

HIV/AIDS law and policy in Cameroon: Overview and challenges

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Summary

From the detection of the first HIV/AIDS case in Cameroon, the government's action has been swift in addressing the situation through defined policies. Although the initial stages were fraught with problems and proved wary, more policies were adopted against the background of instituting a well defined programme and institutional framework to control the pandemic. This article identifies HIV/AIDS strategies in Cameroon from a policy perspective, as well as legal considerations, with the aid of judicial experience elsewhere in Africa, most particularly, the Southern African Development Community (SADC) region. It catalogues and examines some of the major challenges confronting or likely to confront HIV/AIDS policies in Cameroon. In as much as the collaborative involvement of various actors — public, private and the civil society — is necessary to boost the implementation of national strategies, collaborative research, accountability and an appropriate legal framework, amongst others, are vital to give meaningful impetus to control HIV/AIDS in Cameroon.

1 Introduction

[T]he HIV pandemic . . . has been described as 'an incomprehensible calamity' It has ' . . . claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy'.¹

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¹ *Minister of Health & Others v Treatment Action Campaign & Others* 2002 5 SA 721 (CC) para 1.

Le VIH et le SIDA affaiblissent le tissu social et économique. Au-delà des tragédies humaines, le VIH et le SIDA conduisent à la dégradation de la santé et de l'éducation des citoyens . . . Ils peuvent aussi avoir un impact sur l'environnement de l'investissement et les flux des capitaux étrangers.²

The quotes above are neither the words of alarmists, nor are they wilful pronouncements of anxiety aimed at provoking fear and uncertainty. They are simply perspectives wholly in keeping with the gruesome image befittingly depicting a contemporary predicament — HIV/AIDS — and its consequences that have beset humankind. AIDS has killed more than 20 million people since the first cases were diagnosed in 1981, including 2,9 million people in 2003 alone.³ There are currently about 40 million people around the world living with the HIV/AIDS. Sub-Saharan Africa is the worst hit region, alone accounting for 70% of all persons living with HIV. Most African states seem to have accepted this fact in contemporary political rhetoric, but they do not take the required efforts and measures to control the pandemic until the death toll has become disastrous, particularly that of people of working age — the group hardest hit. African states have warily, but steadily, in the last few years, come to realise and accept the consequences of their passive and nonchalant attitude and have joined the international community in the fight against this scourge as a top priority. Indeed, a scourge that 'has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy'.⁴

The HIV/AIDS pandemic is one of the major challenges presently facing the African continent; alongside the scourge of political instability, war and poverty. African states face huge and incessant demands in relation to access to education, land, housing, health care, food, water and social security. Yet, there is this 'unprecedented killer' that is 'claiming more lives than all wars and disasters'.⁵ Although this picture may resemble a hackneyed HIV/AIDS-lamentation scenario, it is no exaggeration. HIV/AIDS therefore is not only a health concern, but equally a human rights concern.⁶ The African Commission on Human and Peoples' Rights (African Commission) has declared that 'the HIV/AIDS pandemic is a human rights issue which is a threat against humanity'.⁷

² *Coalitions des Entreprises Contre le VIH/SIDA 'Lignes directrices pour le développement de coalitions des entreprises contre le VIH/SIDA'* (2004) 1 (HIV and AIDS weaken the social and economic fabric. Beyond the tragedies of humankind, HIV and AIDS engender the health and educational degradation of citizens . . . They may also impact on the investment climate and foreign capital flows (my translation)).

³ M Cichocki 'World AIDS Day 2004, Women, girls, HIV & AIDS' <http://aids.about.com/od/womensresources/a/aidsday.htm> (accessed 31 March 2006).

⁴ n 1 above, para 1.

⁵ Nelson Mandela, addressing a crowd of music fans in December 2003 at a concert organised to support the fight against HIV/AIDS.

⁶ See S Gumede 'HIV/AIDS and human rights: The role of the African Commission on Human and Peoples' Rights' (2004) 4 *African Human Rights Law Journal* 184-189.

⁷ Resolution on the HIV/AIDS Pandemic — Threat Against Human Rights and Humanity (2001) para 1.

In Cameroon, however, the most significant infectious and parasitous pathology remains malaria, accounting for 43% of deaths of infants below five years, followed by serious respiratory infections that account for 27% of deaths of children of the same age group.⁸ To these may be added new forms of deadly and costly diseases that are common to countries in epidemiological transition, such as heart disease, metabolic diseases, trauma and cancers. Yet, the infection rate of HIV/AIDS is alarming.

2 Brief survey of the evolution of HIV seroprevalence in Cameroon

The first HIV/AIDS case in Cameroon was diagnosed and reported in 1985. Since then, the seroprevalence has been increasing systematically, making it the most dreadful disease in Cameroon which has attracted the most intense eradication efforts over the last few years. Indeed, in one decade, 1987 to 1998,⁹ the seroprevalence rose from 0,5% to 7,2% in the general population.¹⁰ In 2000, it rose further to 11% and in 2002 it was almost stagnant, as there was only a slight increase of 0,8% over the last figure, placing the country among the 25 most infected countries in the world.¹¹ Between 1985, the year of the first diagnosed case of HIV/AIDS infection in Cameroon, and 2002, the disease accounted for 53 000 deaths, 210 000 orphans and one million people living with the disease.¹² In the first 13 years of the disease in Cameroon, the infection rate was multiplied by 14, suggesting that about one out of 14 Cameroonians that were sexually active was infected with the virus,¹³ and in 15 years (1987 to 2002), there was a 23-fold increase, the age group between 20 and 39 years. The vulnerable classes within this group are: military personnel (15%); commercial sex workers (25% to 45%); and truck drivers (18%).¹⁴ Other communities with a high infection rate include those living along major high-ways and populations along the Chad-Cameroon pipeline.¹⁵ On the

⁸ *Programme National de Lutte Contre le SIDA (PNLCS) 'Plan stratégique de lutte contre le SIDA au Cameroun 2000-2005'* Yaoundé (October 2000) 5.

⁹ The seroprevalence during the in-between period of that decade was as follows: 1,04% in 1988; 2% in 1992; 3% in 1994; 5% in 1995; and 5.5% in 1996.

¹⁰ In 1986, there were 21 diagnosed cases; 6 843 new cases were officially registered in 1998, bringing the number to 20 419. See PNLCS (n 8 above) 9.

¹¹ *Comité National de Lutte Contre le SIDA (CNLS) 'Le Cameroun face au VIH-SIDA: une réponse ambitieuse, multisectorielle et décentralisée'* 8.

¹² See CNLS (1994) *'La riposte du Cameroun au VIH-SIDA: l'expérience de la prise en charge par les ARV'* ColoriSprint — Cameroon 6. See also National AIDS Control Committee (NACC) *'Impact of HIV/AIDS in Cameroon'* Yaoundé (2000).

¹³ PNLCS (n 8 above) 5.

¹⁴ As above.

¹⁵ CNLS (n 12 above) 8.

whole, women are more vulnerable, with statistics showing three infected women for every two infected men.¹⁶ The 2004 estimates indicate that there has been a considerable decrease in HIV seroprevalence in the active sexual population, estimated at 5,6% by the country's Health Minister in October,¹⁷ and by an undated Technical Explanatory Note on the Third Cameroon Demographic and Health Survey (DHS-III). The Permanent Secretariat of the Central Technical Group of the National AIDS Control Committee (NACC) notes (as proof of the reliability of the findings) in the Technical Explanatory Note that the figures obtained from a representative national sample 'reflect the real situation of HIV seroprevalence in [the] country' and that it 'falls within the range of the estimations for Cameroon by UNAIDS' (that is 6,9%, understood as between 4,8% and 9,8%).

3 The framework of HIV/AIDS policy

Efforts at staging an efficient barrier against the increase of the HIV/AIDS pandemic are essentially national, that is, government's elaboration and implementation of policies, and the putting into place of appropriate infrastructures, particularly institutions, to implement such policies. But, experience in this domain has shown that, generally, governments cannot, alone, formulate and implement such policies, as well as conceive appropriate institutions without aid — financial, material, logistic or otherwise. The international community in this regard heralds aid. The international community has championed financial assistance and has set guidelines to orientate national policy on the subject.

3.1 The legal framework

3.1.1 General considerations

Cameroon has acceded to the major international and regional human rights treaties and instruments. At the international level, they include the International Covenant on Economic, Social and Cultural Rights (CESCR) of 1966 (ratified by Cameroon on 24 June 1984); the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979 (ratified on 23 August, 1994); and the Convention on the Rights of the Child (CRC) of 1989 (ratified on 11 January 1993). At the regional level, they include the African Charter on Human and Peoples' Rights (African Charter) of 1981 (ratified on 20 June 1989) and

¹⁶ As above.

¹⁷ E Tumanjong 'Health survey shows AIDS rate of 5.5 percent in Cameroon' *Associated Press* <http://www.aegis.org/news/ads/2004/ADOY2225.htm> (accessed 31 March 2006).

the African Charter on the Rights and the Welfare of the Child (African Children's Charter) of 1990 (ratified on 5 September 1996).

At the time the first HIV cases were diagnosed, many of these instruments, including CESC, were already in force. They contain provisions relating to health generally, but not to any specific illness(es). Even instruments that succeeded the pandemic and which deal with protection of the rights of specific vulnerable groups of persons such as children (CRC, African Children's Charter), failed to mention HIV/AIDS. Both the Guidelines on State Reporting to the African Committee on the Rights and Welfare of the Child and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol) have barely mentioned HIV/AIDS. Nonetheless, the question is, why specifically mention HIV/AIDS when, at the time of entry into force of the first human rights treaties, there existed (and there still exists) diseases of concern such as malaria, poliomyelitis, tuberculosis, and so on, which could have as well, from the foregoing logic, warranted specific mention. The bottom line, however, is that any aspect of health, including HIV/AIDS, should invariably be read into the right to health provisions in those instruments espousing a minimum standard. Generally, this is referred to as the *best or highest attainable state of physical and mental health*, whatever the purport attributed to this standard.

Also, there are relevant international and regional resolutions, declarations and guidelines on HIV/AIDS, established principally by United Nations (UN) organs and the then Organization of African Unity (OAU), now the African Union (AU), as the case may be.

A remark should be made here on the effect of duly ratified treaties and international agreements entered into by Cameroon. Once they are ratified and published, they 'override national laws, provided, however, that the other party implements the said treaty or agreement'.¹⁸ In other words, they have a direct effect once ratified. The implication is that, since there is no specific bill of rights in Cameroon containing the fundamental rights of citizens, international treaties and agreements have the full force of legislation in the country (in their relevant domains and/or provisions), as long as they have received the fiat of ratification. It is true that in international law, the binding nature of declarations, decisions, guidelines, and such, as compared to duly ratified treaty obligations, remains doubtful. Viljoen strikes the balance as follows:¹⁹

Obligations of states derive from regional and sub-regional levels. These are now discussed, with particular reference to the rights-based approach, and keeping the distinction between moral (non-binding or persuasive) and legal

¹⁸ Art 45 1996 Constitution.

¹⁹ F Viljoen 'The obligation of governments in a time of HIV/AIDS' (2005) 15 *Interights Bulletin* 47.

(or binding) obligations in mind. Moral obligations derive from membership in international organisations and from declarations, statements, policies and ethical guidelines. Legal obligations, taking the form of treaties, laws and decisions, bind states under international law.

At the national level, the legal framework is scanty as there are neither specific legislation nor enough persuasive jurisprudence of national courts in the domain of HIV/AIDS. In this article, ample reference is made to the jurisprudence of foreign courts, especially those of the Southern African region where the culture of litigation in the domain is far more advanced, in order to enhance the understanding, conceiving and shaping of the future national legal framework for HIV/AIDS policies in Cameroon.

The legal framework can thus be examined from three perspectives: international, regional and national, in that order.

3.1.2 The international framework

Cameroon has acceded to a good number of international human rights instruments.²⁰ Those reviewed above, part of the relevant human treaties ratified by and applicable in Cameroon, invariably contain, directly or indirectly, health standards which state parties must ensure for all citizens through relevant measures. These standards should obviously be read in relation to HIV/AIDS, as well as any other illnesses or health conditions. Thus, the obligations under article 25(1) of the Universal Declaration, article 12(1) of CESC, article 24 of CRC and article 12(1) of CEDAW relating to health must be read in relation to HIV/AIDS against the background of the 'highest attainable standard of physical and mental health' (particularly contained in CESC).

The UN Joint Programme on HIV/AIDS (UNAIDS) and the Office of the United Nations High Commissioner for Human Rights adopted International Guidelines on HIV/AIDS and Human Rights, 1996 (Guidelines)²¹ during a joint consultative meeting of these organs. The Guidelines focus on three crucial areas, including the protection of public health.²² The sixth of the Millennium Goals of the UN General Assembly focuses on the need to specifically control HIV/AIDS and malaria pandemics, along with others.

²⁰ See C Heyns & P Tavernier (eds) *Recueil juridique des droits de l'homme en Afrique* (2002) 5.

²¹ Second International Consultation on HIV/AIDS and Human Rights (Geneva, 23-25 September 1996), Report of the Secretary-General E/CN.4/1997/37 Annex 1.

²² Improvement of governmental capacity in relation to its responsibility for multi-sector co-ordination and accountability, reform of laws and legal support services focusing on anti-discrimination, protection of public health, and improvement of the status of women, children and marginalised groups, and increased private sector and community participation, including capacity building and responsibility of civil society .

3.1.3 Regional

The main instrument at the regional level in Africa that guarantees the right to health is the African Charter, which is binding on all AU member states. It has been remarked above that, although the African Charter does not specifically refer to HIV/AIDS or any other pandemic on the continent, even those which existed before its coming into force, such as malaria and tuberculosis, should be read into the ambit of the relevant provision(s) relating to health. The African Charter enjoins state parties in articles 16(1) and (2) to ensure that citizens 'enjoy the best attainable state of physical and mental health' and 'to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick'. In the case of *Purohit and Moore v The Gambia*,²³ the African Commission recognised the fact that millions of African people do not enjoy the right to better physical and mental health because of poverty. Yet, the Commission expressed the desire to read in article 16 of the African Charter, the obligation on state parties to take concrete and selective measures while fully drawing the benefits of available resources, in order to ensure the full realisation of the right to health without discrimination.²⁴

The then OAU adopted a number of resolutions specifically addressing HIV/AIDS. The first in line is the Tunis Declaration on AIDS and the Child in Africa of June 1994. Through this Declaration, member states proclaimed, amongst other issues, their commitment to '[e]laborate a "national policy framework" to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues'.²⁵

The second is the Resolution on Regular Reporting of the Implementation Status of OAU Declarations on HIV/AIDS in Africa, adopted by the Assembly of the 32nd ordinary session of Heads of State and Government. At this meeting, African leaders were urged to implement those declarations and resolutions that were adopted in the past with specific reference to the Tunis Declaration. The third, a special summit of African Heads of State and Government in 2001, was devoted to HIV/AIDS. This resulted in the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases of April 2001²⁶ and the Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases to implement the principles in the Abuja

²³ Communication No 241/2001, decided at the 33rd ordinary session of the African Commission, May 2003, 16th Annual Activity Report.

²⁴ See para 84 of the decision.

²⁵ Att6/Decl.1 (XXX) para II(1).

²⁶ http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (accessed 17 February 2006).

Declaration.²⁷ The Abuja Declaration translated the very lofty perceptions and ambitions of the Heads of State and Government concerning HIV/AIDS through an intimate conviction which they linked to the continent's agenda for poverty reduction. The Heads of State and Government reiterated their strong commitment to address the exceptional challenges of HIV/AIDS, tuberculosis and related infectious diseases by setting aside 15% of annual budgets to improve health.²⁸

It is important to note that the Heads of State and Government realised the massive impact of HIV/AIDS on the African continent, which remains the most hit region in the world by the pandemic. As such, they considered HIV/AIDS as a 'state of emergency in the continent'.²⁹ To this end, the Heads of State and Government vowed to discard tariff and economic barriers to HIV/AIDS funding and related activities, to place the fight against the pandemic at the forefront and of highest priority in national development plans through a comprehensive multi-sector strategy that involves all government development sectors, as well as a broad mobilisation of all levels of society, including the private sector, civil society, trade unions, religious organisations, schools, youths, media, persons living with HIV/AIDS (PLWHA), and so on.³⁰

3.1.4 The national framework

The national legal framework for HIV/AIDS control in Cameroon is very weak as it is still very dependent on international and regional frameworks. The main texts governing the HIV/AIDS policy in Cameroon are those creating the various institutions in charge of implementing HIV/AIDS policy and those governing specific issues, such as decisions relating to the reduction of the cost of anti-retroviral (ARV) drugs and the decentralisation of ARV treatment at the local level. The only law that refers to HIV/AIDS is the 2003 law regulating blood transfusion.³¹ However, there are important texts on HIV/AIDS in the pipeline. This is the case, for example, of a draft law on the rights and obligations of PLWHA. In addition, government has entered into agreements with some pharmaceutical companies for the production of generic drugs at a much lower cost. In the absence of specific HIV/AIDS legislation, the reading of relevant provisos in the revised Constitution of 1996, the Penal Code and case law, may help indicate the possible juristic approaches to HIV/AIDS in Cameroon.

²⁷ The Abuja Framework conceptualises the commitments made in the Abuja Declaration into strategies. These are available at <http://www.onusida-aoc.org/Eng/Abuja%20Declaration.html> (accessed 1 March 2006).

²⁸ Abuja Declaration (n 27 above) para 26.

²⁹ n 27 above, para 22.

³⁰ n 27 above, para 23.

³¹ Law 2003/014 of 22 December 2003 regulating blood transfusion.

The Constitution

As seen above, there is no specific national instrument, such as a bill of rights, that contains and guarantees fundamental rights in Cameroon. The revised 1996 Constitution clearly gives full effect to the fundamental rights and freedoms spelt out in the Universal Declaration, the African Charter and all duly ratified international conventions relating thereto. Unlike the constitutions of some other African countries that clearly and extensively deal with fundamental rights under separate relevant headings,³² the Cameroon Constitution merely recalls the country's commitment to the relevant human rights instruments and specifically mentions some, such as the right to life, the right to work and the right to property. While there may be doubts and a divergence in views as to the persuasiveness and binding power of the preamble of a constitution in comparison with the constitutional provisions themselves, article 65 of the 1996 Constitution unequivocally discards such debate. This article provides that '[t]he Preamble shall be part and parcel of this Constitution'. The obvious implication is that the Preamble is no less than any part of, or provision in, the Constitution; the fundamental rights expressly or impliedly referred to in the Preamble have the same status and effect as individual provisions in the body of the Constitution.

The Preamble to the Cameroonian Constitution guarantees fundamental rights; equal rights and obligations for all persons. It provides that the state should provide 'conditions necessary for their development' and as such, 'every person has a right to life, to physical and moral integrity'. The Preamble does not specifically mention the right to health as it does with other socio-economic rights, such as the right to work or the right to property. However, the right to health may be read into the spirit and broad ambit of the right to life. The upshot is that PLWHA, as much as any other patients or persons afflicted by health problems, have full constitutional rights to be catered for by the state.

The Penal Code

The criminal law of Cameroon does not address the issue of harmful HIV-related behaviour. In the absence of specific anti-HIV/AIDS legislation, the criminal law of Cameroon, as embodied in the Cameroon Penal Code (Penal Code) and other legislation, could have been helpful in incorporating offences relating to criminal conduct amounting to the spread of the disease. However, as a law conceived in the late 1960s, a time when the most criminally reprehensible conduct of the present

³² Eg, Part 1 of the Constitution of the Republic of Mali of 25 February 1992; Part II of the revised Constitution of the Republic of Senegal of 2 March 1998; Part I of the Constitution of the Republic of Gabon of 26 March 1991 (as amended in 2005).

time was not foreseen, it can only be interpreted to make provision, by analogy, for HIV/AIDS-related criminal conduct. This is what effectively happened in the case of *Ministère Public et Noumen Théophile c Kinding Yango Huguette*.³³

In this case, the respondent, Miss Kinding, a nurse and ex-mistress of the accuser, Mr Noumen Théophile, was accused of wilfully injecting two of Théophile's children with HIV. It was established that she acted out of revenge because she could not accept the unilateral termination of their relationship by the accuser and because she had discovered that she was HIV positive, while he was not. She took the two children, Tchantchou Noumen, a secondary school form two student, and his younger brother, Ngachine Noumen, a primary school pupil, away during school hours under false pretences and injected them with a 'red substance' on 24 January 2002. She testified under oath that she injected the children with the BCG and VAT vaccines. The results of the first HIV test carried out a few days after the incident (28 and 29 January) proved negative. However, the results of a second test carried out 90 days later confirmed that Tchantchou Noumen was HIV positive by inoculation and that the same fate had befallen Ngachine Noumen, who additionally was infected with the hepatitis B virus. The Nkong-samba High Court found the accused guilty of capital murder under sections 276(1)(a) and (b) of the Penal Code. That is, committing murder after premeditation and by poisoning. Consequently, she was condemned to death by firing squad. The Court also ordered the accused to pay costs and acceded to the prosecution's prayer to order a symbolic franc as damages.

In the absence of express provisions in the Penal Code relating to HIV/AIDS-related offences, inferences may be drawn from other relevant provisions which have a bearing on the activity that amounted to the contamination of the two children. In fact, facing a legal void, the defence team took this approach and invoked sections of the Penal Code. But the question is whether their reading of the sections they invoked was simply misguided or whether it was a strategy to help their case and obtain a lighter sentence for the accused. However, the Court's own analogy, drawn from existing sections, was logical given the facts of the case. Both positions will be examined briefly to show how relevant provisions of the Penal Code may be used effectively used to criminally punish HIV/AIDS-related conduct.

The defence based its case on sections 228 and 285 of the Penal Code, read together with section 74. The latter section deals with the mental element of a crime, *mens rea* or intention. Section 228 deals

³³ *Tribunal de Grand Instance de Nkongsamba*, judgment 113/crim of 25 June 2003. See generally R Djila 'VIH/SIDA — contamination par inoculation de substances sanguines infectées — tentative de meurtre avec préméditation par empoisonnement' (2005) 60 *Juridique Périodique* 25-30.

with dangerous activities and states in subsection (2)(c) that 'whoever, rashly and in a manner liable to cause harm to any person . . . administers any drug or other substance' will be punished with imprisonment from six days to six months. For its part, section 285 deals with constructive force. It provides in paragraph (b) that 'the administration of any substance harmful to health' is deemed to use force on one's person. Both sections refer to 'harm' as the consequence of the accused's conduct. 'Harm' simply means physical or other injury or damage³⁴ and thus excludes death. The question is whether injecting someone with the HIV virus amounts to 'harm'. If one were to refuse referring to seropositive persons as 'patients' because they have not yet reached AIDS, the impression one is left with is that such persons suffer no harm even if wilfully contaminated. The reasoning here being that they are only carriers of the disease, at least at the time of incubation, before full-blown AIDS. Indeed, the defence in the *Noumen case* contended that since the victims of the accused's act would neither immediately develop AIDS nor immediately die from the consequences of the injected HIV virus if they received the appropriate drugs, the accused's act could be likened to harmful conduct under sections 228(2)(c) and 285(b). This was an attempt to reduce HIV to a transitory and treatable disease or liken it to a situation of a non-lethal overdose, thereby weakening the mental element of intention. However, knowing that the virus is lethal in its long-term effect, the Court refused to concede that the accused's act had simply occasioned harm. Moreover, the concept of intention means that the offender desires his act, foresees and intends the consequences thereof, and acts so that they may happen. The motive of the crime (in the sense of the ultimate objective of committing the offence) is generally irrelevant, save as evidence pertaining to identity or *mens rea*.³⁵ There is no doubt that the accused's act was intended and that she desired the consequences thereof — death. The occurrence of death in HIV infection takes years, such that on distracted reasoning, one may clearly suggest there is a break in the chain of causation between the act and the consequence, coupled with the fact that the death results rather from opportunistic infections than the HIV virus itself.

The Court was left with two alternatives: either to indict under section 260 or under section 276 of the Penal Code, read together with section 74. Section 260 deals with infectious diseases. The first subsection provides that 'whoever by his conduct facilitates the communication of any dangerous infectious disease shall be punished . . .' Once more, the element of intention is weakened and the question is whether at the time of injecting the HIV serum, it *per se* was a 'dangerous infectious

³⁴ *Cambridge advanced learners dictionary* (2003).

³⁵ E Colvin *Principles of criminal law* (1986) 96.

disease'. The latter standard would hardly have been met because the accused herself was HIV positive and had not developed full-blown AIDS. The last option the Court had was sections 276(1)(a) and (b) of the Penal Code under the rubric 'intentional killing and harm'. Sections 276(1)(a) and (b) provide that whoever commits murder, that is causes another's death, after premeditation or by poisoning, shall be punished with death. It is obvious that the mental and the material aspects of the offence were present. Miss Kinding's act was not only premeditated by extracting a portion of her own HIV contaminated blood into a syringe for subsequent injection, but she actually proceeded to the material phase of injection, death not being immediate but certain.

As the *Noumen* case was heard a year before the 2003 law regulating blood transfusions was passed, the decision was solely based on the Penal Code. However, were this case to be heard today, under the 2003 law, the decision would hardly be different. In effect, this law essentially subjects penalties relating to noxious and/or unconsented transfusions to those under the Penal Code. The 2003 law merely metes a sentence of between three months to one year and/or a fine (about US \$181,81 to US \$909) where the transfusion is carried out by a competent person in an approved centre without a (sick) transfusee's consent.³⁶ Obviously by analogy, this provision extends to situations where the transfusee was not sick. The rationale in the *Noumen* case could be read as covering any negligent or wilful conduct leading to transmission of the HIV virus, either by rape or even consensual sexual intercourse, if at the time of the act, the HIV-positive offender actually knew, or reasonably ought to have known, of her or his status.

In the event that the conduct leading to the transmission of the HIV virus is not intentional, such conduct may be slated under section 289 of the Penal Code, which deals with unintentional killing and harm. The section provides that causing the death of another or to cause harm such as sickness, by lack of due skill, carelessness, rashness or disregard of regulation, is punishable by imprisonment of three months to five years or a fine or both.

The legal system and case law

It is important at this juncture to briefly examine the Cameroonian legal system to understand how HIV/AIDS litigation may be carried out in relation to the country's almost unique legal status.

Cameroon has a bijural status by virtue of the country's colonial past. Cameroon was first colonised by the Germans at the close of the 19th

³⁶ Art 14. The transfusee's consent is mandatory and should be clearly stated in written or oral form by herself or himself or a legal representative (art 8(1)). The doctor shall act in the interest of the transfusee if she or he cannot personally express the consent (art 8(2)).

century after the Berlin conference in 1884 on the partition of Africa. Following the defeat of Germany in World Wars I and II, Cameroon became, respectively, a mandated territory of the League of Nations and a trust territory of the UN under both British and French rule. During those periods, Cameroon inherited a dual legal system from its colonial masters. That is why, in the former British controlled section, now commonly referred to as anglophone Cameroon, English common law and procedures are applicable, while French civil law and procedures are applicable in the former French-controlled section, francophone Cameroon. However, in areas of law here harmonisation has been achieved by national, sub-regional or regional efforts,³⁷ the bijurality is inoperational at the level of substantive rules only, save where the harmonisation, as in the case of criminal law, involved adjectival rules. That notwithstanding, in the courts of both parts of Cameroon, in the event of *lacunae*, obscurity or incompleteness in the law, or for simple reasons of inspiration and persuasiveness in the *ratio decidendi* of judgments, recourse is primarily made to French and English law and jurisprudence, as the case may be.³⁸

Litigation against criminal HIV/AIDS-related conduct in both parts of Cameroon may either be criminal or civil. Such litigation will most obviously relate to the transmission of the HIV virus, whether wilfully or not.

Under the French legal system, as applied in francophone Cameroon, the offence is also a crime and a civil wrong. As a crime, the action is instituted by the legal department, since the offence is against the state. As a civil wrong, the action is for damages at the behest of the injured party, to repair the prejudice suffered. The actions are normally separate, with the criminal action being decided before the civil action. There are two situations here. The first is that the injured party may be joined to the criminal action as a civil party (*partie civile*) if she or he so desires. In this situation, the court will sit in both its criminal and civil jurisdiction. However, the rule is that criminal proceedings must first be completed before civil proceedings for damages are commenced. Thus, instead of instituting a separate action, the injured party has the benefit of saving the expenses of a separate civil action in terms of cost and time. The second is that the injured party may decide to institute a separate civil action for damages, but this can be done only after the determination of the criminal action. In both situations, therefore, the criminal action takes precedence over the civil action in time. Even if the separate civil proceedings were commenced before the criminal proceedings, the former must be stayed until the determination of the

³⁷ Such as in the areas of criminal law and procedure, labour law, family law, land law, company law, commercial law, public law, etc.

³⁸ Art 68 of the 1996 Constitution which gives its blessing to this practice.

latter. This precedence of criminal proceedings over civil proceedings is based on the principle in French law that '*le pénal tient le civil en l'état*', meaning the criminal action takes precedence over civil action. However, in both situations, the outcome of the criminal action does not influence the outcome of the civil action.

In the *Noumen* case, the prosecution opted to be joined to the criminal action as a civil party and asked for a symbolic compensation of one franc. However, if the prosecution had preferred to take a separate civil action to claim damages (after the criminal action), it would have been for the moral prejudice suffered by the two infected children, based on article 1382 of the French Civil Code. The article provides that any human act which causes damage to another obligates the author of the act to repair the damage.³⁹ The moral prejudice here would be based on the psychological trauma suffered by the children for knowing that they were infected with the HIV virus.

Under English law, as applied in anglophone Cameroon, such conduct equally amounts to either a criminal and/or a civil action. The difference with the practice in francophone Cameroon is that the injured party cannot be joined to the criminal action as civil party; the two actions are separate. The only similarity is that the criminal action precedes the civil action for damages.

The civil action in anglophone Cameroon would certainly be based on tort for intentionally infecting someone with a disease under the extension of the rule in *Wilkinson v Downton*.⁴⁰ Thus, where, for example, the disease is venereal, as it is likely to be in the case of HIV, contracted from cohabitation, Winfield and Jolowicz hold that the position is doubtful, although they find it hard to see why fraudulent concealment by the person suffering from the disease would not negate the consent of the infected party to continue cohabitation and make the infection tortious battery or even criminal murder.

3.2 The institutional framework

Government has developed an elaborate system for the implementation of the HIV/AIDS policy in Cameroon that ensures a near-sound policing of the policies for effective implementation. This may be because of government's speedy response to the disease and its effects. Way back in 1985, the year of the first diagnosed HIV case in Cameroon, the government put in place a National AIDS Scientific Committee

³⁹ Case ch civ 13 January 1923, DP 1923, 1, 52.

⁴⁰ (1897) 2 QB 57. The rule is that an act wilfully done which is calculated to cause physical harm and that actually causes harm to another is a tort, although it cannot be considered as any specie of trespass to the person or any other specific tort. See WVH Rogers *Winfield & Jolowicz on tort* (1994) 74-75.

(NASC), followed two years later by a National AIDS Control Programme (NACP) in 1987.

The institutions in charge of the HIV/AIDS policy in Cameroon are divided into two groups comprising structures operating at the central and local levels. There are, on the one hand, *ad hoc* structures under the NACC and, on the other hand, structures under the national health system. The NACC is the highest policy-making body at the national level, chaired by the Minister of Health. The NACC is a multi-sector body, involving public and private sectors, bilateral and multilateral partners, as well as non-governmental organisations (NGOs) in the fight against AIDS. Immediately following the NACC is the Joint Follow-up Committee chaired by the Minister in charge of Territorial Administration and Decentralisation. Next is the Central Technical Group (CTG),⁴¹ headed by a permanent secretary. The CTG is the implementing organ. It ensures the co-ordination, monitoring and implementation of AIDS control activities in all sectors. Under the NACC at the provincial level is a Provincial Committee for HIV/AIDS control,⁴² followed by the Provincial Technical Group comprising five units. At the outreach level, there is a Local Committee in charge of community response, that is, linking different communities to the Provincial Technical Group.

The national health system in Cameroon, generally (and for HIV/AIDS control, in particular) is decentralised to meet health needs in distant regions of the country, unlike the services of other ministerial departments that are simply concentrated on the local levels by the central administration following the administrative break-up of the country (provincial, divisional, sub-divisional and district services, in that order). The health system has its own administrative breakdown. For instance, 'district hospitals', which would have been found in districts only by virtue of the normal administrative political break-up, are also found in divisions and sub-divisions.

Parallel to the above structure is traditional medicine that is fully recognised by the state. It should be noted here that in Cameroon, traditional medicine and practice have consistently been recognised by succeeding instruments of the Ministry of Health.⁴³ The 2002 Decree

⁴¹ At the central level, the CTG comprises the following four sections: a health response section, a sector response, a communication and behaviour change section and an administration and finance section.

⁴² A unit for communication and behaviour change, a unit for the management of PLWHA, a monitoring and evaluation unit, an epidemiological and surveillance unit and a unit for research.

⁴³ In fact, traditional medicine is not only recognised, but it is within the organisation chart of the Ministry of Health. See Decree 89/011 of 5 June 1989, repealed and replaced by Decree 95/040 of 7 March 1995, repealed and replaced by Decree 2002/209 of 15 August 2002.

on the organisation chart of the Ministry of Health includes a separate service under the Sub-Directorate in Charge of Primary Health Care in charge of traditional medicine — the Traditional Socio-Sanitary Service.⁴⁴ This service is responsible for the follow-up of activities linked to traditional socio-sanitary services and the enhancement of collaboration between tradi-practitioners and public health services.⁴⁵

Although it has been difficult to regulate this sector due to the surge of quacks in the name of traditional healers and quackery in the name of traditional medicine, accredited tradi-practioners serve as entry points for HIV/AIDS PLWHA into public hospitals for effective management, as we shall see below.

4 Strategies for HIV/AIDS control

It should be noted from the outset that the current framework put in place to combat the spread of the HIV/AIDS pandemic in Cameroon is essentially conceived in the light of international guidelines and policies set out above. It has been mentioned that the initial framework for HIV/AIDS control was contained in the NACP. The NACC and the NACP conceived and implemented a number of plans with success: a short-term plan, a medium-term plan I running from 1988 to 1992, a medium-term plan II running from 1993 to 1995, and a framework plan for HIV/AIDS control for the period 1999 to 2000. The shortcomings of the programme were mainly due to poor co-ordination, inadequate involvement of other non-health sectors, a serious increase in the infection rate and insufficient resources.⁴⁶

4.1 The National AIDS Strategic Plan

The challenges faced by NACP necessitated a more focused and planned approach, to be taken over by the National AIDS Strategic Plan (NASP) 2000-2005.

4.1.1 Context of the National AIDS Strategic Plan

From 2000, there was a new framework for strategies by the government as contained in the NASP for the period 2000 to 2005. This plan was conceived against the background of the failures of the NACP, amidst socio-economic crisis, characterised by corruption and poverty; an atmosphere that only facilitated the spread and increase of the HIV

⁴⁴ 2002 Decree (n 43 above), art 34(2).

⁴⁵ n 43 above, art 37(1).

⁴⁶ See PNLCS (n 8 above) 9. In effect, these shortcomings led to the 14 times multiplication of the prevalence of the infection rate in 13 years mentioned earlier.

infection rate. It therefore became an important issue as government declared the disease an emergency and embarked on a merciless fight. An important point to note about the NASP is that its implementation is both decentralised and multi-sector, that is, it is managed by the NACC through its central, provincial and outreach level structures, as seen above. It was presented to the national and international community and adopted on 4 September 2000 by the Prime Minister. It is important to note here that the control of HIV/AIDS is included in Cameroon's poverty reduction strategy as one of the country's priorities and this inclusion was documented as best practice by UNAIDS.⁴⁷

4.1.2 Objectives of the National AIDS Strategic Plan

Since September 2000, NASP, which covers a period of five years (2000 to 2005), has been run. NASP aims at attaining the following objectives:

- reducing the risk of contamination of children from birth to five years and educating children between the ages of five and 14 years on healthy life skills and healthy sexual behaviour patterns;
- developing an information system geared towards monitoring the sexual behaviour change in adults;
- reducing mother-to-child-transmission (PMTCT);
- reducing the risk of contamination through blood transfusions; and
- increasing solidarity by developing national solidarity mechanisms with regard to PLWHA and their families, assuring their medical coverage and psycho-social management, promoting and protecting their rights, and involving associations in this regard.⁴⁸

The NASP envisages, in addition, measures essentially aimed at attaining the above objectives, namely: the construction of a national and regional blood transfusion centres; the establishment of HIV voluntary counselling and testing centres in the ten provinces of Cameroon; the promotion of condom use, mainly among the following vulnerable groups: students, military personnel, commercial sex workers and truck drivers; community mobilisation; increased involvement of the public and private sectors, including religious denominations; and inter-personal communication.

These objectives and accompanying measures are expected to be achieved through a five-stage process clearly defined in the NASP.⁴⁹ The following are the strategies elaborated to attain those objectives. These strategies may be examined under two heads, namely control strategies and control components.

⁴⁷ CNLS (n 11 above) 11.

⁴⁸ See PNLCS (n 8 above) 11.

⁴⁹ As above, 12-16.

4.2 Control strategies

4.2.1 Health sector strategy

The health sector strategy, within the framework of the diseases control programme, envisages HIV/AIDS control using the following strategies:⁵⁰

- (1) development of medical and social mechanisms for the management of PLWHA;
- (2) prevention of PMTCT, clinical management of sexually transmitted infections (STIs) and safe blood transfusion;
- (3) promotion of voluntary counselling and testing and the use of male and female condoms;
- (4) institution of a communication plan involving the public media (national radio stations); and
- (5) sensitisation of youths in schools, universities and out of school milieus, women, workers and the rural population.

4.2.2 Implementation manuals and action plans

The Central Technical Group elaborates and disseminates implementation manuals on the various components of the Multi-Sector HIV/AIDS Control Programme. These documents define the policy of each component of the programme and the methods of implementation. Meanwhile, the AIDS Control Action Plan aims at implementing the NASP.

4.3 Control components

4.3.1 Health response

The content of this component is the central axis for HIV/AIDS control. It is imbedded in the activities of the health sector that aim at monitoring the evolution of the disease, reducing its spread and improving on the quality of life of PLWHA and persons affected by HIV/AIDS. To achieve these goals, the following activities are carried out:

Secured blood transfusion

In the early days following the discovery of HIV, blood transfusion was the main mode of transmission, apart from sexual relations or the use of contaminated needles. Today, there is fear of blood transfusion for clinical purposes, even where it is aimed at saving life, for fear of contamination or religious beliefs. Some denominations (for example, Jehovah's Witnesses) abhor and reject blood transfusions. However, in order to restore confidence in the practice of blood transfusion (which is vital

⁵⁰ As above, 12-13.

for clinical purposes beyond mere fears or beliefs) and to ensure the safety of those receiving blood, the government has passed the 2003 law. Additionally, the government has created national blood transfusion centres and subsidises agents and consumables to enable proper transfusions.

Prevention of mother-to-child-transmission

The PMTCT programme in Cameroon went operational in 2000 in only one site. The major strands of this programme include: voluntary testing and counselling for pregnant women and their partners; the prescription and administration of ARVs such as Nevirapine during pregnancy and delivery; the promotion of low-risk obstetrical practices; and the promotion of feeding options adapted to newborn babies of seropositive mothers. Between 2000 and 2001, the success of the PMTCT programme sparked its extension to all ten the provinces, 162 sites in 30% of the health districts.⁵¹ A few specialised centres have undertaken a 'PMTCT plus' programme, which is an extension of the PMTCT services to the partners of HIV-positive mothers and caring for such mothers and their babies.⁵² In addition to the implantation of PMTCT sites, guidelines on PMTCT have been elaborated. It should be noted that the PMTCT programme is a joint project funded by the Cameroon government, the World Bank, UN Children's Fund and the Centre for Disease Control (CDC), Atlanta, through the Cameroon Baptist Convention.

Clinical management

Accredited Treatment Centres (ATCs) for the management of PLWHA with ARVs that have trained and qualified personnel were created by the government in all ten provinces.⁵³ ATCs are complemented by Treatment Units (TUs) for the management of PLWHA at the district level of the national health system, involving both private and public hospitals. Within ATCs and TUs, PLWHAs receive ARVs against opportunistic infections and prevention. Only ATCs and TUs are allowed to prescribe ARVs. This involves the recruitment of PLWHA for treatment. The accessibility and affordability of ARVs have been increased considerably by the decentralisation of ARV treatment to the local level (60 units all over the national territory) and the reduction of ARV costs. Before 2000, the

⁵¹ CNLS (n 11 above) 12. In 2003, a total of 62 817 pregnant women received counselling, out of which 42 872 were tested; 7,7% of the women tested were HIV positive; 80% of the 1 432 HIV-positive women were given Nevirapine during pregnancy and continued to take it at delivery; 1 303 babies born of such mothers were treated with Nevirapine.

⁵² CNLS (n 11 above) 12.

⁵³ See Ministerial Decision 0118/MSP/CAB of 16 March 2001.

cost of ARVs was between US \$1 100 and US \$909 per month. A ministerial decision reduced it to about US \$109 per month and further to between US \$27,27 and US \$50 per month, by a second decision in 2003. A third decision in 2004 radically reduced the cost to between US \$5,50 to US \$12,72 per month for the first line of treatment.⁵⁴ The driving force behind the reductions was a number of factors, including:

- government's partnership with the Access Initiative in 2001 and negotiated arrangements with generic pharmaceutical companies such as CIPLA;
- government's contribution through the Highly Indebted Poor Country Initiative (HIPC) as part of the Poverty Reduction Strategy Paper (PRSP) 2000-2004;
- funds received under the World Bank's Multi-Country AIDS Programme (MAP);
- funds received from the Global Fund for the fight against AIDS, Malaria and Tuberculosis (Global Fund) under the World Health Organisation's (WHO) '3-by-5' initiative;
- government's elimination of customs duties on ARVs and other essential drugs;
- direct government subsidy; and
- contribution towards drugs, reagents and laboratory consumables by the World Bank, WHO and the French Co-operation.⁵⁵

The upshot is that by the end of 2003, more than 7 500 PLWHA were on ARV treatment. However, this accounted for only about 8% of PLWHA. The NACC estimated that with increased funds received from the Global Fund under the '3-by-5' initiative, about 50 000 PLWHA would be on ARVs in 2005.

ARVs used in Cameroon are those recommended under national protocols developed on a consensual basis in collaboration with international experts. Quality control of ARVs is ensured by the National Essential Drug Procurement Centre (NEDPC) in partnership with the regional National Drug Quality Control Laboratory (NDQCL) which is approved by WHO. NEDPC is the only institution that is authorised to supply ARVs in ATCs.

Psycho-social management and social de-stigmatisation

An important aspect of the control component is managing the psychological aspects of PLWHA. HIV/AIDS is seen as 'an emotional, frightening and stigma-laden condition'.⁵⁶ Unlike other dreadful diseases,

⁵⁴ By 2000, the average cost of the ARV package was US \$260 per month per PLWHA. From March 2001 to August 2002, it fell to US \$73 per month per PLWHA.

⁵⁵ See CNLS (n 11 above) 13.

⁵⁶ M Kirby 'The never-ending paradoxes of HIV/AIDS and human rights' (2004) 4 *African Human Rights Law Journal* 166.

HIV/AIDS carries stigma that frequently leads to isolation or rejection and/or discrimination by others. The feeling of isolation is characterised by shame. The disease is perceived by many as a shameful disease, since it is considered the result of promiscuous conduct. Rejection and discrimination by others are occasioned by the fear of being contaminated by, or simply the fear of having any physical dealings with, 'a dead person walking' — social stigmatisation or victimisation. Both these phenomena are caused by a lack of knowledge about the disease, and, principally, its modes of transmission.

Paragraph 12 of the Abuja Declaration recognises that stigma, silence, denial and discrimination against people living with HIV/AIDS increase the impact of the epidemic and constitute a major barrier to an effective response to it. The Cameroonian government has since 1992 developed a policy in this regard and created a sub-directorate for AIDS control with a bureau for psycho-social management of PLWHA and persons affected by HIV/AIDS. Also, within the Multi-country AIDS Project (MAP), the government signed agreements with the ministries in charge of women's affairs and social affairs, and these ministries have developed their own sector plans within their various departments. Again, there are training guidelines for psycho-social management of PLWHA and a training module. Both the guidelines and the module were developed by an NGO, Care and Health Programme (CHP), supported by the government of the United States. The government uses the guidelines to train counsellors on psychological management of PLWHA and persons affected by HIV/AIDS. Workshops are organised. It should be noted that the guidelines of Doctors without Borders (*Médecins Sans Frontières*) are also used here. Furthermore, within the Country Control Mechanism (CCM) of the Global Fund, there is a home-based care policy that seeks to link treatment centres to communities, thereby spreading the psycho-social management care of PLWHA to outreach areas.

Social de-stigmatisation is the aim of both the public and the private actors, such as companies and NGOs, including NGOs of PLWHA. Following the creation of the first association of PLWHA, Association of United Brothers and Sisters (*Association des Frères et Soeurs Uni*), in 1994, a first network for the associations of PLWHA, Cameroonian Network of Persons Living with HIV/AIDS (*Réseau Camerounais de Personnes Vivantes avec le VIH/SIDA — Re Cap+*), was created in 2000. It has benefited from the support of the African Network of People Living with HIV/AIDS, UNAIDS and the German Co-operation (GTZ). PLWHA are involved in the implementation of NASP and are statutory members of the NACC, the joint follow-up committee.⁵⁷

⁵⁷ See generally CNLS (n 12 above) 24.

The de-stigmatisation process through psycho-social management, employment and capacity building of PLWHA ultimately results in a respect for their fundamental rights as human beings. In this light, a draft law to govern the rights and obligations of PLWHA and persons affected by HIV/AIDS is underway. This law, it is hoped, will facilitate and foster the implementation of principles of non-discrimination, equality and participation.⁵⁸

Epidemiological surveillance

There is a surveillance system in Cameroon based on international standards. The focus of this surveillance system is to carry out studies and produce estimates on HIV prevalence among the general population, from test results of pregnant women and prenatal consultations. As mentioned earlier, a demographic health study that started in December 2003 in Cameroon had, for the first time, an HIV component. Its first estimate in 2004 produced a more precise estimation of HIV prevalence, if one were to go by the Technical Explanatory Note mentioned earlier on.

Voluntary counselling and testing

Fear of HIV/AIDS caused a sense of 'deliberate ignorance' in the attitude of the general population. This results in people not wanting to know whether they are infected by the HIV virus, probably also because of the fear of social stigmatisation. It has been a struggle to encourage people to realise that knowing their HIV status is an entry point to care, treatment and support and that AIDS is just like other diseases. Indeed, HIV/AIDS is less dangerous than cancer and even less dangerous than a mortal stroke, for example, in terms of immediacy of death, since it can be clinically managed for quite a long time, if only one is psychologically fit. Thus, counselling is done in two phases: the pre-testing phase and the post-testing phase. Voluntary testing is also encouraged, and presently there are 11 voluntary testing and counselling centres created with the support of the French Co-operation service in Cameroon and the Chantal Biya Foundation — the Circle of Friends of Cameroon (CERAC). These centres provide appropriate stigma-free counselling towards voluntary testing to encourage behavioural change.

Community response

This control component is geared towards empowering local communities to undertake activities based on an awareness of the disease, the

⁵⁸ As above.

reduction of its impact by developing prevention action plans⁵⁹ and support for PLWHA and persons affected by HIV/AIDS. Thus, communities in rural and urban areas, as well as vulnerable groups, such as sex workers, truck drivers, street children and others, are provided support adapted to their peculiarities.

Sector response

Sector response is essentially geared towards supporting the public sector, private enterprises, religious denominations and major communities in the design and implementation of their HIV/AIDS control plans. The successes here have been remarkable. HIV/AIDS control plans have been instituted in various public institutions, including those of the ministries of higher education, defence, national education and women and social affairs, religious communities, private institutions, universities and research institutes.⁶⁰ The major focus of this component is on assistance to PLWHA and persons affected by HIV/AIDS to encourage de-stigmatisation.

Funding

There can be no meaningful HIV/AIDS control if there is insufficient funding of strategies. As seen earlier, the state, through the HIPC⁶¹ and partners (private, bilateral and multilateral donors) essentially contribute to the funding of the ARVs. Government subsidises ARVs to the tune of about US \$1 million per year since 2002.⁶² Government received US \$50 million from the World Bank's MAP for the period 2001 to 2005, while funding from other national and international partners for the period 2000 to 2005 amounted to US \$40 million. In other words, the total amount of funding by national and international donors for the period of the NASP (2000 to 2005) stands at US \$90 million. PLWHA contribute by procuring ARVs at affordable prices. The private sector has also been active in this direction, as companies such as ALUCAM, CDC, and CIMENCAM now have their own ARV procurement programmes for their employees and their families. Pilot projects funded by the World Bank in view of increasing accessibility of PLWHA

⁵⁹ A total of 2 442 action plans by local communities have been supported technically or financially by the programme. See CNLS (n 12 above) 17.

⁶⁰ As above.

⁶¹ Government has realised a progressive increase in its HIV/AIDS budget. The Ministry of Health's budget for HIV/AIDS was only US \$13 000 in 1995, but by 2001, it rose to US \$1,8 million. US \$9 million was budgeted from the HIPC initiative for HIV/AIDS within the framework of the execution of PRSP 2000-2004. Some of these funds were allocated to ARV procurement, thereby reducing the average monthly cost of treatment for PLWHA to US \$34 per month. See CNLS (n 11 above) 14.

⁶² CNLS (n 11 above) 9.

to ARV treatment show on the evaluation of the PLWHA's ability to pay for ARVs in 2003 that they either contributed nothing at all or contributed between 25,5% and 75% of the cost.⁶³

Private sector implication

This is a major and salutary component in HIV/AIDS control. Indeed, the government has opted for a decentralised and multisector approach, actively involving the private sector, since it is evident that a single-handed fight cannot be effective. The Abuja Declaration enhances such an approach 'through a comprehensive multisector strategy which involves all . . . development sectors and mobilisation of societies' at all levels, including the private sector, civil society, NGOs and others.⁶⁴ Enterprises of the private sector are resulting in viable partners in HIV/AIDS control. Currently, the NACC has partnership agreements with about 43 private structures, including the Inter-Employers' Union (GICAM) and 42 private companies. The cost of the public/private sector partnership over a period of four years is US \$5 145 458 for the financing of HIV/AIDS control programmes in 43 private enterprises employing about 70 000 people.⁶⁵ Out of that amount, the NACC contributes the lesser share of US \$2 118 032, 84, that is, about 49% of the total budget, while the remaining share of 51% is provided by the private enterprises of the partnership. These figures speak for themselves about the collaboration, zeal and involvement of the private sector in HIV/AIDS control in Cameroon.

Role of parliament

Since 2003, the National Assembly of Cameroon has participated in HIV/AIDS control, although its efforts have remained limited. The Standing Orders of the National Assembly of Cameroon (Standing Orders) establish a number of Parliamentary Committees, each having a specific competence.⁶⁶ Hence, article 16 of the Standing Orders provides for a Committee on Cultural, Social and Affairs which has public health as one of its areas of competence. In 2003, the Speaker of the

⁶³ As above, 15.

⁶⁴ Para 23.

⁶⁵ See CNLS '*Le partenariat public/privé dans la lutte contre le VIH/SIDA*' 9-10. For the major achievements, lessons, challenges and perspectives of the partnership, see above, 10.

⁶⁶ See generally ch VI. Art 19(1) of the Standing Orders provides: 'The substantive study of a matter may be entrusted to only one Committee, other Committees may ask to give their opinion on the same matter.'

National Assembly created a Sector Committee for the Fight against HIV/AIDS (Sector Committee).⁶⁷

The Sector Committee works in collaboration with the NACC and is represented by its Chairperson. The aim of the Sector Committee is ensuring that each ministry has made a budgetary allocation for HIV/AIDS control. The Sector Committee's activities have not been diverse and animated. So far, sensitisation tours in some of the provinces of Cameroon constitute its main activity. Members of parliament who are part of the Sector Committee represent the Committee in their respective provinces.

5 Major challenges in the fight against HIV/AIDS

5.1 State reporting

While some African countries have been very prominent in state reporting on HIV/AIDS as a requirement of international human rights instruments, others have not, despite express commitments in that regard. State reporting is a means of monitoring a country in terms of respect, promotion and protection of human rights through periodic reports to the appropriate body set up for that purpose under a treaty. In the absence of state reporting, it is difficult to assess concretely state responses to HIV/AIDS from an international perspective, that is, whether international standards on the issue have been met. Specialised human rights instruments provide bodies before which state parties are required to submit periodic reports on the human rights situation in their respective countries. These are monitoring bodies or supervisory mechanisms.

⁶⁷ Order 2003/091/AP/AN. Hon Amougou Nkolo, who is the Sector Committee's Chairperson and initiator of its creation, is of the opinion that the Sector Committee is not a 'committee' in the sense of art 16 of the Standing Orders. The article states that committees are set up each legislative year after the election of the Permanent Bureau of the National Assembly. Meanwhile, the Sector Committee is a permanent body. Again, the Secretary-General of the National Assembly convenes Committee meetings, while the Chairperson of the Sector Committee convenes its meetings. In short, the rules of procedure relating to their setting up and functioning of Parliamentary Committees *per* the Standing Orders are not in line with those of the Sector Committee. According to Hon Amougou, though called 'Committee', the Sector Committee is rather a Parliamentary Group. But the worry here is that according to art 15 of the Standing Orders, Parliamentary Groups may only be formed 'according to political parties'. In other words, Parliamentary Groups are Parliamentary alliances aimed at fostering the goals of each political party represented in parliament and as such cannot be made up of Members of Parliament (MPs) from other political parties. Yet, the Sector Committee is a mixed body made up of (all) MPs from all political parties represented in the National Assembly. The only feature that makes the Sector Committee resemble a real Parliamentary Committee in the sense of ch V of the Standing Orders is that it bears the name 'Committee'. It is therefore a *sui generis* Parliamentary Committee.

At the international level, socio-economic rights are governed by CESC. The procedure of reporting is based on articles 16 to 22. Reporting on these rights is on the measures adopted by state parties and the progress made in achieving the observance of the rights recognised under CESC, indicating, where necessary, difficulties confronting their implementation. Unlike the International Covenant on Civil and Political Rights (CCPR), that provided for the creation of a Human Rights Committee (HRC), to implement the rights thereunder, CESC did not provide for the creation of such a committee. CESC simply provided that reports were to be submitted to the UN Secretary-General who shall then transmit them to the Economic and Social Council (ECOSOC) for consideration.⁶⁸ Copies of reports or parts therefrom may be forwarded to specialised agencies, so long as the reports, or the parts therefrom, fall within their competences.⁶⁹ The control of socio-economic rights is currently ensured by an independent organ — the Committee on Economic Social and Cultural Rights (Committee on ESCR), created in 1985 by ECOSOC.⁷⁰

The history of Cameroon's reporting to the Committee on ESCR is dismal. So far, only the initial report has been presented. The first periodic report has still not been submitted. The initial report was submitted in 1998,⁷¹ and was presented in 1999 at the Committee on ESCR's 21st session. Though it was accepted, it was criticised for lacking in terms of form and substance. In the domain of the right to health, not only was the report very scanty, but specifically with respect to HIV/AIDS, which is of relevance here, the report provided no statistics on PLWHA and prevalence rates, as well as no statistics on other related infectious diseases.⁷²

At the regional level, the supervisory mechanism under the African

⁶⁸ Art 16(1).

⁶⁹ Art 16(2)(a).

⁷⁰ Res 1985/17 of 28 May 1985. The peculiarity of the CESC Committee is that, unlike the Human Rights Committee, it is not a treaty-based organ, but rather a subsidiary organ of ECOSOC created by a resolution of the latter. See generally F Sudre *Droit international et européen des droits de l'homme* (2001) 498.

⁷¹ UN Document E/C.12/Q/CAMER/1 of 17 December 1998.

⁷² See art 12 of UN Document E/1990/5/Add 35 on the list of issues to be clarified in Cameroon's initial report on socio-economic rights defined in CESC. The reporting situation to other specialised treaty bodies seems relatively better. To the Committee on the Elimination of Discrimination against Women under CEDAW, Cameroon only presented its initial report in 2000 and no periodic report. To the Committee on the Rights of the Child under CRC, the initial report was presented in 2003 and thereafter no periodic report followed. Before the Committee against Torture (under the Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment 1984), and the HRC under CCPR, three periodic reports have been presented, and before the Committee on the Elimination of Racial Discrimination under the International Convention on the Elimination of All Forms of Racial Discrimination 1965 (ratified in 1971) 14 periodic reports have been presented.

Charter is the African Commission. The African Commission's mandate includes the review of state parties' compliance with the African Charter through periodic reports in addition to its promotion and protective mandate (alongside its power to review complaints from states). Again, Cameroon has not often reported to the African Commission. Cameroon only succeeded in presenting its belated initial report at the 31st session of the African Commission in Pretoria in 2002. Because the delay of the initial report caused delays in the presentation of periodic reports, this initial report was considered to be all the periodic reports in arrears. However, HIV/AIDS was discussed very briefly in the report. Only two issues were addressed very briefly: HIV prevalence rates and four control strategies.

Because of Cameroon's lack of reporting, the success of the country's HIV/AIDS policies cannot be objectively ascertained since the only appropriate mechanisms that could have done so have been neglected. Even when such policies seem to be working from a national perspective, this is not enough, as policies need to be frequently tested and reformed against the background of international standards, independent stakeholders' appreciation and experiences from elsewhere.

5.2 Rights and obligations of PLWHA

PLWHA constitute a vulnerable class in need of special protection by virtue of their status as much as children, women or the disabled. PLWHA, therefore, should have certain rights, including the right to health. The right to health is a central or core human right; a needs-based right that transcends and further enhances the *raison d'être*, enjoyment and realisation of the whole ensemble of human rights. Access to ARVs and drugs for the treatment of opportunistic infections is essential for PLWHA to enjoy their right to life⁷³ and their right to health.⁷⁴ It should be recalled that access to essential medicines forms part of the core content of the right to health, which states should be able to provide irrespective of their available resources.⁷⁵

The right to health in the case of HIV/AIDS comprises access to proper treatment based on human rights principles, including non-discrimination in health as to age, race, sex and disability. Although in Cameroon there are only policies dealing with the rights of PLWHA, the experience elsewhere, such as in Zimbabwe (in the absence of specific legislation dealing with such rights), or the judicial experience

⁷³ Human Rights Committee (HRC) General Comment 6 'The right to life' (1982) para 5.

⁷⁴ LT Diaz 'Protection of access to essential treatment for people living with HIV/AIDS in Uganda from a human rights perspective' unpublished LLM dissertation, University of Pretoria, 2005 1. See also Committee of Social, Economic and Social Rights (CESCR) General Comment No 14 'The right to the highest attainable standard of health' (2000) UN Doc E/C12 2000/4.

⁷⁵ As above.

in South Africa, is instructive. Here, the enhancement of access to proper treatment incorporates a number of specific rights, such as the right to consultation before action is taken, the right to choice of care, the right to drugs, the right to informed prior medical consent to medical action, the right not to be discriminated against in medical schemes and the right to education, as well as encouragement of insurance company schemes that take into consideration the needs of PLWHA.⁷⁶

A few South African cases may be helpful in identifying some specific rights that HIV/AIDS PLWHA may benefit from.⁷⁷ The first is the case of *Joy Mining Machinery Division of Harnischfeger SA Pty Ltd v National Union of Metal Workers of South Africa*.⁷⁸ In this case, the Labour Court ruled that anonymous testing of employees in accordance with the relevant law was legal on 11 conditions, including the fact that at no time should such an employee be asked his name, the information should not be recorded as a sample and the employer must make it clear that it does not intend to discriminate against that employee. In *A v SAA*,⁷⁹ the plaintiff tested HIV positive in a pre-employment test and was refused employment as cabin attendant by South African Airways. The court held that such a refusal on the grounds of the applicant's status was unjustified and awarded compensation. In *Zungu v ET Security Services*,⁸⁰ the applicant, who was a security guard, had full-blown AIDS and was dismissed. He sued for unfair dismissal on the grounds that he could still perform his duties as a security guard. The Commission for Conciliation, Mediation and Arbitration (CCMA) held that the AIDS stage of the illness made it impossible for him to perform his duties. The CCMA found that his dismissal was lawful and that the respondent had acted in good faith. The rationale in this case clearly shows that in as much as PLWHA have rights, so do they have duties, running parallel to those rights. In fact, they owe a duty of care not to intentionally, knowingly or negligently contaminate others at any stage of the illness.

In Zimbabwe, there is specific legislation on HIV-related criminal behaviour — the Sexual Offences Act entitled 'Prevention and Spread of HIV'. It is an offence, punishable by up to 20 years' imprisonment, for someone with knowledge of her or his HIV status to intentionally do anything which she or he knows or reasonably ought to know will infect another person with the virus, or is likely to lead to the infection of another person, whether or not she or he is married to that person.

⁷⁶ See Centre for the Study of AIDS & Centre for Human Rights 'HIV/AIDS and human rights in Zimbabwe' (2004) 23-25.

⁷⁷ See Centre for the Study of AIDS & Centre for Human Rights 'HIV/AIDS and human rights in South Africa' (2004) 22-23.

⁷⁸ J158-2002; (2002) 23 ILJ 391 (LC).

⁷⁹ J1916/99.

⁸⁰ KN505-48.

Where the HIV offender is convicted of rape or sodomy, irrespective of whether she or he was aware of her or his status, she or he can be sentenced to imprisonment of up to 20 years. In fact, the Zimbabwe National HIV/AIDS Policy (1999) in its Guiding Principle recommends that the wilful transmission of HIV in any setting should be considered a crime similar to inflicting other life threatening injuries to another.⁸¹

In Cameroon, the Preamble of the 1996 Constitution proclaims equality and non-discrimination. The rights of PLWHA may easily be abused through stigmatisation and discrimination. It is true that the current practice in Cameroon is to secure the rights of PLWHA, especially their labour rights. This is the thrust of the agreement between the NACC and the employers' network, led by GICAM and *Citoyenne Assurances*, and that between GICAM and ReCAp, mentioned earlier. The South African cases reviewed above show that labour rights of HIV/AIDS victims (especially with regard to employment) are very precarious. Yet, the jurisprudence of South African courts reveals no tolerance in respect of the infringement of labour rights of PLWHA. Such jurisprudence is sound and the *ratio decidendi* could be adopted elsewhere, as in Cameroon, if the national programme for HIV/AIDS control is anything to go by.

Nevertheless, while PLWHA have rights, they also have obligations. Indeed, the approach of the African Charter is that the rights of the African peoples should be complemented by obligations where necessary. Thus, in as much as PLWHA have well defined rights, they also have corresponding obligations in relation to the containment of the disease. The 2003 law on blood transfusion and the *Noumen* case are statutory and judicial efforts in this direction. These are efforts to criminalise and punish negligent or intentional conduct that leads to the transmission of the HIV virus.

5.3 Sensitisation

Sensitisation about HIV/AIDS in Cameroon has been effective. It is estimated that over 90% of the population, both rural and urban, know about HIV/AIDS, its transmission mechanisms and prevention methods.⁸² The Minister of Health (Chairman of the NACC) noted with satisfaction in October 2004 during the signing of the co-operation agreement with the Support to International Partnership Against AIDS in Africa (SIPAA) that 'the silence has so far been successfully broken; this is time to educate the population, especially women and children who are most vulnerable to the pandemic'.⁸³

⁸¹ National HIV/AIDS Strategic Framework 2000-2004 39.

⁸² <http://allafrica.com/stories/200411150553.html> (accessed 31 March 2006).

⁸³ As above.

The creation of awareness about HIV/AIDS has been successful so far but, as mentioned earlier, the success does not reflect on sexual behaviour patterns, especially in the use of condoms or abstinence. As concerns the use of condoms, the 2000-2002 phase of the NASP — the emergency plan phase — had as objective a 100% use of condoms.⁸⁴ That is, to incite the use of both male and female condoms, encourage voluntary testing and information, education and communication in view of inciting sexual behaviour change. The multi-sector approach seems to have added impetus to the awareness of the disease. In addition, the local and community responses have been instrumental in this regard as seen from the demographic and health survey mentioned earlier. For instance, the response rates after seeking consent to collect blood samples for testing was 93% nationwide in 2003.

5.4 Co-operation and research

Co-operation and research on HIV/AIDS in Cameroon have been remarkable. Co-operation has mainly focused on working out, orientating and implementing HIV/AIDS policy. Co-operation involves all sectors, public/private as well as bilateral and multilateral donors and NGOs. The private sector has been instrumental in HIV/AIDS control. This is demonstrated by the actions of GICAM that is engaged in the promotion of HIV/AIDS workers' rights, and private companies that have developed a health-related social security policy in favour of their workers and their families. Some have even gone as far as drawing up an action plan to fight HIV/AIDS and this seems to be a tendency in almost all business enterprises.

In addition to instances of co-operation with bilateral and multilateral donors and NGOs addressed earlier on in this paper, in October 2004, officials of the NACC and the Support to International Partnership against AIDS in Africa (SIPAA) signed a co-operation agreement to intensify activities against the HIV/AIDS pandemic in the country. The SIPAA programme is a three-year initiative, managed by Action Aid International Africa, and funded by the UK Department for International Development to enhance international partnership action against AIDS in Africa.⁸⁵ However, on 6 May 2005, the NACC noted that its activities were not co-ordinated and that those of bilateral donors within the framework of the NASP befell a similar fate, and so recommended harmonised and co-ordinated action plans.

With regard to research on HIV/AIDS in Cameroon, the government has encouraged efforts. Professor Anomah Ngu, a medical researcher and former Minister of Health in Cameroon, for instance, has made

⁸⁴ PNLs (n 8 above) 18.

⁸⁵ http://www.healthlink.org.uk/world/sipaa_01.html (accessed 1 April 2006).

clinically tested breakthroughs in this field that have led to impressive clinical management of PLWHA. Government has recognised and encouraged Anomah Ngu's enterprise through financial support. The visit to HIV/AIDS research centres in 2003 by eminent researcher and co-discoverer of the deadly *ebola* virus, UNAIDS Executive Director and UN Deputy Director, Dr Peter Piot, was considered a recognition of Cameroon's efforts in HIV/AIDS control.⁸⁶ Also, in February 2006 the Chantal Biya International Reference Research Centre for HIV/AIDS Prevention and Management (CIRCB) was inaugurated. The Centre's research largely focuses on post-natal PMTCT, specifically to find a vaccine that protects infants against HIV transmission during breast-feeding. The Centre's immediate goal is to develop paediatric vaccine trial protocols by 2006 and 2007.⁸⁷

Research on HIV/AIDS in Cameroon is undertaken in the public and private spheres. Public research has been operated by the Ministries of Health and Higher Education via the Faculty of Medicine and Bio-Medical Sciences. Private research is very promising, but has remained rather isolated. Research is still uncollaborative and unco-ordinated. Proof of this is that CDC Atlanta has separate projects with the Ministry of Defence, while the Faculty of Bio-Medical Sciences and the Institutes of Tropical Medicines in London and Antwerp sometimes have separate research projects. During these projects, the home ministry — the ministry in charge of scientific research — is not involved directly, but rather has a protocol agreement with the NACC. Thus, one finds public institutions of the same system engaged in isolated and perhaps competing struggles on an issue of national interest. This is a serious dilemma since it weakens national efforts on HIV/AIDS research and confuses private donors who may not know where and how to channel their support. Worse still, the very essence of the NASP is defeated.

The consequences of unco-ordinated research are exemplified by a scandal in early 2005, caused by the implementation of a project by Family Health International. The project, approved by the Ministry of Health under a Protocol Agreement (PA), consisted of testing a purported HIV preventive drug known as Tenofovir at chosen sites in Cameroon on a cohort of 400 commercial sex workers. Four of the women were later found to be infected with the HIV virus. The project was run under conditions described in the findings of the Order of Physicians as 'unethical'.⁸⁸ Although the National Ethics Commission (NEC) observed that there was no proof that the seroconversion of the women was as a result of their participating in the project, NEC, however, paradoxically declared (after stating that it could not find any

⁸⁶ Morikang 'Fighting AIDS: Cameroons efforts recognised' (2003) *Cameroon Tribune* <http://www.harford-hwp.com/archives/35/205.htm> (accessed 11 February 2006).

⁸⁷ *Cameroon Tribune* (27 February 2006) 15.

⁸⁸ 'Tenofovir: l'Ordre des médecins se prononce' *Cameroon Tribune* 24 February 2005 11.

express statement in the Protocol Agreement that the drug prevents HIV infection),⁸⁹ that the Protocol Agreement 'scrupulously' respected standard international norms, including those spelt out in the WHO/UNAIDS reports of 2003 and 2004, and the Helsinki Declaration.⁹⁰ NEC was therefore of the opinion that the problems generated by the project resided in its (administrative) implementation rather than in its entire propriety.⁹¹ The divergence in points of view in the findings of NEC and the Order, the long awaited publication of the report on the findings of the *ad hoc* commission of inquiry put in place by the Minister of Health and the continued silence of the latter over the matter, speak for themselves.

Whatever the upshot of what is now commonly referred to as the Tenofovir affair, international human rights standards show that clinical trials which target a certain group of persons by virtue of their sex, such as women in the instant case, unequivocally amount to sexual discrimination and a violation of their right to health and life. This is evident from the fact that four of the women infected with HIV. Articles 2(d) and (e) of CEDAW are clear on this point. CEDAW requires state parties to refrain from engaging from any act or practice of discrimination against women by any person, organisation or enterprise, and to ensure that *public* authorities and institutions shall act in conformity with this obligation.

Traditional medicine has also been portrayed by tradi-practitioners as being instrumental in research and HIV/AIDS control. Although some tradi-practitioners have made wild claims of being able to manage PLWHA and actually cure HIV/AIDS with herbal concoctions, such allegations remain scientifically unproven. However, in 2003, an international NGO, active in the field of the promotion of traditional medicine, announced a therapy for HIV/AIDS called METRAFAIDS at the 14th International AIDS Conference in Barcelona.⁹² Whether the allegations are founded or not, the major handicap of traditional medicine is that its dosage, conservation and the expiration of concoctions or substances have been based on mystical and spiritual guidance or mere speculation which may lead to the aggravation of the clinical condition of PLWHA, in some cases. Yet, it is also true that traditional practices have been instrumental in the spread of the HIV virus. This is the case, for example, of healing practices that involve the cutting of the body

⁸⁹ The NEC contended amongst other things that there is presently no drug that prevents infection.

⁹⁰ 'Tenofovir: le comité national d'éthiques se prononce' *Cameroun Tribune* 14 March 2005 7.

⁹¹ As above.

⁹² 'Cameroon: HIV/AIDS therapy may stem from traditional methods' *Weekly Indigenous News* <http://209.200.101.189/publications/win/win-article.cmf?id=1833> (accessed 11 February 2006).

with sharp objects for the administration of potions. Also, any hospital diagnosis that does not suit a PLWHA's or relative's expectation provokes recourse to witchdoctors who offer an answer or solution or cure to any problem or illness. Some tradi-practitioners go as far as making claims that they can cure all illnesses, HIV/AIDS included. Whatever the veracity or falsity in such claims, what is certain is that tradi-practitioners have been instrumental in HIV/AIDS control. In fact, since traditional medicine is recognised fully by the state and features on the organisation chart of the Ministry of Health, tradi-practitioners serve as entry points for PLWHA into the public health care system (in that they attract PLWHA who would be subsequently conveyed to public hospitals).

Therefore, the strategy adopted by the government is not to discredit or outlaw the practice of traditional medicine, but rather to regulate it and encourage practitioners to join lawful associations. This is to separate true tradi-practitioners from charlatans. In this way, those the system can collaborate with are easily identified.

The 2001 Abuja Declaration acknowledged and gave impetus to the role and efforts of traditional medicine in HIV/AIDS control. In effect, the Heads of State and Government committed themselves⁹³

to explore and further develop the potential of traditional medicine and traditional health practitioners in the prevention, care and management of HIV/AIDS, tuberculosis and other related infectious diseases.

Even before the Abuja Declaration, traditional medicine and research were acknowledged fully in Cameroon. In a Circular Note of 10 September 1991,⁹⁴ the then Minister of Health, Joseph Mbede, drew the attention of directors of general hospitals and research centres, and provincial health delegates, to the growing importance of traditional medicine in the management of sick persons generally, as a positive cultural gain. He then exhorted them to take the necessary measures to ensure effective collaboration between public health structures and tradi-practitioners in the best interest of patients.

5.5 Management of funds and accountability

One of the most crucial aspects of HIV/AIDS control is funding and the rational use of funds. While funding by the various actors (the state, private sector and bilateral and multilateral donors) has increased and intensified over the years, doubt exists over the use of funds. It has been submitted that the health sector is prone to corruption for the following reasons: imbalance in information, uncertainty in health markets and

⁹³ Abuja Declaration (n 27 above) para 32.

⁹⁴ Circular Note D26/NC/MSP/SG/DMPR/DAMPR/SDMR/SSCMT.

complexity of health systems.⁹⁵ The types of corruption in this sector include embezzlement and theft, corruption in procurement, corruption in payment systems, corruption in the pharmaceutical supply chain and corruption at the point of health service delivery.⁹⁶ Globally, corruption within the health sector is fanned by 'paucity in good record keeping and the difficulty in distinguishing among corruption, inefficiency and honest mistakes'.⁹⁷ Considering this vulnerability in relation to corruption, there should be a sound legal framework to combat this vice.

At the international level, there is a UN Convention against Corruption signed by Cameroon in 2003, but which it has not yet ratified. The UNAIDS Guidelines also focus on the improvement of government capacity for acknowledging the government's responsibility for multi-sector co-ordination and accountability.

At a regional level, Cameroon has not yet signed the AU Convention on Preventing and Combating Corruption. It is therefore doubtful whether internal measures undertaken to fight corruption can be effective. Once more, here, as in the domain of state reporting discussed above, there is no objective standard for measuring national efforts to combat corruption.

At the national level, there is an impressive arsenal of legal instruments and efforts to fight corruption, but the vice persists. For instance, there is a February 2005 Decree establishing the Rules for the Committee for the Fight against Fraud, Smuggling and Corruption, and the Procurement Contracts Code of 2004. It should be noted that there is a national corruption observatory and each ministry has its own component of this national structure. Yet, corrupt practices are far from being cured. While civil servants and high-ranking government officials such as government ministers have been sanctioned for corrupt practices and others removed from public service as 'ghost workers' over the last few years,⁹⁸ corruption continues and heavily engrained corrupt habits that die hard have taken the toll on Cameroonians.

Cameroon topped the chart of the most corrupt nations in the world for the year 1998. In 2006, there was a slight improvement as the country was ranked 23rd out of 159 countries surveyed.⁹⁹ Early in 2006, the head of state articulated a stiff political rhetoric, ensuring a merciless fight against this plight that has seriously ruined the nation. Thus, while in 2005 some officials of the NACC were sacked discreetly for misappropriation of HIV/AIDS funds, in February 2006, ministers

⁹⁵ Transparency International 'Global corruption report 2006: Special focus — Corruption and health' (2006) xvii.

⁹⁶ As above, xviii.

⁹⁷ As above, xvi.

⁹⁸ As above, 141.

⁹⁹ As above, 302.

and former directors of state-owned corporations were arrested on charges of fraud and misappropriation.¹⁰⁰ Corrupt practices and embezzlement of funds are daunting problems that will derail any meaningful HIV/AIDS control if left unchecked.

5.6 The new NASP 2006–2010

The 2006-2010 phase of NASP, launched on 8 March 2006,¹⁰¹ marks a turning point in HIV/AIDS control in Cameroon. It is an ambitious plan. Following the relative success of the first NASP (2000-2005), the new plan aims at preserving and maximising the achievements of the first plan, while addressing its weaknesses. The central objective of this phase therefore is to reduce the proportion of infected women and men to 50% by 2010. Attainment of this objective will necessitate intervention in seven domains: counselling and voluntary screening to scale up awareness of personal serological status amongst women and men; prevention and control of STIs to reduce their prevalence; promotion of the use of condoms to 80% (from 41% for women and 54% for men); blood transmission safety; reinforcement of prevention of HIV amongst children and women; and the reduction of PMTCT among breastfeeding babies to 50%.

There are five major strands of intervention strategies under the 2006-2010 NASP aimed at correcting the shortcomings of the 2000-2005 NASP, while taking up new challenges.

5.6.1 Research and epidemiological surveillance

The 2006-2010 NASP envisages the promotion of research and the application of results, with emphasis on research on vaccines, the diffusion of research findings and ways to involve tradi-paractiners in research. On epidemiological surveillance, the major strive here is to produce viable data on HIV/AIDS, STIs and HIV opportunistic infections.

5.6.2 Involvement of all sectors

Following the success of private actors, NGOs and the civil society under the 2000-2005 NASP leading to a drastic drop in the cost of ARVs and an increase in the number of PLWHA under treatment, an increase in awareness of the pandemic and the introduction of PMTCT, the new strategic plan aims at reducing by half PLWHA in the various sectors.

¹⁰⁰ *Cameroon Tribune* (n 86 above) 3-5; *Situations* 5 (3 March 2006); *La Gazette* No 23 (March 2006); *The Post* 0744 (3 March 2006).

¹⁰¹ CNLS 'Plan stratégique de lutte contre le SIDA au Cameroun 2006-2010' (2006) *The Post* 0744 (3 March 2006).

5.6.3 Management of children affected by HIV/AIDS

The NASP 2006-2010 also proposes the management of orphans and vulnerable children affected by HIV/AIDS, notably in terms of access to health care, education and nutrition.

5.6.4 Access to medication

The target of the precedent NASP was to reduce the cost of ARVs and to place at least 50 000 infected persons on ARVs by 2005. By the end of that phase, 75 000 were on ARVs, representing 18% of all infected persons. The new NASP aims at placing all HIV-infected children and 75% of the infected adult population on ARVs and providing free treatment to 10% to 75% of disserving cases, while ameliorating the nutritional levels of 50% PLWHA generally.¹⁰²

5.6.5 Co-ordination, follow-up and evaluation

This is a very important arm of, and a summary of, the great challenges awaiting the new NASP as its focus transcends all HIV/AIDS control strategies and seeks to address specifically the difficulties and shortcomings of the first NASP. Concerning follow-up and evaluation, unlike the first NASP, the second seeks to cure problems of follow-up and evaluation which in some cases led to poor policy implementation and the improper handling and analysis of data. The follow-up and evaluation will therefore centre on good decision making for a better orientation of HIV/AIDS control and the judicious use of funds. There will be close monitoring of the implementation of the new NASP to identify hitches and take prompt remedial action. With regard to co-ordination, the new plan resolves to discard unco-ordinated control efforts that were a hallmark of the period of the 2000-2005 NASP, especially in relation to research. For this to be attained, there must be a synergy in the present institutional framework, running from central structures to decentralised structures and bringing together a greater part of available funding.¹⁰³

6 Towards rethinking strategies

Never before has humankind been concerned and involved in any health crisis of the magnitude of HIV/AIDS. Indeed, the fight against this pandemic will go down in history. It is the most acute and dramatic of illnesses, perhaps equal to or second only to the Black Death that swept across 14th century Europe. It is most interesting to note that,

¹⁰² *Cameroon Tribune* (2 March 2006) 8.

¹⁰³ As above.

although the HIV/AIDS pandemic stands as the most dreadful of pandemics in modern times, it is only the world's fourth greatest cause of death, but most important in sub-Saharan Africa.¹⁰⁴ The fact that the pandemic accounts for the greatest mortality rate in sub-Saharan Africa, replacing malaria, is indicative of recent concerns and trends in state policies in the region to stage a stiffer resistance to the pandemic.

The HIV/AIDS control programme in Cameroon has been pragmatic in its early efforts, culminating in the setting up of the NACC and the drawing up and implementation of the NASP. Collaboration between government and actors of the private sector has been a wise step towards decentralising the control that requires the attention and assistance of all to put an end to this global health dilemma. But many challenges remain and should be addressed to ensure success of strategies to prevent its propagation. The concept of the change in behaviour of people is a strategic and central component of HIV/AIDS control, and must also be transposed to the level of management of HIV/AIDS funds and implementation of policies.

There can be no successful HIV/AIDS control programme if research strategies among major actors (public and private sectors) are isolated and diverse. The new 2006-2010 NASP outlined above proposes to put an end to this. Not only should there be harmonisation between public/private sector strategies within the framework of NASP, but it will be conducive to have the public/private partnership in HIV/AIDS control reinforced by integrating the services of private enterprises into the national structure. There is a serious lack of horizontal power at the institutional level in the practical management process of NASPs that may be hampering effective policy implementation. The problem is that the NACC is chaired by the Minister of Health who is practically on the same level of power with other ministers and cannot, politically, give them binding instructions. Rather, a typical vertical power structure should be employed to circumvent this institutional handicap. Thus, the chair should be ensured by the Prime Minister and head of government, who is in a position to give instructions to all ministries.

For effective HIV/AIDS control, legislative measures should be taken to ensure binding principles. It is important to place HIV/AIDS strategies and related issues on a statutory footing in Cameroon. Legislation should not be limited to the rights of PLWHA and persons affected by HIV/AIDS in relation to discriminatory tendencies, labour rights, care, nutrition and blood transfusion issues. The rights of PLWHA should begin with the needs and a broad-based right — the right to health — involving effective access to sufficient reasonable medical care, without which any other rights cannot be enjoyed. In the absence of a bill of

¹⁰⁴ In 2005, North Africa and the Middle East had between 470 000 and 730 000 cases. See n 3 above.

rights or an express constitutional recognition of the right to health in Cameroon,¹⁰⁵ and against the background of a legislative vacuum, the ideal solution appears to lie in the adoption of a human rights approach to HIV/AIDS.¹⁰⁶ This approach will empower and enable PLWHA to face the pandemic with dignity and improve their quality of life since it (HIV/AIDS) cannot be tackled through traditional public health programmes.¹⁰⁷ However, it is of cardinal importance (especially as endorsed by the African Charter) that the state's obligation to respect, protect, fulfil and promote the fundamental rights equally entail obligations on the part of the right bearer. Thus, any conduct amounting to the wilful transmission of HIV should be severely reprimanded. This should equally apply to non-HIV-positive offenders who either intentionally or negligently transmit or cause the transmission of the virus. The rationale in the *Noumen Théophile* case and the laws of some countries of the SADC region, such as Zimbabwe and South Africa, are inspiring here.

¹⁰⁵ Contrary to other rights that have specifically been spelt out in the Preamble of the 1996 Constitution, such as the right to work and the right to property.

¹⁰⁶ S Gruskin *et al HIV/AIDS and human rights in a nutshell* (2004) 4.

¹⁰⁷ J Mann 'Human rights and AIDS: The future of the pandemic' (1996) 30 *John Marshall Law Review* 195.