Authoritarian continuity. HIV/AIDS policies as revealing the (non)transformations of the state in Cameroon

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1. Introduction

The technical structuring of public action to fight against HIV/AIDS in Cameroon shows that the inadequacies, dysfunctions and inconsistencies linked to the institutional and financial weaknesses of the Cameroonian State do not affect its political capacities for control and censorship and the locking down of public space. The present article is based on ethnography of HIV/AIDS policies targeting children under 14. It scrutinizes how certain policies are defined and carried out by concrete actors and how these processes articulate power relationships and bring to light the ways in which political domination operates. As Paxton points out, “HIV response management signals the political and technical capacity of a government and society to national and international publics; it is a sign of governmental competence and legitimacy.” (Paxton, 2012, 151). In Cameroon, interpreting the political on the basis of a minor object of public policies is a relatively new exercise. Indeed, analysis of political power has mainly focused on the functioning of the regime (Bayart, 2009; Médard, 1990, 2000; Sindjoun, 1996), on the crisis in the electoral process, or on the reconstruction of public space (Guillermou, 1992; Owona Nguini, 1999; Pommerolle, 2008). Our critique of political power in Cameroon is based on an analysis of the trajectory of support and care programs for children confronted with HIV/AIDS since the early 2000s, from their creation to their contradictions.

In 2013, while access to treatment for adults was around 50%, less than 10% of children infected with HIV had access to Anti Retroviral Treatments (ART). Over 300,000 children identified as highly vulnerable due to HIV/AIDS were awaiting medical,
nutritional or psychosocial support (GTC-CNLS, 2013). However, between 2000 and 2012, various attempts were made at national level to alleviate the medical and social consequences of the epidemic for children under the age of 14. An analysis of the implementation of this public action, dominated by international NGOs and furthered by local organisations, demonstrates the extent of the state’s disengagement. The way that foreign actors have overseen the development and implementation of specific actions for children strengthens the exogenous dimension of the creation of public action to fight against HIV/AIDS. It also raises questions about the governance models of public health policies, including other sectoral policies such as agriculture, environment, transport, education, etc. In other words, it questions the nature of the state, its place, its role, the different modes of operation of the established political power and its capacities for action.

3 Based on a thesis written between 2009 and 2013 on the construction and implications of the political agenda of the fight against HIV/AIDS in Cameroon, the present article defends the argument that there has been an authoritarian continuity of political power in Cameroon stemming from its capacity to control and depoliticize actors, and to produce (often by coercion) a consensus to its domination. We adopt a stance that draws on previous work on politics in Africa, work that explores both the way in which policies are formed in a specific context and the methods of intervention of political officials in public life. Public policies control indeed lies at the heart of the exercise of power. The types of governance of public action targeting children confronted with HIV/AIDS in Cameroon, powerfully affected by relations of subordination, domination or even coercion vis-à-vis national non-governmental actors, raise the question of an authoritarian continuity. It thus makes it possible to question the hegemonic rationales reshaping power and the functioning of the state, despite a relative shift away from the authoritarian practices of pre- and post-independence governments (practices characterized by the use of repression, and various weapons including military or non-military weapons such as the ‘whip’ (Bayart, 2008) to crush any protest movement). These characteristics can be found in the works of Jean-François Bayart (1985) on the challenges of extraversion, Jean-François Médard (1990) on neo-patrimonialism, Luc Sindjoun (1996) on the simplifying myth constituted by the apparent pluralism of Cameroonian political space, and Joseph Keutcheu (2013) on the construction of the Cameroonian state order, made up of strategies and opportunities. Analyzing public action for children confronted with HIV/AIDS thus comes down to seeing what type(s) of links exist(s) between the dynamics of political pluralism and the ways in which political arrangements operate. The aim is precisely to observe the variations in state-society relationships in Cameroon and to identify the specific features of the modes of regulation of public life.

4 Beyond a few scattered programmes, and in the view of the plurality and heterogeneity of the actors who shape, or even govern, public action to fight against HIV/AIDS for children in a relatively independent manner, what sustainable initiatives can guarantee children under 14 old effective access to basic medical and social services? To understand the historical (dis)continuities of the evolution of state-society relations in Cameroon, we first present the historicity of the public action to fight against HIV/AIDS for children. This historical perspective sheds light on the mechanisms that ensure the depoliticization and technicalization of a particular social issue. The moral and political economy of repression through the control and domination of actors
mobilized where the state is absent places the relationships between those who hold state power and the wider society in an authoritarian continuity.

2. Children and HIV/AIDS in Cameroon

5 Asked about HIV/AIDS policies challenges in his town, an opposition legislator declared: ‘HIV/AIDS is not a political issue’. In a context where HIV/AIDS is one of the main causes of adult mortality, this position clearly reveals that what could have been denounced as a weak political response to the epidemic is conceived simply as a biomedical and technical, even private issue, therefor obscuring power dynamics and resources devoted to the fight against the epidemic. This statement might also derived from the type of actors who have brought the issue into to public notice. Indeed, in both paediatric care and psychosocial care, the analysis of public action for children confronted with HIV/AIDS shows that it is dominated by non state actors, particularly medical professionals who have managed to establish themselves as legitimate public policies entrepreneurs, supplanting and discrediting state actors in their leadership as guarantor of the general interest.

2.1 A limited paediatric care

6 Cameroon’s first response to the epidemic dates from 1987. Compared to other countries in the sub-region, this response was in many respects seen as ran early answer. However, the conditions in which HIV/AIDS policies are produced converge towards a model of ‘passive adhesion’ to global dynamics and to the ‘offers’ from biomedical actors and international donors. Care and support programs for children do not escape this rationale.

7 Apart from mother-child prevention programs, paediatric care remains embryonic and the challenges are numerous, starting with early HIV testing, the availability of paediatric drugs and the monitoring of children under treatment. The prevention measures represented by screening and the starting of treatment are not applied systematically, nor everywhere. Before 2013, less than 20% of children born to HIV positive mothers had access to early diagnosis tests. Only two centres were able to perform such medical tests. Thanks to the Clinton Foundation grants, these two centres – the Centre for Disease Control and Prevention in Mutenguéné (CDC) and the Chantal Biya International Reference Centre in Yaoundé (CIRCB) – could analyse tests from all across the country. This posed significant problems of delay and non-return of results. Furthermore, even when paediatric drugs existed, the issue of access was not resolved. Until 2013, barely 10% of 0-14 years old in need of treatment received it, compared to almost 50% of adults (GTC-CNLS, 2014).

8 Even today, paediatric care is not widespread, not only because of the difficulties mentioned above, but also because of the imbalances between care centres in-country, due to the highly unequal integration of actors involved in international public action networks.

9 Indeed, it is mostly private initiatives of medical professionals, which have raised paediatric care to the national attention. Paediatric care has started after prevention of mother-to-child transmission (PMTCT) pilot programs funded by Médecins Sans Frontières and other foreign partners such as the United Nations Children’s Fund (UNICEF) and the CDC. However, when these programs were extended to the national
level thanks to significant funding from the World Bank in 2006, the supply of care for children born to HIV-positive mothers remained confined to three centres: the Essos Hospital Centre, the Mother-Child Centre of the Chantal Biya Foundation in Yaoundé, and the Lanquintinie hospital in Douala. Located in the two capitals of the country – which are not the most affected by the epidemic – this medical offer marks a real territorial disparity. Since the arrival of treatment, a certain number of partnerships have existed between these three centres and foreign partners (partnerships on clinical research projects). Because of these multiple forms of support, often linked to the individual capacities of some biomedical actors, these three structures have the largest active paediatric lists in the country. Beyond the technical supply at their disposal, it is above all their relationships with international actors, which makes it possible to shed light on the inequalities in access to care, and on the disengagement of some health professionals:

‘I send the children to where there is medicine and support. Most of them come from poor families. At least there I know that they will be taken care of [...]. They even reimburse transport. Here, it is not an option’ (Dr B., Yaoundé);

‘Paediatrics is first of all social. Giving children medicine is not enough. AIDS in children is not the same as in adults. You have to manage the child, but you also have to manage the mother, manage the parents, manage the family, think about the child’s environment. It’s not that simple [...] There are even psychologists there.’ (Senior Nurse, Ngaoundéré).

9 Few care centres are able to mobilize resources allowing them to offer additional services (home visits for children, telephone calls, reimbursement of transport costs, nutritional support, counselling for the announcement of HIV status, adult service monitoring), while elsewhere there is an imbalance in the supply of basic services (screening, for example). This keeps paediatric care in the shadows and accentuates the unequal dimension of public action in the fight against HIV/AIDS. Like the state services, these actors manage the field of paediatric HIV care almost autonomously. Although they face regular problems such as depleted stocks and inputs or the failure to return children’s test results, being forced to cut up adult pills by hand to give them to children or reluctantly send the latter elsewhere – to other allegedly ‘richer’ health centres in which their colleagues complain of ‘burn-out’ – few health professionals appear to be assertive. They hardly ever denounce working conditions, resources distribution allocated to the issue, or decision-making procedures. On the contrary, many of them hold themselves responsible; we have often heard people say: ‘anyone can take care of an infected child. We’ve all been trained’, or ‘not everyone can take care of a child. It’s very demanding.’

10 The existence of enclaves of paediatric care, carried out by biomedical actors well integrated into transnational networks, contrasts with the means available to other hospitals, and exposes (as much as it compensates for) the inadequacies of state involvement. In parallel with paediatric care, and despite these shortcomings, a broad spectrum of social intervention has been developed, intended to mitigate the social consequences of the HIV epidemic on children.
2.2 Orphans and vulnerable children (OVC). Tensions between international standards and local realities

Since the early 2000s, several studies have highlighted four main risks faced by children in the context of HIV/AIDS, hence the generic term *orphans and children vulnerable to HIV/AIDS* (OVC). First, they are at high risk of not going to school or of going to school in conditions that make it difficult for them to thrive (due to the burden of stigma, poverty, having to care for a sick relative). Secondly, they risk living in a household where food security is profoundly reduced (risks of undernutrition and malnutrition because the expenses linked to the disease reduce the household’s food resources). Thirdly, they risk suffering from anxiety and depression (young girls face increased responsibilities, there is the pain associated with the illness and death of parents, discrimination, separation from brothers and sisters in the event of the parents’ deaths, etc.); and finally, they are at risk of contracting HIV (through vertical transmission or sexual abuse) (Skinner et al, 2004). In Cameroon, a study conducted in 2010 identified 1,200,000 OVC due to AIDS, 25% of whom were orphans (with the loss of at least one parent) due to AIDS. It concluded that only 9% of OVC received any support, despite the programs developed for them (Nsagha et al, 2012). In a context where almost 40% of the population lives below the poverty line (National Statistics Institute 2011), something which inevitably and negatively affects the social indicators of well-being of all children regardless of HIV infection; where the prevalence of HIV is higher in women than in men (7% as opposed to 3%); and where just half of adults have access to antiretroviral treatment for AIDS compared to under 10% of children, the initiatives of a few health professionals supported by their international partners cannot guarantee 0-14 year-olds sufficient access to basic medical and social services. Their action is in fact geographically limited (confined to a few centres) and circumscribed in time (the time of the duration of funding).

Three national programs have already been implemented (see box). Structured around food provision, medical and health assistance, and school and legal assistance, these programs did not achieve their goals due to the difficulty of systematically aggregating the fact of being an orphan, being infected with HIV, and being vulnerable because of this epidemic environment. Note that a child infected with HIV is not necessarily an orphan, neither vulnerable, and a child in a highly vulnerable situation may be unrelated to HIV/AIDS.

Support programs for orphans and vulnerable children (OVC) in Cameroon, from 2000 to 2012


This was a UNICEF/French/Ministry of Social Affairs bi- and multilateral cooperation project whose objective was to support extra care for OVCs. Duration 36 months. This experimental social action project for AIDS orphans took place in three pilot cities. It aimed at providing multifaceted assistance to around 10,000 OVCs, but only reached 3,200, representing 32% coverage (Brusset et al. 2008). In the North-West region, the head of a local association declared that he focused very quickly his activities on children from the poorest neighbourhoods, children with disabilities, and street children. According to him, OVCs because of AIDS were
impossible to identify due to the lack of knowledge of the status of the children, and that of their parents.

2. The NSP-OVC (2006-2010)

The National Strategic Plan (NSP) to support OVC was the only government program entirely dedicated to children infected or affected by HIV/AIDS. Under the supervision of the National Committee for the Fight against HIV/AIDS (CNLS)/ Ministry of Social Affairs (MINAS), and implemented through the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria grant (Round 4), its aim was to support 75% of the 1,200,000 OVCs identified and classified as urgent, on a quarterly basis. As with the bi-and multilateral programme, the HIV criterion, despite being a central factor of vulnerability, would ultimately not be used in real service provision. In the absence of known or declared status, social agents would be forced to select the children according to the frequency of the declared cases of disease and the family environment. About fifty NGOs and local organisations would be recruited for the occasion, even if later, almost half would be rejected for lack of results. Although it began as if shot from a cannon in 2006, the NSP-OVC quickly ran out of steam before being suspended, barely two years later. No official reasons for suspension were given, but according to some community actors involved, the NSP budget was needed elsewhere. Apparently, it was necessary to find money at all costs to ease the tensions created by the Presidential Decree on free ART drugs signed in May 2007.15

3. The CHA Programme (2008-2012)

The Children, HIV and AIDS programme (CHA) was part of the Cameroon-UNICEF Cooperation Programme 2008-2012. It was one of the three sub-components of Primary Prevention, dedicated to the fight against STIs/HIV/AIDS, early pregnancies and adolescent reproductive health. The operations were no longer carried out by NGOs and local organisations only, but were extended to schools and town halls through Information, Education and Listening Centres for young people. Supported by other United Nations organisations, UNICEF piloted the programme by involving national administration.

The satisfaction of socio-economic needs and guaranteed access to medical care are shared necessities in Cameroon, whatever the status of the children. The construction of the OVC category and the policies associated with it were certainly highly relevant in the East African contexts of the mid-1990s where prevalence rates exceeded 15%, and where thousands of children were left alone and orphaned due to the deaths of parents and grandparents, a dramatic situation that led to the terminology ‘OVC phenomenon’ and ‘children’s villages’ (Williamson, 2008). However, there is no evidence to suggest that the severity and urgency of the problem were the same in the Cameroonian context. Indeed, we can even speak of a forced agenda concerning NSP-OVCs (see box above) because the latter programme would not have seen the light of day if Cameroon’s bid for Round 4th of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria had not been rejected, among other things because it did not address the problem of OVCs: ‘Cameroon’s candidacy had been rejected because there was nothing about OVCs in the overall concept. We urgently had to propose a plan that would make sense. This is...
what we did on the basis of other national experiences’ (Administrative Officer). In the field, it is not clear who OVCs are: ‘OVCs are all children. Not just HIV/AIDS orphans children. Especially here, in the North (...) If we look closely, those with AIDS have fewer problems. In one hour, I can bring over 500 OVCs here’ (Administrative Officer).

With these difficulties of reappropriation and action, under what conditions does such a public problem emerge and unfold? The trajectory of this public action, the characteristics of the actors involved in it and their interactions illustrate a construction from above, thus confirming the thesis of Cameroon’s ‘passive adhesion’ (Eboko et al., 2009) to a model of public action driven by international actors. Health professionals, as well as some technical and financial partners such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, UNICEF and international NGOs, play the role of public policy entrepreneurs. This role depends on their ability to bring to the public’s notice an issue that would not have received the same attention otherwise (Hassenteufel, 2010; Kingdon, 1984). The characteristics of the activities undertaken for children in the fight against HIV/AIDS are inseparable from the cognitive and social work carried out by these entrepreneurs, even if it means reinforcing inequalities where they already exist. Children affected by HIV/AIDS do not form a micro group isolated from the social, economic and cultural context in which they live. However, the positioning of these entrepreneurs made it a separate issue. The priorities as perceived by these entrepreneurs, and the realities on the ground, are not always aligned. The question of a hierarchical architecture between the various stakeholders arises and leads us to question the marginality of the political authorities in this process. As a result of these inconsistencies, public action in favour of children in the context of the fight against HIV/AIDS seems to unfold in a contradictory manner, in the absence of strong national measures that would make it sustainable. Although it shows a form of ‘discharge’ (Hibou, 1999) as a method of managing public policies, this situation also leads us to question public action governance modes in Cameroon.

3. HIV/AIDS policies governance in Cameroon: between openness and the authoritarian reconfigurations of power

The methods used to manage the HIV/AIDS epidemic in the majority of African countries allow us to speak of multi-level governance (Eboko, et al, 2015). Indeed, the plurality of actors who intervene both nationally and internationally modifies the decision-making process by granting various actors – such as health professionals, donors and community actors – a certain power in developing, implementing and conducting a response of variable significance. The configuration of actors in this multi-level governance is highly unbalanced. Owing to the very strong influence of international actors – whose presence and contribution have opened up possibilities for various actors to supplant state services – the proponents of state authority in return deploy (by habitus) strategies of control and domination that contrast with their real capacities for action.
3.1 Openness in question: a state in search of legitimacy

The analysis of public action to fight against HIV/AIDS through the implementation of the NSP-OVC in Cameroon constitutes empirical material for observing the processes of legitimization of political power. A state’s real legitimacy is not in fact normative but results from a mixture of different sources of legitimacy (electoral, traditional, ideological, etc.). It gives added value to power and acts as an element in consolidating its capacity (Bellina et al., 2010). By the quest for legitimacy, we here mean the efforts made by the government to meet certain expectations, to obtain a certain consensus, and to mobilize around it a large number of agreements and support. The opening up of the public space to the fight against HIV/AIDS, as well as the involvement of NGOs and local organisations in the implementation of a programme like the NSP-OVC, constitute elements of this quest for legitimacy, especially vis-à-vis foreign partners.

With the NSP-OVC, for the first time in 2006, the state relied on networks of local organisations to offer, at national level, community services for children identified as vulnerable. After an invitation to tender opened by the Ministry of Social Affairs (Minas), 52 NGOs and organisations were selected in the ten regions of the country. Depending on the density of the populations in the areas where they operated, each association would be responsible for offering services such as medical aid (health checks), nutritional aid (food baskets), and social aid (school support, legal support, etc.) to children of 0-14 years old (sometimes 18 years old) considered vulnerable because of HIV/AIDS. One or two social workers were assigned, depending on the size of the organization, and deployed to act as intermediaries between the central administration and NGOs and organisations, in order to mark the state’s presence at local level. This involvement disappeared completely with the suspension of the programme in 2008. Almost half of the local organisations involved were dismissed after a semester for lack of results, according to some administrative officials. Indeed, several of these local organisations had neither enough experience, nor the capacities to accomplish the missions that were expected:

‘The first part of the programme was a real mess (...). Minas sent social workers to all of the NSP-OVC partner organisations. Some people didn’t even have a place to sit... Some files were unreadable... A lot of money and time wasted’ (international organization official).

Paradoxically, the recruitment and deployment of social workers was not supported by any organizational strengthening at state services level. That could have been the case of the departmental delegations of social affairs or medical centres social services dealing with vulnerable or distressed families. One delegate condemned the situation:

‘I don’t get it! This process is overwhelming (...). We need staff and funds. But the money was for local organisations and our budget remains unchanged. I personally know organisations that pocketed the money without doing anything!’

Placing NGOs and local organisations at the heart of the national OVC support system without dealing with the institutional weaknesses of its own administration is indeed a paradox. It is an opportunistic strategy that does not care about the long term. By establishing formal agreements with community and organisations partners, political authorities admittedly showed a certain openness, as Laurent Vidal and Fred Eboko have already shown with regard to civil society activism in the fight against HIV/AIDS in Cameroon (Eboko and Mandjem, 2011; Vidal, 2014). However, real openness would have involved these local actors right from the beginning, meaning at the conception
phase of the NSP-OVC. Let’s not forget the circumstances under which this programme was developed. By encouraging local NGOs and organisations participation (to the disadvantage of building the capacity of its own administration), the Cameroonian state thus showed to its foreign partners that he was able to mobilise, guide and deliver new services and policies. Indeed, at the central administration level, officials are in fact advocating a horizontal approach, i.e. a *laissez-faire* policy. This horizontality, a result of a neoliberal *governmentality* encouraged by international donors, allowed diverse local actors to take a subsidiary place in the public policy architecture. With the suspension of the NSP-OVC, what stands out is the incapacity of the current government to negotiate its priorities with its foreign partners. This is also a sign of a ‘discharge’ strategy (Hibou, 1999), which consists in anchoring state action in informal networks rather than in its own institutions; state’s duties, supposed public, are then exercised by private actors for private purposes (for example, advantageous positioning on the scene of civil society organisations).

The injunction to participatory policies– posed by the main donors on whom public policies against HIV/AIDS depends – reduces the political significance of this horizontality. The *laissez-faire* argument also did not lead to the decompression of centralist decision-making and control mechanisms: ‘It was Yaoundé that decided everything’; these words, spoken with an air of resignation, were what we heard from certain community actors involved in the NSP-OVC. This attitude was reminiscent of their role as simple operators and not as co-producers of a public action, which nevertheless sought to be inclusive and transparent. Thus, one community actor declared:

‘The NSP-OVC was the first social paediatrics programme in Cameroon. It was the first time that a national plan brought together the hospital, state institutions, NGOs, local organisations, town halls, neighbourhoods, etc. On paper it looked wonderful. That was only on paper. Because when we got down to the groundwork, it was quite different (...) Some elites have spread the belief that it was a gift from the head of state and his wife.’ (Community agent).

The increasing number of actors participating in public action, therefore, does not necessarily make the way public policies are thought out or implemented any more open. To speak of *laissez-faire*, *concerted action*, *openness* or *participation* is, in the words of Luc Sindjoun (1996), to resort to ‘simplifying myths’ which hardly mask forms of power personalization in state-society relationships. Beyond being mere artifices often intended to prove their credentials to donors (extraversion rationales), these rhetorical terms only contribute to the updating and reconfiguration of the hegemonic domination of state power.

### 3.2 Administrative routines and authoritarian adjustments

In an ‘AIDS market’ (Delaunay et al., 1999), the inability of state power to adequately ensure the delivery of goods and services to the populations for which it is responsible does not necessarily mean he is powerless in the face of the economic, social and political challenges that have arisen on its territory since the end of the 1990s.

Before the law of 19 December 1990 on freedom of association in Cameroon, the legal framework for individual and collective rights and freedoms was fundamentally violent. Any private or collective enterprise intended for the defence of rights and freedoms or the tackling of a public problem outside the framework of the state
administration and the single party was vigorously repressed. Spaces for collective action on extremely diverse bases continued to increase with this liberalization of the political process. The arrival of AIDS treatments in the early 2000s also favoured the emergence and spread of transnational actors with significant resources. The impact of these actors in the national response to the epidemic considerably changed political activity. If this modification relativized domestic sovereignty given the marginal position of the state in guaranteeing goods and services essential to populations confronted with HIV/AIDS, it was not able to alter its capacity to reconfigure and maintain different forms of domination. Two elements here lay the foundations for authoritarian continuity: depoliticization, and the control and (very often) violent regulation of public space.

For the various stakeholders in public action against HIV/AIDS, this is first of all a medical and therefore purely technical issue. The epidemic response, however, calls upon the state’s capacities to govern, or for governance (Patterson, 2005). The variety of local actors involved are acting as mere substitutes for the administration. There is a certain form of tacit consensus between these actors, which removes any political significance from the struggle: ‘We don’t do politics, we do what must be done at our level. This is also our responsibility as civil society actors. We also provide advocacy’ (community agent, Douala). Public action is structured around psychosocial, medical, contingent and hypothetical support, the continuity of which rests on the individual responsibilities of families and not on the authorities in charge of policies. The argument of a practical, concrete commitment lessens the responsibility of public authorities and illustrates a depoliticized vision of public action. This vision is admittedly linked to the target of public action (health issues in general are not very prone to conflicts: Buton and Pierru, 2012) or to the profile of actors who intervene (essentially NGOs and community organisations), but it can be understood only from a critical analysis of the context in which this political neutrality is produced, a context marked by the avoidance of conflict and the permanent quest for a technocratic consensus.

Indeed, even though public debate has developed considerably since the mid-1990s, civil society organisations are struggling to constitute a counter-proposal vis-à-vis the state because they are aware of its strike force or its ability to punish (intimidation, suspension, closure, etc.). No conflict, no antagonism, no struggles: ‘It’s difficult to explain. Even if we wanted to, we can’t. What use would it be? The state’s strike force is real. We do what we have to do without getting involved in politics’ (community agent, Bamenda). Depoliticization is produced in the context that we are studying by the internalization of domination through a specific political socialization (Hibou, 2017). What underpins the continuity of authoritarian power in Cameroon is the existence of multifaceted constraints, those which contribute to the exercise of an unequivocal, aggressive and constant authority against any criticism of state legitimacy or of those who hold state power. It is therefore a depoliticization under duress based mainly on the fear of political power. By organizing the framework of action of the various actors, the state has the means to control and regulate access to public space. The means of action are thus in the hands of scattered and diverse actors, but the selection of these actors as well as the modalities of their participation in public action is in the hands of the central authority. Indeed, although relatively autonomous in their agendas, NGOs and community organisations are required to inform the administrative authorities of the development of their activities: ‘They give us nothing but they require reports’ (community agent).
Administrative censorship hovers indiscriminately over organisations; especially those that dare to publicly attack the unspoken rules for avoiding any political conflict:

‘I have been arrested once. We were doing a sit-in outside the National Assembly to challenge the government to respect its commitment to the Bamako agreement. People are dying because they do not have access to care. If the state respects the Bamako agreements, thousands of lives can be saved. They say it is an unauthorized demonstration [...] No Prefect can authorize a protest demonstration’ [...] (community agent, Yaoundé).

This case illustrates an observation made by Pommerolle about collective demobilisation in Cameroon: ‘If the channels of participation are open, the selection of those who are likely to be consulted remains in the hands of the authorities’ (Pommerolle, 2008, 89).

The central administration also remains an important cog in the processes of formalizing relations between the different actors. It therefore has the means to control their action, and can for example prevent an organization from functioning when it judges that its power is threatened or contested: ‘There are guidelines for behaviour. If we find transgressions we take the necessary measures’ (administrative officer, Bamenda). Political authorities have already objected to funding received by local organisations from external sources, blocked disbursements without giving any reasons, or demanded, outside any legal framework, certain types of behaviour under penalty of sanctions. This implies that actors wishing to work peacefully must behave well and play by the rules, including during so-called coordination meetings:

‘We are quite willing to denounce some administrative abuses, the behaviour of some elites or the contradictions in decisions making. But you have to be well seated (...). It can very quickly work against you’ (community agent, Yaoundé).

These different elements show how controlled the access to the public and political sphere is, and reinforce the argument of a ‘stationary state’, firm in maintaining its control methods, not very open to criticism or change (Eboko and Awondo, 2018). Because of this political environment, few elements allow us to break out of an argument of depoliticization under pressure (Vairel and Zaki, 2011). Indeed, the strategies for avoiding conflict and the political neutrality of actors engaging in public action are based above all on the fear of suffering the costs and the attacks that will ensue from open opposition to political choices. One of the characteristics of an authoritarian power isn’t precisely political apathy and the fact that it tolerates little or no protest? (Linz, 2000).

Several studies have shown the transformative role that civil society can have in the development of state institutions and political change. One of the conclusions that we share, clearly illustrated by Anke Draude (2015), is that in terms of governance, the change of public policies depends more on internal dynamics than external ones. In other words, any substantial changes in the conduct of public action, making this consistent with local needs and aligned with a long-term vision, will come neither from international aid, nor from donors, nor from transnational actors: ‘The donor’s political conditionalities, support for civil society groups, technical assistance and other activities appear to affect African democratization only at the margins’ (Goldsmith, 2001, 141). In Cameroon, despite effective mobilization in the fight against HIV/AIDS, technical and pragmatic rhetoric far outweighs the rhetoric of advocacy. Without any explicit political request, there is neither any opposition nor any counter-proposals. Fostered by the control...
exercised by the state over access to public space and the way in which it engages within, this self-exclusion from the field of political demands can be qualified as forced exclusion, and it is a consubstantial feature of authoritarian political systems (Linz, 2000). Already evident in the early 1990s, despite a certain opening of the political game (Abé, 2006; Médard, 1991; Sindjoun and Courade, 1996), the Cameroonian authoritarian tradition is still active today. It is characterized by a higher propensity to resort to intimidation, deterrence, punishment and too often violence to settle conflicts inherent to democratic dynamics. The space left to civil society organisations, however central as a relay in an area where the state seems marginal, remains tenuous and confined to precise limits. The Cameroonian political environment conditions the modalities of intervention of national and transnational actors in public action. This situation maintains a certain balance that consolidates the status quo, and even the reinforcement of a power that has changed almost nothing in its authoritarian methods (Morelle and Planel, 2018). Ensuring that children under 14 years old confronted with HIV/AIDS have equitable and sustainable access to basic medical and social services is not possible without a fundamental transformation in the way public action is managed. In other words, it is necessary to act at levels of action that are as close as possible to the populations and in their interests alone, without opportunistic political calculations that favour a particular regime.

4. Conclusion

The multi-level nature of public action to fight against HIV/AIDS, involving a configuration of actors in which state institutions occupy a relatively marginal place compared to NGOs and local organisations, does not allow us to conclude that the nature of state-society relations in Cameroon has been transformed. Internally, AIDS governance by and with non-state actors certainly puts the state on the back foot, but does not place it in a situation of weakness. While economic constraints limit its autonomy and favour a passive reception of foreign models, political power has other means, notably symbolic and coercive, to reaffirm its dominant and hegemonic role. The dysfunctions of the state apparatus are real; they are also the consequence of authoritarian governmentality which leaves little room for long-term concerted action. Actors who live in fear of thwarting political power are actors who feel threatened, muzzled, unfree. The state is surely one protagonist among others in this public action; it has little control over the issues and is also positioned as an actor in the calculation of opportunities provided by public action, a calculation described as an ‘AIDS market’ in the early 2000s. In this competitive logic however, it is better to be in a dominant position. This requires control of the actors and control of the access to the political space. Concluding of authoritarian reconfigurations of political power is not an extrapolation. So many facts, which point to dysfunctions inherent in the weakness of the political system, concur paradoxically in maintaining this authoritarian continuity.

Far from considering the authoritarian situation in Cameroon solely as a form of failure in the process of state formation or in the process of democratization, the present article also paves the way for a reflection on neoliberal authoritarianism, one which consists in disciplining and shaping state interventions (including in high-income countries) to bring them into line with the needs and structuring of the global financial economy.
BIBLIOGRAPHY


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NOTES

1. Because of its lack of any significant political scope, here understood in a conflictual sense.
2. Here, we prefer the expression 'children confronted with HIV/AIDS' rather than the generic term OVC (Orphans and Vulnerable Children) because of the difficult operationality of the concept of vulnerability in a context like that of Cameroon. In our choice of this term, only two aspects have been taken into account: the medical aspect (HIV infection) which calls for paediatric care, and the environmental aspect which calls for psychological and material support due to the significant social consequences of the epidemic.
3. This was an analysis based on an ethnographic-type survey carried out in nine of the ten regional capitals of the country. Consisting of around a hundred interviews with actors intervening on different scales, participant observations (internship, home visits, paediatric consultations, therapeutic committees, evaluation meetings, etc.) and documentary analyses, this survey focused on the characteristics of public action, the dynamics of the actors, their practices and their logics of intervention, their interactions, the context in which public policies are defined, etc.
4. Interview with a municipal councillor of the Social Democratic Front (SDF) party, 12 June 2012, Bamenda City Council.
5. See note 2 above.
6. The characteristics of this 'general interest' can be found in the preamble to the 1996 Cameroonian constitution, revised in 2008: 'The State provides all citizens with the conditions necessary for their development.'
7. These tests screen infants born to infected mothers. Tests are recommended for between 0-6 weeks instead of 18 months for a normal blood test.
8. In 2012, a large stock of paediatric medicines had been destroyed in the Adamawa region, while paradoxically almost all the care centres had experienced stock shortages in the six months preceding the survey. This was a donation of medicines from the Clinton Foundation, UNITAID and UNICEF to the various paediatric care centres. Professionals were either not aware of the existence of these stocks, or (as a general practitioner stated) were unwilling to take care of children because it was not only a question of dispensing medicines, but of looking after the patients subsequently.
9. An active list indicates the total number of patients treated in a department during a year.
10. Interview carried out on 10 January 2011 in Yaoundé.
11. Interview carried out on 11 April 2012 in Ngaoundéré.
12. This underlines the exhausting character, one not appreciated at its true value, of taking care of the ever more numerous and deprived patients, both children and adults.
13. This is particularly true as the concept of vulnerability remains difficult to operationalize, due to disparities in the degree of exposure to risks (medical, social, economic, psychological, security risks, etc.).
14. It is the double partnership with UNICEF and the Cameroonian government which justifies the term 'bi- and multilateral', to clarify that this cooperation programme is simultaneously bilateral (Cameroon-France) and multilateral (UNICEF-Cameroon).
15. This shows how ungrounded the NSP-OVC was in Cameroon, a yes to unexpected grant offer through poor knowledge procedures.

16. Prior to 2012, the Global Fund granted financing to governments in the form of an appeal called Round. So there was Round 2, Round 4, Round 5, etc. This procedure has changed with the New Funding Model (Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, 2013).

17. Interview carried out on 11 January 2012 in Yaoundé.

18. Interview carried out on 9 April 2012 in Ngaoundéré.

19. Interview carried out on 13 February 2012 in Douala.

20. Interview carried out on 9 April 2012 in Ngaoundéré.

21. Interview carried out on 10 January 2012 in Yaoundé.

22. Understood as the capacity of the political authority to organize, resolve or impose principles for the resolution of its domestic problems such as education, transport, health, agriculture, etc. On sovereignty, see Lerin and Tubiana (2009). This limitation of sovereignty to the internal sphere is a characteristic of states in situations of extraversion or of projected societies, i.e. societies permanently turned towards foreign countries, as well as of the technical, cognitive and financial referents they derive from them. Bayart (2000); Darbon (2003); Peiffer and Englebert (2012).

23. Interview carried out on 18 July 2012 in Mutenguéné.

24. Interview conducted on 13 June in Bamenda.

25. Interview carried out on 12 January 2011 in Yaoundé.

26. Interview conducted on 22 May 2012 in Yaoundé.

27. Interview conducted on 4 May 2012 in Bamenda.

28. In 2011, for example, the Minister of External Relations had expressed his opposition to the European Union funding of a project aimed at sexual minorities in the context of the fight against HIV/AIDS.

29. Interview carried out on July 10, 2012 in Maroua.

ABSTRACTS

The present article examines political practice in Cameroon, its transformations and variations through a sociological analysis of public HIV/AIDS action targeting children. The article hypothesizes that there is an authoritarian continuity of state power, including outside the framework of explicit political mobilizations – in this case in the field of children’s health. This authoritarianism is enshrined in depoliticized practices, carried out under pressure and under the control of public space. The article concludes that political power has indeed been reconfigured, but with almost no change in its methods of control and repression inherited from the post-independence years, despite proven institutional weaknesses. In fact, ensuring that children under 14 years confronted with HIV/AIDS have minimum and sustainable access to basic medical and social services is not possible without a fundamental transformation in the management of public policies. The discussion falls into in two parts. The first traces the historicity of children and HIV/AIDS care policies, taking into account the context, the profile of the different actors involved and the ways in which they interact. The second part analyses how the state reproduces its authoritarian domination, despite his marginal position in HIV/AIDS policies targeting children.