	168 115 000	89,08%	20 608 083
ITEM 6: Organisation of screening campaigns for youths during the holidays	100 000 000	100 000 000	100,00%	0
ITEM 7: Organisation of sensitization and screening campaigns during Cameroon Month and World AIDS Day	100 000 000	100 000 000	100,00%	0
ITEM 8: Production of primary data collection tools for the HIV Programme (lab registers, ANC, etc.)	35 000 000	13 000 000	37,14%	22 000 000
ITEM 9: Organisation of meetings of the Multisectoral HIV Programme Committee at central and regional level, including statutory meetings	55 000 000	55 000 000	100,00%	0
RUB ITEM 10 : Workshops and meetings for monitoring, validating data and producing reports on the responses of the various health sectors to HIV-AIDS, including the PMLS	40 000 000	40 000 000	100,00%	0
SUB-TOTAL GROUP 1	6 480 000 000	955 371 955	14,74%	1 292 488 961
SUB-TOTAL GROUP 2	0	0	0,00%	0
TOTAL GENERAL	**6 480 000 000**	**955 371 955**	**14,74%**	**1 292 488 961**

Source : FCP employment account at 31 December 2024

The main reason for the low budget absorption rate of FCPs in FY2024 is:

• The difficulty in transferring funds abroad from the basket fund for the acquisition of health products.

3.2. Budget execution of the NACC-CDC/PEPFAR project

The achievements we will present in this paragraph concern only the GTC-NACC PEPFAR project, nearly 95.23% of the funds allocated by PEPFAR through US government agencies are not taken into account

TABLE 49: EXPENDITURE ON THE NACC-CDC/PEPFAR PROJECT IN 2024

N°	COMPONENT	BUDGET	REALISATION	% REALISATION
1	Care and treatment	614 385 720	608 385 720	99,02%
2	Information System	191 978 013	191 240 010	99,61%
3	Programme management	109 686 267	100 955 394	92,04%

TOTAL	916 050 000	900 581 124	96,89%

Source : *TOMWEB accounting data*

It is important to point out that the fiscal year in the context of the PEPFAR project runs from October 1, 2023, to September 30, 2024, and the delay in recruiting an IT specialist under PEPFAR funding partly justifies the portion of the budget not consumed.

4. The funding projections for fiscal year 2025

The budgetary projections for the 2025 fiscal year included in the framework of the National Strategic Plan (NSP) 2024-2030 to combat HIV/AIDS adopted by Cameroon in 2023 amount to the sum of 87,894,794,881 FCFA. To date, the amounts already budgeted by the State of Cameroon, the Global Fund and PEPFAR for the CDC-NACC project amount to 33,439,324,628 FCFA for fiscal year 2025.

TABLE 50: BREAKDOWN OF BUDGET ESTIMATES BY DONOR

N°	Bailleur de fonds	Budget (FCFA)
1	State of Cameroon	6 000 000 000
2	Global Fund to Fight AIDS, Tuberculosis and Malaria	26 687 074 628
3	PEPFAR GTC	752 250 000
TOTAL		***33 439 324 628***

Sources : *the 2025 CPF expenditure memorandum, CMR-H-MOH_Detailed_Budget_GC7_GF.*

Conclusion

The year 2024 was marked by notable advances in the national HIV response, reflecting Cameroon's renewed commitment to achieving the UNAIDS 2030 targets. The reduction of new infections, improved access to antiretroviral treatment, efforts for viral suppression, as well as increased community mobilization, reflect a positive dynamic.

Despite a sometimes difficult operational context, particularly related to logistical challenges, financial constraints, and inequalities in access to care, the different actors – public institutions, technical and financial partners, civil society, community organizations – were able to combine their efforts to strengthen the effectiveness of the response.

Technological innovations, differentiated care strategies, the extension of Universal Health Coverage (UHC) and targeted interventions with key populations, children and adolescents, pave the way for a more inclusive, equitable and sustainable response.

As the country commits to the implementation of the National Strategic Plan 2024-2030, it is imperative to capitalize on achievements, bridge gaps, and strengthen synergies at all levels to eradicate the HIV epidemic as a public health threat in Cameroon.

Annexs

List of organisations that have submitted 2024 data

Structures	Reported data
Implementating partners	
EGPAF	2024 Annual Report and 2025 Annual Work Plan
CosMO	2024 Annual Report and 2025 Annual Work Plan
CARE AND HEALTH PROGRAM	Data on condoms and lubricants
NGOs and Associations	
Evidence Action	2024 Annual Report
ACMS	2024 Annual Report and 2025 Annual Work Plan
PAM	2024 Annual Report
OMS	2024 Annual Report
JAPSSO	Data on condoms and lubricants
HORIZONS WOMEN	December 2024 report, January 2025 action plan and data on condoms and lubricants
SYNERGIES AFRICAINES	Technical and financial report on 2024 activities and 2025 Annual Work Plan
CAMCOCHE	2024 Annual Report
AFASO	2024 Annual Report and 2025 Annual Work Plan
CENAME	Data on condoms and lubricants
AEAM	Rapport des activités T3 2024
CEPCA SANTE	2024 Annual Report and 2025 Annual Work Plan
ALECO-PROSACO	2024 Annual Report
AFFIRMATIVE ACTION	2024 Annual Report
RECAJ +	2024 Annual Report and 2025 Annual Work Plan
Universal Help	2024 Annual Report
Entraide médicale	Progress report on International Women's Day 2025
Sectors	
ISDC (Initiative Sous Directive Communautaire)	October-December 2024 Activity Report
MINEFOP	T3 2024 report on the fight against STIs and HIV
MINDEF	2024 Annual Report and 2025 Annual Work Plan
MINESEP	2024 Annual Report and 2025 Annual Work Plan
MINDEF	2024 Annual Report
MINCOMMERCE	2024 Annual Report and 2025 Annual Work Plan
MINJUSTICE	Report on the activities of Cameroon Month and World AIDS Day 2024
MINPROFF	2024 Annual Report and 2025 Annual Work Plan
MINAS	2024 Annual Report and 2025 Annual Work Plan
MINTOUL	2024 Annual Report and 2025 Annual Work Plan
MINAC	2024 Annual Report
MINDDEVEL	2024 Annual Report
Others	

Structures	Reported data
CREMER	2024 Annual Report
VIHeillir	2024 Annual Report