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Positive Living: Nutritional Realities and Interventions for People Living with HIV/AIDS in Northwest Province, Cameroon

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Positive Living: Nutritional Realities and Interventions for People Living with HIV/AIDS in Northwest Province, Cameroon

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Abstract

In this paper I will discuss the range of realities and interventions relating to nutrition for people living with HIV/AIDS (PLWHA) in the Northwest Province of Cameroon. After discussing the background of the topic, including the HIV/AIDS epidemic and the facts about nutrition and HIV, I will move on to discuss the methodology and findings from my fieldwork in the provincial capital, Bamenda. In the section titled “Realities,” I will detail the poverty, local diet, and stigma that PLWHA face everyday, in the context of the province with the nation’s highest prevalence rate, and present PLWHA’s own justification of the importance of nutrition. In the next section, I will describe the existing interventions that address nutrition, beginning with public and government-based institutions and programs, such as the National AIDS Control Committee and National Strategic Plan, Provincial Technical Group in the Fight Against AIDS, Provincial Hospital, and ARV subsidies and Therapy Committees. I will next discuss two private interventions, Heifer Project International and the Mbingo Baptist Health Center. I conclude with recommendations for the future. Throughout the paper, data obtained from fieldwork in Bamenda and individual private interviews will be interspersed with information from official publications and reports.

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**Part I: Introduction**

Nutritional care has only recently come to the forefront as a critical component of any comprehensive treatment, care, and support package for people living with HIV/AIDS (PLWHA). In a developing country like Cameroon, myriad factors contribute to poor nutrition and low food security for many of the 5.5% nationwide living with the disease. In this paper, I will first explain the HIV/AIDS epidemic, the importance of good nutrition to PLWHA, nutrition’s relationship with antiretroviral (ARV) therapy, and justify the topic of study. I will then move on to report my findings on the realities, nutritional and otherwise, that confront PLWHA living in Bamenda, the provincial capital of Cameroon’s Northwest Province, from poverty to stigma to the local diet. Next, I will discuss the interventions that exist to address nutrition for PLWHA in Bamenda, including both public and private initiatives. Finally, I will draw conclusions based on my findings and suggest questions to investigate further in the future.

**The HIV/AIDS Epidemic: From the Global to the Local**

The HIV/AIDS epidemic threatens to be the world’s hardest-hitting disease in human history. HIV/AIDS does not discriminate: it has infected and affected people of every race, creed, gender, nationality, ethnicity, age, and income. Today, 39.5 million people are living with HIV, the virus believed to cause AIDS; 4.3 million have become infected with HIV over the past year; and 2.9 million more have died of AIDS in that same time period. Globally, there is an adult (ages 15-49) prevalence rate of 1.0%, and 39.5 million of the world’s six billion people are living with HIV. ¹

But an astounding two thirds, or 24.7 million, of all people living with HIV/AIDS (PLWHA) can be found in sub-Saharan Africa. Here, the adult prevalence rate is five times as

high as in the next hardest-hit region of the world, the Caribbean—5.9% to its 1.2%. Over half of adults and children newly infected in 2006, 2.8 million out of 4.3 million, are located on the world’s poorest continent. Surely, the AIDS epidemic is a global problem, but any treatment of the subject must acknowledge its uniquely widespread impact throughout Africa.²

Cameroon is no exception to the rule, and interestingly enough may even be the “birthplace of AIDS,” as researchers last May reported that its southeastern rainforests may have even been where the virus first jumped from chimpanzees to humans.³ The country suffers from the highest prevalence rate in the Central Africa region, along with the Central African Republic. Its adult prevalence rate of 5.5% is quite representative of the continent-wide epidemic, as is its unequal gender distribution—6.8% of women are infected, compared with only 4.1% of men. The most vulnerable groups have been identified as truck drivers (a prevalence rate of 16.28%), sex workers (26.39%), people aged 30-34 years old (9%),⁴ and young people in general—over a third of infected Cameroonians are 15-29 years old.⁵ Transmission of the virus is primarily due to heterosexual unprotected sex, but there are also a significant number of mother-to-child and blood transmission cases.⁶ And the crisis may not lessen in the near future. In the last year, according to the United Nations Joint Programme on HIV/AIDS’ December 2006 AIDS Epidemic Update, “There appeared to be a simultaneous shift towards both safer and high-risk behaviours—with increases in the percentages of young people who engage in high risk sexual activities occurring alongside rising rates of condom use during casual sex with a non-regular partner, for example.” Paradoxically, there is a “widespread awareness of AIDS, but poor

⁶ NACC, Cameroon’s Response to HIV/AIDS.
knowledge of HIV” and its transmission.7

Within Cameroon, the most critical HIV/AIDS situation can be found in the Northwest Province, which has the highest prevalence rate in the country: 8.7% total, 5.2% for men, and 11.9% for women. There are 88,373 PLWHA in the province, out of 505,000 nationwide. The infection rate is higher in urban areas than in rural areas, but interestingly, there is a steady increase in rural infection. Risk factors include being more educated, working, self-sufficiency, and being separated from marital homes. Especially vulnerable groups here include hairdressers, who often use the same needles on many clients to braid their hair, and farmers.8

The AIDS crisis in Cameroon must be considered in a wider context. Ranked 144 out of 177 countries on the United Nations Development Program’s Human Development Index, Cameroon is listed as a country of “medium human development.” Half the country lives on less than $2 US per day. According to the World Food Programme, Cameroon is a “low-income, food-deficit” country, and coverage of its food needs has actually decreased in the last 20 years, from 96% coverage in 1980 to 80% coverage in 2003. Life expectancy at birth has also experienced a decrease in recent history, according to UNICEF: in 1990 it had risen to 53 years from 44 years in 1970, but had dropped to 45.7 years by 2004.9

Food Security, Nutrition, and HIV/AIDS

PLWHA often suffer from food and nutrition insecurity due to a loss of productive labor, income, savings, and food reserves, as well as general poverty. These factors restrict food availability and access, and ultimately have an effect on proper nutritional care and support.10

7 UNAIDS, AIDS Epidemic Update.
Unfortunately, “AIDS disproportionately strikes the most productive members of society.”\textsuperscript{11} In the developing world, the most productive members of society are an integral part of the agricultural workforce, and so often this loss of labor has a scope beyond the individual. If a PLWHA is sick, then he or she is less able to work normally, earn income, and produce food, leading to nutritional deficits for themselves as well as their dependents,\textsuperscript{12} which in Africa can include both their immediate as well as many members of their extended family. According to the United Nations’ World Food Programme, “the pandemic worsens malnutrition and reduces the amount of food available to the world’s poorest and most vulnerable people.”\textsuperscript{13}

In \textit{Development as Freedom}, Amartya Sen explains the fundamental causes of hunger:

What is crucial in analyzing hunger is the substantive freedom of the individual and the family to establish ownership over an adequate amount of food, which can be done either by growing the food oneself, or by buying it in the market. A person may be forced into starvation even when there is plenty of food around if he loses his ability to buy food in the market, through a loss of income\textsuperscript{14}…For those who do not themselves produce food, or do not own the food they produce, the ability to acquire food in the market depends on their earnings, the prevailing food prices, and their nonfood necessary expenditures.\textsuperscript{15}

Although Sen did not write this with PLWHA in mind, it captures perfectly the economic underpinnings of the dire situation that many face when their ability to generate either income or food is diminished due to the disease.

Even when PLWHA are able to afford food, they may not be able to eat it, or their bodies may not be able to absorb it. A very common result of HIV/AIDS infection is reduced food intake, due to a diverse range of causes. According to the Food and Agriculture Organization, both illness and medications may reduce appetite and alter the taste of food. Common symptoms

\textsuperscript{13} UNAIDS. “WFP becomes 9th cosponsor of UNAIDS.” 16 October 2003.
\textsuperscript{15} Ibid, p. 164.
like sore mouth, nausea, and vomiting can make eating a struggle. Psychological side effects like tiredness, isolation, and depression may also diminish the desire to eat and the willingness to prepare food and eat regularly. Finally, all of these are compounded by a lack of money to buy food.\textsuperscript{16} PLWHA also experience reduced food intake due to malabsorption, which is often due to frequent bouts of diarrhea and infection of the cells of the gastro-intestinal tract. Transport, storage, and use of some nutrients are also affected, and the body is constantly utilizing antioxidant vitamins and enzymes when the immune system is fighting constant inflammation and infection.\textsuperscript{17}

However, it is crucial that PLWHA have access to good nutrition as part of a comprehensive care, treatment, and support package, for several key reasons. First, eating well is critical in maintaining the immune system, as HIV/AIDS progressively damages the immune system, rendering the person susceptible to a range of opportunistic infections from tuberculosis to pneumonia.\textsuperscript{18} Food can provide a “first line of defense” against the detrimental effects of the illness and help ward off disease.\textsuperscript{19} For instance, tuberculosis “is more common, and gets worse more rapidly, in those who are malnourished.”\textsuperscript{20} A PLWHA who has adequate food security and nutrition is much less likely to fall ill with opportunistic infections, and much more likely to recover from them, according to WHO.\textsuperscript{21}

Second, PLWHA have increased energy needs, due to an altered metabolism and elevations in resting energy expenditure (REE), which means that they must consume more

\textsuperscript{17} SARA p. 7
\textsuperscript{18} WHO, “Fact sheet.”
\textsuperscript{21} WHO, “Fact sheet.”
calories simply to prevent weight loss and wasting by maintaining their body weight. According to WHO, energy requirements are increased by 10% during the first stage of asymptomatic HIV, 20-30% when fighting secondary infections, and 50-100% for HIV-positive children, who need energy to grow as well as maintain vital functions.\(^{22}\)

Most importantly, nutritious food helps PLWHA stay healthier and productive longer, thereby improving their quality of life.\(^{23}\) Though good nutrition is not a substitute for life-extending ARV therapy, it can increase the time between initial HIV infection and full-blown AIDS, thus keeping PLWHA active, allowing them to take care of themselves and dependents. The longer a PLWHA is able to remain productive and able to work, the longer they are able to grow food and contribute to the income of their families and keep food on the table.\(^{24}\)

**Recommended Diet for PLWHA**

So what should PLWHA eat? The World Health Organization recommends the same regimen as it does for the population at large, which is simply a balanced diet. “A good diet that provides the full range of essential micronutrients is important to the health of people infected with HIV and can help bolster the immune system, boost energy levels and maintain body weight and well-being.” It does not recommend any special dosages of micronutrients.\(^{25}\)

The FAO, in conjunction with WHO, has produced a booklet called *Living Well with HIV/AIDS* with poor populations in mind, and offers this specific advice: eat a variety of foods; eat staple foods with every meal; eat legumes if possible every day; eat vegetables and fruit every day; eat animal and milk products regularly; use fats and oils as well as sugar and sugary

\(^{22}\) SARA, p. 7.
\(^{23}\) UNAIDS. “WFP becomes 9th cosponsor of UNAIDS.” 16 October 2003.
\(^{24}\) WFP, “Nutrition and HIV.”
\(^{25}\) WHO, “Fact Sheet.”
foods; and drink plenty of clean and safe water.\textsuperscript{26}

**ARVs and Nutrition**

Antiretroviral therapy has been hailed as a miracle for PLWHA, as it can “greatly decrease the viral load and significantly slow the progression of the disease, thereby increasing life expectancy and improving quality of life.” But nutrition must be considered even here, for two reasons. First, food can affect the absorption, metabolism, distribution, and excretion of medication.\textsuperscript{27} According to WHO, “optimal antiretroviral treatment requires safe, clean drinking water and a balanced diet rich in energy, protein, and micronutrients.”\textsuperscript{28}

Second, failure to manage the interplay between ARV and food can also affect PLWHAs' adherence to drug regimens. Non-adherence to drug regimens involves failure to follow drug schedules, taking incorrect doses, failure to follow other drug directions, or stopping consumption of the drug altogether.\textsuperscript{29} Distressingly, lack of food is often cited as the most likely cause of non-adherence to ARV, and critics discuss the “irony, not captured in the discourse on treatment advocacy, in providing ARV drugs to populations that lack access to safe water or food.” As such nutritional counseling must play a key role for such patients in ensuring the efficacy of and adherence to ARV therapy.\textsuperscript{30}

**Justification of Study**

The topic of HIV and nutrition is timely, as the importance of nutrition as part of a comprehensive care, support, and treatment regiment for PLWHA is a relatively new topic in the research and development communities. Comparatively little research has been done on the subject, either scientific or intervention-oriented, and it has only recently become the focus of

\textsuperscript{26} WHO/FAO, *Living Well with HIV/AIDS.*
\textsuperscript{27} Castleman, et al
\textsuperscript{28} WHO, “Fact sheet.”
\textsuperscript{29} Castleman, et al. “Food and Nutrition Implications of Antiretroviral Therapy in Resource Limited Settings.”
\textsuperscript{30} UNAIDS, *AIDS Epidemic Update.*
several conferences and study groups. However, as more research is done, the role that good nutrition can play in ensuring the efficacy of antiretroviral (ARV) drugs and patient adherence to ARV regimens has only been underscored. Currently, a little less than a quarter of the estimated 4.6 million people in need of ARV therapy in the Sub-Saharan region are receiving it, \(^{31}\) but as ARV treatment begins to become accessible to the poorest populations in the world, who disproportionately suffer from undernutrition and low food security, the international HIV/AIDS community must learn to overcome these challenges if ARV treatment is to be universally successful.

This topic is also relevant, as good nutrition for PLWHA is an important part of staving off opportunistic infections like tuberculosis and pneumonia, preventing wasting, which is considered the hallmark of AIDS patients; and helping to maintain patients’ dignity and strength for positive living. As such, it is imperative that the HIV/AIDS care community learn how best to encourage PLWHA to adopt good nutritional practices and, if necessary, change behavior. However, the best justification perhaps can be found in the problem statement and justification for a training workshop for lab technicians on HIV diagnosis, held at Alpha Royal Clinic in Bamenda and sponsored by New York University’s School of Medicine:

Cameroon has all the strains of HIV/AIDS and an analysis of the situation indicates that there is a continuous increase in the number of persons infected and affected. Statistically, many people become aware of the seropositive status only when they become sick. \(^{32}\)

As such, it is imperative that the international and local HIV/AIDS care communities become as informed as possible on prevention, treatment, care, and support in Cameroon, as the epidemic threatens only to widen in the future.

\(^{31}\) UNAIDS, *AIDS Epidemic Update.*
\(^{32}\) NYU School of Medicine. “Training Workshop for Lab Technicians on HIV Diagnosis.”
Location: Bamenda

Bamenda is the provincial capital of the Northwest Province, which, along with the Southwest, comprises Anglophone Cameroon. Although my topic was pretty far removed from the political sphere, it is necessary to mention Bamenda’s political and linguistic landscape as it may have intangibly influenced some of my interactions, and has certainly influenced the “feel” of the city. Bamenda has served as the seat of political opposition to the current administration since the 1992 presidential elections, in which a Bamenda-based opposition leader, John Fru Ndi, earned more votes than incumbent President Paul Biya, who simply rewrote the results and was backed by the Supreme Court into the position of power that he still maintains after 26 years. Today, the main political pressure group in Bamenda is the Southern Cameroon National Congress, which claims that Anglophone Cameroon, which was colonized by the British rather than the French after the Germans left, was never part of French Cameroon and therefore should never have been joined with it after Independence. As such, they advocate a “restoration” of the former federal system, in which the Northwest and Southwest Provinces would be a separate state from the other eight Francophone provinces, and so independently governed.

As a provincial capital, Bamenda is a relatively large city, both in size and population. Its boundaries stretch far beyond its busy and crowded commercial heart of Commercial Avenue and its governmental center of Upstation. Its British heritage translates to a dearth of boulangeries relative to its Francophone counterparts, and the constant ma cheries and la blanche are replaced with “my friend” and whiteman; surprisingly, hissing and kissing sounds apparently translate well across linguistic boundaries. The major ethnic groups are Bafut, Mankon, Bali, Nkwen, and Mendakwe, all of whom dominate the local traditional chief leadership system of fons and fondoms throughout surrounding villages. However, there is a
small but strong presence of Fulani Muslim cattle herders, who are often treated as second-class citizens by the strongly Christian and agriculturally-based dominant Bafut.

Bamenda is often considered a “poor zone,” despite the decoys of astoundingly large mansions that dot Upstation on the way into town. The city certainly harbors a mix of the financially well-off and the downtrodden, as it is not uncommon to see well-suited businessmen passing a beggar woman in the street. The city also has a distinctly Western flavor, but it is more like Great Britain in the mid-1990s than 21st century America, as the fashions of the former era either have staying power here, or it has taken the last 10 years for them to reach this small vestige of the Commonwealth.

During my time in Bamenda, the weather settled deeper and deeper into the dry season pattern, as the red harmattan dust became more and more unsettled, eventually coming to deposit itself in every pore of my skin and every passage of my airway. However, the absence of thick, viscous mud meant that transportation was much easier than in the wet season, which greatly facilitated my fieldwork.
Part II: Methodology

In all, I interviewed six PLWHA, one in the village of Mambu-Bafut and the other five in different sections of Bamenda; of those, four were members of the Solidarity Group Ntarinkon, support group that my advisor, Nancy Bolima, is involved with. I also interviewed six government health care workers from different sectors, including a doctor, two social workers, a Community Relay Agent, a nutritionist, and an administrator/doctor; all were associated with the Provincial Hospital, Day Hospital, or Provincial Technical Group for the fight against HIV/AIDS—Northwest Province. In addition, I sat in on an ARV Therapy Committee meeting at Mezam Polyclinique, a private hospital designated as an HIV/AIDS treatment center and thus permitted to dispense ARV drugs, and spoke with two doctors that were part of the committee. Additionally, I interviewed a nutritionist at the Baptist Health Center, and a staff member of the Heifer Project International—Cameroon, an international NGO.

For my fieldwork, I primarily utilized formal interview methods, though I did conduct a few semi-formal and one informal interview. Additionally, I consider the three and a half weeks spent living, working, and moving around Bamenda and its environs as a form of participant observation. As a new member of this community, it was imperative that I not remain an outsider looking in from a comfortably-removed vantage point, yet another whiteman working on HIV/AIDS. Instead, I made a concerted effort to take note, and take part in, the daily rhythms of the city, from share taxis (who knew you could fit eight people in a tiny coupe, two in the driver’s seat, when the car is a stick-shift?); to the national obsession, shared by my neighboring “homestay family,” with an English-dubbed Venezuelan soap opera called La Revancha; to the buyemsellems from which I always bought perfect papayas, pineapples, and carrots; to asking people “How is it?” instead of “How are you?” I believe that my fieldwork benefited
immeasurably by becoming a working, living, breathing resident of Bamenda, however short my tenure may have been.

As mentioned above, the majority of my interviews were formal interviews, for which I would set up an appointment and prepare questions in advance. During these interviews, I wrote down as much of my interviewees’ responses, verbatim, as possible. Though I tried to stick to the main, pre-arranged topics, often my interviewees would go off on an interesting or unexpected tangent, and I would follow them away from my preset agenda. Often this would lead to ideas or questions I had not considered before, and so remaining flexible during my formal interviews was essential to my fieldwork. In the few semi-formal interviews I conducted, I would arrive with questions in my head, and jot down notes during the exchange. I only conducted one informal interview, for which I recorded notes only after the conversation was over. Most of my interviews were set up in advance, usually with the help of Nancy, as she is on very good terms with most stakeholders in the provincial fight against HIV/AIDS and proved to be an invaluable networking resource and knowledge base.

**Initial Objectives/Project Evolution**

Originally, I set out to survey the nutritional landscape for PLWHA in the Northwest Province, by interviewing PLWHA, their caregivers, and health care workers. My initial objective was to determine the perceptions of nutrition by PLWHA; the realities confronting them due to their seropositive status and their location; and the interventions currently in place to address the nutritional needs of PLWHA in the province.

However, in facing the constraints and limitations discussed below, I eliminated the “perceptions” piece and came to focus solely on the realities and interventions. In doing so, I came to realize that there are many “realities” that factor into PLWHAs’ inadequate food and
nutritional security that go beyond simple poverty, including stigma, and I came to see the nutritional puzzle as pieced together out of so much more than the local diet. Similarly, one cannot discuss nutritional interventions without discussing the larger context of HIV/AIDS prevention, care, support, and treatment in Cameroon and the Northwest Province, most of which is administered through the National AIDS Control Committee and the National HIV/AIDS Control Strategic Plan. At the same time, it was difficult to locate more than two private initiatives that addressed nutritional issues, and so I ended up focusing more on the public HIV/AIDS structures than I initially expected.

Constraints/Limitations

The most influential limiting factor in carrying out my research was access to PLWHA and their home caregivers. Initially, I had wanted to interview 15-20 PLWHA, along with each of their caregivers, in order to obtain a representative sample, as well as introduce a range of experiences into my findings. However, three connected root problems prevented me from reaching my goal—stigma, privacy and confidentiality, and time limitations. Concerning stigma, because I was known to be researching HIV/AIDS, some people were afraid to talk to me because they thought that if others saw us together, they would assume that my interviewee is seropositive. Similarly, health care workers were reluctant to introduce me to PLWHAs around their offices, or to allow me to simply talk with people waiting, in order to respect the patient’s privacy and confidentiality; in a country with very few privacy laws, I was very impressed by these efforts. Finally, because I had only three and a half weeks total in Bamenda, and only three weeks to complete my fieldwork, I was extremely limited in the depth of relationships that I could build with potential informants. If I had three months instead of three weeks, I would have ideally been able to cultivate friendships with PLWHAs, and so build trust over time with people
who may not have been willing to speak with me initially, as well as gain access to their family and caregivers.

In the majority of instances, being in Anglophone Cameroon was a facilitating factor, as I was thus on my lingua terra firma of English rather than the unstable ground of my shaky French. However, in some cases it proved to be something of a challenge because many people can only speak Pidgin English, and so mutual understanding was limited to greetings and very basic facts. For nuance, a translator was necessary, and my advisor, Nancy Bolima, was able to perform this role, greatly easing the linguistic pressure of several interviews.

Although mentioned previously in the context of access to PLWHAs, the time constraint of three and a half weeks was acutely felt in all aspects of my research. Because I had only spent a weekend in Bamenda before, I had to spend some time learning the physical and sociological layout of a new city, as well as discovering the nuances of optimal day-to-day functioning, from picking up necessary Pidgin phrases to knowing the difference between a fair and whiteman taxi price. The time limitation also meant that I was unable to interview informants more than once, which I think would have greatly enhanced the depth of my fieldwork.

Facilitating Factors

I was very fortunate to have a very active advisor, Nancy Bolima, who was both extremely knowledgeable in my subject matter as well as extremely well-connected to the local HIV/AIDS network. As a well-respected social worker for Alpha Medical Services Organisation (AMSO), a local non-governmental organization (NGO) “committed to providing adequate health care to rural communities by fighting HIV/AIDS and other diseases,”33 especially through the creation of Local AIDS Control Committees (LACCs), Nancy was uniquely well-positioned

to introduce me to a wide range of health care workers, local and provincial officials, and PLWHAs. More often than not, if Nancy had not directly connected me to an interviewee, my legitimacy would be immediately established as soon as I mentioned that I was working with her.

Additionally, my project was also facilitated by the fact that nutrition and HIV/AIDS is a topic of rising importance, both globally and locally. International organizations like the United Nations Joint Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), the UN Food and Agricultural Organization (FAO), and the UN World Food Programme (WFP) have all begun looking more in depth at the relationships between nutrition, hunger, food security, anti-retroviral drugs, and HIV/AIDS at policy, research, and practical levels. Similarly, health care workers in the Northwest Province have started to understand and educate others on the importance of good nutrition for PLWHAs, and many want to know and do much more in the future. Almost everyone I talked to, from the PLWHAs themselves to doctors to NGO employees like Bih Afanga of the Heifer Project, that this is “something which needs to be addressed,” and that they hope to utilize my findings in their own lives and programs.

Finally, the Northwest Province’s strong network for HIV/AIDS care, support, and treatment greatly aided me in my research. The strong presence of both public programs (the PTG, the Day Hospital, LACCs) and private undertakings (the Baptist Health Center, various international and local NGOs) meant that there was a large pool of dedicated and informed individuals to interview. Whether or not this is in response to the Northwest’s high prevalence rate, a contributing factor (people may come here for treatment and thus artificially raise the rate), or a happy coincidence is as yet unknown, but my work certainly benefited from the high concentration of HIV/AIDS personnel, institutions, and projects.

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Part III: Realities

In the Northwest Province, each PLWHA faces a uniquely challenging reality. However, there are several elements common to all of their experiences, all of which affect nutrition. The first is that their experience is widely shared, as the Northwest Province is home to Cameroon’s highest HIV prevalence rate. Second, most are poor, and poverty’s effects are deep and wide-ranging, especially concerning food and nutrition. Third, most share a common culture and traditional local diet. Fourth, many must confront appalling and staggering stigma.

The veritable icon of global health, Paul Farmer, has written, “To explain suffering, one must embed individual biography in the larger matrix of culture, history, and political economy.”35 In the following sections, I will attempt to explain a part of that larger matrix. However, the stories of individual biography must also be shared and told for others to make sense, on a human scale, of that larger macro-matrix. As such, I will relate, alongside the facts and others’ remarks, PLWHAs’ own words on the realities they face each day, and in the last section, I will allow PLWHA themselves to explain why good nutrition is important in their lives.

Highest Prevalence Rate: An Unsolved Mystery

Perhaps the most pertinent reality facing PLWHA in the Northwest Province is that this reality is shared by so many: the Northwest Province suffers from the highest HIV/AIDS prevalence rates in the country, 8.7% total and 11.9% for women. Statistically speaking, that means that for every ten women I met, selling in the market or greeting me “good evening” while “doing the sport,” at least one was likely to be a PLWHA. The reasons behind this are unclear and unproven, but there are several theories among local care providers. Some, like my advisor

Nancy Bolima, believe that the high level of psychosocial care that is available in this province convinces many PLWHA originally from other provinces to move here for treatment, and so the rate has become artificially inflated. She also thinks that many home caregivers may not be educated enough on prevention and so many caregivers become infected through their care of PLWHA.

Another theory is that traditional cultural practices have a much larger role in the spread of HIV infection than previously thought, especially in an area with polygamous populations and traditional leadership structures, like the Northwest’s fons and fondoms. Dr. Kefie Arrey, at the Provincial Day Hospital in Bamenda, concurs, and he is not the only one: on the launch of World AIDS Week in Bamenda in late November, Cameroon’s Ministers of Public Health, Social Affairs, and Women’s Empowerment were all present to sign a convention of commitment with all 300-plus of the Northwest’s fons and traditional leaders. Dr. Arrey hypothesizes that a number of factors combine to produce prevalence rates that are higher within fons’ palaces relative to the general population. He believes that infidelity of both sexes is rampant within fons’ palaces, since a fon may have 20 or even 30 wives, many who are 15, 30, or even 40 years his junior; young wives may be sexually unsatisfied, and fons may have partners outside his sanctioned milieu. Another contributing tradition may be widow inheritance, in which a man’s wives, as his property during life, may be inherited by his relatives or used to pay off debts after his death. Dr. Arrey also cites traditional dances as a contributing factor to promiscuity, as there is a tendency to become very drunk and engage in unprotected sexes.

However, the problem is not confined to the Northwest. In fact, as the New York Times

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36 Bolima, Nancy. Advisor meeting, 15 November 2006, PTG.
37 Ibid.
38 Arrey, Dr. Kefie. Formal interview, 29 November 2006.
39 Ibid.
40 Ibid.
recently reported with a byline from Southern Cameroon, “Researchers have come to agree [that] a host of traditional ceremonies and practices is creating transmission routes unique to Africa— dangers that have, up to now, been ignored.” In the Southwest Province and elsewhere across Africa, genital mutilation (also called female circumcision) and scarification are conducted with instruments of questionable cleanliness and sterility, practices like community breast-feeding are deeply entrenched in the social order, and many traditional healers’ “remedies” involve cutting and “blood-letting.”  

Clearly, the Northwest Province is not the only place where potentially dangerous cultural practices can be found in Cameroon. So what else may contribute to its singularly high rate? Dr. Arrey has another suggestion—feminism, or rather, one form of it. Though women in the Northwest do not enjoy gender equality by any measure—the “man is still supreme”—but they do possess a relative freedom of mobility within their communities. Many are highly visible in their occupations in the market, on the street, or in shops. This contrasts sharply with many Muslim women of the North, who are often housewives and stay almost exclusively within the confines of their home or compound. Whereas the woman here is “open to the public,” and thus more exposed to infidelity and unprotected sex, the woman of the North is often closeted away or hidden behind her veil, and very unlikely to be unfaithful. But again, this is not a phenomenon unique to the Northwest; women of the West Province, and throughout the Grand-Ouest, are remarkably free outside the home, even if that freedom is checked at the marital home’s door.

Most likely, it is some unique synergy between all of these factors, as well the denial, low

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42 Arrey, Dr. Kefie.
condom use, and early marriages that can be found throughout sub-Saharan Africa, that sinisterly works to achieve the Northwest’s high prevalence rate.

**Poverty: “A Poor Zone”**

There can be no discussion of good nutrition for PLWHA without first examining the most difficult reality of all for most of them, backbreaking and unrelenting poverty. The Northwest’s high prevalence rate combines with widespread poverty to produce a dire situation, nutritionally speaking or otherwise. The single most common response to the question, “What is the greatest challenge that PLWHAs face in getting good nutrition?” was poverty. PLWHA often spoke of “no finances” and “financial problems,” explaining that “if you don’t’ have the means” then good nutrition is simply not affordable. Prisca Amajeh, whose husband is also HIV-positive, described her situation succinctly: “Most things we need, we need to buy, so if there’s no money then we cannot afford it.” Though they work a farm plot on which they grow corn, yams, and groundnuts, their situation is insecure; the plot may be taken away from them next year. It is in this context of uncertainty that Prisca’s family must strive to eat enough to stay healthy and productive.

As the nutritionist at the Provincial Hospital, Balbina Nkwain, plainly stated, “What is killing us in Cameroon is poverty. They just die, there is no way out when they don’t have the monies.” Though this is also not unique to the Northwest Province, the area is a “poor zone,” according to the Director of the Provincial Technical Group in the Fight Against HIV/AIDS, Dr. Magdalene Mayer. Income-generating activities are hard to find and sustain, people generally don’t have the requisite technical skills to fully exploit the land, and consequently, productivity

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45 Ibid.
is very low. 47

All of which is made immeasurably worse for PLWHA and their families. According to
the PTG, “A process of impoverishment develops with increased household costs,” including
medications and food, “and diminished capacity to meet them because of the loss of productive
labour of both the sick persons and the caretakers.” 48 As the family becomes poorer and the
PLWHA is less able to work, food and nutrition become less and less important or accessible.
As Dr. Mayer notes, “what little money they have they spend on medications rather than proper
nutrition for themselves,” and even if they don’t need money to buy food (for example, if they
own their own farms or gardens), many choose instead to get money for medications by selling
the food rather than feeding themselves. 49 And PLWHA are not the only ones who suffer,
especially in farming families, as once they become sick, there is “nobody there to tend the
crops, to harvest, to feed the family.” 50

Local Diet: Imbalance Among Plenty

Like most of the cultivation-heavy Grand Ouest of Cameroon, the diet of the Northwest
Province is full of carbohydrates and starches, with animal products and meat less common.
Meals are often anchored by a staple food like yams or rice, accompanied by a sauce made from
peanuts, tomatoes, or other vegetable or protein mix. The signature dish is achu, made from
taros and drenched in a day-glo orange sauce, eaten by scooping up by hand the sauce with the
taro mush. Another popular food is njama njama, a bitter green leafy vegetable cooked heavily
in palm oil. Fruits, vegetables, and spices are plentiful and cheap relative to other regions.

When I was in Bamenda, one could easily find gorgeous pineapple, papaya, watermelon, banana,

47 Mayer, Dr. Magdalene. Formal interview, 17 November 2006.
49 Mayer, Dr. Magdalene. Formal interview, 17 November 2006.
50 Ibid.
bananas, *pawpaws* (like a mix between a papaya and a pumpkin), and avocados; green beans, tomatoes, carrots, onions, cabbage, vegetables (a catchall phrase, also found in French as *legumes*, that is used to denote any and all green, leafy vegetable), and peppers; and basil, garlic, *piment*, celery root, ginger, ginseng, and white peppercorns.

As the nutritionist at the Provincial Hospital, Balbina Nkwain, said, “In town, food is cheap and we have much different varieties. What bothers us here is the way they find their foods and how they prepare it, too.” 51 Despite the veritable cornucopia of agricultural goodness, fresh produce does not often figure prominently into most meals, are often unrecognizably processed by the time they are eaten, and many times are not as nutritious as they look. Balbina explained that farmers in the area “use a lot of fertilizers, which results in the foods containing less nutrients, and so people need to eat more food to obtain enough vitamins.” 52 She also explained with frustration people’s ignorance about overcooking food, washing out vitamins, and the universal overuse of palm oil. “They will think that what they are eating is nourishing, but it is not.” 53

**Stigma: Crippling Effects**

Another startling reality for PLWHA in the Northwest Province is the level of stigma that many, if not most, confront within their communities, and even their own families. Local actors in the fight against HIV/AIDS note this as one of major challenges in delivering both prevention and treatment, care, and support activities. In an instance that may not be that extreme, in a report on the creation of a LACC in the community of Oshie, AMSO informed the PTG-NW, “A few people are of the opinion that HIV persons or PLWHA should be quarantined or given an

52 Ibid.
53 Ibid.
injection to die in order not to contaminate the rest. This is a serious threat to the idea of care and support to PLWHAs.” In the same report, AMSO suggested, “The aspect of care and support to PLWHA should be paid more attention to avoid stigmatization and the negative attitudinal dispositions noticed toward PLWHA.”

Sometimes the effects of stigma are crippling, and can even negatively influence a PLWHA’s nutrition or access to food. Before she became very ill and was diagnosed with HIV, Helena Mankaa owned and operated a small café-restau in town, selling achu, plantains, rice, beans and other small meals. But once her status became known, she related how “all my family run away from me,” except for one born-again Christian brother, and “people won’t buy my food because I am infected.” Whereas before she “was eating the little I had,” she was soon out of business and heading for a breakdown, jobless and penniless. Though she keeps a small garden with vegetables, huckleberry, and spinach, she struggles to simply eat enough to keep her weight up, testifying to the power of stigma to devastate PLWHAs’ daily lives.

In Their Words: The Importance of Nutrition to PLWHA

Winifred Beri knows more than a little about nutrition— in fact, she went to nutrition school, so “can share her knowledge with friends and support group” in Ntarinkon, and can add information at presentations. When a PLWHA is able to obtain good nutrition, she “feels healthy, has normal stool, less rashes and sores.” Proper nutrition “keeps the defense system strong,” and enables her to “feel happy and free” and to “live healthy like normal, not like an infected person.” So far she has not had any infections, though she was diagnosed in 2003; her husband is also infected, but so far neither of her two children born since then have been

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positive.\textsuperscript{55}

Prisca Amajeh, whose husband is also HIV-positive but so far all her children are negative, praised the effects of a “balanced diet,” as helping her to “look fresh and strong,” and “nobody knows that you’re sick.” Eating right “encourages me to live long,” and has seen a definite difference and improvement since she started paying attention to nutrition; before she was “always sick,” but now the changes have convinced her that “if you live strong, all things are possible.” In explaining why others should consider good nutrition, she said, “I want the people to live long and strong.”\textsuperscript{56}

Though stymied by stigma, Helena Mankaa has seen a great improvement in the last six months, in both her health and her outlook. In that time period, she joined the Ntarinkon support group, and saw the positive effects of the ARV therapy she was put on immediately when diagnosed one year ago. Though she has very little money, she tries to “go for balanced diet,” and “now that I know I am HIV I don’t buy rich things.” She also “thinks about it more now,” since “I know that I have to live healthy.” She eats the produce she grows in her garden, and for now is trying to find another means of employment to help support herself and her 18-year-old son.\textsuperscript{57}

\textsuperscript{55} Beri, Winifred. Formal interview, 27 November 2006.
\textsuperscript{56} Amajeh, Prisca. Formal interview, 27 November 2006.
\textsuperscript{57} Mankaa, Helena. Formal interview, 27 November 2006.
Part IV: Interventions

In examining the existing interventions in the Northwest Province that address PLWHA nutritional status and needs, I divide the field into two categories: public interventions, which include all activities that fall under the Cameroonian government’s national HIV/AIDS structure; and private interventions, which covers all non-governmental programs. The interaction between all of these actors is complex, and often their activities overlap or are coordinated, with many PLWHA benefiting from multiple efforts. Almost all stakeholders were at least aware of the others’ existence and purpose, if not intimately acquainted with the details of their programs. I will begin with addressing the public interventions, and then move on to the private interventions in the next section.

Public Interventions

As stated above, public interventions include all activities that fall under the guise of the Cameroonian government, whether at the national or provincial level. In discussing these efforts, I will move from the macro, national level, and move on down the ranks to look at the activities of individual health care workers. As such, I will begin with the National AIDS Control Committee’s National Strategic Plan. Next, I will look at the Provincial Technical Group—Northwest Province. I will then discuss the Provincial and Day Hospitals, including their nutritionist, social workers, and Community Relay Agents. Lastly, I will report on ARV subsidies and Therapy Committees.

National AIDS Control Committee/National Strategic Plan

The National AIDS Control Committee (NACC) was set up in 1986, in response to the first reported case of AIDS in 1985. Initially there was a low level of involvement of non-health sectors and the absence of a management scheme (prise en charge) for PLWHA, so its first
efforts met with mixed outcomes.\textsuperscript{58} Today, its activities are funded by a variety of international and national organizations and aid agencies, including the World Bank Multi-Country HIV/AIDS Program, WHO, UNAIDS, UNICEF, UN Population Fund, UNDP, FAO; French Cooperation, Canadian International Development Agency, German Technical Coordination (GTZ), and Belgian Cooperation (USAID is conspicuously lacking); the Global Fund to Fight AIDS, TB, and Malaria; International Red Cross/Red Crescent, Medecins sans Frontieres, the Cameroon Network of People Living with AIDS, CARE Cameroon, PLAN Cameroon, African Synergy and the Circle of Friends of Cameroon\textsuperscript{59}

The National HIV/AIDS Control Strategic Plan for 2006-2010 is Cameroon’s second such plan; the first was in place from 2000-2005. The NACC has identified three objectives to be accomplished by 2010:

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

Nutrition for PLWHA falls under the second objective of universal access, which is also in line with UNAIDS’ initiative towards the same goal. Of six specific objectives that are enumerated under this second macro-objective of universal access to treatment and care, the fifth is “to reduce malnutrition among 50% of PLWHA suffering from nutritional deficiencies,” through the following strategies:

Objective 5: Reduction of malnutrition:
- Instituting a national policy of nutritional management of PLWHA
- Paying particular attention to nutritional counseling within the purview of this national policy
- Adequate nutritional management of patients and their families\textsuperscript{60}

\textsuperscript{59} Ibid.
\textsuperscript{60} National AIDS Control Committee. \textit{National HIV/AIDS Control Strategic Plan—2006-2010}.
Beyond the rhetoric of the strategic plans, the national fight against HIV/AIDS has a real presence on the ground. The NACC has described this structure as “multisectoral and decentralized,” meaning that there is control of HIV/AIDS activities at the national, provincial, district, and community levels, not just at the central level. In order to coordinate activities among all levels, there is a Central Technical Group in Yaoundé for the Fight Against HIV/AIDS that oversees all 10 Provincial Technical Groups in each of the provincial capitals, which in turn supervise each of the District Medical Officers in the province; at the bottom of the hierarchy are Communal Correspondents from each community in the District.

According to WHO, “the political leadership in Cameroon has expressed a clear and strong commitment to the fight against HIV/AIDS since early 1986,” and their plan “also reinforces the country’s commitment to the UNAIDS ‘three ones’ principles—one agreed HIV/AIDS action framework that drives alignment of all partners; one national AIDS authority with a broad-based multisectoral mandate; and one agreed country-level monitoring and evaluation system.” But critical issues and major challenges remain. The current system “needs to be supported by strengthening the health system, both in terms of human resource and infrastructure capacity, especially at the district level. Additionally, “the overall management and coordination among partners needs to be strengthened, mainly at the peripheral level.”

Provincial Technical Group—Northwest Province

As mentioned above, the Provincial Technical Group—Northwest Province (PTG-NW), as a decentralized portion of the National AIDS Control Program, “coordinates, monitors, and supervises” all HIV-related activities implemented at the provincial level, according to PTG-NW Coordinator Dr. Magdalene Mayer. Its partners include NGOs, Common Initiative Groups

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(CIGs, or GICs in Francophone areas), associations, health facilities, informal and formal sectors, the community, enterprises, and international organizations. In short, it is the “focal point” of the fight against HIV/AIDS in the province.

Though the PTG-NW coordinates many diverse prevention activities, their focus has increasingly widened to include the care, support, and treatment of PLWHA. There are several underlying principles of HIV/AIDS care, support, and treatment at the provincial level. First, people with HIV can live for many years with “good quality life,” and with early care and support interventions and ART therapy, this period can be extended significantly. Second, the earlier HIV infection is detected, the more effective management can be. Third, care and support must include the affected as well as the infected, and programs need to target individuals, spouses, families, and communities.

The range of interventions is vast and deep, beginning with voluntary counseling and testing (VCT), and moving on to include psychological counseling at individual, couple, family and community levels and for caregivers; prophylaxis and management of opportunistic infections; positive living/lifestyle changes; home-based care; income-generating activities; providing legal support; social safety networks, support for organizations, reduction of stigma, discrimination, denial and ostracization; and nutrition and food security.

It is this last category of interventions by the PTG-NW that I will focus on. Though most activities are “outsourced” to the Provincial or Day Hospitals, which fall under the PTG-NW’s purview, they lend their support to such activities as nutritional education and counseling with flyers and pictorial information; peer support and education; demonstrations in communities and

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62 Mayer, Dr. Magdalene. 17 November 2006.
64 PTG-NW. “HIV and AIDS Care, Support, and Treatment.” Bamenda: PTG NW, 10-30 July 2006.
65 PTG-NW. “HIV and AIDS Care, Support and Treatment.”
patients’ homes; education on basic hygiene, water safety, adequate nutrition and how to manage common problems like nausea and diarrhea; and helping patients to understand food restrictions relating to therapy. Less often, they provide nutritional supplementation through multivitamins, food assistance, vegetables, and seeds; teach gardening skills; and support income generating projects.  

According to Dr. Mayer, many of these nutritional interventions are recent developments. “We started off timidly with [nutritional] care,” she said, but now the PTG-NW is “trying to realize nutritional aspects, since they were a little bit lacking in the early days.” She cites good nutrition as key to keeping healthy, and especially the handling of food in preventing secondary infections. However, in administering and ensuring the success of all of these endeavors, “money is the biggest challenge,” both in terms of funding by the PTG-NW and for PLWHA themselves.

**Provincial and Day Hospitals**

The Provincial Hospital for the Northwest Province is located in Bamenda, and within the hospital complex, the Day Hospital is exclusively designated to handle all HIV/AIDS outpatients and related activities, including CD4 counts and other laboratory tests, VCT, and, as a designated treatment center, ARV therapy. However, it also sees HIV-negative patients with malaria and other problems. It does not hospitalize patients overnight, and keeps strict a daylight-hours schedule.

Despite that it is the only hospital run at the provincial level, it is staffed by only one doctor and, last year, only four nurses. Dr. Kefie Arrey, the one doctor, notes that he sees so many patients each day that “at a certain point, the work is not effective.” Even though other

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66 PTG-NW. “Nutritional Assessment and Support in HIV.” August 2006.
doctors are trained to handle HIV/AIDS cases in other parts of the hospital, patients are reluctant to leave the Day Hospital with their blue file folder marked with “DH” under their arms for fear of resulting stigma. Nationally, Dr. Arrey notes that the “staffing situation is very poor”—doctors and nurses are aging, retiring, and going overseas “for greener pastures” and higher pay.\(^{67}\)

Though nutrition is of rising importance to the staff and patients of the Day Hospital, they do not have a nutritionist on staff, only social workers and Community Relay Agents that dispense nutritional advice. However, patients are sometimes referred to the one nutritional nurse, employed by the Provincial Hospital, found a few building away from the Day Hospital. Though in the past there was a certified dietician/nutritionist at the Provincial Hospital, she has since retired, and according to Dr. Arrey, you “can count the number of dieticians in the country,” and there was no one trained or available to replace her.\(^{68}\)

For patients who do venture over to the nutrition department, they will find a willing teacher in Balbina Nkwain. She advises eating a lot of foods with high calories, and notes that PLWHA “need a lot of nutrients to build them up” or they “will break down faster.” As such, she encourages “balanced and well-nourishing foods,” especially soya beans, groundnuts (which is the Pidgin word for peanuts), crayfish, fruits, and vegetables, and bans “stimulants,” such as anything hot or spicy, with excessive sugar, or alcohol. Since she knows most can’t afford ARV therapy if they need it, “not to talk of food,” she advises the following “1000-franc meal”: soya beans, groundnuts, or cornflower oil; green beans; vegetables, \textit{tomates}, onion, carrot, and salt. She tells PLWHA that if they maintain a balanced diet permanently, they will improve, and their CD4 count (a measure of the health of the immune system) will go up. In counseling both

\(^{67}\) Arrey, Dr. Kefie. Formal interview, 29 November 2006.

\(^{68}\) Ibid.
patients and caregivers, she often gives demonstrations in the nutrition department’s kitchen.
However, she spoke distressingly of the challenges that most face: “they have no food, no energy, no job, no drugs, so they die.” ⁶⁹

Within the confines of the Day Hospital, social workers provide psychosocial support and home-based carer training, of which nutritional counseling is a component. Two of these social workers are Esther Amungwa and Nicole Ndakwa, who are jointly employed by the Ministers of Social Affairs and Public Health. They advise the following to PLWHA: no smoking, alcohol, “exciters” (tea, coffee, or kola nuts), or stress, combined with a “balanced diet,” especially soya beans. Though they describe the province as a “poor setting,” they are “able to know a patient’s income and lifestyle from their history” and so adapt their advice accordingly. For patients on ARV therapy, they warn that you “can’t take drugs without good nutrition,” but if you adhere to both, then your immune system will be boosted, and there will be a “psychological improvement.” ⁷⁰

However, even if PLWHA accept their status and are coping, nutrition remains a problem due to several reasons, the “degree of destitution” ⁷¹ chief among them; both Esther and Nicole sometimes give money out of their own pockets to help patients buy food. They also describe HIV- and drug-related symptoms as barriers to good nutrition, since “a patient can have something to eat, but most have medical problems of losing appetite.” ⁷² Stigma also stands in the way. Esther described many mothers’ reactions to their children’s seropositive status: “You are my asset of tomorrow and you have disappointed me. I don’t want to see you again, you are

⁷¹ Ibid.
a failure to my life.” 73 “The real problem is that society doesn’t accept them; they can accept 50%, but not 100%.” Additionally, “if they deny their status, they won’t change” their diet; but if “they like to live, they ask lots of advice.” Further challenges to proper nutrition include weak support systems relative to ARV therapy; poor living conditions; ignorance; frustration; and depression. 74

For food and nutrition aid through social workers, funding is limited. There is a special fund set up under social affairs, NGOs can help, and church groups “like to feed,” so Esther and Nicole try to direct them to the neediest cases. They are currently considering applying for food aid from national or international agencies or organizations. Both lamented that there are drug subsidies but nothing to “subsidize feeding.”

Working in conjunction with doctors, social workers, and nurses are seven Community Relay Agents (CRA) based at the Provincial and Day Hospitals, one in the tuberculosis unit and six for HIV/AIDS, including Florence Amah. They are joined by 25 CRAs at private and district hospitals throughout the province. At the Provincial and Day Hospitals, the CRAs alternate weeks between the office and the field; three CRAs are in the office while three are in the field throughout the Province. Florence’s range includes the communities of Bafut, urban and rural Mankon, Nkwen, and Babanki. 75 She began working at the Day Hospital in 2002 as a volunteer worker, and was recruited in 2003 to be trained as a CRA for five years;

Her activities in the field include nutrition, clinical care, palliative care, financial support, psychological support, legal support, spiritual support, referral of clients and other patients to doctors and social workers, social assistance, sensitization on HIV/AIDS, and drug adherence.

74 Ibid.
and compliance. When in the Day Hospital, she focuses on information, education and communication; advice on drug adherence and compliance, positive living (including nutrition), condom use, and sanitation; and sensitization.76

In her post-test counseling sessions with her clients, she stresses the “need to live” on “balanced diet and fruits everyday,” and to stay away from smoking, drinking, eating kola “Bamenda red” beans, excessive pepper, spices, tea leaves, Lipton, Tole tea, and Nescafe. In her visits to PLWHA homes, she tries to give examples of the types of food that are around, asking, “Mama, do you know you grow balanced diet? Around you, what foods do you have? You have corn, beans, vegetables, crayfish. And beans are protein, corn is carbohydrates, green leaves are vitamins.” She also teaches patients how to prepare meals, focusing on “practical information.” She encourages patients to mix foods, emphasizing “clean, 100% hygiene” for meals by warming up meals to kill bacteria. If anything “worries their stomach,” she tells them to stop. Most people she visits in the community are farmers, so she advises them to grow soya beans and other “good foods” rather than go to market. Her advised balanced diet at the lowest cost includes crayfish, groundnuts, soya beans, and other beans; “you don’t need meat and chicken every day.” 77

Florence says she sees definite improvement among PLWHA who take her nutritional advice: “I was dying of ignorance, but now I am very happy.” Often if they are not on ARV therapy, they will question if they will die the next day, but she tells them they “need to rejoice” because their immune system is still strong. Thus they need to boost their health further with good nutrition, as “sometimes it helps them to stay off it.” 78

77 Ibid.
78 Ibid.
She lists the most critical challenge facing PLWHA as “no money,” especially since the “low class has been affected.” They simply “don’t have any money to buy food. If they are sick at home, they have no money for consultation, can’t take ARV in time, and can’t respect appointment dates due to financial difficulties.” Her words echo those of each and every person I interviewed on the topic—poverty is the major barrier in obtaining good nutrition for PLWHA.  

ARV Subsidies and Therapy Committees

Increasingly, ARV therapy is proving a critical ally in prolonging the lives of PLWHA and maintaining their health and productivity. As discussed in the introduction, good nutrition can only go so far in prolonging PLWHAs’ lives, and proper nutrition is essential in ensuring the efficacy of the drugs. Thus the two topics are closely related and ARV-based interventions in the province must also be discussed. Since the state controls the ARV supply within Cameroon, I have labeled ARV subsidies and Therapy Committees as a “public intervention,” though many private health facilities are involved in the process. Within each province, there are hospitals and clinics designated as “treatment centers,” which are the only medical facilities permitted to provide ARV therapy. Nationally, there are currently more than 25 approved treatment centers, including seven in the Northwest Province—the Provincial Hospital and Mezam Polyclinique in Bamenda; Njinikom Catholic Hospital, Banso Baptist Hospital, Batibo District Hospital, Wum District Hospital, and Nkambe District Hospital in more rural areas; and Mbingo Baptist Hospital (Bamenda), Shisong Catholic Hospital, and Mambu Catholic Hospital are all pending approval.  

As discussed above on the section addressing the NACC’s Strategic Plan, the government has identified universal access to treatment, care, and support for PLWHA as a goal for the

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79 Ibid.
period of 2006-2010. In a shift towards recognizing the increasingly important role that ARV therapy is coming to play throughout Africa, the metric of success for this goal is “To increase the percentage of adults and children infected by HIV, who are still alive and who are on ARV therapy 12 months after the beginning of treatment.” 80 But that is easier said than done, as drugs are expensive and must be paid for by patients themselves on a monthly basis, ad infinitum for the rest of their lives. However, recently, with funding from the state, the World Bank, and the Global Fund for AIDS, Malaria, and Tuberculosis, the government was able to subsidize ARV regimens, lowering their cost from 22,000 francs CFA per month to either 3,000 or 7,000 CFA/month, depending on the drug, and all children up to 15 years old receive ARV treatment free of cost. But as Dr. Arrey of the Day Hospital said, “The subsidies are enormous, but 3,000 CFA or 7,000 CFA per month is still expensive” for many people in the Northwest Province and throughout the country. “If the drugs were free, many more people would be able to access them.” 81

In a nod to the reality of pervasive and persistent poverty throughout Cameroon, there is a special fund earmarked for “paupers;” but only a maximum of 15% of patients currently on ARVs in a single treatment center can be designated as such. A patient who wishes to be considered for this funding must apply to an ARV Therapy Committee made up of doctors, social workers, CRAs, and pharmacists at the treatment center they are attending, This is the same committee that decides whether patients are ready to start and likely to adhere to ARV regimens. 82 To determine whether or not the applicant qualifies for assistance, the Therapy Committees utilizes a “score of destitution” rubric that assigns points for the number of

81 Arrey, Dr. Kefie. Formal interview, 29 November 2006.
82 NACC, Cameroon’s Response to HIV/AIDS.
children/dependents, other sources of assistance, insurance, rent, sum of conditions, food difficulties, and other living conditions. But as Dr. Arrey stressed, “there are dynamics involved, and you don’t remain a pauper forever.” People on assistance are expected to find income-generating activities and save their money during the period of assistance, so “the moment we stop you can pay.” Conversely, a patient can also become a pauper if their situation takes a turn for the worst. Thus with patients moving in and out of the program each month, the treatment centers are able to stay under the 15% cap mandated by the state, though most health care workers believe that many more could stand to benefit from financial assistance.

I was able to sit in on Mezam Polyclinique’s Therapy Committee Meeting, in which 10 cases were discussed; only one was applying for “indigent” funding, and a decision on that application was deferred to the next week. The patient was a 33-year old widow, whose husband died of AIDS. Her last of three children is 3 years, 5 months, but she does not know his status as he is still to be tested. She is a “businesswoman” who makes 2,000 CFA/month, less than the minimum amount needed for ARV therapy, by selling fish in Bafut, but the business is not doing well.

So what does any of this have to do with nutrition? According to Dr. Paul Achu, the proprietor of Mezam Polyclinique, “without good nutrition, ARVs won’t work—the importance is 50/50, maybe even 60/40,” with nutrition outweighing drugs. ARV therapy often comes with a complicated set of rules: for example, you must take the drug every eight hours, with a full glass of water, no less than two hours before and one hour after eating. “There are too many rules,” so patients face difficulty in adhering to the therapy, despite that they are “happiest

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83 Arrey, Dr. Kefie. Formal interview, 29 November 2006.
84 Achu, Dr. Paul. Semi-formal interview, 30 November 2006.
85 Ibid.
when they are on treatment,” as his colleague, Dr. Njinkoh, added.86

Dr. Achu explained, “When you take care of AIDS patients in the ward, it’s obvious that nutrition is a problem.” Many need special foods because of HIV-related symptoms, such as mouth sores, and he lamented that the hospital “has no finances to prepare special foods,” and home “caregivers are not aware how to adapt to problems.” Voicing a common refrain, patients have “no money to buy food,” and are limited by “types, availability, and how they prepare meals.”87

Private Interventions

In the following section, I will discuss two private interventions addressing nutrition for PLWHA, beginning with an international NGO, Heifer Project International, and ending with the Baptist Health Center. Though the PTG-NW lists several international NGOs among its partners, including Plan International and the GTZ, Heifer is the only one working on issues of food and nutrition security; most other focus on prevention efforts or mother-to-child transmission. Similarly, though there are many private clinics and hospitals in the Province, the Baptist Health Center was the only one continually mentioned to me as addressing nutrition needs.

Heifer Project

Heifer Project International (HPI) “strives to end hunger and poverty and cares for the earth by providing life-sustaining farm animals, related appropriate training, technical and material support to impoverished farm families around the world.” Within its Cameroon program, begun in 1974, it has assisted 15,000 farm families. Throughout the past 30 years, HPI “has been supporting animal adaptive research and grassroots ecologically sound, economically

86 Njinjoh, Dr. Nwama Aloysius. Semi-formal interview, 30 November 2006.
87 Achu, Dr. Paul. Semi-formal interview, 30 November 2006.
viable and culturally appropriate smallholder integrated animal agricultural development in the country, which has enable resource-limited farm families to seek self-reliance in food production and income generation on a sustainable basis, in their struggle to conquer hunger and poverty.”  

There are three field offices: Western Highlands, which covers the Northwest and West Provinces; Humid Rainforest, in charge of the Littoral and South West Provinces; and Equatorial Rainforest, encompassing the Center, South, and East Provinces. They will also soon be opening a Sudano-Sahelian office for the Adamawa, North, and Far North Provinces.

Field staff is composed exclusively of Cameroonian nationals, and the scope of development assistance in Cameroon includes the following: provision of all types of livestock-related training and technical backup, provision of farm and food producing animals on in-kind loan or Passing On the Gift basis, support of local project leadership development, support of the development of functional self-help farmer organizations (cooperatives or CIG/GICs), promotion of natural resource management to enhance sustainable agriculture and environmental protection, and sensitization and training on issues of gender equity and HIV/AIDS in the context of sustainable livelihoods and development. It is this last activity that I will examine more in-depth.

In the Western Highlands office, HIV/AIDS-related projects began in 2000, with a 3-day staff retreat conducted by the PTG-NW on HIV sensitization, after which staff went out into the field to conduct sensitization workshops for each of the farmers groups they work with.

According to Bih Afanga, the Zonal Field Officer in charge of HIV/AIDS-related activities, “People were actually infected,” so HPI began assisting PLWHA groups in addition to

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89 Ibid.
continuing the sensitization workshops for all groups. Since HPI only works with groups, and not individuals, they identify groups by applications for assistance; the office then tries to identify genuine need and whether the group is actually resource-limited. Based on availability of funds, the office decides whether to accept a group’s proposal, with a preference for HIV/AIDS groups, the disadvantaged, women, and the handicapped.

Since beginning assistance to PLWHA groups, HPI’s Western Highlands office has worked with two HIV/AIDS support groups at Banso Baptist Hospital, in a rural area of the Northwest Province. For both, they started out with farmer training, and focused especially on vegetable gardens. According to Ms. Afanga, these both “worked out so well” that they began training on human nutrition next, as it is “not enough to grow vegetables, they need to know how to prepare them” to ensure as many nutrients as possible are available. Sessions included HPI staff and the Baptist Health Center nutritionist, and were practical and participatory—“we had men in there chopping onions, everyone cooking all together.”

In 2005, HPI began a sheep project with these same two groups, placing five sheep—four ewes and one ram—with 15 total participants; one support group received nine sheep packages, and one received six. The project benefits participants in several ways, but “targets income generation and nutrition.” Though sheep are used to feed families, ewes give birth twice a year, and after three years that’s “a lot of animals” available to sell, which fetch a good price, especially during the annual Ramadan feast. Even the participant who has sold off the most animals still has 15 in his possession. In order to ensure sustainability in keeping with HPI’s principles, the project reduces assistance as years go by, and are expected to “stand on their own” after a period of support, though HPI is currently training the groups on millet production and

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91 Ibid.
dry season feeding. Most are gardeners now, and make their living by selling their produce and animals.\textsuperscript{92}

HPI expects to have the following nutrition-related impacts on all beneficiaries:
“improved nutritional status of members in farm households from increased consumption of protein-rich foods of animal origin; improved healthcare of members of farm households as supplemental income from livestock and livestock products helps them pay for primary healthcare and other medical services; alleviation of hunger through improved household food security.”\textsuperscript{93} But PLWHA involved in HPI projects experience some unique benefits, beginning with an improved outlook on life. In facing the pervasive stigma found throughout Cameroon, Ms. Afanga explained, HIV “hurts self-esteem” as PLWHAs’ “communities look at them as outcasts.” So many people consider them “finished” that many leave their communities, but HPI can provide a “huge cushion.” Ms. Afanga sees their mission as not only about money, but also about “building them, their hope, integrity,” and instilling “a lot of hope for the future.”\textsuperscript{94}

As HPI heavily targets income generation, PLWHA participants are also able to overcome the poverty that is otherwise so omnipresent. Ms. Afanga related that before becoming involved in support groups and HPI projects, many “sat at home and thought, ‘I’ll die tomorrow,’” “but now “they are working and saving, opening personal bank accounts, saving money for their children.”\textsuperscript{95}

Finally, PLWHA benefit nutritionally from HPI projects. Before participating in nutrition sessions, most members cooked using traditional preparation, “letting food spoil, using palm oil, and eating the same things everyday.” Though there is “a lot of food in the Northwest,

\textsuperscript{92} Ibid.
\textsuperscript{93} Heifer Project International—Cameroon. \textit{Heifer Project International—Cameroon}, 2006.
\textsuperscript{94} Afanga, Bih. Formal interview, 20 November 2006.
\textsuperscript{95} Ibid.
it’s the combination that matters,” and preparation in the village is different than elsewhere, as people rarely use spices like onion or garlic, even though they are available in the market. But now, participants have learned to mix vegetables, “not just boil it, eat different things, and use other things, especially from their own gardens and farms.” When their nutrition has improved, they are “healthier, they put on weight, and they are not hiding anymore.”

But HPI projects face many of the same challenges cited both other interventions, most notably poverty and “low resources,” which is why HPI targets capacity building and garden training. Since PLWHA group members are spread far away from one another, transport costs can be problematic for attending meetings. Shared obstacles include stigmatization, “a lack of openness and acceptance,” no access to clean water, and a lack of education. Ms. Afanga mentioned culture and tradition, especially as related to gender, as a major barrier in the fight against HIV/AIDS, as it is “the man who take the lead, and women have no say in sex.” On the staffing side, HPI’s main limitation is funding, as HIV/AIDS projects are more expensive; members are not from same locality and widespread about, and during training HPI needs to provide food. Additionally, Ms. Afanga said that “not everybody may want to do it,” and she has “gotten so attached” that she often has no dreams about sick families, though luckily there has been no incidence of death yet within the support groups.

Baptist Health Convention

No matter with whom I was discussing nutrition interventions for PLWHA in the Northwest, the Baptist Health Center (BHC) nutritionist, Mary Bumuh, would always come up. This may have something to do with the fact she is one of the only trained nutritionists in the region, but she also has regular contact with all 28 BHC-supported support groups in the

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96 Ibid.  
97 Ibid.
Bamenda area, out of 72 nationwide that include 265 of Cameroon’s 300-plus clans. As a nutritionist/adherence counselor at Mbingo Annex Baptist Convention Health Center and the sole nutritionist associated with the Cameroon Baptist Health Convention, her main work is now with HIV patients, whether in the office or while traveling to lecture each of the support groups, composed of up to 200 members (though most hover at around 60 or 75), at their monthly meetings.  

During such lectures, she answers questions and “does practical” by cooking a balanced meal each month. In order to keep advice relevant and realistic, she asks, “What grows around her?” and tries to “get the local foods that are cheapest.” As Ms. Bumuh explained, “I only look at those things that are very rich and very cheap,” such as soya beans, groundnuts, vegetables, fruits, coconut oil, and cheap fish. She said that she was grateful that “the Northwest is really blessed,” and that “Cameroon is very rich in food production.” She also encourages people to collect vegetables and herbs “growing wild in the bush,” such as wild spinach, beet roots and leaves, carrots, bitter leaves, pumpkin leaves, melon seeds with peelings, sunflower seeds. Though “everything is so rich,” many people are hesitant to cook “poor man’s soup,” which is what they call the dish resulting from such a collection of foods.

The information and demonstrations often results in improved nutrition, and Ms. Bumuh reported high interest and enthusiasm: “When I teach, they learn immediately.” Bamenda support group member Frida Sayah is proof. She considers nutrition “very, very important—looking at me as I was before and now, I have really improved. Formerly, I was just eating food, and I didn’t know I could combine things, like garlic and carrots.” As Ms. Bumuh said,

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99 Ibid.
100 Ibid.
101 Sayah, Frida. Semi-formal interview, 1 December 2006.
“Some come in looking so pale, but when I follow-up and show them what to do, one month later they look different.”

Though the nutrition lectures have often proved successful, the BHC’s more innovative project targets income generation through a variety of schemes. At the Bamenda BHC, Frida gave me a grand tour of the nutrition department’s kitchen, which she and several others have commandeered in the production of various foods and toiletries, including baby and adult formula, cookies, soya bean milk, soyatin, coconut oil, soya bean powder, ground and whole-bean coffee, detergent, and body lotion. All are made from local ingredients found in the market, including soyabeans, groundnuts, yellow corn, and powdered milk. Items are sold for between 200 (soya bean powder) and 3000 (large coconut oil) CFA, though profit is not their primary objective for the formula, which they sell half-price to support group members and give away free to new mothers that choose not to breastfeed due to their seropositive status. Otherwise, they sell their products during small group meetings and outside the BHC clinic everyday.

Other support groups also make toilet soap, medical soap, soya tea, and Vaseline, and three hospital-based support groups have agreements with doctors to be the exclusive provider of OMO (a laundry detergent) at 14,000 CFA per month for two buckets.

Ms. Bumuh expressed her surprise at the success of such ventures: “I never knew they would get it so well, pick it up like that.” Another support group manages a cocoyam farm, while one in Ndu received a PTG-NW grant to purchase and run a photocopier, phone booth, and canteen. In addition to helping them combat poverty, participants benefit psychologically as well, as “they don’t think so much about condition when they’re busy with business.”

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103 Sayah, Frida. Semi-formal interview, 1 December 2006.
105 Ibid.
But poverty can prove a persistent challenge, as it has for so many other interventions. “We like doing these things but we don’t have the money.” There is little food aid to give to even the neediest cases, but BHC does reimburse transport and prepares “a nice quality meal for participants” once a month during the kitchen demonstrations. The funds marked for food aid concentrate on children, and they give away the BHC-produced baby formula to women who choose not to breastfeed given their HIV status. Ms. Bumuh cited culture and tradition as also getting in the way of behavior change, in the form of traditional healers, as sometimes “native doctors tell them not to eat certain foods, like eggs, often the opposite of what we tell them.” She also admits that her limited knowledge about the Grand North’s customs and diet prevents her from achieving the same level of effectiveness as in her home of the Northwest, though she had just returned from a UNICEF-sponsored trip as part of a team sent to set up support groups in the region. UNICEF just sent a team to open them in the North. \(^{106}\)

In the future, she would “really like to go to school and learn more” about HIV and nutrition; when she went to school HIV “wasn’t even around.” Her priority is to encourage every BHC clinic to produce income-generating goods, and to begin looking at fishing as a complementary activity to gardening. \(^{107}\)

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106 Ibid.
107 Ibid.
Part V: Conclusion

In summary, PLWHA in the Northwest Province face many sobering realities that serve as challenges to food and nutritional security, including the highest HIV prevalence rate in the country, poverty, the local diet, and stigma. However, there are many dedicated individuals and organizations that are committed to overcoming these barriers in implementing interventions to aid PLWHA in the Northwest in obtaining good nutrition and staying healthy, strong, and productive. In stark contrast to many such efforts, I was sincerely impressed by the fact that all stakeholders were well-acquainted with the cultural context with which they were working, and have adapted their interventions accordingly.

However, so far these efforts are not enough for several reasons, the first being the persistence and pervasiveness of poverty in the Province. Though many people are poor in the Northwest, PLWHA must grapple with being poor and potentially sick, affecting both their lives and the lives of their families and dependents. Income-generating activities initiated by organizations like the Heifer Project and the Baptist Health Center are right on target, but so far their scope is not wide enough to have a large-scale effect on PLWHA in the area. They should work to expand their efforts in order to impact as many PLWHA as possible; even if their assistance is not direct, they could encourage other organizations to adapt the same structure for similar programs. However, no matter how many small-scale income-generating projects are launched, the problem of poverty in the Northwest will remain. What PLWHA need is the same thing that most Cameroonians need—widespread poverty alleviation. Unfortunately, that is a task bigger than any one organization, and requires the long-term commitment and willingness to change of the current government in power. It is a tall order.

The Northwest’s PLWHA are also suffering from a lack of skilled and trained
professionals able to address their nutritional needs, especially in relation to ARV therapy. Again, this is not a problem limited to the HIV/AIDS or nutrition spheres, but is reflected throughout the Cameroonian public health system in a scarcity of medical qualified clinicians and practitioners. If the NACC truly wants to achieve the goals listed in the National Strategic Plan, they should focus on training Cameroonian doctors, nurses, and other health care workers, and encouraging them and providing enough incentives for them to stay in the country.

Finally, good nutrition is not enough; ARV therapy must be made accessible and affordable to all PLWHA who need it. This is becoming an increasingly recognized issue in the international HIV/AIDS community, and health care workers should continue their advocacy efforts to bring the drugs to those who need them. Perhaps in ten or twenty years, ARV therapy will be free to all PLWHA in sub-Saharan Africa, and Africa will cease needlessly losing its most productive members of society, when they can be kept active and alive longer and longer. Additionally, as ARV therapy becomes more accessible, more health care workers should be trained on the importance of nutrition to the efficacy of the drugs, and be educated on drug-specific side effects and interactions.

In the future, organizations and institutions committed to helping PLWHA live long, healthy, productive lives should look more closely at income-generating activities, gardening, and other projects that can keep PLWHA self-sufficient and provide a way out of poverty and around stigma and discrimination. More work should be done to pinpoint how to make such projects successful in different contexts, and how to replicate them to be implemented on a large-scale basis. Lastly, concerned individuals and organizations should keep in mind that PLWHA would most likely benefit most from what all Cameroonians would benefit from: free and fair elections, and a government and bureaucracy free of corruption.
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