NATIONAL HIV/AIDS CONTROL STRATEGIC PLAN

2006-2010
UNGASS  United Nations General Extraordinary Assembly on HIV/AIDS
USAID  United states Agency for International Development
VCT  Voluntary Counselling and Testing
AIDS Fund
AIDS  Acquired Immunodeficiency Syndrome
ARV  Antiretroviral
ATB  Antibiotic
ATC  Approved Treatment Centre
BEA  Blood Exposure Accident
CACC  Communal AIDS Control Committee
CAP  Community Action Plan
CBC  Communication for Behaviour Change
CMC  Country Coordinating Mechanism
CENAME  National Centre for the Procurement of Essential Drugs and Supplies
CFC  Communal Focal Point
CRIS  Country Response Information Centre
CTG  Central Technical Group
DDC  Department of Disease Control
DH  District Hospital
DHOR  Department of Health Operations Research
DHS  Demographic and Health Survey
EPI  Expanded Programme on Immunization
GF  Global Fund
HD  Health District
HIV  Human Immunodeficiency Virus
IGA  Income Generating Activity
IHC  Integrated Health Centre
JMC  Joint Monitoring Committee
KFV
LACC  Local AIDS Control Committee
MCT  Mother-to-Child Transmission
ME  Monitoring and evaluation
MEWG  Monitoring and Evaluation Working Group
Mgt.  Management
MOH  Ministry of Public Health
MU  Management Unit
NACC  National AIDS Control Committee
NACP  National AIDS Control Programme
NBTC  National Blood Transfusion Centre
NGO  Non Governmental Organization
NSP  National Strategic Plan
NTCP  National Tuberculosis Control Programme
OI  Opportunistic Infection
OVC  Orphan and Vulnerable Child
PACC  Provincial AIDS Control Committee
PBTC  Provincial Blood Transfusion Centre
PDPH  Provincial Delegation of Public Health
PH  Provincial Hospital
PLWHA  Persons Living with HIV/AIDS
PMCT  Prevention of Mother-to-Child Transmission
PNC  Prenatal Consultation
PS/NACC  Permanent Secretary of the National AIDS Control Committee
PSO  Provincial Support Organization
PTG  Provincial Technical Group
PVTC  Prevention and Voluntary Testing Centre
SHC  School Health Centre
SMC  Sub-Divisional Medical Centre
STI  Sexually Transmitted Infection
TTC  Testing and Treatment Centre
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNFPA  United Nations Population Fund
EXECUTIVE SUMMARY

Between 1986 and 2000, more than 34000 cumulated cases of HIV/AIDS were reported in Cameroon, after the appearance of the first cases in 1986. HIV prevalence during this same period rose from 0.5 % to 11% in 2000 (sentinel sites). At the close of 2001, the number of persons living with HIV was estimated at 920 000, seroprevalence at 11.8% and the total number of AIDS-related deaths among children and adults at 53000 (UNAIDS, 2002)\textsuperscript{1}.

According to data obtained from DHS III (Demographic and Health Survey), Cameroon at the end of 2004 was still in a context of a generalized epidemic with an average prevalence of 5.5% with 6.8% of this figure among women. The age group between 15 and 24 years is still regarded as a very vulnerable group; other high-risk groups have been identified: Men in uniform, sex workers, truck-drivers and the population living along the Chad-Cameroon Pipeline. The method of transmission by unprotected heterosexual activity is the most common but mother-to-child transmission remains a concern, and the number of paediatric infections was estimated at 69,000 cases at the end of 2001 and 43000 at the end of 2003 (UNAIDS). The number of orphans in 2005 was estimated at 122,670 (Spectrum).

In 2005, the number of PLWHA was estimated at 505,000, among which 61% are women. The characteristics of the epidemic are as follows: it mostly affects women and youths, is more prevalent in urban areas and presents regional disparities. Of note in particular is the high prevalence of the infection among women in the North-West (11.7%), South-West (11%) provinces and in the city of Yaounde. Higher prevalence figures among men are recorded in East (7.6%), North-West (5.2%), West (5.2%) and the South-West (5.1%) provinces. Prevalence among pregnant women is higher than that among the general population. (UNAIDS 2005)

In view of the tragic impact on human, social and economic development and the threat on the future of the nation, the government of Cameroon declared HIV/AIDS control as being a health emergency and a priority programme included in the Poverty Reduction Strategy Paper (PRSP).

After commencement of HIV/AIDS control activities in 1986 with the setting up of a National AIDS Control Committee and a National AIDS Control Programme (NACP), various plans were drawn up and implemented more or less successfully from 1987 to 2000.

Thereafter, a strategic planning process within the framework of intensification and extension of the national response led to the development of the first national HIV/AIDS control strategic plan for the 2000-2005 period.

The priority domains of this plan were six in number:

- Prevention of transmission of HIV/AIDS and STDs
- Prevention of the transmission through blood;
- HIV/AIDS case management
- Protection and promotion of the rights of PLWHA
- Promotion of research.
- Programme coordination

At the end of this 5-year period, significant progress was recorded both in the domain of prevention and management. Prominent therein were better knowledge of the HIV/AIDS infection and the methods of prevention among the general population. Very encouraging results were obtained with respect to condom use the rate of which multiplied by 15 among women and by 8 among men during the last sexual relations with non live-in partners. 23% of men and 5% of women start their sexual activity before the age of 15. Among youths from 15 to 24 years, however, risk-taking remains high and only 57% of the men and 47% women used a condom during the last risky sexual intercourse.

The development of national service provision in terms of prevention is real (19 PVTC and 400 PMCT sites) in 2005. In addition, the management of infected persons experienced a significant acceleration through the antiretroviral access initiative; from 600 patients on ARV in 2001, the number of patients on ARV rose to 14000 in 2005, all managed in 24 ATC and 63 MU countrywide, representing a coverage rate of 18%; it should be noted, however, that the number of children on ARV remains low. It stands at 470, which hardly represents a coverage rate of 3% of infected children.

The real involvement of the community materialized decentralization through the setting up of communal and local AIDS control committees as well as the development of community control plans. Moreover, the multi-sector approach is objectified through sector-specific plans developed in the public and private sectors. Technical, material and financial support provided to the committees by the government and its development partners thus reinforces partnership between the public and private sectors.

On the whole, while the main results recorded at the end of 2005 are encouraging both in the domain of prevention and management, the impact thereof on the regression of prevalence and increase in the survival of PLWHA and infected children cannot yet be assessed.

The results are still largely inadequate in particular in terms of coverage to reverse in a sustainable manner the evolution of the pandemic (level of coverage estimated at 20 for sensitization, 10 for condom use, 4 for disease detection - NACC evaluation report -). In fact, national response between 2000 and 2005 presented some inadequacies among which can be noted:

- poor appropriation of the fight and community participation by the communities and sectors
- absence of continuous quality assurance through the reinforcement of procurement systems, continuous quality control, and the continuing training of actors
- inadequate operations research
- insufficient coordination of the stakeholders and partners of the programme;
- inadequacy of resources allocated (Human, material and financial) in particular at the peripheral level;
- inadequacy of interventions specifically targeting the rural areas
- shortage of equipment and technical material for the diagnosis and management of STIs;
- lack of effective decentralization
- low coverage of PLWHA management, in particular, inadequate management of children and orphans;
- low coverage in terms of management of OI and STI;
- absence / deficient organization of the blood transfusion system;
- insufficient number of trained personnel.

Tremendous problems persist and deserve to be solved in order to enhance the rational use of available funding in activities likely to effectively reduce new infections and improve the quality of life of persons living with HIV (PLWHA).

It thus will be necessary to:

- Extend prevention services, in particular among youths, public sectors such as education, labour and denominational circles, taking into account the context of the growing epidemic among women and youths.
- Extend and generalize prevention of mother-to-child HIV transmission programmes
- Reinforce treatment, access to antiretroviral therapies and psychosocial PLWHA management programmes
- guarantee the protection and comprehensive management of vulnerable orphans and children as well as the protection and promotion of the rights of PLWHA.

To meet this challenge, a plan based on time-tested strategies is essential. During the period 2006/2010, it will be based of life scenarios through operational plans to produce a generation of AIDS-free Cameroonian.

As a preliminary, the National AIDS Control Committee shall have to:
- reinforce its role as coordinator of the control activity
- set up a unique operational monitoring/evaluation framework preceded by the adoption of key indicators in collaboration with all the partners
- strengthen partnership with all the actors including traditional and religious leaders acting within a single strategic framework.
To face up to such a prospect, after a review of the situation in 2005, “the 2006-2010 Strategic Plan” comprises 6 strategic directions and four priority target groups, namely:
- Reinforcement of comprehensive prevention
- Universal access to treatments for adults and children
- Protection and support for affected and infected persons
- appropriation of control by the actors
- promotion of research and epidemiological surveillance
- reinforcement of coordination of partnership and monitoring/evaluation.

The priority target groups are youths, women, orphans, vulnerable children, and high-risk groups.

This strategic plan, thanks to full funding from the national budget and international assistance, is expected to make it possible, within 5 years, to reduce the incidence of HIV/AIDS among youths and women by at least 50%; reduce the prevalence of the infection among infants by at least 70% and finally, improve survival of persons infected by reducing their mortality by at least 50%.
INTRODUCTION

I. NSP: GENERAL INFORMATION ON CAMEROON

I-1. Geographical situation

Cameroon is a Central African Country situated at the end of the Gulf of Guinea WITH a total surface area of 475,650 km². It is bordered to the west by Nigeria, to the South by Congo, Gabon and Equatorial Guinea, to the East by the Central African Republic, and to the Northeast by Chad.

I-2. Political/administrative organization and socio-economic overview

Cameroon is a bilingual country, made of a French-speaking zone and an English-speaking zone

The economic development of Cameroon as is the case with the majority of developing countries, hinges mainly on the primary sector. In 2002, GDP was estimated at FCFA 7 609 thousand million, that is, about half of that of CEMAC estimated at FCFA 16 627 thousand million.

However, according to the second Cameroon Household Survey (CHS II), in 2001, two people out of five (40 %) lived below the poverty line, estimated at FCFA 232 547 per adult and per annum. Access to education is real with a schooling rate (persons of 6-14 years), which stood at 73% in 1987, estimated in 2001 at 79%.

On the macroeconomic level, it should be noted that after a period of sustained growth until the middle of the eighties, Cameroon underwent an economic crisis as from 1986.

After a satisfactory execution of its first economic and financial programme between 1997 and 2000, Cameroon recorded good macroeconomic performances in this beginning of the millennium, which enabled it to be admitted into the HIPC (Heavily Indebted Poor Countries) initiative. The decision point was reached in October 2000 and the completion point is planned for 2006.

I-3. Human environment and demography

Cameroon has about 15.5 million inhabitants (2003) divided into six large ethnic groups, in turn subdivided into more than 230 groups:

- the Sudanese, Hamites and Semites living in the Adamawa, North and Far North provinces; they are generally animists or Muslims;
- the Bantus, semi Bantus and related tribes, and the Pygmies in the rest of the country; they are generally animists or Christians.
According to the results of the last general population and housing census (GPHC), the average population density stood at 23 inhabitants per square kilometre. This population was unevenly distributed over the national territory, the urban proportion being 38 %. Moreover, the population of Cameroon is young: as per the last GPHC, persons between 0 and 14 years represented 46 % of the total population.

The population is growing rapidly; the average annual growth rate estimated at 1.9% in 1950 was evaluated at 2.9% in 1987. This evolution is attributable to a drop in mortality and a relatively constant fertility rate, although the latter remains high. If this growth rate were to be maintained, the population would double in less than 24 years; in other words, the population of Cameroon would be approximately 23 million inhabitants by 2014.

II. ORGANIZATION OF THE HEALTH SYSTEM IN CAMEROON

II-1. The various levels of the Health Pyramid

The national health system is organized into three levels, each comprising administrative structures, health units and dialogue structures for specific functions.

- the central level is made up of the central services of the Ministry of Public Health and general hospitals, University Teaching Hospital and central hospitals;
- the intermediate level is composed of the Provincial Delegations for Public Health, Provincial Hospitals and others ranking as such;
- the peripheral level is made up of District Health Services (DHS), sub-divisional medical centres (SMC), integrated health centres (IHC) within health areas.
The health sector comprises three sub-sectors:
- the public sub-sector;
- the private sub-sector;
- The traditional medicine sub-sector.

The Public Sub-Sector equally includes other health structures under the authority of other ministries such as MINDEF, MINETPS, MINEDUC, MINESUP, NSIF.

Health units are classified in categories and according to level of referral. Thus, the DH is the first level of referral and 4\textsuperscript{th} category health unit. In decreasing order SMC, IHC, ACC are 5\textsuperscript{th}, 6\textsuperscript{th} and 7\textsuperscript{th} category health units respectively.

The table below defines the various levels of the health system and their categories.

**Table 1:** Various levels of the Health System and categories of healthcare structures

<table>
<thead>
<tr>
<th>Level</th>
<th>Administrative Structures</th>
<th>Functions</th>
<th>Healthcare Structures and their referral level</th>
<th>Dialogue Structures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>Office of the Minister, Secretariat General, Departments and structures ranking as such</td>
<td>Policy making, formulation of concepts, policies and strategies -co-ordination -regulation</td>
<td>1\textsuperscript{st} category General Hospitals or 4\textsuperscript{th} referral hospitals; UTH 2\textsuperscript{nd} category Central Hospitals or 3\textsuperscript{rd} referral hospitals;</td>
<td>Boards of Directors or Management Committees</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Provincial Delegations</td>
<td>Technical support to health districts</td>
<td>3\textsuperscript{rd} category Provincial Hospitals and others ranking as such or 2\textsuperscript{nd} referral hospitals</td>
<td>Provincial Special Fund for Health</td>
</tr>
<tr>
<td>Peripheral</td>
<td>Health District service</td>
<td>Implementation of Programmes</td>
<td>4\textsuperscript{th} category DH or 1\textsuperscript{st} referral hospitals 5\textsuperscript{th} category: SMC 6\textsuperscript{th} category: IHC 7\textsuperscript{th} category: Ambulatory Care centres (ACC)</td>
<td>DMC DHC HC MC</td>
</tr>
</tbody>
</table>

Source: adapted from the conceptual framework of the viable HD (MOH) and 2002 organization chart

**II-2. Health coverage**

According to the 2002 health map (DEPI/WHO), Cameroon has 143 health districts, 1 398 health areas, 6 national hospitals, 9 provincial hospitals, 130 district hospitals, 977 leading health centres and 713 others. The 2004 health map will make it possible to update these figures.
In June 2000, the health personnel ratio was estimated as follows:
- 1 doctor for 10 083 inhabitants
- 1 pharmacist for 250 000 inhabitants
- 1 nurse for 2 249 inhabitants
- 1 midwife for 200 000 inhabitants
- 1 assistant nurse for 3 100 inhabitants

Special recruitments took place with HIPC funds
- In 2002 : 1200 health personnel including 100 doctors and 1100 nurses
- In 2004 : 600 health personnel including 39 doctors, 10 dental surgeons, 9 pharmacists, 413 nurses, 20 laboratory nurses, as well as Engineers, Assistant health technicians and administrative staff.

II-3. Drug policy

In Cameroon, there is a National Essential Drugs Procurement System (SYNAME). Its objective is to bring the drug closer to the patient through the adoption of the essential generic drugs policy, the setting up of Provincial Pharmaceuticals Supply Centres (PPSC) and of a National Essential Drugs Procurement Centre (CENAME), in the public sector. PPSC ensure the distribution of essential drugs and medical accessories to public and private voluntary health units at the provincial (intermediate) and district (peripheral) levels.

As regards HIV/AIDS, ARVs do not pass through PPSC but rather directly from CENAME to ATC. The PPSC of the North-West Province is the only exception.

II-4. Funding

The main sources of funding of the health sector are the State budget, households through cost recovery by way of user fees, local government bodies and external funding. Resources are inequitably distributed. Health insurance is still at its initial stages.

The majority of households in Cameroon are still very poor. It is estimated that 40% live below the poverty line (UNDP, Human Development Report, 2001).

ARVs are currently funded by state subsidy, MAP funds from IDA/World Bank and the Global Fund NGOs (MSF-CH, CERAC), some employers and especially direct payment by patients. The cost of certain drugs for opportunistic infections and laboratory examinations are borne in the same manner and in addition by the HIPC fund.

The establishment of a solidarity fund for AIDS is recent. Its aims are to meet the needs of the poorest and destitute population among PLWHA.
Cameroon was eligible to funding from the Global Fund to fight AIDS, tuberculosis and malaria.

III. ORGANIZATION OF HIV/AIDS CONTROL IN CAMEROON

![Diagram of the organization structure of HIV/AIDS control in Cameroon]

- **NACC**
  - **Central Technical Group**
    - Monitoring and Evaluation Section
    - Health response support Section
    - Administrative and financial Section
    - Communication for behaviour change Section
    - Local response Section
    - Sector response and partnership section
  - Joint monitoring committee
- **Provincial Technical Group**
  - Provincial AIDS control committee
- **Communal Correspondent**
  - Communal AIDS control committee
- **Local Committee**
The third Cameroon Demographic and Health Survey (DHS III) was conducted in 2004 on a representative sample of the entire population of Cameroonians aged 15 to 49 years. The results of this survey paint a global picture of the AIDS epidemic at the end of the 2000/2005 national strategic plan. These results and the progress reports of the National Programmes are crucial for an efficient planning of HIV/AIDS control through the judicious allocation of resources.

DHS III reveals that the epidemic increasingly affects women and youths, with a higher prevalence rate in the rural and high-risk areas. The growing number of PLWHA, orphans and the affected sectors are also quite disturbing.

I. HIV/AIDS: AN UNPRECEDENTED THREAT TO THE CAMEROONIAN YOUTH

Youths of between 15 and 24 years constitute a high-risk population given that during this age period, sexual intercourse is generally unstable while multiplicity in partnership is so frequent. DHS III reveals a disturbing situation among youths notably young women.

Graph 1: HIV prevalence among youths of 15 to 24 years in Cameroon in 2004

![Graph 1: HIV prevalence among youths of 15 to 24 years in Cameroon in 2004](image)

The average HIV prevalence among youths of 15-24 years in Cameroon stands at 3.2 %, that is, 4.8 % among women and 1.4 % among men, corresponding to a women/men ratio of 3.4. This means that in this age group, 340 women are infected as against 100 men. This ratio which is twice higher than that of the whole population of 15-49 years (ratio of 1.7) is still higher than 2.0 regardless of the age group. It is particularly high among the youths of 23-24 years (ratio of 5.4).
The situation of the epidemic in Cameroon somewhat contrasts with the level of awareness of HIV/AIDS which seems high: virtually everyone acknowledges having heard of HIV/AIDS and more than 70% of the youths of 15-24 years know at least one of the two main prevention methods, namely, the use of condoms and fidelity. However, much still has to be done at the level of ensuring greater awareness of the disease given that only close to 30% of the youths say they know two prevention methods and reject erroneous local ideas.

As concerns the use of prevention methods (abstinence, fidelity and use of condoms by the youths of 15-24 years), the following are observed:

- youths who have never run any risk of transmission of HIV through sex because they have never had any sexual intercourse constitute 27% among girls and 38% among men;

- youths who already had sex but have never run the risk of transmission of HIV through sexual intercourse (a single partner and use of condoms during the last sexual intercourse) constitute 21% and 23% among women and men respectively;

- among women of 15-24 years, 5% had their first sexual intercourse before the age of 15 and 88% before the age of 18. Among the men of 15-24 years, approximately 23% had their first sexual intercourse before 15 years. In addition, among people of 18-24 years, 82% had their first sexual relations before they were 18 years old;

- only 18% of women of 15 to 24 years old said they used a condom during their first sexual intercourse as against 27% of men of the same age bracket;

- more than two young women out of five (44 %) had risky sexual intercourse during the last 12 months that preceded the survey. Among men, this proportion is much higher for it goes up to 91%;

- among women, who have had risky sexual intercourse, 47% said they used a condom during the said intercourse whereas more than one out of two men (57%) said they used a condom during the last risky sexual intercourse;

- the youths who ran the risk of contracting HIV because they adopted risky behaviours, that is, those who either had only one partner but did not use condoms during the last sexual intercourse or used condoms but had several partners or, finally, those who had sexual intercourse with several partners without using a condom, constitute 48% among women as against 26% among men.
II. RISING FEMINISATION OF THE EPIDEMIC IN CAMEROON

The results of the DHS III show that in Cameroon, the HIV prevalence rate among women of 15-49 years, estimated at 6.8% is higher than the estimated rate among men of the same age group which is 4.1%. This gives an infection ratio between women and men of 1:7, which means that for every 100 men, 170 women are infected.

The state of HIV infection in Cameroonian women very significantly varies from one province to another and requires specific and targeted control approaches.

**Graph 2:** HIV prevalence among women per province in Cameroon in 2004 (DHS III)

![HIV prevalence among women per province in Cameroon in 2004 (DHS III)](image)

HIV prevalence among women also presents very great variations depending on marital status. Divorced women have a prevalence which is three times higher than that of married women (18.5 % as against 6.2 %). The prevalence rate is particularly high among widows (26.4%). Married women are almost twice more frequently infected than unmarried ones (6.2 % as against 3.5%). Women in a monogamous marriage situation have a higher prevalence than those who are in polygamous marriages (6.6% as against 5.5%).

Among the women who indulged in risky sexual intercourse, only 41 % use condoms. About 75% of infected women do not know their HIV status, either because they never carried out the AIDS test or they did the test but do not know the results.

The overall situation also became alarming because women, who were hitherto less contaminated, are now at the centre of the HIV/AIDS epidemic in Cameroon. What is more, rural households which are often headed by women are increasingly becoming poorer for there are obstacles which hinder the access of women to education and treatment thereby making it
impossible for them to find gainful employment. Consequently, this problem should be the concern of all.

III. RISKY SEXUAL BEHAVIOURS

It is observed that the more men indulged in high-risk sexual intercourse\(^1\), the more the HIV prevalence remained high: from 2.1% among men who did not have sexual intercourse in the past 12 months, the prevalence rose to 4.1% among those who had risk-free sexual intercourse and 5.6% among those who had high-risk sexual intercourse.

Among women and men, the prevalence rate also increases according to the total number of sexual partners in one’s lifetime: from 2.7% among women who had only one sexual partner in their lifetime, the prevalence rose to 9.3% among women who had 3-4 sexual partners, and even went up to 14.2% among women who said they had 10-24 sexual partners.

Among men, prevalence rose from a minimum of 0.5% among those who said that they had only one sexual partner in their lifetime to a maximum of 8.9% among those declared that they had 25 partners or more.

It is necessary to adopt a specific HIV/AIDS control approach that is suitable to areas prone to high-risk behaviour such as bars, nightclubs, hotels, inns, beaches, motor parks, video clubs, etc...

IV. POORLY INFORMED RURAL POPULATION

DHS III reveals that men and women in the urban area are clearly more likely to be HIV-positive than those in the rural area: the prevalence rate is up to 6.7% in urban areas as against 4.0% in rural areas. However, this situation contrasts with the level of knowledge and sexual behaviour of the people in the rural areas. As a matter of fact, the level of full knowledge is particularly low among women in the rural area (12% as against 36% in Yaounde and Douala); one quarter of men can be considered as having full knowledge of HIV/AIDS in the rural areas (as against 43% in Yaounde and Douala).

As concerns sexual behaviour, only 24% of the women living in rural areas say they used a condom during high-risk sexual intercourse as against 47.1% in urban areas; 39% of men use a condom during high-risk sexual intercourse in rural areas as against 62.6% in urban areas. Only 4% of women and 8% of men in rural areas know their HIV status, the ratios being by far lower than in other towns (10% and 14%) and Yaounde/Douala (22% and 24%).

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\(^1\) All through this document, “high-risk” sexual relations shall refer to sexual intercourse out of wedlock with a non regular partner
V  GROWING POPULATION OF PLWHA AND ORPHANS

Following the results of the DHS III and out of the concern to have statistics for better planning of the national response to HIV/AIDS, NACC statisticians participated in a workshop organized by WHO, UNAIDS and Futures Group in OUIDAH, Benin, in June 2005. The objective of the workshop was to simulate databases and future projections based on available statistical sources in the various countries.

Based on estimates updated by UNAIDS in January 2006, the number of people living with HIV/AIDS was going to rise in 2005 to 470,000 among adults (15 years and more) and to 35,000 among children (0-14 years) (UNAIDS/WHO, 2005). The number of new infections was, in its part, going to rise, according to the same projections, to 48 000 among adults and 10,000 among children. Based on the same UNAIDS estimates, the number of cumulated HIV/AIDS-related deaths since the beginning of the epidemic would rise to 48,700, including 40,000 among adults and 8,700 among children.

Table 2: Basic statistics on the impact of HIV/AIDS in Cameroon in 2005 simulated on Spectrum

<table>
<thead>
<tr>
<th></th>
<th>Year 2005</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>505 000</td>
<td>100%</td>
</tr>
<tr>
<td>Men</td>
<td>196 950</td>
<td>39%</td>
</tr>
<tr>
<td>Women</td>
<td>308 050</td>
<td>61%</td>
</tr>
<tr>
<td><strong>Number of PLWHA in need of ARV therapy</strong></td>
<td>75 750</td>
<td></td>
</tr>
<tr>
<td><strong>Number of orphans</strong></td>
<td>122 670</td>
<td></td>
</tr>
</tbody>
</table>

It follows from this table that at the end of 2005, Cameroon had about 505,000 persons living with HIV out of which 61% were women and 122 670 AIDS orphans. Thus, on account of the disease, a whole generation of children will be orphaned, a scenario which requires an adequate response from the authorities for their management. The AIDS epidemic contributed to impoverishing many communities, given that it is the role of the extended families - women or grandparents with scanty resources - already hard-pressed to take care of the majority of orphaned children. For want of a real security guarantee, many orphans suffering from a precarious health situation, traumas and psychological disorders, will find themselves in the street and will, consequently, be more vulnerable to abuse and exploitation.

VI. GROWING NUMBER OF SECTORS AFFECTED BY THE EPIDEMIC

With a significant increase in opportunistic infections, notably tuberculosis (40 to 50% of HIV/TB co-infection) which is on the rise on account of HIV/AIDS, the bed occupancy rate in health establishments stands at 30%
on average because of AIDS. This scenario, moreover, entails extra work for health staff and a sore need for more and more qualified health personnel for an efficient response to the spreading pandemic.

The impact of this pandemic extends to other sectors of the society notably education and the world of work where some data are available. In the educational sector, for instance, where HIV prevalence within the teaching corps varied between 5% and 28% depending on the region (UNESCO/UNAIDS, 2005) a quantitative and qualitative drop in teaching has been noted as a result of HIV-positive teachers who, in 95% cases, have problems of punctuality and regularity at work as well as difficulties in easily preparing their lessons (UNESCO/UNAIDS, 2005). In the working environment, HIV/AIDS affects 16% of the workforce (GICAM, 2002), a situation which results in significant losses in output and profit.
2006/2010 STRATEGIC PLAN
The 2006-2010 strategic plan, which is meant to be a second-generation programme, builds on a firm political commitment and responsibility assumed at the highest level with a view to putting the epidemic under control. Efficient prevention, care, support and treatment strategies and the consolidation of collaboration with communities, the civil society, persons living with HIV/AIDS and vulnerable groups constitute the essential pillars of the plan. This strategic plan also aims to promote the active protection of the rights of persons with HIV/AIDS, develop traditional medicine and ensure the effective use of available resources through better coordination and adequate follow-up of activities while strengthening regional and international co-operation. Based on an analysis of the HIV/AIDS situation in Cameroon, the government has set three main objectives for the next five years:

GOVERNMENT’S OBJECTIVES FOR 2006/2010

1. Reduce the number of new infections among the entire population
2. Move towards universal access to treatment and care for persons living with HIV
3. Reduce the overall impact of HIV/AIDS on orphans and vulnerable children

The six strategies (see box...) and their priority areas decided upon for the 2005-2010 period have been identified based on the results of evaluation of the 2000-2005 NSP (National Strategic Plan) and of the 2004 DHS III. For each aspect, the current situation is presented followed by overall, specific and strategic objectives aimed at meeting these objectives. The overall objectives mainly correspond to the indicators of the impact, namely the reduction of HIV transmission and reduction of the impact of AIDS. The specific objectives relate to expected outcomes of the National Programme, namely the changes in behaviour and access to treatment and management of the victims (see the following diagram).
Diagram: The logical monitoring and evaluation framework of the 2006-2010 Strategic Plan in Cameroon

Generally, the assessment of the 2000-2005 NSP revealed two major flaws that this new plan took into account through the following aspects:

1. Coordination, monitoring and evaluation of the national programme with an entire aspect devoted to this phase;
2. Communication strategy that will be reinforced with a view to ensuring better integration.

This new 2006-2010 NSP has been drawn up in close collaboration with all the stakeholders involved in HIV/AIDS control through a series of consultations and workshops.

6 STRATEGIC DIRECTIONS OF THE 2006-2010 NSP

- Strategic direction 1: Scaling up comprehensive prevention
- Strategic direction 2: towards universal access to treatment and care for children and adults living with HIV/AIDS
- Strategic direction 3: Protection and support to OVC (Orphans and vulnerable children)
- Strategic direction 4: Appropriation of control by all the stakeholders.
- Strategic direction 5: Promotion of research and epidemiological surveillance
- Strategic direction 6: Scaling up coordination, management, partnership and monitoring/evaluation
I. STRATEGIC DIRECTION I: SCALING UP COMPREHENSIVE PREVENTION
Principles of efficient HIV prevention

- All HIV prevention programmes/actions have to be based on the promotion, protection and respect of **human rights including gender equality**;

- HIV prevention programmes have to be **differentiated and locally adapted** to epidemiological, economic, social and cultural contexts in which they are implemented;

- HIV prevention actions have to be **based on clear proofs**; on time-tested actions; and investments for widening knowledge have to be intensified;

- HIV prevention programmes have to be **exhaustive and complete**, using the whole gamut of policy and programme interventions known to be efficient;

- HIV prevention is made to last; **consequently, the use of existing interventions as well the research and development of new techniques require sustained effort over time**, knowing that the results will only be known in the long run and that they have to be continued;

- HIV prevention programmes have to achieve sufficient **coverage, scope and intensity** so as to make a real difference;

- **Community participation** of the people for whom HIV prevention programmes are designed is necessary for the success thereof.

*Source: Intensification of HIV prevention: UNAIDS policy orientation Document; 2005*
Prevention programmes in Cameroon progressed in the past few years. Aspects of this progress are presented according to priority domains in this chapter. However, additional efforts are required in order to improve their performance and coverage. The principles of efficient HIV prevention presented on page...will constitute the basic framework of this new strategic plan.

**PRIORITY DOMAINS**

- Promotion of condom use;
- Voluntary counselling and testing
- Prevention of mother-to-child HIV transmission;
- Scaling up HIV prevention among youths;
- Prevention and management of STIs
- Blood safety
- Prevention of new infections among women

**Overall objective**

To reduce by at least 50% the percentage of HIV-infected women and men by 2010.

**I-1. PROMOTION OF CONDOM USE**

The promotion of condom use in Cameroon progressed spectacularly during the past few years. This is evidenced by the sales indicator of the main distribution agency, the Cameroon Association for Social Marketing (ACMS) - from less than 1 million in 1989 to more than 21 million 2005.

Actually, it follows from the evaluation of the 2000-2005 NSP that the male condom was popularized thanks to the involvement of Non Governmental Organizations and associations in its promotion and distribution by way of demonstration and advertisement. However, they are still inaccessible notably in rural areas. On its part, the female condom is still unavailable and inaccessible both in rural and urban areas. Consequently, it was recommended that male and female condoms be made available and accessible by increasing sales points, adapting the approaches and awareness messages according to targets and increasing demonstration sessions on the correct use of the condom.

Procurement of condoms in Cameroon, so far, hinges on subsidies from foreign aid. The partners involved in this domain include USAID, UNFPA and KFW. Since 2003, USAID announced its withdrawal from the granting of subsidies for the acquisition of condoms in some countries including Cameroon. This withdrawal took effect as from the end of 2005.
Faced with this situation, Cameroon intends to continue an aggressive policy for the availability of male and female condoms in all the villages and high-risk areas, subsidies and sensitization on correct contraceptive use. Special attention will also be paid to partnership for the effective implementation of the programme.

I-1.1. Specific objectives

1. To increase from 41% and from 54% respectively to 80% the percentage of women and men indicating that they used a condom during the last high-risk sexual intercourse by 2010.

2. To increase by 24% and 39% respectively to 80% the percentage of women and men who indicate that they used a condom during the last high-risk sexual intercourse.

I-1.2. Strategies

- Availability of the female and male condom in the 24,000 villages of Cameroon;
- Policy of subsidizing prices in order to improve the affordability of female and male condoms in the 24,000 villages of Cameroon;
- Promotion of the systematic and correct use of the female and male condoms in the 24,000 villages of Cameroon;
- Use of automatic condom dispensers in high-risk areas;
- Contracting with associations and organizations at grassroots level in the distribution and promotion of condoms;
- Strengthening of partnership between the structures involved in the promotion of the female and male condoms;
- Strengthening of national and international partnerships for subsidies and support for the promotion of condoms.

I-2. VOLUNTARY COUNSELLING AND TESTING (VCT)

The promotion of voluntary counselling and testing was carried out through:

(1) the establishment of a network of 19 HIV Prevention and voluntary counselling and testing Centres (PVCTC) (whose services will soon be integrated into the activities at the Health District level) and

(2) the reduction of testing cost, down to $1.5 within the network.
The assessment of the 2000-2005 NSP reveals a certain number of flaws in the programme, including the insufficient number of VCT services; reagent stock-outs and the lack of harmonization of prices. Consequently, it was recommended that the provision of quality VCT services in rural and urban areas be increased and that emphasis be laid on work places and other known high-risk areas.

The 2004 DHS III figures on coverage and knowledge of serological status confirm the main observation of the assessment. As a matter of fact, 76% of women and 83% of men never did any HIV test. What is even more disturbing is the fact that 75% of women and 76% of men infected do not know their HIV status either because they never carried out the test or because they did the test but do not know the results.

These figures require that actions be intensified in the domain through consolidation of the provision of VCT in various health structures, its inclusion in the basic health package of these structures, as well as an aggressive coverage extension policy.

I-2.1. Specific objectives

1. To increase from 24% and 17% to 75% the percentage of women and men having carried out an HIV screening test by 2010.

2. To increase from 10% and 14% to at least 75% the percentage of women and men who know their HIV status by 2010.

I-2.2. Strategies

- Consolidation of VCT provision in the 19 existing PVCTC, health structures responsible for PMCT/PNC, DTC, STIs and transfusion centres;

- Integration of VCT into the basic health package of all the health structures (MU, SMC, IHC, company dispensaries, prisons, school SHC and universities etc.);

- Consolidation of VCT provision in all the consultation services that are not specialized in HIV;

- Contracting of screening with associations;

- Intensification of outreach strategy through mobile testing units for the uncovered target population;

- Promotion of HIV testing during the pre-marital period;

- Use of the “contact tracing” in testing (seeking out partners).
I-3. BLOOD SAFETY

Currently, HIV-contaminated blood accounts for approximately 5% of HIV infections in Africa. In many countries, transfusion services are increasingly embarking on analyses with a view to obtaining safe blood, but in most developing countries, even the most basic compulsory tests aimed at testing for diseases such as AIDS or hepatitis B and C, are not yet practised.

Cameroon as is the case with many other developing countries does not yet have coordinated blood transfusion services at the national level. The use of family blood donors is still widespread and accounts for more than 75% of blood bags collected. Meanwhile, it is worth noting that transfusion safety was recently the subject of institutional reforms, notably the enactment of a law on blood transfusion and a Government decision rendering the management of blood exposure accidents and rapes free of charge. Since 2004, significant progress in the implementation of activities of the “Transfusion Safety Programme” translated into the training or retraining of personnel in transfusion quality assurance and the setting up of donor associations.

The government intends to continue these efforts within the framework of the 2006-2010 NSP by ensuring the implementation of this new policy in all the structures concerned.

I-3.1. Specific objective

1. To increase the percentage of transfused blood units screened for HIV².

I-3.2. Strategies

- Strengthening of the political and legal framework regulating transfusion safety in Cameroon including the putting in place of a national programme for the recruitment and retention of voluntary donors;

- The putting in place and/or capacity building of blood transfusion structures and establishments (NBTC, PBTC, Blood banks) and any person involved in the transfusion chain;

- Strengthening quality assurance in blood transfusion (injection safety and hospital hygiene etc.);

- Management of blood exposure accidents and blood products;

- Promotion of the transfusion economy.

I-4. PREVENTION AND MANAGEMENT OF STIs

The national STI control policy was developed and disseminated during the 2000-2005 national strategic plan. The implementation of this phase was recently transferred to the Department of Disease Control. The actions taken for improved management of STI/HIV/AIDS activities include:

² A study shall be carried out in 2006 to obtain the percentage of referral and make it possible to determine a target in the domain of transfusion safety
(1) developing and making available to healthcare structures the standardized management algorithm according to the syndrome approach;

(2) the training of close to 500 health personnel for district health structures in the use of the said algorithm, follow-up of frequent control missions for the improvement of output;

(3) the distribution of essential drugs for the syndrome management of STIs and the reduction of the prices of these drugs.

The results of the 2004 DHS III on the management of STIs call for more action though prevalence is relatively low (5% among women and 3% among men). Among women and men, note has been taken that it is among the respondents who more often had high-risk sexual intercourse that the “declared” prevalence of STIs and/or symptoms is highest. About half of the people having admitted that they had STI or symptoms went to a health institution or consulted a health worker for counselling or treatment.

The new 2006-2010 NSP intends to lay emphasis on the inclusion of STIs in the basic health package of reproductive health services and in youth socio-educational centres and to target high-risk groups mainly.

1-4.1 Specific Objectives

1. To reduce the prevalence STIs by 50% within the overall population and notably in high-risk groups.

I-4.2. Strategies

- Inclusion STI control in the basic package of reproductive health services;
- Inclusion of the prevention and management of STIs in youth socio-educational centres;
- Adequate STI syndrome management at the level of 2 278 health units during the first three years of the plan;
- Strengthening of aetiological management of STIs in 143 district hospitals and 10 Provincial Hospitals during the first 2 years of the plan;
- Provision of quality services to some target groups: 28 000 truck drivers in 18 sites of the project by 2010; 100 000 STI patients out of 5 vulnerable groups (sectors of defence, Police, educated and uneducated youths, students, prison staff/prisoners);
- Availability and accessibility of drugs, laboratory reagents and accessories;
- Epidemiological surveillance and monitoring of germ resistance;
I-5. SCALING UP HIV PREVENTION AMONG THE YOUTHS

Prevention programmes targeting youths were implemented in the past few years through new strategies focusing on school and out-of-school environments. Out of school, one can cite the introduction of testing campaigns within the framework of the national youth day; “Holidays without AIDS” during which 10 600 youths were tested, and proximity community-centred campaigns thanks to mobile units reaching the population in their localities.

In addition to more comprehensive communication for behaviour change activities, the youths in educational milieus benefited from actions carried out within the specific framework of the education sector strategy. The actions carried out with the support of partners include the organisation of education days on STIs/HIV/AIDS; the introduction of family life education modules within the framework of education programmes; the implementation of the programme "Participation and Development of Adolescents“ in 6 provinces, 56 schools and 22 out-of-school sites; and the “NO AIDS” caravan.

However, ongoing programmes in this sector are all in the pilot phase with a national coverage of less than 5%. This low coverage probably contributed to the alarming situation among the youths and notably young women as revealed by the DHSIII survey and presented in the chapter “Overview of the epidemic at the end of the 2006-2010 National Strategic Plan.” This new plan aims to extend the coverage and reorient the strategies based on lessons learnt in the past few years: special emphasis will be laid on the appropriation, by youths, of HIV/AIDS programmes, the teaching of life skills in schools and in out-of-school settings through influential communication media and the provision of quality health care services suitable for the youths.

I-5.1. Overall Objective

To reduce by at least 50% the percentage of youths aged 15 to 24 years infected with the HIV by 2010.

I-5.2. Specific objectives

1. To reduce by 50% the percentage of youths aged 15 to 24 years, who admitted that they had sexual intercourse before reaching the age of 15 (for girls and 18 years for boys) by 2010.

2. To increase from 47% to 90% and from 57% to 95% the percentage of women and men aged 15 to 24 years, who admitted that they used a condom during the last high-risk sexual intercourse by 2010.
I-5.3. Strategies

- Appropriation by associations of youths notably young women in HIV/AIDS and STI control programmes;
- Development and dissemination of “life skills” among youths and promotion of abstinence, fidelity and correct condom use;
- Awareness, information and training of parents, traditional and religious communities and health workers for youth guidance notably the girl child in safe and responsible sexual life;
- Development of actions for the defence of the rights and dignity of vulnerable youths;
- Introduction in formal education and in youth training structures of an education programme in sexual and reproductive life adapted to all the levels of learning and for all ages;
- Strengthening the provision and quality of health care services adapted to the youth notably the young woman and the promotion of counselling and testing among youths;
- Promotion and strengthening of Income generating activities among youths out of school.
- Promotion and setting up of youths’ guidance structures.

1-6. PREVENTION OF NEW INFECTIONS AMONG WOMEN

The 2000/2005 National Strategic Plan did not sufficiently consider the vulnerability of the Cameroonian woman, who was less affected by the epidemic towards the end of the 90s. The situation however became alarming as shown by the results of the DHS III on HIV/AIDS prevalence rate among women (6.8%), which varies from one province to the other and according to marital status. This high rate is partly related to high-risk sexual behaviour, namely multiple partners, casual and/or paid sexual relations, which is not systematically protected. For further information on the situation of the epidemic, see Chapter I. Overview of the epidemic at the end of the 2000/2005 National Strategic Plan.

Given that the woman is now at the centre of the HIV/AIDS epidemic, the new plan intends to pay particular attention to her through strategies aiming to improve their status and adapted to the geographical and matrimonial situation. Rural households managed by women shall be given particular support due to a certain number of obstacles blocking their access to education, treatment and gainful employment.

Overall Objective

To reduce, by at least 50%, the percentage of HIV-infected women by 2010.
Specific objectives

1. To increase from 10% to at least 75% the percentage of women who know their HIV status by 2010.

2. To increase from 41% to 80% the percentage of women who indicate they used a condom during the last high-risk sexual relations by 2010.

3. To increase from 22% and from 36% to 80% the percentage of women aged respectively from 20 to 24 and from 25 to 29 years who indicate they used a condom during the last high-risk sexual relations by 2010.

4. To reduce from 10.5% to less than 2% the percentage of women who have more than one high-risk partner within a year by 2010.

II.1.2.3. Strategies

- Appropriation by women of the HIV/AIDS control programmes and promotion of female leadership in the reduction of their own vulnerability;
- Development of the actions of defence of women’s rights and dignity;
- Development, production and dissemination of awareness messages specific to women;
- Reinforcement of the provision and quality of health services adapted to women;
- Promotion and reinforcement of income generating activities.

1–7. SCALING UP PREVENTION OF MOTHER-TO-CHILD HIV TRANSMISSION

To reduce the risk of mother-to-child transmission, Cameroon put in place a PMCT programme in 2000. After a pilot phase which clearly showed its feasibility and efficiency, the programme, within three years, was extended to the ten provinces of the country and is already established in 400 sites covering 64% of health districts.

Services are provided in public, private, religious and lay sectors. Moreover, the intervention of massive awareness targeting pregnant women and others of childbearing age is carried out through associations, NGOs and opinion leaders in rural and urban areas. Counselling and voluntary screening occupies a key place with an average acceptability rate of 70% and pregnant women tested HIV-positive are referred, after birth, to specialized structures that handle such cases.

Some health structures began putting in place PMCT+ which comprises the management of the mother-child couple and the partner. In 2004, about 60,000 women were tested (2005 CTG/NACC annual report). Within the
purview of this programme, Nevirapine is distributed free of charge. Since October 2004 the bi- prophylaxis (associating Nevirapine to AZT or AZT to Lamivudine) has been proposed and the PMCT services are included in the basic reproductive health package. In terms of national coverage, about 12% of pregnant women in urban areas (as against 4% only in rural areas) benefited from counselling and voluntary testing during pregnancy with results made available in 2005. The national coverage of PMCT services is estimated at 9% for the same period.

Given the HIV prevalence rate among pregnant women – slightly above the overall HIV prevalence among women (7.4% as against 6.8%) – the government of Cameroon intends to continue and scale up these efforts within the purview of this new plan. An extension, integration and overall management policy following the district approach will be defined. A communication strategy for greater use of maternal and infant health services will also be defined.

1-7.1. Overall Objective

To reduce, by at least 50%, the percentage of HIV-infected babies born of mothers who are also infected by the virus by 2010.

1-7.2. Specific Objectives

1. To increase, from 12% and 4% in the urban and rural areas to 70% and 60% respectively, the percentage of pregnant women that underwent counselling and HIV testing during their pre-natal consultations by 2010.
2. To increase, from 9% to 90%, the percentage of HIV-positive pregnant women who received ARV (Antiretroviral drugs) prophylaxis by 2010.
3. To reduce, from 64% to 30%, the percentage of women practising mixed feeding.

1-7.3. Strategies

- Availability of quality PMCT services in all health units in Cameroon;
- Integration of PMCT/reproductive health/EPI in all health units by 2008;
- Comprehensive management (medical, psychological, nutritional) of infected women, children and their families;
- Strengthening of the procurement system and subsidies for major inputs for PMCT (testing and ARV);
- Intensification of PMCT management according to the district approach throughout the country;
- Communication for behaviour change and social mobilisation for greater use of maternal and infant health services (PNC, delivery in health structures);
- Sensitisation of HIV-positive women with a view to preventing unwanted pregnancies.
II. STRATEGIC DIRECTION 2: TOWARDS UNIVERSAL ACCESS TO TREATMENT AND CARE FOR CHILDREN AND ADULTS LIVING WITH HIV/AIDS
To free the future African generations from AIDS, by significantly reducing the number of HIV infections and by working with the WHO, UNAIDS and other international organisations in the drawing up and implementation of a comprehensive AIDS prevention, treatment and management programme in order to obtain, as far as possible, a universal access to treatment by 2010 for all those in need. The limited capacities of health systems constitute a major obstacle to the pursuit of this objective, and we shall work with our partners in Africa for its remedy, notably by contributing to the implementation of reliable and reasonable systems for the management of the supply chain and the notification of diseases. We shall equally work with these organisations in such a way that all children orphaned by or vulnerable on account of AIDS or other pandemics get adequate support. We shall try hard to meet the financial needs pertaining to HIV/AIDS, notably by the replenishment, this year, of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and by working actively with the local actors to apply the “Three principles” in all the countries.”

**G8 Summit, Gleneagles, July 6-8 2005**

The clinical and psychosocial management of PLWHA and the treatment of opportunistic infections witnessed significant progress thanks to a voluntarist policy made possible by the body of rules reproduced in appendix 1.

Within the framework of this policy, a vast programme for the building of institutional and personnel capacity was launched and today, a pool of 1960 personnel including community relay workers, has been trained in the various fields, with priority given to the following: management of Paediatric AIDS cases; management of PLWHA and treatment of Opportunistic Infections (OI); psychosocial management of PLWHA; assistance in view of compliance with ARV treatments; conducting clinical follow-up examinations of PLWHA.

The prices of monthly ARV treatment were reduced considerably from 600,000 in 2001 to FCFA 3,000-7,000 per month and per patient in 2005.

In addition to this spectacular reduction of the monthly cost of the ARV triple-drug therapy, it should be emphasized that children aged 0 to 15 years and economically vulnerable (poor) persons are given free treatment. Treatment against tuberculosis, one of the most recurrent opportunistic infections, and "cotrimoxazole" prophylaxis are equally free.
Graph 3: Evolution of monthly ARV treatment in Cameroon between 2001 and 2005

This drop/NON PAYMENT brought about effective increase in consumption, which is promising: the National Essential Drugs Procurement Centre (CENAME) ran out of stocks just for the first half of the year 2005, the equivalent of the yearly ARV consumption throughout 2004 (see Graph 3).

Graph 4: Number of triple-drug therapies that left CENAME during the first half of 2001 to 2005
This voluntarist policy of universalising access to ARV largely contributed to increase access to treatment, and especially to extend it to the underprivileged social classes, in such a way that in September 2005, there were 13,503 PLWHA (18% of the 75,750 eligible PLWHA) under treatment (600 in 2001). Management of PLWHA is done in 24 Approved Treatment Centres (ACT) at the provincial level and in 25 Management Units (MU) already operational out of 63 set up at the level of district hospitals.

However, in spite of progress made towards improving access of adults to antiretroviral treatment, paediatric management remains embryonic. In 2005, it was estimated that less than 3% (427/15,000) of children living with HIV received treatment (the National PMCT Programme review report of 2005).

The challenges to be met in order to achieve total coverage of needs by 2010 were taken into account in this new plan which lays emphasis on:

1. voluntarist policy of voluntary counselling and testing (VCT);
2. financial accessibility of patients to the pre-therapeutic assessments;
3. quality care provision and decentralized interventions;
4. reinforcement of health system in terms of human resources and equipment;
5. putting in place a solid follow-up and evaluation system.

II-1. Overall objective

To increase the percentage of adults and children infected by HIV, who are still alive and who are on antiretroviral therapy, 12 months after the beginning of treatment³.

II-2. Specific objectives

1. To render ARV treatment accessible to at least 75% of eligible adults.
2. To render ARV treatment accessible to 100% of eligible children.
3. To improve the compliance of at least 80% of PLWHA on ARV treatment.
4. To render prophylactic treatment of OI accessible to 75% of eligible cases (meningeal cryptococcoses, cerebral toxoplasmosis, oesophageal candidiasis, etc).
5. To reduce malnutrition among 50% of PLWHA suffering from nutritional deficiencies.

³ A new database was put in place at the end of 2005 for the follow-up of patients under triple-drug therapy. This makes it possible to measure this impact indicator
II-3. Strategies

For objective 1: Accessibility of ARV treatment to adults

- Continuation of decentralization of the overall management of HIV/AIDS through the district approach;
- Development/extension of "gateways": STI, DTC, PMCT, medical consultation services for the recruitment of new PLWHA needing treatment;
- Integration of HIV/AIDS and Tuberculosis activities;
- Reinforcement of the system of ARV supply and quality control of ARV and related products (OI drugs, reagents, etc.);
- Provision of subsidies for ARV treatment and clinical tests and 100 % free management of the poor eligible for ARV;
- Extension of the range of ARV treatments

For objective 2: Accessibility of ARV treatment to children

- Availability and reduction of the costs of early diagnosis of HIV infection among children born of HIV-positive mothers
- Diversification of gateways for the recruitment and follow-up of HIV-positive children
- Continuation of the reduction of cost/freeness of ARV treatment and of clinical tests

For objective 3: Improvement of compliance

- Counselling for compliance with treatments
- Nutritional support for patients and their families
- Involvement of families and communities

For objective 4: Accessibility to OI prophylactic treatment

- Continuity of subsidy to treatment
- Extension of the range of free OI treatment

For objective 5: Reduction of malnutrition

- Instituting a national policy of nutritional management of PLWHA
- Paying particular attention to nutritional counselling and to adequate nutritional management within the framework of this national policy
Moreover, support strategies shall be adopted to achieve the specific and general goals. The focus will be on:

1. Building human resource capacities (doctors, social workers, pharmacy assistants, nurses, nutritionists, association officials...) on the management of AIDS patients;
2. Reinforcing technical level of treatment centres (renovation, equipment, etc.)
3. Strengthening the ARV resistance monitoring system.
III. STRATEGIC DIRECTION 3: PROTECTION AND SUPPORT TO ORPHANS AND VULNERABLE CHILDREN (OVC)
Support to orphans and vulnerable children is taken into account in the sector policies of the Ministries of Public Health, Social Affairs, and in the action plans of some national and international NGOs.

Some major interventions have already been recorded in this domain, notably, the psychosocial support project to OVC based in the towns of Bamenda, Douala and Ngaoundere, carried out by MINAS with the support of the French Cooperation Mission and UNICEF. This project targets 2,850 OVC by the end of 2005 and 10,000 by the end of 2007. The NGOs, Plan Cameroon and Care Cameroon, still in collaboration with the Ministry of Social Affairs with financing from the Global Fund, carry out actions within this framework relating primarily to medical and nutritional support to OVC. This partnership made it possible to cover three provinces in 2004 (East, Centre and Northwest) and three others in 2005 (Littoral, Southwest and Far North). In September 2005, the number of orphans and vulnerable children in these zones of intervention who already received medical and nutritional support was estimated at 3,500.

However, this progress remains insufficient as evidenced by recent estimates with regard to the number of AIDS orphans in Cameroon in 2005 (122,670). This new plan aims to extend coverage of the OVC prevention and care programs while tackling the problem on the following three fronts: (1) access to basic services; (2) instituting a legal protection system; (3) building the capacities of families and communities.

III-1. Overall objective

To improve, by 10%, the socio-economic status of families with OVC by 2010

III-2. Specific objectives

1. To increase, at least by 20% per year, the percentage of OVC whose families received external support for their child (support related to health, hygiene, education, nutrition or psychosocial support).

2. To reduce to less than 10%, the percentage of OVC in specialized institutions.

III-3. Strategies

- Drawing up an integrated framework of OVC access to the basic social services (health, education, nutrition, psychosocial support);
- Instituting a functional legal system of OVC protection;
- Empowering civil society organizations in OVC management;

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4 Source : 2005 NACC
- Building institutional capacities for protection and holistic management of OVC (families, governmental and non-governmental social structures, etc.);
- Support to community initiatives in OVC management.
IV. STRATEGIC DIRECTION 4:

APPROPRIATION OF CONTROL BY THE ACTORS
IV-1. SCALING UP HIV/AIDS CONTROL AT WORK PLACES

IV-1.1. PUBLIC SECTOR

The evaluation of the 2000/2005 NSP indicates that 19 ministries of the public sector received financial support for elaboration of sector plans. Some of them received funds to carry out priority activities, while waiting for the finalization of their plans. Contrary to predictions, the great majority of these partners expected funds from the NACC, whereas each one of them ought to mobilize own funds or look for it from the traditional partners to implement their plan. The results of the interventions at this level are not very visible.

Within the framework of the new plan, the foundation of the NACC/public sector partnership shall be reoriented in order to limit it to coordination and follow-up / evaluation. Advocacy action shall be carried out with the aim of integrating into the letter/circular relating to the preparation of the state budget, instructions for the provision, in each ministry, of a specific budget heading for HIV/AIDS control representing at least 1% of the envelope envisaged. In the same way, an advocacy shall be carried out at the level of the National Assembly so that it takes care of the endorsement of a budget heading within the envelope of each public sector.

Nevertheless, some priority public sectors shall be given particular attention, with regard to the strong vulnerability of their personnel to HIV/AIDS. This concerns the sectors of education with its 105,000 personnel; prison administration with its 3,200 personnel and 22,000 prisoners; defence with 29,000 military and civilian personnel, as well as the police with 16,200 personnel.

IV-1.1.1. Overall objective

To reduce, by at least by 50%, the percentage of persons infected by HIV in the various sectors\(^5\) and offer adequate management to infected persons by 2010.

IV-1.1.2. Specific objectives

Prison administration

1. To see to it that at least 90% of the 3,200 personnel and 22,000 prisoners to adopt less risky sexual behaviour.

2. To see to it that at least 95% of the 3,200 personnel and 22,000 prisoners know their HIV status.

\(^5\) Prison administration, education, police, defence
3. To ensure medical, nutritional and psychosocial management of all PLWHA in the 10 main prisons.

**Education**

1. To see to it that 105,000 personnel in the Education Sector adopt less risky sex behaviour.

2. To see to it that at least 105,000 teachers know their HIV status.

3. To ensure the medical and psychosocial management of all PLWHA in the 10 medical and school inspectorates.

**Police**

1. To see to it that the 16,200 personnel in the police sector adopt less risky sex behaviour.

2. To see to it that at least 97,200 persons of the police sector and their families know their HIV status.

3. To ensure availability of the medical and psychosocial management of PLWHA in the 5 Police health facilities.

**Defence**

1. To see to it that 29,000 military and civilian personnel of the defence sector adopt less risky sex behaviour.

2. To see to it that at least 203,000 persons of the defence sector and their families know their HIV status.

3. To ensure medical and psychosocial management of PLWHA in the 12 military health facilities.

**Health**

1. To see to it that 10,000 personnel in the health sector adopt less risky sex behaviour.

2. To see to it at least 10,000 personnel in the health sector know their HIV status.
3. To ensure medical and psychosocial management of all PLWHA in health facilities.

**Other public sectors**

1. To see to it that 90% of the personnel in the other public sectors adopt less risky sex behaviour

2. To see to it that at least 90% of the personnel of the other public sectors and their families know HIV status.

**IV-1.1.3. Strategies**

**For all the sectors**

- Instituting, in the various sectors, an awareness, information and training programme on HIV/AIDS adapted to various audiences;
- Building capacities of health and health facility personnel in various milieus and welfare structures;
- Setting up/Extending units for comprehensive management (medical, psychosocial, nutritional) of HIV/AIDS in the various milieus;
- Promoting research in the sectors.

**Education**

- Involving Parent/Teacher Associations (PTA), students and trade unions of teachers in HIV/AIDS control;
- Integrating AIDS control lessons in the curricula of schools, colleges and universities.

**Defence**

- Installing automatic condom dispensers in barracks

**Health**

- Promotion of voluntary screening for health personnel;
- Training health personnel in the techniques of universal precautions;
- Involvement of trade unions of health personnel in HIV/AIDS control.

**Tourism**

- Installing automatic condom dispensers; initiating HIV screening campaign, etc).
Economy and Finance

- Carrying out advocacy for allocation and provision of adequate financial resources for HIV/AIDS control.

National Assembly

- Carrying out advocacy for the enactment of laws in favour of HIV/AIDS control;
- Carrying out advocacy for the effective involvement of members of Parliament in their constituencies.

Women

The Women’s sector is responsible for the priority domain “Prevention of new infections among women”.

IV-1.2. PRIVATE ENTERPRISES

The involvement of enterprises in the national response falls primarily within the framework of the public/private partnership against HIV/AIDS. The aim of this partnership is to create an environment conducive to the prevention and overall management of HIV/AIDS infections in work environment, through the:

1. Implementation of awareness and training programmes for workers,
2. Facilitation of the creation of HIV/AIDS control units in enterprises and
3. Mobilisation of adequate resources for their operation. This partnership concerns all private enterprises, with priority given to those whose workforce are above 100 people and to those whose activities contribute to the spread of HIV/AIDS.

About 52 HIV/AIDS control conventions have been signed since 2003 between NACC and private sector enterprises financed by NACC to the tune of 59% and 41% by the companies themselves.

In view of assessing the results obtained in this domain, an investigation was carried out in a representative sample of 29 enterprises eligible to the public/private partnership within the framework of the 2005 Cameroon UNGASS report. This study made it possible to highlight the following facts:

1. A great majority of the sampled organizations have specific programmes and/or prevention actions against HIV/AIDS;
2. In about half of these structures, one person is responsible for the follow-up and management of such actions. This situation is certainly due to the fact that AIDS is henceforth a reality lived by all the
organisations: as a matter of fact, there are cases of HIV-positive persons in close to 80% of the sampled organizations.

The prevention of HIV/AIDS-related stigma and discrimination is essentially implicit in nature and non-speak. Thus, in most of the cases, knowing the HIV/AIDS status of personnel “is not a requirement”. In effect, testing is not obligatory though persons interviewed admitted that ignorance of HIV status constitutes a risk of transmission within the enterprise, insofar as sexual relationship between staff members is a reality.

Tolerance by managers with respect to infected persons was however noted in about half of the sample. This tolerance concerns the shortcomings related to professional obligations (absences and delays); reduction of workload; maintaining, right to the end, persons infected within the organisation’s workforce; and discrete but effective medical care.

These data will make it possible for the government to redirect partnership and to better target interventions in the private sector.

**IV-1.2.1. Overall objective**

To reduce, by at least 50%, the percentage of HIV infected persons in the private companies and provide adequate care to persons infected by 2010.

**IV-1.2.2. Specific objectives**

1. To see to it that workers of the private sector, their families as well as the surrounding population know their HIV status;

2. To reduce high-risk behaviour within private enterprises, agro industries and surrounding populations.

3. To ensure medical and psychosocial management of all PLWHA in health facilities.

**IV-1.2.3. Strategies**

- Instituting and generalising an awareness, information and training programme on HIV/AIDS for workers of the private sector, their families and the surrounding population;
- Building capacities of health personnel and social workers in enterprises;
- Setting up/Extending units for comprehensive HIV/AIDS management in enterprise health facilities;
- Effective involvement of workers’ trade unions in HIV/AIDS control within the enterprises;
- Contracting with privates enterprises;
Building capacities of company workers as regards planning, implementation and monitoring/evaluation of AIDS control interventions;
Promoting co-financing of AIDS control activities within enterprises.

**IV-1.3. INFORMAL SECTOR**

The informal sector, which often accounts for approximately 85% of the workers without job security, did not receive any particular support.

**IV-1.3.1. Overall objective**

To reduce, by at least 50%, the percentage of HIV infected persons among workers of the informal sector by 2010.

**IV-1.3.2. Specific objectives**

1. To reduce the high-risk behaviour among workers of the informal sector.

2. To see to it that 80% of those who frequent high-risk milieus (bars, night clubs, hotels, inns, beaches) use condoms in a correct and systematic manner during casual sexual relationship by 2010.

3. To encourage workers of the informal sector and their families to know their HIV status.

**IV-1.3.3. Strategies**

- Setting up of a general framework for HIV/AIDS control in the informal sector;
- Instituting and generalising an awareness, information and training programme on HIV/AIDS for workers of the informal sector and their families;
- Building the capacities of trade unions and associations of the informal sector as regards HIV/AIDS control;
- Facilitating access of workers of the informal sector and their families to prevention and management structures;
- Providing support to AIDS control initiatives in the sector (CBC, testing, automatic condom dispensers, application of regulations governing the operation of high-risk milieus).
**IV-1.4. INVOLVEMENT OF KEY ACTORS IN HIV/AIDS CONTROL**

To achieve, by the year 2010, the three overall objectives that Cameroon set for herself, namely, the reduction of prevalence, universal access to treatment for PLWHA and reduction of the overall impact of HIV/AIDS on OVC, it is necessary to enlist the involvement of a certain number of key actors. By appropriating HIV/AIDS control, actors who are as influential as PLWHA, communities, religious organizations, opinion leaders and the media can make a difference and contribute largely to the success of the national programme.

**IV-1.4.1. PERSONS LIVING WITH HIV (PLWHA)**

The evaluation of NACP shows that the rights of PLWHA are not always respected. They continue to experience negative reactions within families and the society. This indicates that there is a shortcoming in the strategies to sensitise the general population.

**Strategies**

- Promoting the coming together of Persons Living With HIV in Associations and structured Networks;
- Regular updating of a directory of all Associations of PLWHA in Cameroon and their networks (areas of intervention, numbers, area of intervention, etc.);
- Setting up of at least an association of PLWHA per council and its adherence to a national association network;
- Increasing the number of representatives of PLWHA, their Associations and Networks at the various levels of the fight against the pandemic (NACC, CCM, SHC, NBTC, PACC, PTG, institutional, decision-making and operational);
- Institution of a legal framework, which supports promotion of the rights and obligations of PLWHA;
- Ensuring legal management of at least 500 needy PLWHA;
- Building the capacities of all associations of PLWHA and their networks.

**IV-1.4.2. COMMUNITIES**

It is obvious with regard to DHS III statistics that local response which made it possible to implement the Community Action Plans of more than 6,300 Communities at the grassroots level, favoured the dissemination of AIDS
control messages in all the regions of Cameroon. However, data on the knowledge of HIV status and sexual behaviours call for action:

- 3.7% of women and 7.7% of men living in the rural milieu know their HIV status.
- 24% of women in the rural milieu use a condom during high-risk sexual relations (47% in urban area)
- 39% of the men in rural milieu use a condom during high-risk sexual relations (62.6% in urban area)

The challenge today for local response is to maintain the level of awareness reached while starting a true behaviour change vis-à-vis HIV/AIDS. The challenge remains the awareness of HIV status, enhancement of systematic counselling and voluntary testing during pregnancy in the rural milieu, and adequate condom use during high-risk sexual relationships.

**Strategies**

- Setting up in each of the 339 councils of Cameroon of multi-sector and functional Local AIDS Control Committees;
- Identification in each of the 1,500 health areas of Cameroon of an AIDS control organization approved by the Local AIDS Control Committee entrusted with specifications;
- Conduct of advocacy for community leaders, sensitising and building capacities of the communities as regards planning, access result-centred management, monitoring and evaluation;
- Support for community AIDS control initiatives;
- Contracting with community organizations;
- Systematic inclusion of HIV/AIDS control in the planning and implementation of development projects at all levels;
- Targeting AIDS control actions on vulnerable groups at the local level;
- Taking into account the socio-cultural aspect of HIV/AIDS control at the local level

**IV-1.4.3. RELIGIOUS ORGANIZATIONS**

According to DHS III, the rate of HIV infection varies only very little between the Catholics, Protestants, Moslems and followers of the new religions. However, prevalence is definitely lower among Moslem women (4.9 %) than Catholics (7.6%), Protestant (7.7%) and especially among women belonging to the new religions (10.7 %).

Religious organizations therefore have to play a key role in the "inoculation of the social vaccine against HIV/AIDS," which is education among the people concerned. Already involved in the implementation of the preceding plan, religious organizations, considering the feminisation of the epidemic and its impact on the young people, must redouble efforts so that the
principles of abstinence and fidelity should be appropriated and implemented by their faithfuls.

Strategies

- Conduct of advocacy for leaders of various religious denominations;
- Contracting AIDS control actions;
- Building capacity of the religious leaders on HIV/AIDS problems;
- Integration of AIDS control messages in all sermons;
- Conduct of awareness, education and testing activities in all religious organizations of Cameroon;
- Involvement religious organizations in holistic PLWHA and OVC management activities;
- Building the capacity of religious organizations in the management of AIDS control programmes.

IV-1.4.4. OPINION LEADERS (Political, Traditional, Administrative, Tradi-practitioner, healers, soothsayer, etc.)

Beliefs will determine if HIV and AIDS are considered in terms of sin and punishment. If HIV infection is considered as inevitable, the ensuing fatalism can impede prevention. If it is considered that AIDS is caused by witchcraft, by the disregard of sexual taboos or by poverty, then it is unlikely that biomedical prevention and treatment strategies should be adopted or have a real impact. Moreover, blame, stigma, shame and discrimination slow down efficient prevention and treatment. For instance, the idea that HIV infection is the result of an “immoral” behaviour limits compassion and understanding. If it is believed that HIV infection is primarily the outcome of personal choices, this implies that factors, which determine the range of existing options, were not taken into account. The ability which societies will have to absorb the various beliefs and values shall greatly impact on the future course of AIDS.

After the enormous progress made in understanding HIV/AIDS, it is important to involve behaviour change vectors, which, for the greater part of our population, are traditional leaders.

Strategies

- Seeing to it that 100% of associations of opinion leaders are involved in HIV/AIDS control
- Providing support for 5,000 opinion leaders’ initiatives on AIDS control by 2010
- Conduct of advocacy for opinion leaders in view in their involvement in and follow-up of AIDS control actions
- Support for opinion leaders’ initiatives in AIDS control;
- Contracting with opinion leaders’ associations (Tradi-practitioners, mayors, traditional rulers, etc.);
- Consideration of the socio-cultural aspect of HIV/AIDS control through an effective involvement of opinion leaders.

**IV-1.4.5. THE MEDIA**

The evaluation of the 2000/2005 NSP highlighted a multiplicity of promising media initiatives with respect to HIV/AIDS control, especially the involvement of community radios. The quality of tools developed and broadcast and a manifest will to use all occasions to develop communication actions for behaviour change were documented as good practices. Collaboration between some partners for the production and broadcast of sensitisation tools is evident.

However, communication strategies do not effectively take into consideration cultural barriers and existing local potential. They do not use traditional channels, past experiences in community radio to better organise and carry out advocacy activities for policy makers and to sensitize the general population and especially the various high-risk groups, notably young girls and boys.

The evaluation proposes to improve communication strategies at the peripheral level by utilizing local potential in traditional communication especially with regard to the social classes living in the Cameroon hinterland. These strategies, combined with the use of community radios, can make a difference.

**Strategies**

- Capacity building for 100 national and 300 local media in sensitising the public on HIV/AIDS from 2006-2010 at all levels;
- Broadcast on a permanent basis of messages focussed on HIV/AIDS in 100 national and 300 local press organs;
- Adaptation and translation of awareness messages in all the written local languages of Cameroon;
- Contracting the broadcast of micro programmes and HIV/AIDS/STI messages with press organs (Radio, TV, print media)
- Provision of the media with all scientific updates on HIV/AIDS
- Setting up of a media observatory on HIV/AIDS
- Assessment, on a monthly basis, of media production on HIV/AIDS from 2006 to 2010.
V. STRATEGIC DIRECTION 5: PROMOTING RESEARCH AND EPIDEMIOLOGICAL SURVEILLANCE
V-1. EPIDEMIOLOGICAL SURVEILLANCE

V-1-1. Overall objective

To produce reliable epidemiological data on HIV/AIDS, STIs as well as opportunistic infections in order to ensure the proper implementation of the 2006-2010 strategic plan.

V-1-2. Specific objectives

1. To determine behavioural trends of the active population and risk groups, on a biannual basis;
2. To assess, on a biannual basis, the risk of HIV transmission amongst pregnant women, risk groups and the active population through the production of reliable data;
3. To assess, on a biannual basis, susceptibility to antibiotics (ATB), germs responsible for various STIs;
4. To measure, on a biannual basis, the burden of the epidemic on health services;
5. To include AIDS and STI case notification in the National Health Information System (NHIS);
6. To monitor resistance to ARV within the scope of the network of public health laboratories involved in HIV/AIDS control activities;
7. To monitor the microbiological, epidemiological and parasitological trends of opportunistic infections within the scope of the network of laboratories;
8. To improve the coordination and implementation of epidemiological surveillance activities;
9. To monitor incidence amongst blood donors and pregnant women.

V-1-3. Strategies

- Monitoring of behaviour with respect to HIV/AIDS through cross-sectional surveys;
- Monitoring of HIV infection (prevalence and incidence) through seroprevalence surveys;
- Monitoring of susceptibility of germs, STIs and OI to (antibiotic) drugs, and HIV resistance to ARV through surveys;
- Reinforcement of AIDS/STIs monitoring by integrating systematic AIDS and STI notification in the health information system;
- Monitoring of STIs through surveys on prevalence of major STIs;
- Capacity building for structures and staff involved in epidemiological surveillance at all levels of the health system.

**V-2. RESEARCH**

**V-2.1. Overall objective**

To promote and apply research results in HIV/AIDS control during the period 2006 – 2010.

**V-2.2. Specific objectives**

1. To regularly update the file of HIV/AIDS research activities carried out in Cameroon;
2. To put in place a tool for disseminating and popularising results of research carried out in Cameroon;
3. To facilitate the implementation of the Strategic Vaccine Research Plan;
4. To build the capacity of managers of the operations research programme and promote its use as a NACP management tool;
5. To carry out an operations research to ensure the most effective involvement of tradipractitioners in the HIV/AIDS control;
6. To put in place a mechanism for the development of the traditional therapeutic heritage in the treatment of HIV/AIDS and opportunistic diseases.

**V-2.3. Strategies**

- Reinforcement of coordination between actors involved in research;
- Capacity building for actors;
- Capacity building for research structures;
- Drawing up a platform for collaboration between tradipractitioners and doctors;
- Development of results of previous research;
- Carrying out an inventory of traditional products declared active against HIV;
- Putting in place a simplified protocol for evaluating traditional HIV/AIDS-related pharmacopoeia;
- Capacity building for tradipractitioners in the adoption of safe practices in the preparation, packaging and preservation of phyto drugs;
- Protection of the knowledge of tradipractitioners and listed effective products identified;
- Popularisation of products with proven properties HIV/AIDS control;
- Setting up of a process for the regeneration and sustainable management of selected plant species.
VI STRATEGIC DIRECTION 6:
REINFORCING COORDINATION, PARTNERSHIP, MONITORING AND EVALUATION
Following the evaluation of the 2000-2005 Strategic Plan, it was realized that the NACP suffered from highly inadequate internal and external coordination by the CTG at the central level and the PTG at the provincial level. This inadequacy translates into ineffective internal communication between the various hierarchies and centralization of information as a whole, and then by inadequate collaboration and coordination between partners, leaving the management of AIDS control activities to the initiative of each actor.

VI-1. COORDINATION AND MANAGEMENT

VI-1.1. Overall objective

To encourage actors involved in AIDS control to work together and improve the efficiency of their actions.

VI-1.2. Specific objectives

1. To improve the functioning of all existing coordination structures at the central and local levels;
2. To put in place a common planning tool at central and local levels;
3. To pool at least 80% of available funds for HIV/AIDS control;
4. To improve the common framework for the implementation of interventions at central and local levels;
5. To ensure performance at each position by staff posted to the programme.
6. To set up a mechanism that guarantees good governance at all levels;
7. To set up a funds disbursement system adapted to the emergency of HIV/AIDS.

VI-1.3. Strategy

Implementation of the principles of evaluation, harmonization, alignment and result-centred management.
VI-2. MONITORING AND EVALUATION SYSTEM

A sound monitoring and evaluation (M-E) system will allow for regular evaluation of execution of the new 2006-2010 National Strategic Plan (NSP) and lead to necessary changes to ensure efficient and effective use of resources. The overall strategic information obtained through such a system will also promote decision-making for improved management of HIV/AIDS control and the judicious allocation of resources.

This chapter comprises two parts: the first part briefly describes the national plan for the collection, processing, analysis and use of information for the next five years, the detailed annual plan included in operational plans; the second part reviews the new structures of the monitoring and evaluation system that will make for the implementation of this plan.

VI-2.1. PLAN FOR THE COLLECTION, PROCESSING, ANALYSIS AND USE OF DATA FOR 2006-2010

VI-2.1.1. Data-collection Plan

Monitoring activities: A certain number of key monitoring indicators were decided on at the national level for the implementation of the NSP. They are presented in the table below according to level and field of activity: (1) impact indicators, (2) knowledge and behaviour indicators, (3) national programme indicators, and (4) indicators on national actions and commitments. This list takes into account indicators defined at the international level, namely those resulting from the declaration of commitment on HIV/AIDS of the United Nations General Assembly Special Session (UNGASS) held from 25 to 27 June 2001, and those of the Millennium Development Goals. The table also indicates the objectives, which Cameroon sets for some indicators by 2010, the periodicity as well as methods of collection of information. For a complete list of indicators of the process and product decided on at the national and local levels, consult the 2006 operational plan.

National programme data: The collection of primary data constitutes the hub of the national programme monitoring system. Given that the evaluation of previous NSP revealed the flaws of the current routine information system, a decision was taken to reinforce it by laying emphasis on:
(1) data standardization at the local level to enable the aggregation of information at the national level and
(2) regular supervisory and control missions to obtain reliable data enabling decision-making.

The general system will comprise two basic elements at the level of the execution structures, namely:

- Collection of primary data in the field by the field actors of each execution structure;
- Regular conduct of primary synthesis at the level of the execution structure.

First level execution structures will ensure daily collection of data recorded in media such as daily consultation registers for health establishments, progress reports for other sectors and notebooks for individual actors like teachers, trainers, etc.

A Field Guide (containing data collection forms) will be sent to all execution structures. However, it should be noted that the collection of primary data indicator should not be limited to those proposed in the Guide. Each execution structure may choose additional indicators to monitor the implementation of its project. Nevertheless, the Field Guide indicates the compulsory national indicators to be followed and reported by all actors.

**Impact data:** It is important to note that the capacity of provincial laboratories for the screening investigation of STIs and HIV/AIDS was built during the last few years. Tools for second-generation HIV surveillance were also developed and personnel at provincial and central levels trained on how to set up such a system. These assets notwithstanding, insufficient planning and management of monitoring activities, lack of involvement of technical structures authorized to carry out monitoring activities and absence of reports by trained personnel were noted.

The new plan seeks to remedy this situation beginning with the transfer of sero-surveillance management to the Department of Disease Control (DDC) and to the Division of Health Operations Research (DHOR). Emphasis will also be laid on reinforcing sentinel sites and resuming the regular collection of data, thus supplementing information obtained from DHS III investigations.
The epidemiological surveillance system – henceforth included in the National Health Information System – will be based on three data sources:

(1) regular AIDS and STI notification;

(2) regular serosurveillance of HIV infection and AIDS surveillance in sentinel sites;

(3) DHS+ investigation every 4 -5 years.

**Evaluation activities:** Given that the evaluation and operations research component was not adequately developed during the last five years, the decision was taken to work out a plan in consultation with the Monitoring and Evaluation Working Group (MEWG) based on priorities identified in this new National Health Programme. Among the activities to be carried out, special attention will be paid to regular evaluation of various components of the national programme (an annual priority area) and operations research. The latter will enable Government to make necessary changes in the strategies developed for the priority areas for more effective results.

**VI-2.1.2. Processing, computerization and analysis of data**

**Processing:** The Country Response Information System (CRIS) designed by UNAIDS will be used to store all strategic information put together by the Planning, Monitoring Evaluation Unit of the CTG/NACC. This system will be updated periodically on the basis of reports prepared by execution and coordination structures. To ensure that it is functioning at central and local levels, the CTG team already trained will undertake to organize in 2006 – with the support of UNAIDS – the training of a user group made up of monitoring and evaluation officials and sector focal points at the decentralised level.

**Analysis:** The analysis or interpretation of results will make it possible to draw conclusions in terms of performance and propose actions to be carried out. Analysis will be carried out at different degrees according to level.

At the level of execution structures, analysis will consist in making a progress report of activities while highlighting deviations with respect to programming and their reasons, as well as problems encountered. This analysis is also expected to lead to suggestions for improving performance. At the level of coordinating structures, analysis will consist in making a consolidated balance sheet of reports of execution structures by indicating progress towards attaining their planning objectives. The PS/NACC, as a national coordinating structure, through
its units and sections, will highlight the contribution of each sector to the achievement of national objectives. Executing and coordinating structures will receive the support of resource persons in data processing and analysis.

**Information use:** This important aspect of the monitoring and evaluation system was also not sufficiently utilized during the last few years. A communication strategy will therefore be developed in consultation with the Communication for behaviour change Section, enabling the dissemination of strategic information through several communication channels identified according to target audiences (see box). Adequate resources will be allocated to enable the regular dissemination of information on HIV/AIDS.

The PS/NACC will be responsible for disseminating results of analyses to decision makers, partners, execution structures and the population in collaboration with decentralized coordination structures. Each coordination structure head will ensure feedback of analysis results so that those in charge of data-collection can perceive its usefulness.

<table>
<thead>
<tr>
<th>Channels and frameworks for concerted action for the dissemination of information</th>
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<tbody>
<tr>
<td>• Quarterly SHC session</td>
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<td>• Evaluation and planning workshops</td>
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<td>• Supervisory missions</td>
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<td>• Advocacy Meetings</td>
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<tr>
<td>• Bi-annual meetings of the partners forum</td>
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<tr>
<td>• Bi-annual review of the NACC “against AIDS”</td>
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<tr>
<td>• Annual PS/NACC report</td>
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<td>• Bi-annual UNGASS report</td>
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<tr>
<td>• Reports of studies and research</td>
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<td>• Press and media</td>
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<tr>
<td>• NACC/UNAIDS website</td>
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</table>

The **bi-annual review of the NACC “against AIDS”** will treat information on HIV/ AIDS in Cameroon and in the world and give an account of the activities of NACC, its Permanent Secretariat, its field actors as well as technical and financial partners involved in HIV/AIDS control. It will give more visibility on the national HIV/AIDS control policy and shall be distributed to the public, technical, and financial partners free of
charge. It shall serve as a medium for the communication policy of the PS/NACC and be used for awareness purposes.

The annual PS/NACC report will aim to present the state of execution of the NSP according to sector of intervention. It shall be drawn up by the PS/NACC and shall be intended for all actors involved in AIDS control in Cameroon.

The bi-annual UNGASS report mainly presents the indicators adopted in the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS held in June 2001. These indicators are the result of the national and international action programme for HIV/AIDS control upon which the governments of 189 countries embarked.

The NACC/UNAIDS Web site, developed in collaboration with UNAIDS, will provide information on HIV/AIDS control in Cameroon to the (national and international) public, all actors involved HIV/AIDS control, and technical and financial partners.

**VI-2.2. MONITORING AND EVALUATION STRUCTURES IN CAMEROON**

This section reviews the main actors involved in monitoring and evaluation activities and describes the HIV/AIDS information chain from the local to the central level.

The main actors involved in monitoring and evaluation activities at the central and local levels are presented in the diagram below:
<table>
<thead>
<tr>
<th>Structures/Institutions</th>
<th>Levels</th>
<th>Role</th>
</tr>
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<tbody>
<tr>
<td>- M-E Section of CTG/NACC</td>
<td>National Coordination Structures</td>
<td>Synthesis</td>
</tr>
<tr>
<td>- Technical coordination structures of the other ministries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- M-E Working Group</td>
<td>Decentralized Coordination Structures</td>
<td>Synthesis</td>
</tr>
<tr>
<td>- SHC</td>
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<tr>
<td>- PTG</td>
<td>Execution structures</td>
<td>Primary Synthesis</td>
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<tr>
<td>- PDPH</td>
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<tr>
<td>- CFP</td>
<td></td>
<td>Primary Data</td>
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<tr>
<td>- HD</td>
<td></td>
<td></td>
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<tr>
<td>- NGOs/Associations</td>
<td></td>
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<tr>
<td>- LACC</td>
<td>Field Actors</td>
<td></td>
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<tr>
<td>- IHC</td>
<td></td>
<td></td>
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<tr>
<td>- NGOs/Associations</td>
<td></td>
<td></td>
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<tr>
<td>- Educators, health personnel, trainers, etc.</td>
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</table>

At the central level, the Monitoring Evaluation and Planning Section of the CTG/NACC is responsible for monitoring and evaluating the national HIV/AIDS programme. Its role is to ensure that all activities carried out by actors involved in HIV/AIDS control are in line with a single national monitoring-evaluation system. Given its key role, it was decided that it should be reinforced in 2006 to ensure effective coordination of activities. The team will comprise experts in public health, strategy, social sciences and information technology. Coordination will be facilitated through regular meetings of the Monitoring-Evaluation Working Group (see below). The main tasks of the unit will include:

- Preparing the annual Monitoring and Evaluation Plan;
- Controlling the quality and deadlines of monitoring and evaluation products;
• Coordinating evaluation activities earmarked for the coming years and promoting the self-evaluation of sector actors;
• Analysing data collected by actors and preparing the various PS reports for programme planning and reorientation;
• Ensuring the dissemination and circulation of information on HIV/AIDS.

With regard to the execution of M-E activities, the section will resort to external sources such as universities, research institutes, consultants, accounting firms, etc.

At the provincial level, a small monitoring-evaluation unit will be set up to enable the Coordinator to effectively monitor, coordinate and manage the programme.

The mission of the M-E Working Group, comprising monitoring and evaluation experts from Government, bilateral agencies, the UN system, academic institutions and civil society, will be to advise the section on aspects relating to monitoring and evaluation during the implementation of monitoring-evaluation action plans. It will meet each month, and as need arises, to give advice and review the achievements of the programme.

**Information chain:** Experience in Cameroon and other countries have shown the importance of investing in the development of a mechanism that makes for an efficient information chain that is independent of the sources of financing. Special efforts will be therefore be made to ensure that the activities of most actors are included in the national information system, through an efficient coordination mechanism set up by CTG/NACC.

Within the scope of this new system, each execution or coordination structure will submit its report to the appropriate hierarchical level according to the information chain (see diagram above). These reports will be submitted each quarter to the CTG/NACC for the follow-up of indicators and review of progress made and major trends.

With regard to financial results, the section in charge of administration and finance will draw up quarterly, bi-annual and annual financial reports of funds allocated for HIV/AIDS control at the national level based on the reports of financial partners and the financial statements of the various sectors. These reports will be submitted to the
monitoring, evaluation and planning section for incorporation in the balance sheet of the NSP.
### Appendix 1: Ministerial decisions regulating access to ARV

<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>OBJECTIVE</th>
</tr>
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<tbody>
<tr>
<td>Decision No. 190/D/MSP/CAB of 30 March 2001</td>
<td>To designate approved treatment centres</td>
</tr>
<tr>
<td>Circular No. D36-37/C/MSP/CAB of 13 August 2003</td>
<td>To prescribe the standardisation of ARV treatment protocols for PLWHA</td>
</tr>
<tr>
<td>Decision No. 455/D/MSP/DLM/SD-VIH-IST/PCC/BPECM of 22 September 2004</td>
<td>To designate, as a first phase, management units for PLWHA using ARV in Cameroon</td>
</tr>
<tr>
<td>Decision No. 455/D/MSP/CAB of 22 September 2004</td>
<td><strong>To set up and organize management units for PLWHA using ARV in Cameroon</strong></td>
</tr>
<tr>
<td>Decision No. 468/MSP/CAB of 24 September 2004</td>
<td>To set the rates of first-line protocols of management units for PLWHA through ARV therapy in Cameroon</td>
</tr>
<tr>
<td>Decision No. 468 B/MSP/CAB of 24 September 2004</td>
<td>To set new rates for first-line protocols of management units for PLWHA through ARV, drugs against OI and laboratory follow-up examinations</td>
</tr>
<tr>
<td>Decision No. 8/MSP/CAB of 14 January 2005</td>
<td>To fix subsidised package of laboratory follow-up examinations for PLWHA under ARV in Cameroon</td>
</tr>
<tr>
<td>Decision No. 9/MSP/CAB of 14 January 2005</td>
<td>To supplement the provisions of Decision No. 468 B/MSP/CAB of 24 September 2004 to fix the rates of first-line protocols of management units for PLWHA through ARV, drugs against OI and laboratory follow-up examinations in Cameroon.</td>
</tr>
<tr>
<td>Service Note D 31-47 03 Mai 2005</td>
<td>To designate structures attached to care units</td>
</tr>
</tbody>
</table>
## ANNEX 2: National UNGASS key indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Period</th>
<th>Method of data collection</th>
</tr>
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<tbody>
<tr>
<td><strong>National actions and commitments</strong></td>
<td></td>
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<tr>
<td><strong>Expenditure</strong></td>
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<tr>
<td><strong>Formulation of policies and implementation</strong></td>
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<tr>
<td>2. Composite index of national policies</td>
<td>Annual</td>
<td>Review of documents and discussion with key informants</td>
</tr>
<tr>
<td>Domains covered: prevention, treatment and support, human rights, participation of civil society, monitoring and evaluation</td>
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<tr>
<td>Target groups: persons living with HIV/AIDS, women, youth, orphaned children and risk population</td>
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<tr>
<td><strong>National programme: education, employment, health, care for orphans and children at risk</strong></td>
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<tr>
<td>3. % of schools in which teachers have been provided an HIV-related training based on psychosocial aptitudes and who have taught them during the last school year</td>
<td>Annual</td>
<td>Surveys in schools Monitoring of programme implementation Review of educative programmes</td>
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<tr>
<td>4. % of large-scale organizations/companies which have implemented HIV/AIDS response policies and programmes at the workplace</td>
<td>Annual</td>
<td>Monitoring of programme implementation</td>
</tr>
<tr>
<td>5. Percentage of correctly diagnosed patients with STIs attended to in care centres, treated and counselled at the suitable moment.</td>
<td>Annual</td>
<td>Monitoring of programme implementation /surveys in health centres</td>
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<tr>
<td>6. % of HIV-infected pregnant women who received complete ARV treatment to reduce the risk of MCT</td>
<td>Annual</td>
<td>Monitoring of programmes</td>
</tr>
<tr>
<td>7. % of persons whose HIV infection is at an advanced stage who receive ARV association</td>
<td>Annual</td>
<td>Monitoring of programme implementation</td>
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<tr>
<td><strong>Cameroon objective: 75% ARV access to ARV by 2010</strong></td>
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<tr>
<td>8. % of orphaned children and other children at risk living in homes receiving free external assistance for their care</td>
<td>Annual</td>
<td>Monitoring of programmes and estimates</td>
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<tr>
<td>Knowledge and behaviour (specific objectives)</td>
<td>Annual</td>
<td>Monitoring of programmes</td>
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<tr>
<td>10. % of youth aged 15 to 24 possessing accurate knowledge on how to prevent the risk of HIV transmission through sex and who reject major misconceptions concerning the transmission of the virus.</td>
<td>Every 4 to 5 years</td>
<td>DHS population survey</td>
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<tr>
<td><strong>Cameroon’s objective by 2010: 95% by 2010</strong></td>
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<tr>
<td><strong>UNGASS objective: 95% by 2010</strong></td>
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<tr>
<td>11. Percentage of young women aged 15 to 24 who had sexual relations before 15 (18 years for men)</td>
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<tr>
<td><strong>Cameroon’s objective: reduction by 50%</strong></td>
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<tr>
<td>12. Percentage of youth aged between 15 and 24 who claim to have used the condom during the last sexual relations with a casual sexual partner, out of wedlock.</td>
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<tr>
<td><strong>Cameroon’s objective by 2010: from 14% to 90% among women and 57% to 95% among men.</strong></td>
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<tr>
<td>Impact (overall objectives)</td>
<td>Annual</td>
<td>HIV sentinel monitoring survey</td>
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<tr>
<td>13. Percentage of HIV-infected youth aged 15 to 24</td>
<td>4 to 5 years</td>
<td>Population survey</td>
</tr>
<tr>
<td><strong>Cameroon’s objective by 2010: reduction by at least 50%</strong></td>
<td></td>
<td>Monitoring of programmes</td>
</tr>
<tr>
<td><strong>UNGASS objective by 2010: reduction by 25%</strong></td>
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<td>14. Percentage of HIV-infected adults and children still alive and under ARV treatment 12 months after the outbreak of the disease</td>
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<td>15. Percentage of HIV-infected new-born babies with HIV-infected mothers</td>
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<tr>
<td><strong>Cameroon’s objective by 2010: reduction by 50%</strong></td>
<td></td>
<td>Estimates based on programme coverage</td>
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<tr>
<td><strong>UNGASS by 2010: reduction by 50%</strong></td>
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