
Background and evolution of an international solidarity instrument (eng)

Fred EBOKO and And the "Governance and AIDS in Africa group"

- 1 The advent of the Global Fund in 2002 marks the end of a period of international procrastination in the midst of one of the most difficult tragedies the health world has ever experienced, the AIDS pandemic. Sub-Saharan Africa undoubtedly represents the urgency to which the international community has had to respond by inventing this instrument of solidarity, which is unprecedented in the history of public health (De Cock, Mbori-Ngacha, Marum, 2002). While the creation of the Global Fund provides a decisive impetus for the care and prevention of the three diseases to which it is dedicated, it has been the subject of failed attempts, and has come up against *Real Politik* and the financial interests that govern the neo-liberal economy. The pharmaceutical industry has thus been the cornerstone of the system (Dixneuf, 2003a; 2003b) within which the Global Fund has set itself the task of clearing a path. The aim was to enable patients in countries modestly called "resource-limited" to access care and survive a combination of lethal threats (Moatti, 2013).
- 2 The work to which international personalities have devoted their strengths and authority integrates and goes far beyond the field of health alone. For the Global Fund to emerge, these energies have drawn their essence from the virtues and workings of diplomacy, have been inspired by diplomatic contests, have activated social networks, invented new directories of collective action or manipulated certain habits to which some Western opinions are sensitive, such as the issue of security (Chabrol, 2002). The struggle was fought on several fronts: from transnational collective mobilizations to diplomatic negotiations led by first-class professionals. The idiom of international solidarity was far from enough to face disparate interests. The battle was thought and carried out on political grounds (Buse and Altman, 2010).
- 3 In 1997, at the 10th International Conference on AIDS and Communicable Diseases in Africa (CISMA), the French Minister of Health, Bernard Kouchner and the President of

the Republic Jacques Chirac launched the idea of an International Therapeutic Solidarity Fund (ITSF) in Abidjan. He gave birth to a field of wasteland. Indeed, the UNAIDS initiative to which the ITSF initially leaned had some lead in the wing: patent enforcement in the hands of the major pharmaceutical companies with which agreements were signed (Desclaux, et al. 2002).

- 4 The three pilot projects that emerged from this initiative, in Côte d'Ivoire, Uganda and Chile, produced a slow increase in the rate of patients undergoing treatment. Indeed, the cost of treatment, although reduced, remained a significant barrier. This constituted a socio-economic filter, with no causal link to the clinical criteria of patients' eligibility for treatment.

International contingencies facing a public health threat

- 5 As early as the late 1980s, the US Democratic Executive, including Vice President Al Gore, launched the idea of supporting the fight against AIDS in Africa, given the dramatic seroprevalence rates in southern Africa. He received strong opposition from the Republicans, one of whom argued that he did not see how the United States was concerned about HIV/AIDS-related mortality in Africa. On the other hand, the Republicans were not very reluctant to join the project for African-American economic cooperation: the African Growth and Opportunity Act (AGOA)¹.
- 6 Meanwhile, AIDS associations in Europe and the United States were committed to translating the efforts resulting from the discovery of antiretroviral combination therapies from North to South (Eboko, Bourdier, Broqua, 2011). The diplomats took their lead with a mobilization of personalities for whom the field of health was not the preferred one and in which they showed a cold and pragmatic strategic intelligence.
- 7 In this respect, American soil was a beautiful scene for diplomatic bypasses in 2000. US Ambassador to the United Nations in New York, Richard Holbrooke, and UN Secretary General Kofi Annan, who had just returned from a mission in southern Africa, succeeded in placing the issue of AIDS in Africa on the agenda of the UN Security Council. This is the first time in the history of the United Nations that a health issue has emerged from the Security Council's register, which is more inclined to rule on armed conflicts.
- 8 Thus Resolution 1308 of the said Council represented an international awareness at the top of the world's political power. This resolution, from a media, political and diplomatic point of view, puts health in Africa on the official agenda of priorities for industrialized countries. In this dynamic Kofi Annan will take his pilgrim's stick and launch in several steps the idea of the "Global Fund".

The Global Fund, a political alliance

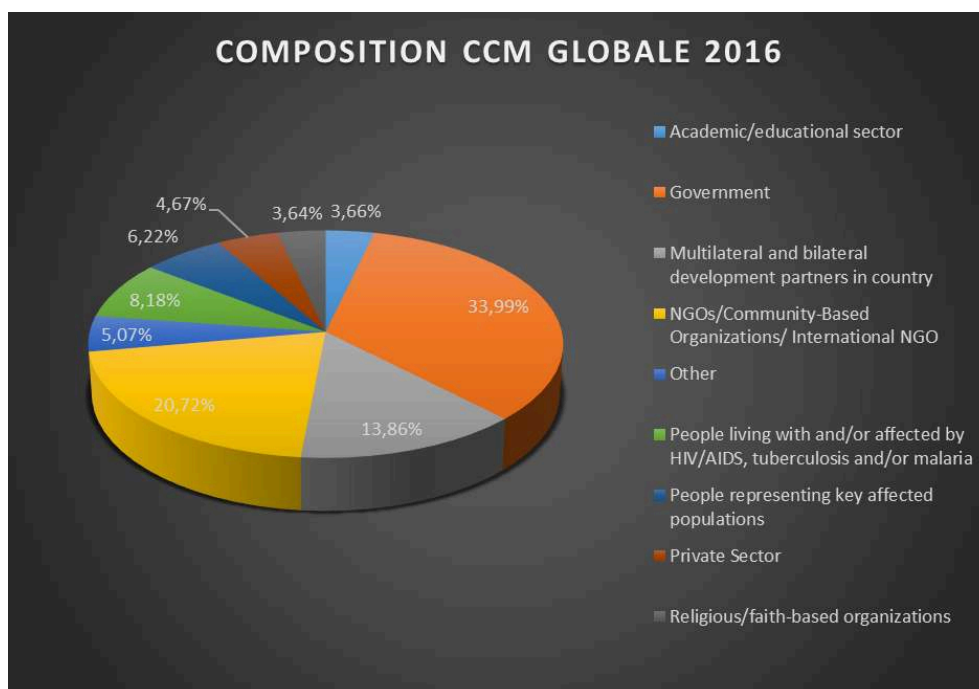
- 9 During 2001, the Secretary General of the United Nations was active in media coverage of a new international impetus, first focused on the HIV epidemic and then extended to tuberculosis and malaria. At the Conference of French and African Heads of State held in Yaoundé in January 2001, Kofi Annan went there with his wife, with whom he supported the launch of a Forum dedicated to the fight against AIDS, on the sidelines of the Summit of Heads of State. The wives of the heads of state thus launched the organisation "African Synergies" (Eboko 2004).

- 10 In April of the same year, Kofi Annan travelled to Abuja, Nigeria, with the Director-General of WHO, for the Summit of African Heads of State and Government on AIDS in Africa. He formally launched the idea of the "Global Fund to Fight AIDS" at the end of the meeting, which will also see the same Heads of State and/or their representatives sign the famous "Abuja Declaration". Through the latter, the African authorities commit to devoting 15% of their national budgets to health.
- 11 In June 2001, the United Nations, under the leadership of the same Kofi Annan, hosted the United Nations Special General Assembly on AIDS (UNGASS) in New York. The Secretary-General officially launched the Global Fund, whose NGOs strongly suggest that it be extended to tuberculosis and malaria. The Global Fund to Fight AIDS, Tuberculosis and Malaria is formally established. In January 2002, at the G8 meeting in Genoa, Italy, it was officially launched, and the first grants were awarded.
- 12 Since its inception, the Global Fund has been led by four prominent individuals. Two medical professors succeeded each other at the head: the American Richard Feachem between 2002 and 2007, Michel Kazatchkine between 2007 and 2012. Peter Sands of the United Kingdom was appointed Executive Director of the Global Fund on 17 November 2017 by the Board of Directors. He officially took office in March 2018. He succeeds the American Mark Dybul. Peter Sands, an international finance specialist and graduate of Harvard University,² is the first non-physician to lead the Global Fund, except for the interim role of another financier, the Brazilian Gabriel Jaramillo, between 2012 and 2013, the period corresponding to the implementation of the *New Funding Model* (NFM) implemented in 2014³. Since 2002, the Global Fund has raised and spent \$27 billion (€23 billion), of which 50% has been spent on HIV/AIDS, 32% on malaria and 18% on tuberculosis. It is estimated that it has saved 22 million lives and resulted in a 30% reduction in HIV-related mortality.
- 13 This study takes the opportunity of the Global Fund's Replenishment Conference to publish these first qualitative results.
- 14 Between 2017 and 2019, the Fund invested \$14 billion to "save 14 million lives". While France has maintained its contribution above €360 million over this period, the Replenishment Conference is of crucial importance, particularly because of the 18% drop in funding provided by the United States of America, the largest contributor.
- 15 In preparation for this Replenishment Conference in Lyon, the Executive Director of the Global Fund plans to "mobilize at least \$14 billion (€12.23 billion). At his meeting in Paris with French President Emmanuel Macron on 11 January 2019, Peter Sands estimated that this amount would "help save 16 million lives, halve mortality rates from HIV, tuberculosis and malaria, and build stronger health systems by 2023"⁴.

The Global Fund from an African perspective

- 16 The purpose of this dossier is to analyse the contexts in which Global Fund financing is provided in the region of the world most affected by the diseases to which this mechanism owes its birth: sub-Saharan Africa. Based on the *Country Coordinating Mechanism* (CCM), which form the multi-stakeholder collegial structures within which the distribution of funds with multisectoral action plans is organised, this dossier proposes downstream studies, on the "ground" from four countries. The latter have the

particularity of having experienced progress due to international financing but also of being the area in Africa in which this progress is slowest: West and Central Africa.



- 17 This dossier is the result of a research project conducted since 2015 with funding from the National Research Agency on AIDS and viral hepatitis. Initially devoted to three countries: Senegal, Côte d'Ivoire and Cameroon, this collective work was extended to Burkina Faso through doctoral research that joined the research activities of this project.

CCM Composition in 2016 and Cumulative FM/Country Funding (Burkina Faso, Cameroon, Côte d'Ivoire, Senegal)				
Sector	Burkina Faso	Cameroon	Ivory Coast	Senegal
Academic institutions			3	2
Government	24	24	13	24
Multi- and bilateral partners	5	9	13	10
NGOs/Community-Based Organizations/International NGOs	11	10	11	11
People living with and/or affected by the diseases	5	4	1	4
Key populations	3	2		1
Private sector	3	4	6	3

Faith-based organizations	3	4	4	4
Others	5		7	3
Grand total	59	57	58	62
Amount disbursed to date (USD)	431,490,104	486,090,585	525,834,139	298,219,981

Presentation of the context and justification of the project

- 18 The international financial crisis and the governance crisis of the Global Fund Secretariat (Pizarro, 2012; Global Fund Report, 2012; Eboko et al, 2015) have come at the opposite end of a period of high expectations for the region of the world most affected by the HIV/AIDS epidemic, sub-Saharan Africa. The paradoxical combination of international uncertainties, the "return to economic growth" of African states and exceptional progress in international and national responses to HIV/AIDS sets a new context since the late 2000s. The international financial crisis comes at a time when Africa is emerging from the tunnel of the economic crisis in the strict sense of the term and during the period when it has made remarkable progress, with its international partners, in the fight against the three priority diseases. Between 2010 and 2012, in sub-Saharan Africa, "a record 2.3 million people gained access to HIV treatment" (UNAIDS, 2012), with ever-increasing financial needs (Pizarro, 2012: 12). Between changes in the priorities of the fight itself (marked by *Scaling-up* and re-medicalisation embodied by *Test-and-treat*), international recession, particularly in Europe, and African economic "renewal" - underlined by observers sensitive to market economy indicators - the central question is therefore that of the articulation of the financial challenges of the fight against AIDS and the clusters of transnational actors that accompany the implementation of national responses: this is to say the question of "governance" in the context of the AIDS response.
- 19 The expansion of the AIDS pandemic and international responses between the mid-1980s and the early 2000s meant that African states were faced with conflicting international injunctions. On the one hand, Structural Adjustment Programmes (SAPs) reduced public investment, resulting in a reduction in health spending by forceps; on the other hand, international AIDS responses have provided resources, mobilized new expertise, led to the establishment of new health bureaucracies in the field of AIDS, tuberculosis and malaria and generated reversals of economic paradigms (Moatti et al., 2003; Moatti and Eboko, 2010; Coriat, 2008). Between the "State withdrawal" imposed by SAPs and "bureaucratization" (Eboko, 1999, Gruénais 1999) in the health sub-sector of HIV/AIDS, a model of public action has emerged that concerns the broader "global health" landscape. In the more general configuration of public policies, African States are now "framed" by a constellation of actors with whom they co-write public action (Eboko, 2013a and 2013b). Understanding and guiding action in such a complex landscape is a challenge for the social sciences.
- 20 This project proposes action research in the social sciences focusing on the main funding and public action mechanism in the field of HIV-AIDS, the Global Fund. It is

particularly interested in *Country Coordinating Mechanisms (CCMs)*, which are both the strategic link in its work in African countries and, as part of this research, an empirical entry point for more general research on the governance of the AIDS response in Africa. A comparative approach at the heart of these bodies is the subject of this project, based on three countries whose common points and differences allow for in-depth investigation and concerted actions to improve coordination, based on the deconstruction of policy issues that cut across the CCMs and the constellation of actors that underpin public action against HIV/AIDS in Senegal, Côte d'Ivoire, Burkina Faso and Cameroon.

1. research objectives

Main objective

- 21 Describe how the work of consultation and negotiation between CCM actors is the product and revealing of the *specific* political trajectories of the different African States. The comparison of Senegal, Côte d'Ivoire and Cameroon makes it possible to contrast three very different configurations of control policies, ranging from "active participation" to "passive adherence" to international recommendations.
- 22 This study will propose a general theoretical framework to analyse how sub-Saharan Africa is governed within the framework of "global health" policies, considering the construction of public action within a *matrix* that includes representatives of international organizations (IOs), bilateral partners, representatives of civil society organizations (CSOs) including patient representatives, private partners and, of course, the public.

Secondary objectives

- 23 Compare and communicate, as the research progresses, the elements resulting from this comparison to the actors involved in CCM governance.

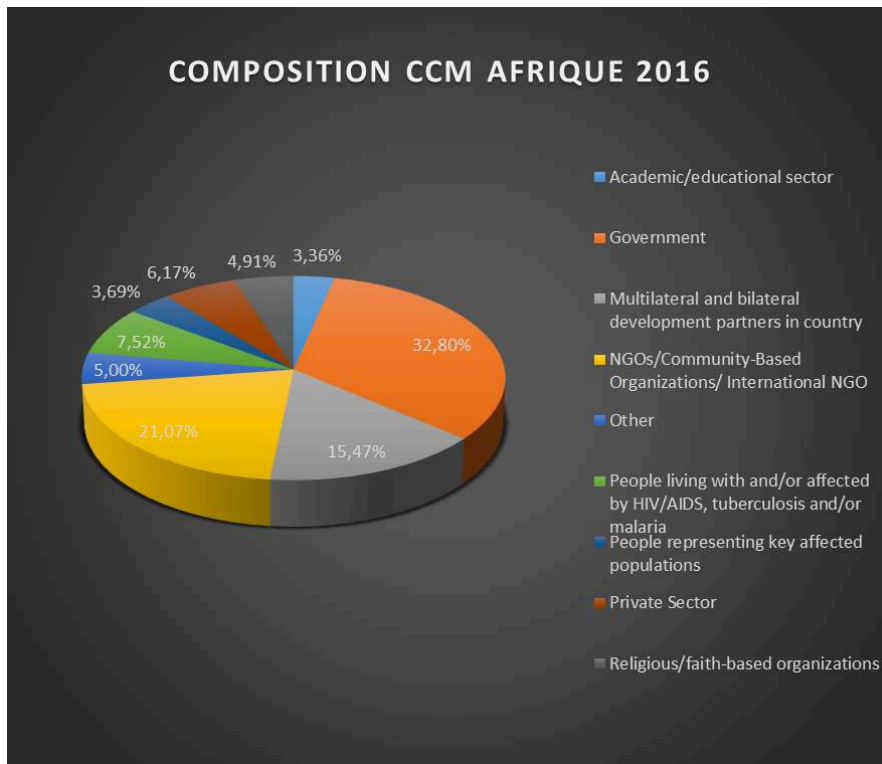
CCM, African States and Global Fund, between dependencies and negotiations: presentation and issues

- 24 When it was created, the Global Fund presented itself as an "innovative, flexible and lightweight mechanism" to break away from international organizations and the criticisms addressed to them (Dozon and Fassin, 2001). In this respect, its creation coincides with the rise of "Global Health", presented as a new way of conceiving and implementing health research and action in the South (Farmer et al. 2013). The Fund also embodies the "new paradigm" of development assistance, as set out in the Paris Declaration: effectiveness, ownership, participation and alignment with country needs/demand and not with aid supply (Nantulya, 2004). This ambition is reflected in the Fund's institutional architecture. These principles make it the embodiment of the new international aid paradigm, which is reflected in the Fund's organization and operating procedures.
- 25 The CCMs, created in the wake of the Global Fund's creation in 2002, are responsible for generating funding applications to the Global Fund, identifying the beneficiaries of these funds, and monitoring grant implementation. More than simple mechanisms,

CCMs are therefore real institutions that are intended to be at the heart of national AIDS governance. These institutions are also formatted by the Fund, which issues a set of criteria, recommendations, and incentive mechanisms (CCM self-assessment grids, etc.) that should determine the eligibility of applications. Ownership of this governance modality appears to be uneven across countries, and CCM (dys) operations are seen as obstacles to the effective functioning of the Fund. Their composition itself is extremely variable and their members are not always the ones who actually produce the national AIDS response in countries (see Table 1 above).

On the composition of the CCMs

- 26 A CCM is the main channel through which requests for funding from the Global Fund in the form of National Coordinated Proposals (NCPs) are channelled. However, the Fund also reviews so-called non-CCM requests according to very strict criteria: this requires that the requesting agency (usually an NGO) has a national context marked by the absence of a legitimate government, the absence or termination of partnership with civil society and NGOs, or a situation of conflict (as in the case of Côte d'Ivoire in Round 3) or natural disaster. In addition, the Global Fund also receives funding requests from Regional Coordinating Mechanism (RCM) or Regional Organisations (RO) for *Multi-Country Catalyst Investments*. However, the CCM is the consultation agency par excellence that acts as a local relay for the Global Fund's action and coordinates the implementation of the actions it finances at the national level.
- 27 According to the Global Fund's guidelines adopted from the resolutions of the 9th Board of Directors held in November 2004, the CCM must be composed of at least 40% representatives of the non-governmental sector such as NGOs, people living with diseases, religious or faith-based organizations, the private sector and academic institutions. This configuration leaves a considerable margin for government in terms of representation on the CCM, which is used in very different ways in different countries. Thus, while governments are the most numerically represented sector on CCMs worldwide, there is an over-representation of this category within the Cameroon CCM compared to the overall average.



Cameroon, Senegal, Cote d'Ivoire, Burkina Faso: four countries in crisis facing HIV-AIDS

- 28 The four countries involved in this project share a common historical sequence. They were grouped in so-called "middle-income" African countries before the second oil crisis of 1979, which caused the long economic crisis and the SAPs from the 1980s to the early 2000s. (Cooper, 2003).
- 29 The transition to a multi-party system has shaken up the monolithism of Cameroon and Côte d'Ivoire, while Senegal had already begun this transition. Indeed, from a political point of view, Senegal is the country that has the most regular democratic procedures (elections with uncontested or slightly contested results, peaceful and democratic political alternation, etc.) while Cameroon has, under the guise of a multi-party system, seen a reproduction of a regime without alternation since its independence, despite the transition to a multi-party system (Eboussi Boulaga, 2007). For its part, Côte d'Ivoire entered the post-Houphouët-Boigny multi-party era through a succession dispute and constitutional conflicts that marked the country from the 1990s until Alassane Ouattara came to power, which sealed a decade of crisis and armed violence (Akindes, 2017).
- 30 Confronted in the 1980s with the HIV-AIDS epidemic, most of African States had implemented National AIDS Control Programmes, in line with the approach launched by the Global Programme on AIDS (GPA, WHO) (Iliffe, 2006). Senegal was one of the very first to adopt it in 1986. While Senegal is known for its "active" response and proactive adherence to international strategies, the other two countries have adopted postures that were part of a "passive adherence" to international strategies. Cameroon and Côte d'Ivoire, like most of their African counterparts, experienced a period of political latency (1987-2000) although national programmes were formally implemented (Eboko, 2005; Kerouedan, 2010). The "therapeutic revolution" that followed the opening

towards access to ARVs changed this perspective. To date, the introduction of antiretroviral molecules in the form of "generics" distributed mainly by Indian laboratories, and the support of the Global Fund and PEPFAR (for the Ivorian case) have led to an exponential increase in the care of patients eligible for ARVs.

- 31 This success is accompanied, in the four countries concerned, by a high dependence on international aid to finance the fight against AIDS - today, 67% of AIDS funding in sub-Saharan Africa comes from foreign donors. Senegal and Cameroon benefit from the main assistance of the Global Fund, while Côte d'Ivoire, which also benefits from it, has had much greater financial support from PEPFAR since 2004 - making Côte d'Ivoire a useful case study for comparative analysis of the role of the Global Fund. This common dependence actually covers the four countries' differing capacities to integrate into the international relations order of "global health", based on very different epidemiological situations. These differences are also reflected in the varied composition of the CCMs themselves (Table 1): while there are more State/government representatives in the three countries, Cameroon, for example, shows a high number of government representatives, reflecting a desire for political control by the administration (Pigeaud, 2011), apparently offset by the strong presence of associations.
- 32 In short, the common and differentiated trajectory of the four countries bases their comparability and justifies their choice for this study - even if they all belong to the French-speaking area, they illustrate a large part of the range of political configurations in the fight against HIV-AIDS present on a continental scale (Eboko, 2013a).

2.3. Differentiated trajectories

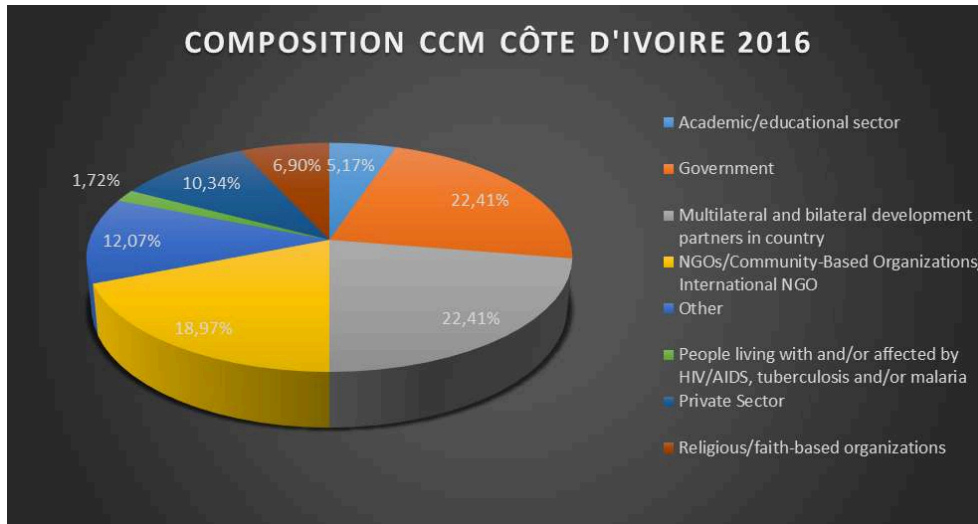
Senegal: a pioneering country at a crossroads

- 33 In 1998, Senegal was the first African country to launch a public initiative on its own to access antiretrovirals: the Senegalese Initiative on Access to ARVs (ISAARV) (Desclaux, Lanièce, Ndoye, Taverne, 2002). This is again done through agreements with an oligopoly of patent-holding pharmaceutical companies, but this time without the intermediation of UNAIDS. Although Senegal is a special case due to its relatively low HIV/AIDS seroprevalence rate (0.7% for 15-49-year olds) compared to its African counterparts, its action has highlighted political opportunities for direct negotiation at the level of African countries.
- 34 The Senegalese government's share of funding for the fight against HIV/AIDS for the period 2010-2013 represents 21% ('17,802,994) of the general resources dedicated to the national response. 24% (19,496,788 euros) come from international organizations and cooperation partners in Senegal. The Global Fund covers 55% (€45,263,730) of the needs (CNLS-Senegal, February 2013).
- 35 The priority given to the health sector has resulted in a constant increase in the Ministry of Health's budget from CFAF 29 billion in 2000 to CFAF 108.4 billion in 2010⁵. This budget now represents 10.4% of the State's operating budget. In addition, the State has undertaken to finance 40% of the ARV budget and provides a counterpart in the functioning of the National Council for the Fight against AIDS (CNLS Senegal, 2013).

- 36 Senegal has a very high acceptance rate for its applications to the Global Fund, due to the relative continuity of actors and in particular the Executive Secretary of the CNLS, who is the oldest "boss" of an AIDS programme in Africa (since 1986).

Côte d'Ivoire: emerging from one crisis, facing another

- 37 While Côte d'Ivoire was a pioneer in launching ARV access programmes, notably as one of the four countries chosen to set up the "UNAIDS/Ministry of Public Health Initiative" in 1998 (Msellati, Vidal, Moatti, 2001), the "scaling up" and decentralization of comprehensive care for infected people has been made possible, although the various political and military crises of the last decade have slowed its implementation.



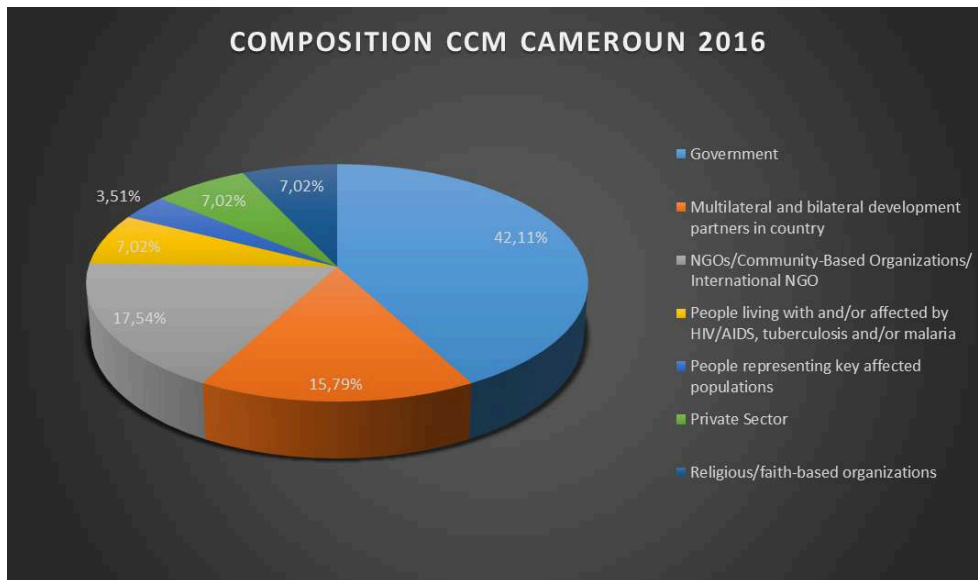
- 38 Côte d'Ivoire is the only French-speaking country to have been chosen in 2003 by the United States to benefit from its PEPFAR program. US bilateral aid thus represents 74% of its external aid dedicated to HIV/AIDS, which in turn represents 87% of its overall budget (UNGASS 2010). This massive support has made it possible, despite political instability, to increase the number of people receiving care tenfold, from 2000 people on ARVs in 2004 to nearly 75,000 in 2010, with the introduction of free care in 2008. However, Côte d'Ivoire's ARV coverage remains blocked at 37%, in a context where the epidemic is widespread (3.4%).
- 39 In 2014, Côte d'Ivoire deplored a \$20 million shortfall in implementing its national programme. Indeed, although Global Fund Round 9 financing was disbursed and the World Bank reinitialized its PUMLS program in 2009 (suspended in 2003 for arrears), Côte d'Ivoire was doubly affected by the global economic crisis and the violent post-election crisis whose outcome reconfigured the Ivorian political landscape (Akindas 2017). The Ivorian crisis has disrupted the global health system (looting and deterioration of equipment, exceptional free medical expenses from April 2010 to February 2011), stopped the inclusion of people eligible for treatment and accelerated the disengagement of some partners. Health structures, NGOs and associations have experienced serious difficulties: layoffs of medical and technical staff, technical unemployment, reduced support for prevention and training activities, purchase of equipment, etc. The lull in 2011 was part of the search for new sustainable financing strategies: debt reduction and development contracts (C2D) between Côte d'Ivoire and

France, low-interest loans from the African Development Bank and taxes on mobile phones.

- 40 The fight against HIV/AIDS in Côte d'Ivoire is also facing the challenge of its institutional reorganization. In order to simplify its coordination, the technical committee in charge of decentralization have been abolished and the merger of its new Ministry of HIV/AIDS with the Ministry of Health has been decreed, leaving national public actors on hold, pending further concrete alternative measures.
- 41 The State's share of funding in the fight against AIDS is CFAF 445,443,610: 19%. The State in its efforts is supported by bilateral partners: PEPFAR (1,437,249,756.5 CFA francs: 63%), the Global Fund (148,624,054 CFA francs: 6%), the World Bank (116,870,585 CFA francs: 5%) and organizations of the United Nations and international system: UNICEF (116,796,479 CFA francs: 5%), WHO (11,919,500 CFA francs: 1%), APHL (8,110,700 CFA francs: 0.8%) and MSF Holland (2 350 942 FCFA : 0.2%)⁶. Recently, "*Côte d'Ivoire has raised US\$8 million from tobacco and airline taxes*", which testifies to the Ivorian authorities' awareness of the danger represented by its dependence on international funding.
- 42 Investigations conducted in Côte d'Ivoire show varying power relations between public authorities, international actors and associations. PEPFAR's financial contribution represents 78% of the resources allocated to the fight against the three diseases, compared to 15% of the funding provided by the Global Fund. This makes Côte d'Ivoire a case control compared to the other three countries in this study. At the same time, this situation erects this country in the event of a school of tension between multilateral aid embodied by the Global Fund and bilateral aid, which forms the seal of the influence of countries such as the United States and France, under an offensive marked by the American PEPFAR.

Cameroon: from a dynamic of success to the beginning of an ARV crisis?

- 43 While Cameroon has long been a relatively passive country in the fight against AIDS (Eboko, 1999b), multiple changes in the international and national context have marked the Cameroonian programme since the EVAL survey and other parallel evaluation work were carried out (Eboko, Laurent, Abé, 2010).
- 44 The first significant development concerns the adoption by the Cameroonian government, in May 2007, of free ARVs for all, with a view to strengthening universal access to treatment (Gilks, Crowley, Ekpini et al. 2006; Souteyrand, Collard, Moatti, 2008 ; Eboko, Abé, Laurent, 2010). This measure has strengthened the decentralization of access to ARVs (Boyer et al, 2010) and significantly increased the number of patients receiving ARV treatment, from 23,800 in September 2006, when the EVAL survey began, to 45,000 in December 2007 and 105,653 at the end of 2011 (CNLS-Cameroon/UNAIDS, 2012).



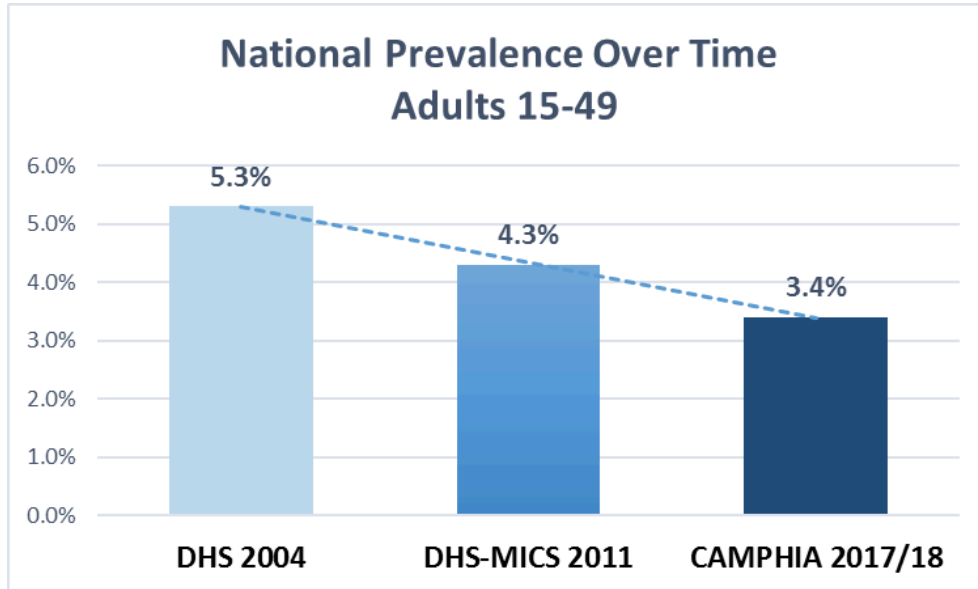
- 45 At the same time, the 2010 revision of WHO's recommendations for initiating ARV treatment in low-resource countries has the dual effect of increasing immediate treatment needs and the cost of first lines, increasing financial pressure on programmes (WHO, 2010). These developments are taking place in an international context marked by a major economic crisis that is affecting official development assistance and resources allocated to the fight against HIV, which, after a decade marked by a spectacular increase, has been declining since 2010 in terms of funding from international donors. While since 2000, the PNLs has been mainly financed by development assistance (74 per cent of programme expenditure, including 47.4 per cent of funds, for the Global Fund) (World Bank, 2012: 8), the situation is now worrying.

PEPFAR: a new impetus for Cameroon?

- 46 In addition to these funding opportunities, PEPFAR has arrived in Cameroon with a US\$24 million project for activities in the Adamaoua, East and two English-speaking regions, South-West and North-West. To this, PEPFAR plans to add US\$100 million for complete free access to health care and biological examinations throughout the country, as of ¹ January 2020. This promise is accompanied by an unprecedented decision by the new Minister of Public Health. On 4 April 2019, it decided to make HIV management services free of charge for all: biological monitoring tests (CD4 and viral load); drugs to prevent opportunistic infections and their collection. This decision shall take effect as from ¹ January 2020⁸. In addition, the same decision also applies to health facilities: "reagents and medicines for all examinations (...) are provided free of charge to health facilities and laboratories selected by the Ministry of Public Health".
- 47 At the same time, the concern for "impact" observed in Côte d'Ivoire is emerging in Cameroon from American cooperation. A pilot study called "Camphia" (Cameroon Population-based HIV Impact Assessment), conducted in 2017-2018, successfully reviewed the situation of HIV/AIDS, tuberculosis and hepatitis B. Conducted under the leadership of the CDC of Atlanta, Columbia University of New York and PEPFAR, this research conducted in the 10 regions of the country made it possible to carry out HIV testing in 11,623 households for 15,419 women and 13,216 men (aged 15 to 64) and 8,018

children (aged 0 to 14). The test for the hepatitis B virus involved 1962 adults (15-64 years old)⁹.

HIV prevalence in Cameroon in 2018



Source: Camphia 2018

(DHS: Demographic and Health Survey (DHS))

Prevalence of HIV (HIV) and Hepatitis B Virus (HBV) in Cameroon in 2018

Hepatitis B/HIV coinfection

HIV Status and Age	HBV Prevalence		
	Females	Males	Total
HIV Positive			
15-64 years	7,9	9,5	8,4
HIV Negative			
15-64 years	5,4	11,3	8,3
Total			
15-49 Years	6	12,4	9,2
15-64 Years	5,5	11,2	8,3

Among the age group 15-64 years old

- National prevalence of Hep B : 8,3
- National prevalence of coinfection HepB/HIV: 8,4

Source: Camphia 2018

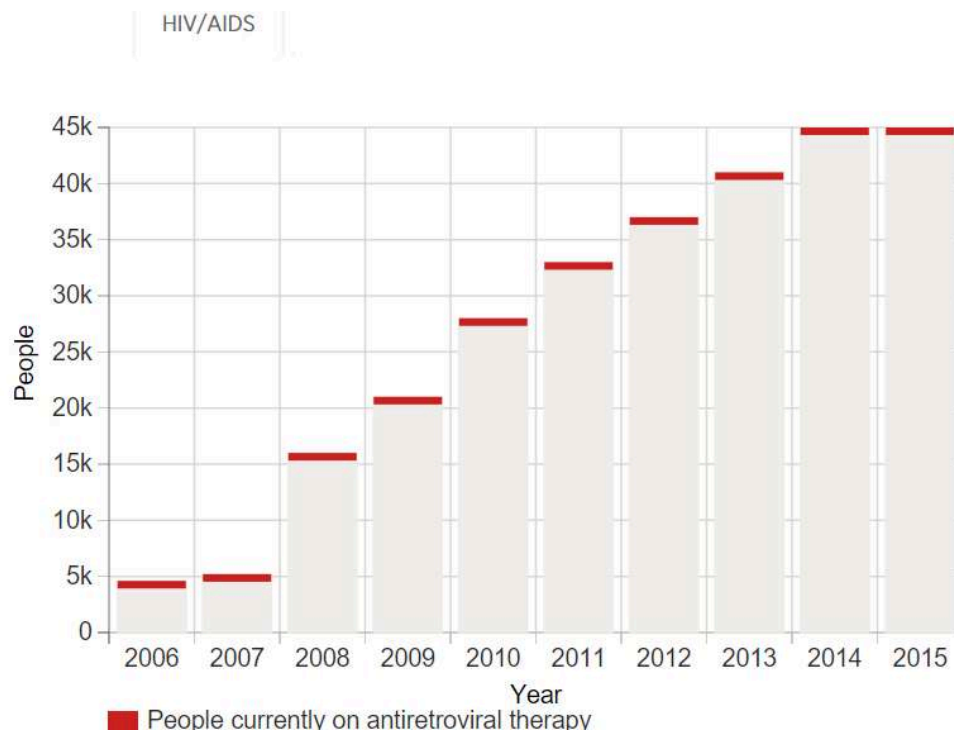
- 48 Cameroon's major problem is its "governance", in general in terms of health in particular, due in particular to the hyper-focus of local actors on very short-term political and material issues (World Bank, 2013). This detachment from long-term challenges explains the very strong breakdown of experts beyond the available skills.

The "counter-offensive" of the American PEPFAR and the changes that occurred in 2018 in the governance of the Ministry of Health suggest short-term developments that could fall between a change of perspective or a dramatic reversal of the situation brought about by a new health leadership.

Burkina Faso: militant demand for free ARVs

- 49 The first demonstrations of demands for free ARVs were organized in 2004 in Burkina Faso by civil society organizations (Eboko, Owona Nguini, Enguéléguélé, 2009: 58-59). Antiretroviral drugs were made free of charge later than in other countries in 2010, thanks to the mobilization of associations and their advocacy with the then President of the Republic. Blaise Compaoré, who also had the particularity of being the president of the National AIDS Council. Transnational collective mobilizations took on a particular importance in this country at the beginning of the 2000s (Desclaux, Kouanda, Obermayer, 2010; Soubeiga, 2018).
- 50 Burkina Faso has undergone the same institutional evolution as other countries in the fight against AIDS before the advent of the Global Fund. The scarcity of its resources places it in a situation of high dependency, which is nevertheless reduced by a relatively low HIV prevalence compared to Côte d'Ivoire and Cameroon (3.7%) and closer to that of Senegal (0.7%) and the countries of the Sahel region.

Figure 1: Trends in the number of people on antiretroviral treatment from 2006 to 2015 in Burkina Faso

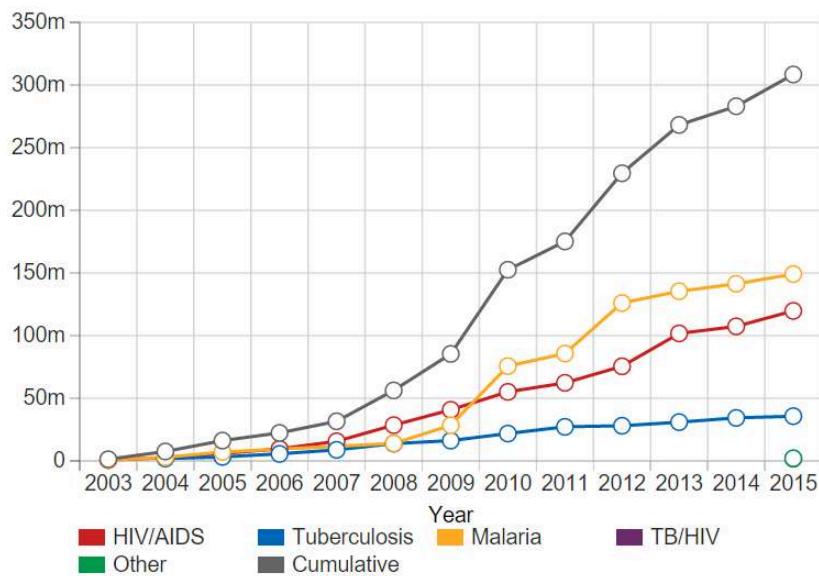


Source: Global Fund 2017

- 51 The periods 2007-2008, 2008-2009 and 2014-2015 are the most significant in the evolution of PLWHA ARV coverage in Burkina Faso over the period from 2006 to 2015.

Graph 2: Evolution of financing by component in Burkina Faso

Disbursements by Component



Source: Global Fund 2017

- 52 The Global Fund's funding for AIDS in Burkina Faso has gradually increased. Unlike Côte d'Ivoire and Cameroon, which recently received PEPFAR grants, the main funder of the fight against this disease in this country is the Global Fund.
- 53 The total amount of funds granted by the Global Fund to fight the three diseases in Burkina Faso has increased significantly since 2007. Within seven years (2007-2014), the total amount of funds provided by the Global Fund has increased nine times (9). The amount of the grant for the fight against HIV/AIDS has increased from \$15 million to \$110 million. This curve highlights the moments when the Global Fund's investment in the fight against the three diseases is increasing: 2008, 2009, 2010, 2012 and 2013. This illustrates the Global Fund's commitment to strengthen actions to fight these diseases on the ground in Burkina Faso. Nevertheless, the euphoria resulting from treatment protocols that reduce HIV transmission must be relativized, particularly in sub-Saharan Africa, because of the lack of attention paid by health policies to resistance that recent research suggests could constitute a "fourth epidemic" (Laborde-Balen, Taverne, N'Dour, Ndoye et al, 2018).

3. Beyond communicable diseases, universal access to care? The Global Fund driving a paradigm shift?

- 54 It is undeniable that the 2000s saw significant progress at the international and national levels in the three diseases to which the Global Fund devotes the majority of its resources and to which it owes its essence since 2002: AIDS, tuberculosis and malaria. There is now talk of "ending these epidemics" (Global Fund Observer, April 2016). At the same time, the focus on other diseases and health issues affecting sub-Saharan Africa has found, in contrast, in the exceptional mobilization against AIDS in particular, the means to highlight the need to place on the international agenda all the

specific epidemiological shocks that this region of the world is experiencing. This theoretical conjunction between health issues and their inclusion in international agendas is one of the definitions of "global health" (Atlani-Duault & Vidal, 2013; Almeida, Eboko, Moatti, 2013; Farmer et al, 2013). In recent years, major progress has been made in the prevention and management of hepatitis through the commercialization of a vaccine for HBV that is now available at low cost, but also through new diagnostic tools and new treatments that are highly effective and better tolerated. Paradoxically, the countries of sub-Saharan Africa, most of which are affected by the epidemic, have benefited little from these medical advances and health responses remain very inadequate. Nevertheless, progress is being made, from an institutional point of view, with the creation of a Global Hepatitis Programme in 2011. WHO states that "in 2014, the Global Hepatitis Programme was integrated into the HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases Group to intensify control efforts while creating the necessary synergies to combat viral hepatitis among people living with HIV"¹⁰. In this configuration, the issue of non-communicable diseases emerges that must benefit from an international response commensurate with the impact they represent and the mortality rate from which Africa is paying a heavy price. In this respect, cardiovascular diseases, which account for a third of deaths in sub-Saharan Africa, represent a major challenge, as highlighted by recent studies that highlight the health risk facing Africa and, more broadly, resource-limited countries.

4. Cardiovascular disease (CVD): old pathologies, new challenge¹¹

55 The relative success of the unprecedented mobilization of global health resources since the inception of the Global Fund has highlighted the inadequacies of responses to other causes of morbidity and mortality in resource-limited countries. Cardiovascular diseases are an almost perfect illustration of this.

56 Etiology of CVD

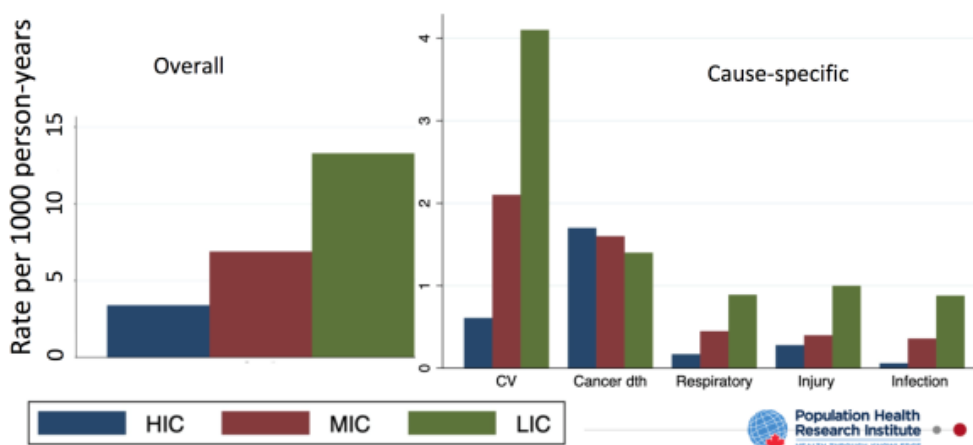
57 *Cardiovascular diseases are diseases affecting the heart and blood vessels, mainly the arteries that carry blood to all organs of the human body. The main CVD are ischemic heart disease (insufficient blood supply to the heart muscle due to narrowing of the coronary arteries by fat plaques), non-ischemic heart muscle disease (including viral myocarditis) responsible for dilated cardiomyopathies, Valvulopathies (heart valve disease) including aortic stenosis (calculated narrowing of the aortic valve which is the first valve in the West), mitral valve stenosis or insufficiency due to rheumatic fever in poor countries, pericarditis (inflammation of the pericardium which is the envelope of the heart) of essentially viral (in the West) or tubercular origin and other immunodeficiency areas (in Africa). Heart rhythm disorders, which cause sudden death, are another group of heart diseases. Strokes complicate high blood pressure or atrial fibrillation (irregular heartbeat).*

Epidemiological benchmarks

58 CVD accounts for 31% of all causes of death worldwide, or 17.5 million victims per year. While cancers have replaced CVD in terms of the annual incidence of total deaths in Europe, heart disease (heart disease) and stroke are the leading cause of death in poor countries, accounting for an estimated 80% of the global incidence worldwide.

- 59 The recent results of the PURE study (Prospective Urban Rural Epidemiology¹²) are edifying. This study followed a total of 155,722 people in 21 countries from 2005 to 2016, divided into three groups of countries: high-income, middle-income and low- and low-income countries. This work combines 14 modifiable risk factors with overall mortality and the occurrence of CVD. The main lessons of this study confirm the projections that in the near future (2025) CVD will become the leading cause of death in poor countries: (1) there is a close link between poverty and overall mortality rates; (2) the incidence of CVD increases more in low-income countries compared to middle-income countries and more than in high-income countries, justified by a more operational prevention policy in these developed countries; (3) new risk factors for CVD (including domestic air pollution, poor nutrition and especially low levels of education) have been identified as major causes of death.

Age- & Sex-Standardized Mortality Rates



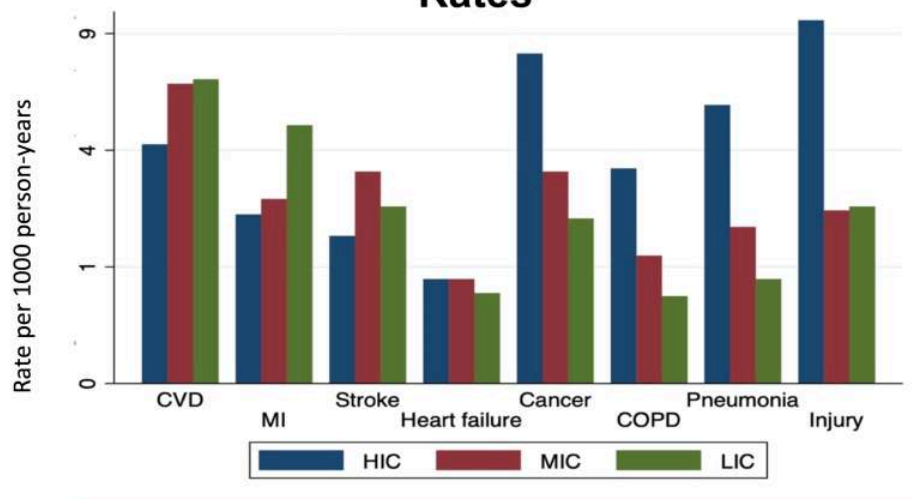
Age- and sex-standardized mortality rates: comparison of general and disease-specific mortality rates by country resource level

- 60 HIC= high income countries; MIC= middle income countries, LIC= low income countries. CV= heart disease; Injury= trauma

Cardiovascular disease management in Africa

- 61 Once considered in Africa as a specificity of rich countries, CVD has become a frequent reason for consultations in medical facilities in Africa. Unfortunately, public health policies in these countries have not sufficiently taken into account this epidemiological mutation through preventive actions (screening, awareness-raising and population training campaigns, restrictive legislative measures on smoking, diets rich in salt and sugar, etc.).

Age- & Sex-Standardized Disease Incidence Rates

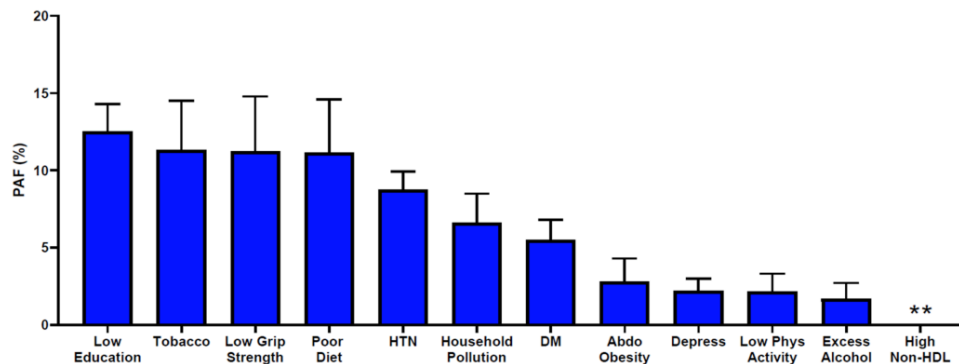


Age- and sex-standardized incidence rates: comparison of general and disease-specific mortality rates for selected diseases by country resource levels

- 62 CVD= cardiovascular disease, MI= myocardial infarction, Stroke= stroke, Heart failure= heart failure, COPD= chronic obstructive pulmonary disease, injury= trauma, HIC= high income country, MIC= middle income country, LIC= low income country. Source: Population Health Research Institute
- 63 In addition, the curative care of CVD is one of the most expensive in medicine. Diagnostic tools are difficult to access for community health centres, which are in the front line - see the only care structure - of most medical consultations in rural African areas. The electrocardiogram device (ECG), which is the basic diagnostic tool, costs on average 1500 euros and the cardiac ultrasound (essential to make more than 70% of the most frequent diagnoses) costs 20 000 euros. Consequently, user devices (often donations) whose age limits the quality of the rendering (significant rate of misdiagnosis) are a frequent recourse.
- 64 Africa faces significant heterogeneity in the management of CVD. Sub-Saharan French-speaking Africa is the most lagging behind, particularly Central Africa (Bonny A., Ngantcha M. et al, 2017 and 2018; Talle, Bonny, Scholtz, 2018). About 20% of sub-Saharan African countries cannot treat patients with curable heart rhythm disorders requiring pacemaker implantation, thus exposing hundreds of millions of Africans to the risk of sudden cardiac death due to lack of care (human expertise and technical support) whose average cost is less than 1,500 euros. Among the determinants of mortality due to cardiovascular disease, the level of education - and therefore information - is the most decisive. This shows a strong classical correlation between health and living standards and a lethal articulation with poverty.



Population Attributable Fraction: Mortality



Impact of risk factors on mortality

65 HTN= high blood pressure, DM= diabetes mellitus

Source: PURE study

66 In general, the lack of universal health coverage in most African countries is a major barrier to access to health care for families whose average monthly income is significantly lower than the average cost of a day's hospitalization for cardiac decompensation.

5. Universal Health Coverage: global project, specific trajectories

67 *Universal Health Coverage (CMU)*, also known as "*universal health coverage*" (CSU), is a major challenge, both at the international level and in so-called resource-limited countries. This challenge mobilizes bilateral and multilateral actors, NGOs, associations and African States, in a framework that recalls the objectives and concerns that international initiatives have generated for the response to the AIDS pandemic in Africa. However, there are several differences between this translation from international to national as the fight against AIDS occurred at the same time as the Structural Adjustment Programmes (SAPs). African states were subject to conflicting injunctions, between the need to reduce public spending imposed on them and the need to encourage political mobilization to respond to the HIV/AIDS epidemiological crisis.

68 The case of the CMU occurs in a context of a "return to growth" of African States¹³ and, more generally, of "return of the State to Africa". Health policies and, through them, the global project of universal health coverage for poor countries also represents an exciting challenge for the political sociology of public action in a globalized Africa. It is in this context that the issue of access to health care and prevention for Africans has undergone a major transformation with the resolution adopted in December 2012 by the United Nations General Assembly on Universal Health Coverage. The project is ambitious and its implementation is marked by obstacles that make the political analysis of its construction important, both from the point of view of meeting several other approaches (health economics, public health, socio-anthropology of health, development, etc.). Although known and recognized difficulties affecting access to

health care for populations in sub-Saharan Africa remain to be overcome, this resolution is part of a dynamic of which WHO Assembly resolution 58.33 of 2005 was already a significant step forward. Indeed, after an abundant literature had already attempted to show that direct payment for health services by users was a barrier to access to care, WHO recognized and encouraged its members to break with the ideology of direct cost to patients. This resolution noted that "every individual should be able to access health services without facing financial difficulties". In other words, the principle of exemption from direct payment is proclaimed for the most vulnerable or in situations where the price to be paid would represent for anyone a "catastrophic health expenditure" for the patient and/or his family.

- 69 One of the major characteristics of the purpose of universal health/health coverage is to highlight very different national trajectories in countries, including in sub-Saharan Africa, where a few countries have initiated this public action since the 2000s. For example, Ghana (Agyepong, 2016) and Rwanda (Chemouni, 2018) or Ethiopia (Lavers, 2019) are often cited as examples, based on very different modalities of universal access.
- 70 100 million people fall into poverty because they must pay for the services they receive. The objective of the CSU is to meet the challenge of ensuring that as many people as possible have access to health services. In this context, the historicity of public action in health in African countries must inform us of the political and not only financial capacities that govern the gradual implementation of universal health coverage.
- 71 This great diversity of situations is also related to the question of state regulation of poly-governance, which is also applied in the case of support to public authorities by the various international partners in public action in Africa.

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119 ANNEX

120 Methodology of the project "Governance and AIDS in Africa" (ANRS 12315)

- 121 The comparison of Senegal, Côte d'Ivoire, Burkina Faso and Cameroon allows us to contrast four very different configurations of control policies, ranging from "active participation" to "passive adherence" to international recommendations (Eboko, 2005).
- 122 Our hypothesis was that the national specificities of how CCMs operate only partially reflect the levels of dependence on international financial assistance, but rather are marked by differentiated political, economic and epidemiological trajectories that guide the ethos of power (the way of governing) in each country: the regulation of forces within CCMs depends on these state trajectories, which CCMs can, in turn, influence, both in operational terms and in terms of democratizing governance itself.

123 Method used

- 124 The method used in this research is qualitative, involving in-depth interviews with CCM stakeholders and the use of documents and archives. It is also accompanied by comments from the four CCMs.

125 Semi-directive interviews

- 126 They were conducted with representatives of the CCM member sectors who are:

- The public sector;
- The private sector;
- Associations of people living with and/or affected by AIDS, tuberculosis and/or malaria (APASTP);
- Development partners.

127 The interviews, with common and specific themes for each actor, were addressed as follows:

- Common themes related to:
- The person's background
- The modalities/history of integration into the CCM
- The place within the category of actors it represents
- The quality of relations between different sectors represented
- The quality of coordination
- Experience in writing applications
- The view/sense of the binding nature of standards/guidelines
- The difficulties
- Tensions
- Changes/improvements
- Specific topics

128 *Public sector*

- The actor's opinion on the weight of public authorities
- Is their representativeness sufficient?
- Is the sub-sector represented (health, education, finances, higher education, etc.) sufficient?
- The actor's view on the political necessity (or not) of the control of government authorities
- Advice on the "independence" of CCMs and the desire to avoid conflicts of interest
- Relationship with international partners
- Relationship with civil society organizations

129 *Bilateral partners*

- The strategy and mechanisms of influence it brings to the CCM
- Relations with multilateral partners
- Relations with other bilateral partners
- Relations with civil society organizations
- Views on the "independence" of the CCM

130 *Associations*

- Position on the representativeness and qualitative and quantitative weight of associations in the CCM
- Relations with government authorities
- Relations with international partners
- Relations with other association representatives
- The margin of manoeuvre on the "advocacy" of associations to take into account the problems of vulnerable populations

131 4.4. Analysis of the data collected

132 Based on the respondents' comments, which combine consultation, power relations, negotiation, etc., the country approaches and comparative analyses are based on certain themes such as "agency", "networks" or "epistemic communities"¹⁴. Precisely, these are :

1. one or more UN or international multilateral organizations: standards and/or standardization agencies, such as the Global Fund (Eboko 2015a; 2015b). These agencies constitute "the international quotas imposed by agencies for standardization and standardization of

social management methods relayed by the games of African and non-African actors" (Darbon, 2010).

1. One or more Western bilateral cooperation agencies (European or North American): adjustment agencies that correct, enhance or support countries and/or social and political actors in the implementation of international guidelines to which these agencies can provide new guidance.
 1. - A platform for the coordination of national and international actors present on the territory of the African States concerned: consultation agencies that act on administrative and technical procedures whose mission is to organize the bureaucratic implementation of the public action in question. Depending on the sector, these agencies meet according to an agenda defined on the spot in African countries. This is the case with CCMs.
 1. A state structure officially responsible for the implementation of public action in the sector concerned: national regulatory agencies. They are known as the National Programme, the National Committee or the National AIDS Council.
 1. A so-called "public-private" partnership between state and international structures on the one hand and companies or foundations involved in the promotion, management and sustainability of the sector in question.
 1. African national associations - or regional in some cases - representing individuals and groups directly concerned by public action in a specific sector: implementing agencies [Otayek, 2004, Eboko in Otayek, 2004; Eboko, 1999] counter-proposal agencies that specialize in a so-called "advocacy" activity. These agencies are linked to international non-governmental organizations with which they form transnational action/collective mobilization networks. 7- Non-state actors, in particular Western International Foundations (United States) or Public Interest Groups (GIP, France) that support and assist the work of adjustment agencies and/or executive agencies. They are also mediators (Palier & Surel, 2005). 8- Networks of international public or private experts (academics, consultants, etc.). It is within this framework that we find the "epistemic communities".
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NOTES

1. AGOA is a U.S. federal law passed in May 2000 by the U.S. Congress and signed by President Bill Clinton. This law aims to promote the entry into the American market of African entrepreneurs. See Zackaria Toure (2009).
 2. Voir : <https://www.theglobalfund.org/fr/news/2017-11-14-global-fund-appoints-peter-sands-as-executive-director/>
 3. See in this volume the contribution of Stéphanie Tchiombiano.
 4. See Paul Benkimoun, "The Global Fund sets its financial targets for 2020-2022", Le Monde, 17 January 2019.
 5. According to the 2010 Finance Act.
 6. Source: PNPEC, Côte d'Ivoire and internal report of the Governance Group (Bah, 2012).
 7. Which now advocated raising the eligibility threshold for treatment initiation to 350 CD4/mm³ and phasing out stavudine in first-line treatments, replaced by zidovudine or tenofovir (in case of anemia or HBV co-infection for the latter). To date, the directive is that of the Test and Treat.
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8. Decision No. 0498 of April 04, 2019 signed by Dr. Manouda Malachie, Minister of Public Health of Cameroon.
9. The results of this study were presented to the general public in Yaoundé, on 16 July 2018 at the Hilton Hotel by the representative of the Ministry of Public Health of Cameroon, Professor Anne-Cécile Zoung Kanyi Bisseck, chair of the steering committee of the Camphia study.
10. See: <https://www.who.int/hepatitis/about/fr/>
11. We warmly thank Pr Aimé Bonny, cardiologist, University of Douala (Cameroon), for the guidance and information concerning this part of the article.
12. Lancet 2019, 3 September; [https://doi.org/10.1016/S0140-6736\(19\)32008-2](https://doi.org/10.1016/S0140-6736(19)32008-2)
13. African countries have grown by an average of about 5% over the last decade. The year 2014 saw a slight drop in this average, with an average of 4.2% due to the slowdown in some international investments due to the fear of Ebola and the fall in commodity prices.
14. Definitions should be recalled here: "These are *networks of professionals with recognized expertise and competence in a particular field who can provide relevant knowledge on public policy*" (Haas, 1992: 4). "The *notion of epistemic community refers to the channels through which new ideas flow from societies to governments and from one country to another*" (Bossy & Evrard, 2010: 140).