

# CAMEROON BAPTIST CONVENTION HEALTH BOARD



## AIDS CARE AND PREVENTION PROGRAM (ACP)



**Annual Report, 2007**

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*Mission:*

*The Cameroon Baptist Convention Health Board (CBCHB) seeks to assist in the provision of care to all who need it as an expression of Christian love and as a means of witness, in order that they might be brought to God through Jesus Christ. Thus the Health Board shall provide exemplary health care with genuine compassion with overriding purpose of evangelical witness.*

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## **Introduction**

The Cameroon Baptist Convention Health Board AIDS Care and Prevention Program (CBCHB-ACP) is comprehensive and ongoing. It began in 1999 with Community AIDS Education and Tuberculosis Control. Today, it runs 11 components, two of which were introduced this year. Activities of the program include prevention, care and treatment for the infected and psychosocial support for affected and infected people. The program works with the National AIDS Program besides other national and international partners. Components of the program include:

1. Community AIDS Education
2. Prevention of Mother to Child Transmission (PMTCT) of HIV
3. Tuberculosis (TB) Control
4. Orphan Care (Chosen Children)
5. Support Groups for HIV-infected men and women
6. MTCT Plus Program
7. Youth Network for Abstinence
8. Adopt a Health Care Worker
9. Palliative Care
10. Extended Forum for Care (Contact tracing)
11. Reproductive Health (Cervical Cancer Screening)

Each of these components witnessed remarkable progress in 2007. This report highlights the major activities of each component.

## **COMMUNITY AIDS EDUCATION**

We are gradually empowering communities to take care of this aspect of the program. Selected persons from various communities are trained as resource persons on HIV

and AIDS to enable them address issues surrounding the epidemic in their respective communities. These resource persons help to disseminate information on HIV and AIDS in their communities, and then act as a link between the program staff and their communities. HIV Voluntary counselling and testing has been identified as an effective tool for reversing the spread of the pandemic, and so efforts are being made to promote it.

Ten (10) training sessions took place in 2007 and a total of 673 persons (430 males and 143 females) were trained. The trainees were drawn from diverse walks of life including youths, health workers, village development meeting group leaders, traditional practitioners and plantation workers.

VCT activities equally increased this year. The protocol agreement signed between CBCHB and HEIFER International Cameroon enabled us to disseminate sensitization materials and carry out VCT in some communities in the Northwest, Southwest, Littoral, West and Centre provinces. A total of 3,162 persons were screened and 159 (05.0%) were HIV positive. Most infected persons were within the age range 25 to 50 with more infected females than males. The prevalence rate obtained was slightly below the national one (05.5 %) of 2004, indicating a gradual drop in the trend. Besides those screened through the HEIFER project, over 1000 other persons were screened for HIV in 2007.

The 2007 World AIDS Campaign was celebrated with much pomp as every CBCHB institution carried out sensitization talks and VCT. Health Board staffs were urged to live exemplary lives to facilitate behaviour change in vulnerable others.

Movement into remote areas and the inability to meet the VCT demands in communities remain the major challenges of this component of the program.

## PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) OF HIV

The CBCHB-PMTCT activities increased tremendously in 2007. The number of active sites rose from 250 in 2006 to 374 in 2007 (44%) (See appendix 1), and the number of ANC clients counselled moved from 61,588 in 2006 to 79,088 in 2007 (27.9%). Acceptance rate for HIV testing and return rate for test results equally increased. Treatment rate for infected mothers and their HIV exposed infants also increased. The prevalence rate of HIV infection among pregnant mothers reduced slightly (See table below).

**Table 1**

CBCHB – PMTCT FEBRUARY 2000 – DECEMBER 2007								
Year	N° of sites	N° of ANC Women Receiving HIV Counselling	N° of Women Who Were Tested	% of Women Who Were Tested	% of Women Who Returned for Test Results	% OF Women with an HIV (+) Test	% of Mothers Receiving Nevirapine	% of Infants Receiving Nevirapine
2000	5	1,469	1,391	94.7	96.5	10.5	37.7	37.7
2001	9	4,022	3,826	95.1	99.8	09.9	38.9	38.9
2002	58	12,297	11,433	93.0	99.0	09.5	40.7	38.8
2003	89	21,447	19,961	93.1	98.4	07.6	30.1	31.4
2004	115	29,510	26,584	90.1	98.6	08.9	39.0	36.5
2005	175	47,661	42,976	90.2	97.4	08.1	74.3	40.8
2006	250	61,588	57,951	94.1	98.9	08.5	74.8	44.2
2007	374	79,088	75,869	95.9	98.6	07.7	78.4	44.0
<b>Total</b>		<b>257,082</b>	<b>239,991</b>	<b>93.3</b>	<b>98.4</b>	<b>08.4</b>	<b>65.2</b>	<b>41.1</b>

The 374 CBCHB PMTCT sites belong to the government, other church organizations, lay private organisations and CBCHB itself. CBCHB has over 50 sites whose activities have been stabilised in the past five years. The table below shows the evolution of PMTCT activities in CBCHB institutions from 2000 – 2007.

**Table 2**

PMTCT IN CBCHB INSTITUTIONS FROM 2000 - 2007							
CURRENT YEAR	N° of ANC Women Receiving HIV Counselling	N° of Women Who Were Tested	% of Women Who Were Tested	% of Women Who Returned for Test Results	% OF Women with an HIV (+) Test	% of Mothers Receiving Nevirapine	% of Infants Receiving Nevirapine
2000	1,469	1,391	94.7	96.5	10.9	37.7	37.7
2001	4,022	3,826	95.1	99.8	9.9	38.9	38.9
2002	7,693	7,456	96.9	99.7	8.2	51.6	46.5
2003	8,184	7,927	96.9	99.2	7.1	36.2	37.3
2004	8,679	8,438	97.2	98.6	7.6	49.2	39.1
2005	8,679	8,438	97.2	98.6	7.6	49.2	39.1
2006	10,491	10,313	98.3	99.0	7.0	86.3	44.7
2007	11,055	10,752	97.3	98.1	7.2	90.8	44.2
<b>Total</b>	<b>60,272</b>	<b>58,541</b>	<b>97.1</b>	<b>98.8</b>	<b>07.7</b>	<b>59.8</b>	<b>41.6</b>

The scaling up of PMTCT was accompanied by training at District levels for service providers and others.

Capacity building was done in preparation for the introduction and scale up of bi and tri-therapy. The pilot phase of the bi and tri-therapy in four sites of the CBCHB-PMTCT has very promising results. The PCR results in these sites indicate a drop in positivity rate from 13.8 % in 2006 to 7.6% in 2007 (See appendix 2). The scale up of bi and tri-therapy remains a big challenge because it requires more staff and additional equipment like CD4 counters.

The CBCHB PMTCT sub-program is progressing rapidly and we hope to attain the target of 500 sites by 2009 despite challenges faced such as staff movement and funding insufficiency.

## TUBERCULOSIS (TB) CONTROL

- Completion of tuberculosis treatment in the CBCHB has continued to improve with the introduction of free treatment and the creation and approval of more treatment sites. In 2007 BHM and Nkwen Baptist Health Center were approved as TB treatment sites bringing the number of CBCHB TB treatment sites to six.
- The number of TB patients screened for HIV increased from 60-70% in 2005-2006 to 88.7% in 2007.
- Potts Foundation provided US \$30,000 worth of funding for TB activities.
- Response to the adherence study questionnaire by patients is good.
- The pilot phase of the culture and sensitivity study was successfully completed and the results are being awaited.
- The CBCHB TB program was represented at the IUATLD conference in S. Africa and presented an abstract.
- Our major concern now is the high number of patients defaulting treatment at Mboppi Health Centre.

**Table 3: Tuberculosis activities in 2007**

Description	BBH	MBH	BHM	NKWEN	ETOUG-EBE	MBOPPI	Total
Number Registered	244	312	22	13	70	222	<b>883</b>
Sputum Positive Pulmonary TB	185	153	14	10	59	198	<b>619</b>
Sputum Negative Pulmonary TB	14	92	1	2	7	14	<b>130</b>
Extra Pulmonary TB	45	67	7	1	4	10	<b>134</b>
No. Screened for HIV	240	307	20	12	39	166	<b>784</b>
No Screened HIV+	168	157	4	5	11	58	<b>403</b>
<b>Outcomes</b>							<b>0</b>
No. Cured	78	53	0	0	21	51	<b>203</b>
No. Completed Treatment	28	76	0	0	6	26	<b>136</b>
No. Transferred Out	11	69	0	0	0	6	<b>86</b>
No. Died	33	26	0	0	0	0	<b>59</b>
Treatment Failure	1	0	0	0	0	6	<b>7</b>
Lost to follow up	1	9	0	0	1	40	<b>51</b>
No. On Treatment	92	79	22	13	42	93	<b>341</b>
Total Screened for AFB	959		82		351	800	<b>2,192</b>

With the available funds and support from the Cameroon government, we hope to achieve more in TB management in the years ahead.

## **ORPHAN CARE (CHOSEN CHILDREN)**

The program operates in fourteen fields within the CBC, particularly in the North West and South West provinces. It has three full time staff and 12 field agents. The following activities took place in 2007:

1. **Disbursement of School fees** covered 14 fields of the CBC, 10 in the NW and 4 in the SW provinces. Fees were paid for 457 children in primary schools and 367 in secondary school, giving a total of 824 children who received school subsidies in 2007 as compared to 702 in 2006.
2. For **HIV voluntary counselling and testing of Chosen Children and caregivers**, 958 persons were tested and 48 (5%) tested HIV positive. Of the total number of people tested, 430 were Chosen Children, 10 (2.3%) of whom tested HIV positive.
3. The program conducted an **impact assessment survey** on the various families it supports to measure the impact of this support on these families. 410 families were available and responded to the questioner, indicating that the program has a positive impact on its beneficiaries and their communities.
4. The program equally **received and distributed 220 bag packs** from the Sunrise team in the USA led by Yvonne Martinez. The packs included school bags, used T-shirts, sunglasses, tooth brushes, hair combs, pencils, pens, writing pads, colouring /activity books, stencils, rulers, crayons/highlighters, stickers, jump ropes, toy cans, and soccer/plastic balls. The children and caregivers were very pleased with the gifts.
5. The **highest funding** came from PMTCT (J & J) -10 million FCFA. Funding from NAB reduced from 15 million in 2006 to 8.7 million FCFA in 2007. We hope to raise more funds to enable us continue supporting the increasing number of orphans and other vulnerable children.

## **SUPPORT GROUPS FOR HIV-INFECTED MEN AND WOMEN**

### **Introduction**

The CBCHB-ACP program currently supports 87 groups with a membership of 3,032 in 6 of Cameroon's 10 provinces (see appendix 3). Membership of some of these groups are mixed (both men and women) while 5 others are for men only. Routine activities of support groups include:

- Bible studies using a prepared guide
- Health education
- Testimonies
- Questions and answers
- Crafts and other income generating activities like knitting, crocheting, as well as local cosmetics such as powder soap, body lotions, Vaseline and nutritional formula.
- Njangi/saving schemes
- Sharing of infant feed, Bactrim, Multivits and preservatives.
- Plans for subsequent meetings and transport reimbursements

### **Management**

Day to day running is ensured by the general supervisor and his assistant, and a management committee answerable to the Director of Health Services. There are eight coordination areas for support groups to facilitate effective implementation of activities and supervision.

### **Training/capacity building**

Capacity building of support group members is an ongoing activity whereby peer educators share knowledge and skills they have acquired on topics such as positive living and crafts. 113 support group leaders were mobilized for a two-day peer educators' seminar in Bamenda. They now serve as community outreach agents to follow up treatment defaulters, identify new members and refer them to the MTCT+ program. We thank the MTCT+ program for the organization and sponsorship of this training.

## **Financial and moral support**

Mrs. Yong of CBTS donated one million francs to facilitate movement for support group members found around Ndu area to Bango for baseline tests and treatment. This is a laudable effort worth emulating.

Sister Hedwig of the Sisterhood of La Verna, situated behind St. John's Parish in Bamenda supported 372 children of some support group members around Bamenda and Mbingo areas with school fees amounting to three million francs. This was a welcomed relief and source of joy for the families and children concerned.

Our Support groups in the South West Province benefited from the CARE Cameroon program by way of baseline tests, treatment of opportunistic infections, household items, and individual and group loans for income generating activities.

## **Support Group Annual Conferences**

We organized support group annual conferences in Bafoussam, Mutengene, Yaounde, Ndu, Bango, Mbingo and Bamenda. Attendance was very impressive and members left each conference determined to live positively with their infection. In all, 1,378 persons (196 males i.e. 14.2 % and 1,182 females i.e. 85.8 %) attended the conferences. (See table 4 in appendix 3 for attendance details per coordination area)

## **Successes**

- Increased male participation with new male support groups.
- Increased number of babies with negative anti-body tests.
- Reduction of self-stigma.
- Joy for free ARV and preservatives.
- Many support group members now live independent lives thanks to the income generating activities.
- Great improvement on the live-span and living standards of support group members.
- Recruitment of some of our support group members who had been trained as peer educators as volunteer peer educators for the MTCT+ program.

## **Challenges/Difficulties**

- Lack of production space in health facilities for support group activities.
- Some members shy away from support groups located near their communities in favour of distant ones.
- Withdrawal of members as a result of refusal to join nearby support groups or be reimbursed only part of their transport cost.
- Many support group members are becoming pregnant.
- Difficult terrain and bad roads.
- Lack of sufficient means to assist orphans and widows within support groups.
- Lack of standardization in distributing formula milk, multivitamins and bactrim in the different coordination areas.

## **Recommendations**

- The program needs a strong vehicle to facilitate supervision.
- Desperate support group members with opportunistic infections should be assisted.
- The Chosen Children Program should consider children of support group members in their next budget.

## **MTCT PLUS PROGRAM**

MTCT Plus extended its activities in 2007 to Mboppi Baptist Health Center and Baptist Hospital Mutengene. This increased the number of CBCHB MTCT Plus sites from three to five. These new sites are very busy as they receive over 300 visits each month. The five sites put together received a total of 24,856 visits in 2007. The increase in activities is due to free ARVs from the government and good leadership of the sub program.

**Table 4: SUMMARY of MTCT Plus in 2007**

	Male	Female	Pediatric	Total
Enrolment	245	1,475	891	2,611
On Antiretroviral Therapy	98	466	40	604
On Cotrimoxazole	85	556	442	1,083
Discontinued	Male	Female	Pediatric	Total
Deceased	40	8	36	84
Lost to follow up	0	14	0	14
Others	8	17	22	47
Total	48	39	58	145
<b>Follow up</b>				
Number of PCR collected				345
Number of positive PCR				12
<b>SELF PAID</b>				
	Male	Female	Pediatric	Total
On ARV	821	1,607	163	2,591
Defaulters	547	710	24	1,281
Transferred in	31	59	1	91
Transferred out	46	70	6	122
Deceased	11	16	2	29
Totals	Male	Female	Pediatric	Total
	919	2,073	203	3,195
Total clinic visits 2007				24,856

## YOUTH NETWORK FOR ABSTINENCE

### Introduction

The program supports 93 abstinence clubs with an enrolment of 3,639 youths (2,531 females and 1,208 males). In 2007, 13 new clubs were formed and 822 new members enrolled into both the old and new clubs. HIV voluntary counselling and testing is a regular activity of the clubs and 1,681 members (1,197 females and 480 males) have been tested. Of this, 23 [1.4%] tested HIV positive. The prevalence rate among females (1.8%) was greater than that of males (0.2%). 118 youths repeated their tests after 6 months and they all tested HIV negative. All the 206 youths (169 females and 37 males) who joined the clubs in 2007 tested for HIV and were all negative.

## **Youths at Large**

From April to September the program carried out communication for behaviour change and VCT in communities, churches, youth camps and schools. Some 2,926 youths were screened for HIV and 22 (0.75%) tested positive.

## **Trainings Seminars**

- To ensure continuity and good follow-up, the program trained 57 leaders/gatekeepers from 25 - 27 January 2007 at BBH on communication for behaviour change for the NW Province.
- Program staff among others had a 2-day training on data management offered by the program's pioneer supervisor, Mr. Ndosak George, to enhance better management of the program's statistics.

## **Education and Sensitization**

- Routine activities like education and sensitization continued in schools, churches, communities and work places; and about 25,000 young people were reached.
- Thirteen thousand (13,000) posters were produced in English alongside the French version and are being distributed.
- At the level of the office, a 3-day orientation meeting took place at BBH in mid September 2007 in a bid to ensure continuity given the change of leadership in the program's supervision.
- With support from Community Initiative AIDS Control (CIACP), YONEFAB was able to conduct a follow-up sex survey both in the NW and SW provinces from October to early December 2007. About 5000 youths were interviewed. Data entry started immediately. The purpose was to assess the impact of the program so as to better adapt its strategies and materials to the educational needs of the youths in the fight against HIV.

## **Support**

The Health Board, CIACP, and Johnson & Johnson were the three main sponsors of YONEFAB Program activities in 2007. We therefore owe them infinite gratitude.

## Challenges

- Replication of the program in quality and focus in other areas.
- Limited personnel (complete absence of volunteers) and finances.
- Maintain and/or intensify activities and expand to Francophone areas as well.
- Go beyond moral support to financial by subsidizing the cost of treatment for infected members.
- Difficult access to some institutions.
- No Cameras to have pictures of events in archives for better reporting

## PALLIATIVE CARE

This is one of the new components of CBCHB-ACP. In its first two years of existence it has seen a total of 280 clients in 2 sites (BBH and Provincial Hospital Bamenda (PHB)). MBH and BHM have received training and begun carrying out consultations but registered no patient in 2006 and 2007. Chronic disease conditions requiring palliative care are gradually increasing in our communities, many of which are indicated in the table below. The table also has details of activities carried within the last two years.

**Table 5: Palliative care activities from 2006 - 2007**

	INSTITUTION	BBH		MBH	BHM	PHB	
S#	YEAR / REPORT TOPICS	2006	2007	2007	2007	2007	TOTAL
1	New patients Registered	89	89	0	0	13	191
2	New and old patients Reg.	89	178	0	0	13	280
3	No of HIV positive patients	20	28	0	0	4	52
4	No of PCP	1	0		0	0	1
5	No of Oesophageal Candidiasis	0	1	0	0	0	1
6	No of Toxoplasmosis	0	0	0	0	0	0
7	No of Cryptococcus meningitis	0	1	0	0	0	1

	INSTITUTION	BBH		MBH	BHM	PHB	
8	No of Kaposi Sarcomas	12	17	0	0	0	29
9	No of other lymphomas	6	11	0	0	3	20
10	No of Liver ca	16	8	0	0	1	25
11	No of Abdominal tumour	15	15	0	0	0	30
12	No of Prostate Cancer	8	14	0	0	2	24
13	No cancer of the cervix	6	6	0	0	1	13
14	No cancer of the breast	4	3	0	0	0	7
15	No of TB complications	5	0	0	0	1	6
16	No of sickle cell crises	5	3	0	0	0	8
17	No other chronic condition	11	11	0	0	2	24
18	No lost to F/U	1	1	0	0	0	2
19	No of patient deaths/month	24	44	0	0	4	72
20	No of consultations	56	266	18	23	0	363

Consultations at Bansa Baptist Hospital increased sharply but enrolment remained low because patients living more than 30 km from the coverage area cannot be recruited. More patients are referred as a result of increasing awareness about the intervention. Consumption of morphine has equally increased.

A consultant from Hospice Africa Uganda visited the program in November 2007 to share standards.

A student from the Faculty of Social Sciences and Anthropology did her internship with the program in August 2007.

Training for health professionals were conducted in Mutegene Baptist Hospital, MBH, Bamenda Provincial Hospital. A special training was conducted for the final year nursing students of the University of Buea.

The program's leader underwent some training in the University of North Carolina during which he made a number of useful contacts.

Lobby and advocacy for this intervention continues and meaningful achievements have been made at the level of most of the stakeholders especially the Cameroon government.

### **ADOPT A HEALTH CARE WORKER**

Staff contributions to the Adopt a Health Care Worker (AHCW) fund dropped very significantly in 2007 because of misunderstandings resulting from the free ARV donated by the government. The table in appendix 4 shows details of the amounts and ratings of the contributions of different institutions. The committee for the management of the fund met and came up with some clarifications on the issue. It agreed that staffs should continue to contribute to the fund despite the free ARVs from the government because the infected staffs still need to pay for other tests required for the ARV treatment. They also agreed that the fund should subsidize treatment for staffs with other chronic conditions like cancer, diabetes, hypertension, etc. Orphans of deceased staffs shall also be supported by the fund. Staffs who do not contribute to the fund shall receive no support from the fund.

We currently have 42 staffs on treatment from different Health Board institutions supported by the fund.

### **EXTENDED FORUM OF CARE (CONTACT TRACING)**

Contact tracing and partner notification went on for the last 5 months (August to December) of 2007. To make the program more user-friendly, management decided on a new appellation Extended Forum of Care (EFC) with the motto: Empathy, Faithfulness and Compassion. The project aims at breaking the chain of HIV transmission and reducing AIDS in the community. It started with the training of 15 ACP leaders by Prof. Tih Pius on June 20, 2007 in Bamenda. Implementation started on August 1, 2007. Activities are limited to Mezam Division for now (pilot phase). Monthly meetings to assess the evolution of the project were organized during which team members shared field experiences and the challenges that they encountered. Each team member is assigned to cover each of the sub-divisions in Mezam Division. Currently, 8 health personnel are doing contact tracing and notifying partners who have been sexually exposed to HIV within the past twelve months. Health Advisers

received training on Determine HIV rapid testing. With this additional skill, they screen contact persons (who consent) for HIV during field work.

In addition to daily Out Patient Department (OPD) and ANC units where index persons are identified, we organized 5 mobile voluntary counselling and testing sessions in four different communities to identify more index persons, notably at Nkwen CBC Church, Alumbie - Kwighe, Ibal - Oku, Elak - Oku and Noni. During the Cameroon Baptist Convention Bible conference, we organized free screening for Christians in Ndop, Bamenda and Gebuaer Fields to identify more index persons as a step to reaching more contacts. After this exercise, many index persons and their contact persons have been contact-traced, and now most of them know their CD4 level and some placed on treatment.

So far, we have been able to carry out the following activities with the accompanying results:

**Table 6**

<b>Activity</b>	<b>Outcome</b>
Index persons (persons who tested HIV positive)	222
Contact persons (persons who have had sexual contacts with index persons)	241
No. of contact persons who were traced and notified	126 (52.3%)
No. of contact persons who were traced and tested	70 (55.6%)
No. of contact persons who were traced and tested HIV positive	37 (52.8%)

Note: The number of contact persons is greater than the number of index persons because some index persons report more than one contact person.

### **Highlights**

1. We came across 19 index persons with more than two contact persons.
2. Two index persons had six contact persons.
3. One contact person remarked that ‘if this program had started earlier, it would have greatly reduced the spread of HIV & AIDS in our communities.’
4. One contact person who was notified and tested was a contact of two different

index persons on separate occasions.

5. Majority of the index persons are females.
6. We have been able to trace and notify 126 (52.3%) of the 241 contact persons. Of the 126 traced and notified 70 (55.6%) of them accepted to be tested. Of these 70 who accepted to be tested, 37 (52.8%) of them had HIV positive results.

### **Challenges**

1. Social mobility and change of address makes tracing difficult.
2. Because of stigmatization, exposed contacts do not want to open up or collaborate.
3. A case of threat of assault was reported.
4. A case of domestic violence was also reported.

### **Acknowledgement**

We remain grateful to Dr. Tom Welty for constantly sending us didactic materials. Our gratitude equally goes to Prof. Tih Pius for initiating this program. We want to acknowledge Suzzie Welty for providing the initial funds to start the program. Special appreciation goes to the University of North Carolina for training Prof. Tih Pius and others on contact tracing. We look forward to financial support from any donor organization interested in contact tracing and partner notification as a tool for disease control and prevention. Our appreciation goes to John Potterat for producing the stock of literature material that has been of great help to our team members.

### **REPRODUCTIVE HEALTH (CERVICAL CANCER SCREENING)**

Cervical cancer today stands as the leading cause of death from cancer among women in developing countries. Universal statistics reveal that of the 400,000 annual cases of cervical cancer 80% occur in developing countries; and most of the women die in their 30s and 40s. There are over 1.7 million cases of cervical cancer and 5 – 13 million cases of pre-cancer in developing countries. In Cameroon, like in many developing countries, pap smears are neither available nor affordable to a vast majority of women.

Two physicians from Zambia, affiliated with the University of Alabama, have developed a new and low-cost method of diagnosing cervical cancer using magnifying digital photographs of the cervix.

In March 2007, these 2 physicians came to Cameroon and trained 2 doctors and 11 nurses of the CBC Health Board on using this technique as well as in the treatment of pre-cancer. The program is already gaining grounds at BBH and BHM, which have all the required equipment for cancer screening and treatment. MBH, Mboppi, Etoug-Ebe and Nkwen are using a less sensitive approach, and suspicious cases are referred for confirmation and/or treatment at BBH or BHM depending on proximity.

### **Achievements**

- The program coordinator attended a two-week practical training on “See and Treat” cervical cancer screening at the University Teaching Hospital of Zambia from August 13 - 27, 2007. The training was sponsored by Prof. Groesbeck Parham, Co-Director of Cervical Health Program, Zambia and Dr. Eddie Welty.
- More than 400 women have been screened in the program and over 50 treated for pre-cancers. Four women were identified with early invasive cancers in January 2008 and were referred to specialists for rapid intervention and expert management.
- Dr. Okorie, Consultant Surgeon at BBH and Interim PACCS Director has expressed his commitment to provide surgical backups and support for the program whenever need arises.
- A large van has been reassigned to the program to serve as a mobile clinic.
- Drs. Thomas and Eddie Welty donated \$16,000 to the program.
- Colposcopic evaluation is now available at BBH as a backup screening method.
- The administrative aspect of the program’s development is underway.
- The program has the endorsement and backing of Prof. Doh Anderson, Executive Secretary of Cameroon National Fight against Cancer.
- Two (2) new staffs have been added to the program - an SRN and a Secretary
- The CBCHB Website facilitates uploading pictures for clarification or confirmation.

## **CHALLENGES**

- Insufficient staff to work in the program
- Insufficient funds to expand training and purchase screening and treatment equipment for other sites.

The cancer screening program is a source of hope for many young women susceptible to cervical cancer. We hope to prevent death from cervical cancer through education and screening.

## **Others**

### **AWARE Sub agreement**

Activities under the AWARE project entered the last phase in 2007 as the project ends on March 31, 2008. In 2007, focus was on strengthening and consolidating what was initiated in the previous years. However, a few new activities were implemented. About 85% of all planned activities were implemented before December 31, 2007. The last three months of the project shall focus on the closeout process. Below are some of the activities implemented under both projects.

#### **A. AWARE HIV/AIDS**

The following activities were accomplished in 2007:

- Brochures and posters (marketing tools) were developed and printed for various Health Board institutions. These were distributed to clients and partners.
- Three videos were produced for the board thus: a 52 minute video documentary on CBCHB; a 30 minute video documentary on the CBCHB ACP and a 7 minute video documentary on the PACCS program. These videos are being distributed to partners and institutions; and plans are underway to post them on the CBCHB website and also have them shown on popular TV stations in the country.
- A web site was developed to be launched early 2008. This already has a lot of information and has been visited by more than a thousand people all over the world. The creation of this site is a giant stride for the CBCHB as it is a very powerful marketing tool, which can be used to lure more funding partners, stakeholders and

clients to the organization. A very apt team has been put in place to manage and constantly up-date the site.

- CBCHB leaders and staff (including frontline staff) are constantly being sensitized on the need to provide quality services to clients as well as to regularly market the Board's services. Institutions are implementing various marketing strategies depending on their environment.
- Follow-up in countries trained on PMTCT has been ongoing, and this has been proving more successful in the English speaking countries like Liberia, Sierra Leone and The Gambia. Two technical assistance visits were made to these countries to help them in training more service providers, evaluate what has already been done, and introduce quality improvement tools like COPE, Facilitative Supervision (FS), and Infection prevention (IP). Mauritania – a French speaking country started PMTCT activities on Dec 1, 2005 with support from CBCHB and AWARE HV/AIDS and has continued to receive TA from the Board.
- PMTCT services were further scaled up in the AWARE region with every country being assisted moving from pilot sites to many and more permanent sites. In Cameroon, more than 100 new sites were started with support from CBCHB while the national program did a rapid scale-up in all health districts.
- CBC leaders were trained on leadership - Coaching and Mentoring. Participants who were drawn from all the three boards of the CBC deeply appreciated the training and called for refresher courses every year.
- Eighteen (18) more staffs were trained on monitoring and evaluation while 12 were trained on marketing.
- Guidelines for organizing international trainings were developed and are being printed.
- There was regular quarterly supervision of activities in the field.

Pending activities which must be completed before March 31, 2008 include the development of a checklist for providing TA, a TA visit to The Gambia and the organization of one regional training for PMTCT with funds raised using the marketing skills and tools acquired through the project.

## **B. AWARE Reproductive Health**

Integration of the activities introduced through the AWARE RH into routine health facility activities is very remarkable.

The following were achieved in 2007;

- COPE exercises were organized at least once in all institutions. Most institutions performed two exercises. Institutions also budgeted for quality improvement activities, as a guarantee for sustainability. Workshops were organized at institutional levels on facilitative supervision. Implementation of IP activities was intensified with specific days for clean-up by every staff in some Health Board stations.
- Trainings on family planning were intensified. A training session was organized for effective counseling in family planning using the REDI framework which helps providers to avoid provider bias. Another training session taught participants the new techniques of IUD insertion. A training on minilaparotomy was organized in Mutengene for some nurses and doctors. A major training session on Fundamentals of Care and Medical Monitoring was organized for all clinical supervisors, chief medical officers and nursing supervisors.
- More instruments were acquired for FP services. They included three “Zoe” models for teaching, IUD, Norplant and Minilap kits.
- Bi-annual meetings were organized for COPE supervisors to share ideas and seek ways of improving on services.
- Men As Partners (MAP) services were implemented from February 2007. This offered free VCT to men with focus on spouses of PMTCT clients. More than 5,000 men were tested through this effort. Most of them were linked to their spouses for positive living while the positive ones were linked to treatment.
- An end of project evaluation was carried out by AWARE, MOH and CBCHB. The results will be shared at a national dissemination workshop which will take place before March 31, 2008.
- Supervision of activities was intensified at all levels.

## **Challenges**

The major worry on everyone's mind now is, "After March 31, 2008, what next?" The project actually ends on this date, and there are no plans for its renewal. There hopes hope that USAID would donate the assets acquired through the project to CBCHB. However, other projects may come up and CBCHB would compete and win. Resource mobilization has to be intensified. Nevertheless, the integration of services is proof that activities would continue after the project ends.

## **Conclusion**

Both AWARE HIV/AIDS and AWARE RH, together with their managing partners – Family Health International (FHI) and Engender Health respectively - have been wonderful partners to work with. We pray that this partnership should continue even beyond the AWARE project.

## **PMTCT Effectiveness in Africa: Research and Linkages to Care (PEARL) Study**

The CBC Health Board is involved in the PEARL Study, which is aimed at assessing the effectiveness of expected services delivered by the PMTCT program since its inception some five years ago. The study involves the clinical aspect, which is facility based (collection and testing of cord blood HIV/Nvp from pregnant mothers) and community based aspect (involving children less than two years old) It also involves the Cost Effectiveness aspect, which is interested in assessing whether the PMTCT Intervention is making adequate use of our scarce resources. The study is multi-country, involving Cameroon, Cote D'Ivoire, Zambia and South Africa.

Data collectors for all the components of the project have been trained and a trial phase of the data collection process has been done. So far 4,199 cord blood samples have been collected and tested for HIV. The positive samples are also tested for Nevirapine. HIV results indicate that 99.5% of women at the sites concerned accepted to be tested. From these results, the prevalence rate stands at 9.7%. Incidence of HIV during pregnancy remains very low (0.1%). Nevirapine results indicate the presence of Sd-NVP in 77.2 % of the 346 samples collected from infected women who are supposed to have taken the Sd-NVP at labour ( see table 7 below).

This is similar to the overall intake of Sd-NVP by infected women in the CBCHB PMTCT program (78.4 %).

**Table 7: Summary of Cameroon Sd-NVP Test Results**

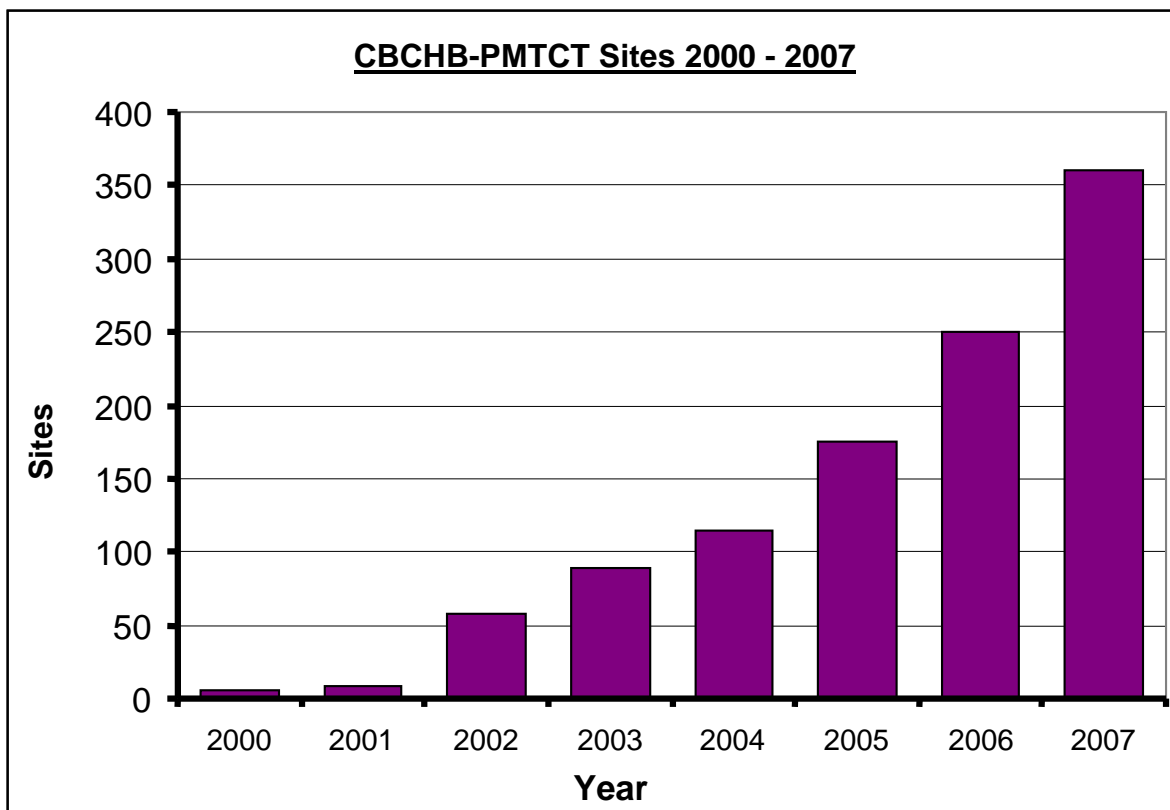
<b>Description</b>	<b>Number</b>	<b>Percent</b>
Positive	267	77.2
Negative	79	22.8
Undetermined	0	0.0
<b>Total</b>	<b>346</b>	<b>100.0</b>

### **Conclusion**

The CBCHB-ACP has grown rapidly over the past years. The program's main focus now is to consolidate and standardize what has so far been achieved. More efforts will also be made on quality improvement. The program remains grateful to all its partners, staff and clients.

## Appendices

### Appendix 1: Evolution of CBCHB - PMTCT sites, 2000 – 2007



### Appendix 2: PCR Results in 4 CBCHB Treatment Sites from 2005 - 2007

Year	No. done	No. Positive	Percentage (%)
2005	70	10	14.3
2006	195	27	13.8
2007	210	16	7.6
<b>Total</b>	<b>475</b>	<b>53</b>	<b>11.2</b>

### Appendix 3: Support group Statistics as at 2007

**Table 1: Support Group enrolment**

Treatment sites	No. of Affiliated groups	Enrolment	Males	Females	Deaths
NKWEN	29	1033	137	896	54
MBH	7	306	22	284	36
BBH	23	627	119	508	69
BHM	17	333	21	312	4
Douala	4	119	21	98	
Y'de area	11	614	26	588	4
<b>Total</b>	<b>87</b>	<b>3032</b>	<b>346</b>	<b>2686</b>	<b>167 (5.5%)</b>

**Table 2: Situation of ARVs and Prophylaxis among support group members**

Members on Prophylaxis	871
Members who have done CD4	793
Receiving ARV	774

**Table 3: Information on sexuality and birth control**

Spouses with unknown status	Members receiving condoms	Members with pregnancies	Babies 0-2 years born to HIV+ moms
91	992	113	296

**Table 4: Babies born to HIV positive mothers**

0-6mths on exclusive breastfeeding	0-6mths on replacement feeds	0-2 years dead
100	146	46

**Table 5: Support Group conference attendance**

Coordination area	Attendance		
	Male	Female	Total per area
Bafoussam	09	60	69
Mutengene	31	180	211
Yaounde	05	69	74
Ndu	18	136	154
Banso	50	220	270
Mbingo	23	157	180
Bamenda	60	360	420
<b>Total</b>	<b>196</b>	<b>1,182</b>	<b>1,378</b>

#### Appendix 4: Annual contribution of Health Institutions to the AHCW in 2007

S / N	INSTITUTIONS	2007 Budget (1% of annual salary)	2007 Actual	% Actual
1	Central Adm./TSD	1,000,740	90,127	9.0
2	Nkwen Baptist H. C	540,000	40,511	7.5
3	Kwighe Baptist H. C	50,000	20,698	41.4
4	Sabga Baptist H. C	30,000	2,567	8.6
5	Bafoussam Baptist H. C	95,000	68,903	72.5
6	Mbingo Baptist Hospital	3,602,890	451,416	12.5
7	Belo Baptist H. C.	110,000	73,436	66.8
8	Akeh Baptist H. C	50,000	32,010	64.0
9	Kumba Baptist H. C	305,000	29,211	9.6
10	Etoug-Ebe Baptist H. C	572,866	72,576	12.7
11	Mboppi Baptist H. C	626,000	-	-
12	Baptist Hospital Mutengene	1,200,000	207,563	17.3
13	Health Services Complex	937,500	355,564	37.9
14	Banso Baptist Hospital	3,947,753	-	-
15	Jikijem Baptist H. C	108,000	-	-
16	Mbem Baptist H. C	110,000	-	-
17	Ngeptang Baptist H. C	70,000	-	-
18	Lassin Baptist H. C	73,000	-	-
19	Bangolan Baptist H. C	140,000	-	-
20	Nyamboya Baptist H. C	80,000	35,616	44.5
21	Sarki Baka Baptist H. C	23,000	-	-
22	Allat Baptist Health Centre	75,000	27,977	37.3
23	Banyo Baptist H. C	175,000	81,473	46.6
24	Ngounso Baptist H. C	105,000	55,177	52.5
25	Kouhouat Baptist H. C	138,000	63,867	46.3
26	Ndu Baptist Health Centre	215,000	99,263	46.2
27	Romkong Baptist H. C	20,000	34,815	174.1
28	Finkwi Baptist H. C	26,000	-	-
29	Ekounou Baptist H.C	127,500	51,150	40.1
30	Ashong Baptist H.C	85,000	-	-
31	Life Abundant Program*	211,000	-	-
	<b>Total Contributed by HB Institutns</b>	<b>14,849,248</b>	<b>1,893,918</b>	<b>12.8</b>