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**TRIP REPORT B -** #177-1  
and 2

**Travelers:** Dr. James W. Lea, INTRAH Director  
Mr. Pape Gaye, INTRAH Regional  
Director for Francophone Africa

**Country Visited:** Cameroon

**Date of Trip:** December 1-7, 1990

**Purpose:** To conduct a planning visit to the  
Ministry of Public Health and USAID  
to plan needs assessment and other  
FP training activities, December  
2-7, 1990, at the request of USAID/  
Cameroon and the MOPH.

**Program for International Training in Health**

**PAC IIb**

**University of North Carolina at Chapel Hill  
Chapel Hill, North Carolina 27514 USA**

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**EXECUTIVE SUMMARY**

From December 1 to December 7, 1990, an INTRAH team of Dr. James Lea, INTRAH Director, and Mr. Pape Gaye, Regional Director for Francophone Africa, made a planning visit to Yaoundé, Cameroon, to plan needs assessment and other FP training activities at the request of Mr. Richard Greene, HPNO Chief, USAID/Cameroon, and Dr. David Awasum, Director of the Division of Family and Mental Health (DFMH), Ministry of Public Health, Republic of Cameroon.

The visit took place during the week when the Government of the Republic of Cameroon (GRC) adopted a number of legislative measures for political, economic and social reform. The public mood in Cameroon seemed largely conducive to the successful implementation of a new FP program.

The INTRAH team learned of the scope and goals of USAID's planned five-year bilateral Integrated Family Health Project (IFHP) and discussed INTRAH's prospective role in the project for developing national in-service FP training capabilities. The team also discussed the national plan to integrate maternal health/child spacing (MH/CS) services into PHC with leaders of the Division of Family and Mental Health, MOPH, and with other key MOPH officials, health professionals and international assistance organizations. The team found USAID, the MOPH and other organizations enthusiastic about the new program and welcoming of INTRAH's participation.

The team briefed at USAID/Cameroon with the Chief, HPNO and the Population Coordinator and debriefed with the Chief of the Education and Human Resources Development (EHRD) Division, the Population Coordinator and Population Assistant and with a project development specialist visiting Yaoundé from REDSO/WCA. A tentative plan of action for

INTRAH assistance was reviewed and approved. The first proposed step will be a training needs assessment to be conducted in early 1991.

SCHEDULE OF ACTIVITIES

- December 1** Dr. James Lea and Mr. Pape Gaye arrived in Yaoundé at 8:00 p.m.
- December 2** Reviewed reports and project documents of other CAs and agencies providing FP assistance in Cameroon.
- December 3** Briefing at USAID/Cameroon with Mr. Richard Greene, Chief, HPNO, and Mrs. Regina Nana, Population Coordinator.
- Lunch meeting with Mr. James Washington, Chief, EHRD, USAID/Cameroon.
- Meetings with Dr. David Awasum, Director of DFMH, MOPH; and with Mr. M'baye Seye, SEATS/WARO IEC Specialist.
- Meeting with Mrs. Sarah Mpouli, Deputy Director of Maternal and Child Health, MOPH.
- Visit to PMI (MCH) Centrale and meeting with Dr. Martina Baye, Consulting Physician, and Mrs. Odilia Kukah, Senior Service Provider.
- December 4** Meeting with Dr. Robert Leke, Professor/Chief of Service, Obstetrics and Gynecology, Maternité Principale.
- Meeting with Mr. Greene and Mrs. Nana at USAID/Cameroon.
- Informal meeting with Mrs. Grace Walla, Executive Director, CAMNAFAW.
- Dinner meeting with Dr. Awasum.
- December 5** Escorted by Dr. Awasum to the MOPH to meet Dr. T. Saoude Etienne, Principal Advisor to the Minister; Dr. Cecile Bomba, Chief, Training Division; and Dr. Yao, Deputy Director of Preventive Medicine.
- Visit to Djoungelo Hospital and Family Planning Clinic, Yaoundé.
- Meeting with Mr. Alain P. Mouchiroud, Director, UNFPA/Cameroon and introduction to Mr. Leslie Smith, UNFPA Contraceptives Logistics Consultant.

**December 5**

Meeting with Dr. Jay Johnson, Director, USAID/Cameroon.

Escorted by Dr. Awasum to the MOPH to meet Dr. Christophe Bekoe-Ngouba, Director of Hospital Medicine, and Mr. Samuel Mbamba, Director of Studies, Planning and Health Statistics.

Meeting with Dr. Awasum and Mr. Mbofung Lucas Mfuh, designated as INTRAH point-of-contact in the DFMH.

**December 6**

Meeting with Mr. Steven D. LaVake, Director, Peace Corps/Cameroon.

Meeting with Mrs. Walla, CAMNAFAW.

Meeting (Mr. Gaye) with Mrs. Agma Prins, PRITECH Representative.

Prepared debriefing memo (Dr. Lea) for the MOPH and USAID/Cameroon.

**December 7**

Debriefing with Mr. Washington, Mrs. Nana and Mr. George Vishio, Health and Population Assistant, of USAID/Cameroon, and a representative of the REDSO/WCA Development Office.

Meeting with Mr. Richard Crayne, Chief of Party, Sahel Regional Financial Management Project.

Departure for Togo (Mr. Gaye) and the U.S. (Dr. Lea).

**LIST OF ABBREVIATIONS**

<b>CAMNAFAW</b>	Cameroon National Association for Family Welfare (Family Planning Association)
<b>CUSS</b>	University Center of Health Sciences
<b>DFMH</b>	Division of Family and Mental Health
<b>EHRD</b>	Education and Human Resources Development
<b>FHI-II</b>	Family Health Initiatives-II Project
<b>FPMD</b>	Family Planning Management Development Project (Management Sciences for Health)
<b>GRC</b>	Government of the Republic of Cameroon
<b>IFFLP</b>	International Federation for Family Life Promotion
<b>IFHP</b>	Integrated Family Health Project
<b>MH/CS</b>	Maternal Health/Child Spacing
<b>PMI</b>	Protection Maternelle et Infantile (Maternal and Child Health)

**I. PURPOSE OF TRIP**

The purpose of the December 2-7, 1990 trip was to conduct a planning visit to the Ministry of Public Health and USAID to plan needs assessment and other FP training activities, at the request of USAID/Cameroon and the MOPH.

**II. ACCOMPLISHMENTS**

- A. The prospective role of INTRAH in the FHI-II project and the prospective 5-year Integrated Family Health project were discussed with USAID/Cameroon officials, and a tentative schedule of INTRAH activities was prepared.
- B. Official introductory visits were made to nine key officials of the MOPH. Prospects for INTRAH assistance were described and discussed, and assurances of planning input and long-term commitment from each official were secured.
- C. The full spectrum of current and planned health and FP activities in Cameroon was reviewed and discussed with MOPH and USAID/Cameroon officials and with representatives of selected donor and assistance organizations.
- D. Visits were made to three prospective Yaoundé practicum sites, and discussions were held with clinic managers, and prospective trainers and preceptors at each site.
- E. Cost factors and sources of banking and accounting services necessary for the implementation of an INTRAH project were collected and reviewed.

**III. BACKGROUND**

INTRAH provided limited assistance for institutional development in Cameroon during PAC-I (1979-1984), developing a family health curriculum and training key national nursing and midwifery educators in training management. Because of

firm GRC resistance to expanding family planning services, there were few opportunities during PAC-IIa for INTRAH to provide direct assistance in FP training. In addition, the USAID mission chose not to request PAC training assistance. As a result, INTRAH was not active in Cameroon during the period 1984-1990, although efforts were made to maintain contacts with Cameroonian colleagues.

The trip described in this report was the first visit to Cameroon by INTRAH representatives since 1984 and was made at the request of Mr. Richard Greene, HPNO Chief at USAID/Cameroon, and Dr. David Awasum, Director of the Division of Family and Mental Health, MOPH.

#### **IV. DESCRIPTION OF ACTIVITIES**

##### **A. Preparation**

Prior to meeting with USAID and Cameroonian officials, the INTRAH team carried out a detailed review of demographic, cultural and economic information on Cameroon and all available reports and project documents describing current and planned family planning assistance in the country.

##### **B. USAID/Cameroon**

The INTRAH team was briefed first by Mrs. Regina Nana, Population Coordinator, and then by Mr. Richard Greene, HPNO Chief, on planned mission support for the new MOPH initiative to integrate child spacing services into the recently (1989) reorganized national primary health care program. The team was told that the GRC's program will focus on community-managed PHC/MH/CS services and includes as a cost-recovery feature --a "drug store"-- in each community where common medications and contraceptives will be sold at subsidized prices. Family planning (officially termed responsible parenthood) is rationalized in the national health

program as a means of decreasing maternal and child morbidity and mortality.

USAID assistance is provided under the FHI-II project, which terminates on September 30, 1991. FHI-II has supported commodities and equipment, and technical assistance by JHPIEGO, FPMD, SEATS, PCS, IFFLP, Futures and some other agencies. Other active family planning donors include UNFPA, which is assisting in population policy development and IEC activities; WHO, which supports a few village PMIs; and IPPF, which supports CAMNAFAW, the family planning association of Cameroon.

According to USAID, there are four government MCH centers (PMIs) in Yaoundé that currently offer FP services with limited commodities and equipment. Services are also offered at Djoungelo Hospital, a Protestant mission clinic, and the Maternité Principale at the University (of Yaoundé) Center of Health Sciences (CUSS). SEATS was to have supplied contraceptives to 26 pilot sites in five target provinces and trained nurses at those sites in logistics management. However, the contraceptives cannot be released until the MOPH issues formal approval, and the training of service providers is one of the approval criteria.

The mission expects that the proposed five-year (FY 1992-1997) bilateral Integrated Family Health Project (IFHP) will be signed by the GRC in October 1991. USAID/Cameroon will contribute approximately \$7.5 million in project funds, including a sizeable sector grant, and the GRC contribution will be approximately \$3.3 million. The implementing agency will be the Division of Family and Mental Health. USAID/Cameroon expects to draw heavily upon SEATS (as the lead

assistance agency), and INTRAH, PCS and JHPIEGO for technical assistance under the bilateral project.

C. **Division of Family and Mental Health, MOPH**

The INTRAH team was escorted by Mr. Greene and Mrs. Nana to the Division of Family and Mental Health. The DFMH was created by the MOPH in 1989, an action widely viewed as representing a major turnaround in support for family planning by the traditionally pro-natalist GRC. Dr. David N. Awasum, a bilingual MD with an MPH from the University of Hawaii, is DFMH's founding director. Dr. Awasum has experience in developing and managing both hospital-based and village-based FP services.

The DFMH is responsible for integration of MH/CS services into the PHC system. Dr. Awasum (as well as USAID) strongly emphasized the integrated features of the program. Family planning services will not be managed and provided vertically, so it is assumed that some of the assistance directed at implementing FP will cross over into strengthening maternal health and general PHC services. The MH/CS effort will focus on improving capabilities at the health post, health centre, sub-divisional (district) hospital and provincial levels. In-service training capabilities will be built primarily at the sub-divisional, provincial and central levels.

Because his responsibilities cut across existing lines of authority within the MOPH, Dr. Awasum is sensitive to the need to coordinate closely with other MOPH divisions, including Hospital Medicine (responsible for almost all MOPH physical facilities), MCH, Preventive Medicine and Training. He urges all of "his consultants" to coordinate closely with him in order to

ensure that the DFMH's efforts have the support of other MOPH divisions.

Dr. Awasum is anxious to begin work on two important basic documents for the new program: (1) a national service policy and service standards with accompanying method protocols; and (2) a core in-service training curriculum from which specific service skills curricula will be produced for training, initially at the provincial level. Completion of these two documents was also determined to be a condition precedent for the release of USAID sector grant funds for use by the DFMH in the family planning program.

D. Other MOPH Divisions

The INTRAH team met with MOPH officials in the Divisions of Maternal and Child Health, Training, Preventive Medicine and Hospital Medicine. Meetings were also conducted with the Director of Studies, Planning and Health Statistics and with the principal advisor to the Minister of Public Health.

In-service training in MCH and family planning was cited unanimously as one of the Ministry's high priority areas. All MOPH officials interviewed identified improved management, formal training of personnel and on-the-job training as means of improving the quality of MH/CS services. According to the director of the Training Division, in-service training is even more essential now during economic hard times when many professional schools have been forced to close or to substantially reduce their enrollments. Fewer nurses are being graduated, and the need for retraining is greater than ever.

The Division of Maternal and Child Health, which oversees the country's PMIs, sees training in family

planning as crucial if the newly adopted strategy for integrated MH/CS service delivery to succeed.

E. Dr. Robert Leke, Maternité Principale, CHU/CUSS, Yaoundé

Dr. Leke is a senior obstetrician-gynecologist and surgeon practicing at the Maternité Principale. He is a strong advocate for child spacing in Cameroon and provides and manages a full range of FP services in his clinic. Dr. Leke is considered one of the country's pioneers in family planning. He has been working on a JHPIEGO-sponsored project to develop a team of FP trainers and to introduce FP into the curricula of the medical and nursing schools. As director of the JHPIEGO project, Dr. Leke recently led a workshop on development and evaluation of reproductive health training programs. The workshop report could be a valuable resource in the preparation of a core in-service MH/CS curriculum.

F. PMI Centrale

The PMI Centrale is a large, spacious MCH center where child spacing services have recently been integrated with pre-natal and post-natal care, ORT, nutrition, vaccination, medical consultation and family planning, along with pharmacy and laboratory services.

The INTRAH team met at the PMI Centrale with Mrs. Odilia Kukah, Senior Service Provider, and Dr. Martina Baye, Consulting Physician, who described the center's child spacing effort as "embryonic." The PMI Centrale has three staff members in the FP unit who have received clinical FP training outside Cameroon. All other staff members rotate through the unit regularly to get on-the-job training in FP service delivery skills. The center's goal is to train all staff as FP providers by this means, but they welcome formal in-

service FP skills training, as well as assistance in training clinical preceptors and designing and implementing an MH/CS supervision system.

G. **Djougelo Hospital and Family Planning Center**

Family planning services at the Protestant mission's Djougelo center have been supported by FPIA for more than ten years. (With termination of FPIA support, the USAID mission hopes that SEATS will help compensate for the funding shortfall.) Djougelo's FP center has an active community outreach program implemented in collaboration with church groups and through the social centers of the Ministries of Social Affairs and Condition of Women. The Djougelo center is now preparing a mobile team to expand community outreach services. JHPIEGO and CAMNAFAW have used Djougelo as a site for FP practicum training. The Djougelo center and its energetic and experienced staff are likely to be strong resources for FP training and service site development.

The INTRAH team, accompanied by Mrs. Nana of USAID/Cameroon, met with Mr. Emmanuel Ile, Senior Service Provider at the Djougelo FP Clinic, and with his assistant, Mrs. Bakonou.

H. **Cameroon National Association for Family Welfare (CAMNAFAW)**

CAMNAFAW was granted official government permission to operate in 1988, and is now working toward formal affiliation with the IPPF. Mrs. Grace Walla, Executive Director, told the INTRAH team that CAMNAFAW's activities to date have included IEC activities, seminars and workshops for journalists, youth counseling, and distribution of limited numbers of contraceptives provided by IPPF.

CAMNAFAW's sources of financial support are IPPF and local membership dues; staff include the Executive Director, a finance officer and a secretary in the association's offices and local volunteers in the community. CAMNAFAW is interested in supporting the integration of MH/CS into the PHC system, and is chartered "to assist the government." The association has no further training scheduled until 1992 but is interested in developing a youth counseling center in Yaoundé.

I. UNFPA

The INTRAH team paid a brief visit to the office of Mr. Alain P. Mouchiroud, Director of UNFPA/Cameroon. Mr. Mouchiroud described UNFPA's support to the MOPH and NGO family planning organizations as supporting third-country training, providing contraceptives and assisting with logistics management improvements. The team was introduced to Mr. Leslie V. Smith, a logistics management consultant working for UNFPA, in Mr. Mouchiroud's office.

J. General Information

The week of the INTRAH visit, December 3-7, was a period of considerable national political interest. Early in the week, rumors were rampant in the country that an immunization campaign in some provinces was being used to sterilize school girls. Cameroon was simultaneously trying to absorb political refugees following the overthrow of the government in Chad.

Then, declaring that "Cameroon is ready for democracy," President Paul Biya chose that week to introduce 30 new pieces of legislation for enactment by the National Assembly that, if implemented, will have profoundly liberalizing effects on the country's economy, political structure, freedom of the press and

individual rights and freedoms. Later in the week, Assembly members and government ministers held a precedent-setting televised press conference and answered questions on topics ranging from capital flight to family planning.

**V. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

**A. Findings/Conclusions**

**Finding**

Cameroon has launched a number of major national initiatives in political, social and economic reform. To some extent, these are related to pressures from international and donor organizations for democratization and economic restructuring. The government's announced intention to produce a population policy, for instance, is related to an IMF/World Bank requirement.

**Conclusion**

The climate in Cameroon appears favorable for social and health services development including the national introduction of integrated MH/CS services into PHC.

**Finding**

The USAID mission has developed a favorable rapport with the GRC and has organized a coherent, carefully-planned program of assistance for the GRC's new PHC and MH/CS initiative. There is strong support for MH/CS activities from the mission director and strong mission management capability is in place.

**Conclusion**

If the climate in Cameroon remains favorable and support resources are available, there is a strong likelihood of success for the mission's planned five-year bilateral project.

**Finding**

The Division of Family and Mental Health of the MOPH is relatively new and still in the process of articulating

its role and capabilities. However, Dr. Awasum's leadership of the division is astute, visionary and practical. He and his staff are building appropriate linkages and bases of support throughout the MOPH.

### **Conclusion**

The DFMH will be a capable implementing agency for the national MH/CS program and for the USAID bilateral project.

### **Finding**

There are a significant number of well-trained persons among MOPH officials. However, because family planning has only recently been accepted by the GRC, many of those officials have no practical understanding of how family planning service delivery is planned, integrated and managed.

### **Conclusion**

Selected officials of the MOPH would benefit from learning first-hand of the experiences of other countries where MH/CS services have already been established.

### **Finding**

At present, there seem to be very few fully prepared sites for the training of FP providers. Outside of the very good services provided at the Maternité Principale and the Djoungelo FP Clinic in Yaoundé and at scattered sites elsewhere in the country, child spacing services are not well developed in Cameroon. Training and technical assistance from donor agencies has been generally unsystematic and has not produced much institutionalization of training or service delivery capabilities.

### **Conclusion**

The development of sustainable institutional capacities for the training, supervision and support of MH/CS service personnel will require careful planning and management, extensive technical assistance, considerable financial investment, and strong, stable commitment by national and international agencies.

Physical facilities and material support at in-service training and service delivery sites will be required, and strengthening of human resources will be a very important element in capacity-building for improved FP services.

### **Finding**

The Director of the DFMH informed the INTRAH team that he might designate one of his staff to serve as the contact person for the training development project. The most likely designee is an experienced nurse supervisor who has completed studies in post-basic nursing and has a masters degree from Tulane University. He worked previously in an FPMD project.

### **Conclusion**

The assignment of designated staff contact persons for the various CAs working with the DFMH would be valuable for coordinating assistance activities and avoiding duplication of efforts.

### **Finding**

The DFMH is concerned that national service policies and standards be installed and that a national core curriculum for in-service training be developed before a major thrust in services expansion begins.

### **Conclusion**

The DFMH intends to manage all aspects of the new integration effort consistently and carefully and has organized its priorities accordingly.

## **B. Recommendations**

1. INTRAH should move as expeditiously as possible to respond to requests by USAID/Cameroon and the MOPH for technical assistance to develop national, provincial and sub-divisional FP training capabilities. The first step--fielding of a technical team to conduct a training needs assessment/clinical site inventory and to begin planning for service policy/standards development by studying medical standards now being developed by a special DFMH committee--should be taken in early 1991.

2. A carefully planned program of technical assistance for policy/standards development, core curriculum development, and preceptor training should be developed by INTRAH, the DFMH and USAID for funding and implementation under the mission's FHI-II project.
3. During the initial work under FHI-II, INTRAH should develop a country training strategy and 3-5 year in-service training plan to meet the training and institutional development goals of the USAID-supported bilateral Integrated Family Health Project.
4. PAC-IIb assistance in Cameroon should include observational visits for selected officials of the MOPH and other ministries to be involved in project implementation. Given the GRC's new orientation to primary health care and integrated MH/CS services, Chogoria Hospital in Kenya should be considered as a model to be observed.
5. The DFMH should proceed with plans to designate a contact person for INTRAH's PAC-IIb work in Cameroon. The contact person should be available to work on a full-time basis with the INTRAH team conducting a training needs assessment and clinic inventory in early 1991.
6. To ensure full coordination with other CAs and organizations that will be active in FP development in Cameroon, INTRAH should develop coordination mechanisms at central, regional and country levels with SEATS, JHPIEGO, PCS, UNFPA and IPPF. The USAID mission should be kept informed of all coordination planning.

**APPENDIX A**

**Persons Contacted/Met**

## **APPENDIX A**

### **Persons Contacted/Met**

#### **USAID/Cameroon**

Dr. Jay P. JOHNSON, Director

Mr. James WASHINGTON, Chief, Education and Human Resources  
Development

Mr. Richard GREENE, Chief, Health/Population/Nutrition  
Office

Mrs. Regina NANA, Population Coordinator

Mr. George VISHIO, Health and Population Assistant

#### **Ministry of Public Health**

Dr. Temgoua SAOUNDE Etienne, Principal Advisor to the  
Minister

Dr. Christophe BEKOE-NGOUBA, Director of Hospital Medicine

Dr. YAO, Deputy Director of Preventive Medicine

Mr. Samuel MBAMBA Bityeki, Director of Studies, Planning and  
Health Statistics

Dr. Cecile BOMBA Nkolo, Chief, Training Division

#### **Division of Family and Mental Health, MOPH**

Dr. David Neba AWASUM, Director

Mr. Mbofung LUCAS Mfuh, Assistant

Mrs. Sarah MPOULI, Deputy Director, Maternal and Child  
Health

#### **PMI Centrale**

Dr. BAYE Martina, Consulting Physician

Mrs. KUKAH Odilia, Senior Service Provider

#### **Djougelo Hospital**

Mr. ILE Emmanuel, Senior Service Provider

Mrs. BAKONOU, Assistant

**CHU/CUSS**

Dr. Robert LEKE, Professor/Chief of Service, Obstetrics and Gynecology

**CAMNAFAW**

Mrs. Grace WALLA, Executive Director

**Others**

Mr. Steven D. LAVAKE, Director, Peace Corps/Cameroon

Mr. Alain MOUCHIROUD, Director, UNFPA/Cameroon

Mr. Leslie SMITH, UNFPA Contraceptives Logistics Consultant

Mrs. Agma PRINS, PRITECH Representative

Ms. Vickie ASSEVERO, World Bank Consultant

Dr. SANOGO, Population Council/Dakar

Mr. M'baye SEYE, IEC Specialist, SEATS/WARO

Mr. Richard CRAYNE, Chief of Party, Sahel Regional Financial Management Project

**APPENDIX B**

**USAID Summary of Project Implementation Document (PID)  
for the Integrated Family Health Project**

**(Prepared for Distribution to the Ministry of  
Public Health, Cameroon, and Released to  
INTRAH, December 1990)**

INTEGRATED FAMILY HEALTH PROJECT

THIS PROJECT REPRESENTS A NEW USAID CONTRIBUTION TO CAMEROON'S SOCIAL DIMENSIONS OF ADJUSTMENT PROGRAM

DURATION: 5 Years to begin in late 1991

FUNDING: APPROXIMATELY 7 MILLION DOLLARS

GOAL: To lower the prevailing high infant and maternal mortality rates.

PURPOSE: To support the National Primary Health Care Program by integrating child spacing and related maternal health services into the program. Probable maternal health activities will include infertility diagnosis and treatment, strengthening pre and post-natal care, identification and case management of sexually transmitted diseases, the promotion of early and exclusive breastfeeding, and maternal high risk assessment.

IMPLEMENTING AGENCIES: The Project will be implemented by the Directorate of Family and Mental Health in close coordination with the Directorate of Preventive and Rural Health which will be directly responsible for the integration of child spacing and maternal health activities in the provinces.

PROJECT DESCRIPTION:

The Project will support the MOPH's revised PHC program by integrating quality child spacing and related maternal health activities into approximately 100 MOPH health centers and reference hospitals in five provinces where the revised PHC strategy is being initiated. The tentative list of provinces are as follows: Extreme North, Adamaoua, and South (PHC program presently funded by USAID), North (PHC program to be funded by French Cooperation beginning in 1991), and Central (PHC program to be funded by UNICEF and EEC beginning in 1991). The health centers and reference hospitals targetted under the project are expected to have the following profile as outlined by the revised PHC Program:

- a functioning community health committee to co-manage the health facility;
- a revolving-fund drug store (and other health cost recovery measures) managed by the community health committee;
- fully-integrated PHC services supervised by the health district team.

In the process of strengthening child spacing/infertility/MRA services, the Project will provide important generalized support to the national PHC program by:

- providing start-up supplies of maternal health drugs to community pharmacies;
- providing contraceptives to community pharmacies during the life of the project;

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- providing essential MCH/child spacing equipment;
- minor rehabilitation of selected health centers;
- strengthening of integrated supervision, refresher training, and information, education, and communication (IEC).

#### ACTIVITIES

##### 1. Development of Medical Standards and Referral Guidelines

With the assistance of USAID's Family Planning Training for Paramedical, Auxiliary, and Community (PAC) Personnel II Program, the Project will assist the MOPH's Directorate of Family and Mental Health (DFMH) to develop child spacing standards (including quality of care guidelines), service delivery protocols, and reference and continuity of care guidelines by facility (primary, reference, and tertiary). These guidelines, protocols, and standards will conform to the overall structure for primary, secondary, and tertiary care established by the MOPH in its revised PHC strategy. The DFMH will sponsor a seminar of national reproductive health experts to develop the guidelines.

##### 2. Strengthening of Pre-service Training

With the assistance of USAID's Training in Reproductive Health Program, the Project will strengthen the reproductive health curriculums in Cameroon's nursing/midwifery, and medical schools by revising curriculums, developing lesson plans, providing refresher training for tutors, strengthening practical training sites, and providing training and resource materials. Illustrative activities include:

- didactic and clinical reproductive health training for faculty members from the nursing/midwifery schools;
- curriculum and lesson plan development workshops for faculty members from the nursing/midwifery schools;
- training of trainers courses in reproductive health and education skills for faculty trainers from the medical and nurse/midwifery schools;
- evaluation of the teaching of the existing reproductive health modules at the medical and nursing/midwifery schools;
- provision of educational and audio-visual materials.

This component will be implemented by the University Center of Health Sciences (CUSS) with the coordination of the MOPH's Training Division.. The training activities will be facilitated by senior faculty members from CUSS and the CESSI.

##### 3. In-service Training

With the assistance of USAID's PCT II Program, the Project will expand the national PHC in-service training program to include child spacing.

and related maternal health topics. The training strategy outlined below conforms to the guidelines established for in-service training by the revised PHC program. Implementation steps are as follows:

- Establish a pool of national reproductive health experts to serve as national trainers in child spacing/infertility/MHRA. The national trainers, consisting of faculty members from CUSS, CESSI, the nurse training schools, and at least 2 senior practitioners from each of the five targetted provinces will be trained in the following areas: the revised PHC strategy; pedagogic training; PHC logistics, supervision, and evaluation; IEC; advanced reproductive health; and mini-laparotomy (for selected trainers). Training will likely take place at practical training sites in Yaounde.
- Development by the national trainers of a 4 week technical curriculum in child spacing and maternal health which reflects and conforms to the new integrated and community-managed PHC approach of the MOPH.
- Training of the district (arrondissement level) PHC training teams in child spacing and related topics in maternal health. The trainers will include the provincial practitioners trained as national trainers. Training will take place in provincial hospitals.
- Training by the district PHC teams of 1-2 service providers by targetted health center and 2-3 service providers by targetted reference hospital in child spacing/infertility/MHRA. Training will likely take place in the arrondissement hospitals. Trainees will conduct supervised IUD insertions both during their training and at their sites (supervised by visiting practitioners) until minimum competency can be established.
- Mini-laparotomy training for 1-2 physicians from provincial hospitals and selected physicians from departmental and arrondissement hospitals. (Technical assistance provided by the Training in Reproductive Health Program).
- Provision of technical and reference materials for national trainers, DPMH staff, and service providers.

### 3. Integrated Service Delivery

The Project will support the integration of child spacing and related maternal health topics in health centers and reference hospitals participating in the MOPH's revised PHC program. These services will be programmed and implemented by health district teams through their annual plans of action and coordinated by the Directorate of Preventive and Rural Health. Support for service delivery will include:

- provision of essential MCH/Child spacing equipment, as required, to targetted service sites. Provision of laparoscopes to provincial hospitals for infertility diagnosis and treatment.
- minor renovation of selected service sites.

- provision of contraceptives to community-managed pharmacies. Contraceptives will be distributed from the DFMH's national contraceptive warehouse. These contraceptives will enhance the cost recovery programs of the service sites and generate income to support integrated PHC supervision, outreach, refresher training, and other PHC operating costs.
- provision of start-up supplies of selected maternal health pharmaceuticals to the community-managed pharmacies (e.g., iron and folic acid supplements, antibiotics to combat pelvic inflammatory disease, chloroquine for pre-natal care, tetanus vaccine etc).
- printing of initial supplies of child-spacing forms and clinic registers.

#### 4. Information, Education and Communication

With support from USAID's Population Communication Services Program, the Project will assist the MOH's DFMH to develop, implement, and evaluate integrated IEC programs to support the national PHC strategy. Specific messages on child spacing, responsible parenthood, prolonged breast feeding, pre and post-natal care services, and STD and infertility prevention will be developed as part of a comprehensive PHC IEC strategy. The delivery of IEC programs will be coordinated with the availability of services.

The Project will have two main approaches to delivering child spacing and maternal health messages:

- counseling during regular pre-natal, under five, and curative consultations which are conducted at community managed PHC facilities;
- sensitization of community health committees, traditional and religious leaders, and the population at large.

Specific IEC activities will include:

- conducting formative and qualitative research in order to develop integrated IEC strategies and messages;
- developing and testing targetted IEC materials, campaigns, and mass media programs;
- inclusion of IEC training in all in-service training courses;
- developing and implementing a program to train animation workers of the Ministry of Social and Women's Affairs and extension workers of the Ministry of Agriculture in population-based IEC programs in areas where the new PHC strategy is being implemented;
- provision of audio-visual equipment and supplies to the DFMH.

5. Strengthening PHC Management Systems

The Project will reinforce the PHC management system as follows:

Supervision: The present PHC supervision system will be strengthened in the areas of child spacing/infertility/MRA. Supervision will be an integrated activity.

Refresher Training: The present PHC refresher training strategy calls for two 2-3 day integrated PHC workshops per health worker per year. Topics will be determined based on results of supervision activities. child spacing and maternal health topics will be included as appropriate.

National Health Management Information System (HMIS): The Project will assist the national HMIS commission to integrate data on child spacing, infertility, and MHA.

Operations Research: The Project will fund selected operations research topics related to maternal and child health. Guidance on the design, implementation, and dissemination of study results will be provided by the newly created National Epidemiologic Board. With the assistance of USAID's Training in Reproductive Health Program, the Project will conduct a trial of Norplant.

6. Strategic Planning

With the assistance of USAID's SEATS Program, the Project will provide short-term technical assistance to the DFMH to strategically plan the expansion of maternal child health/child spacing services in Cameroon in the context of the MOH's revised PHC program. Strategy planning will emphasize the effective integration of various components (services, IEC, etc.) and sectors (public, NGO, and private) and strengthen management and quality of care systems and donor coordination.

7. Commodity Support for the National Condom Social Marketing Program

The project will procure condoms to support the ongoing Condom Social Marketing program managed by the National AIDS Committee. The provision of condoms during the duration of the Project will permit the Condom Social Marketing program to expand nationwide.

8. Private Sector Support

With the assistance of USAID's SEATS Program, the Project will support the integration of child spacing and related maternal health services in the health programs of 26 Protestant Hospitals, the health clinics of the Cameroon Development Corporation, and in the health clinics of approximately 40 other businesses. Assistance will include commodity support, contraceptives, training, and IEC materials.

**APPENDIX C**

**Inventory of Family Health Projects  
in Cameroon: August 1990**

**(Prepared and Distributed by the  
Division of Family and Mental Health,  
Ministry of Public Health, Cameroon)**

LA SANTE FAMILIALE AU CAMEROUN  
L'INVENTAIRE DES PROJETS PF : AOUT 1990

N°	TITLE OF PROJECT	FUNDING AGENCY	EXECUTING AGENCY	SUB. CONT. AGENCY.
1-	CAMEROON-01/02, CHILD SPACING H/I	U.S.A.I.D.	F P I A	Djoungolo, Pres.Hopital Mr ELLE
2 -	T.C. 16, CLINICAL TRAINING, CURRICULUM, DEVELOPMENT, N REPRODUCTIVE HEALTH	U.S.A.I.D.	JHPEIGO	CUSS/DSFM/MSP Pr. LEKE R/DSFM
3 -!	A.F. CAM-01, I.E.C. for F.P. C.C.S.P.P.	U.S.A.I.D.	JHU/PCS	MOH/SES
4 -	MANAGEMENT TRAINING PROJECT ON F.P.	U.S.A.I.D.	MANAGEMENT SCIENCES FOR HEALTH-USAID/USA	MINASCOF - DPF
5 -!	POPULATION POLICY DEVELOPMENT	U.S.A.I.D.	FUTURES GROUP.USA	MINPAT DIRECTORATE OF PLANIFICATION
6 -	SESA	U.S.A.I.D.	HAVARD CONSOTUM	MSP/DMPR Dr OWONA Tél: 22-44-19
7 -!	REPRODUCTIVE HEALTH TRAINING	U.S.A.I.D.	JHPIEGO	Mr. TIA Pius: MUFFIH BBH KUMBO, BUI
8 -	CONTRACEPTIVE LOGISTICS SYSTEM	U.S.A.I.D.	S E A T S	DSFM - MOH
9 -!	INTEGRATING CBD-FP EDUCATION	U.S.A.I.D.	POPULATION COUNCIL	SAVE THE CHILDREN YDE TIM MANCHESTER
10 -!	MBO HOSPITAL RESP.PARENT.PROGRAM.	U.S.A.I.D.	F P I A	MBO HOPITAL, BAFOUSSAM Dr. PAUL TCHAKOUTE
11 -!	ENQUETE DEMOGRAPHIQUE AU CAMEROUN (DHS)	U.S.A.I.D.		MINPAT
12 -!	BIEN ETRE FAMILIAL (NGONGA/LIMBE)	O.M.S.	MOH/MSP	MOH/MSP/DS/DAMPH Dr. OWONA Tél: 22-44-19
13 !	CAE/MCH/001, PMI VILLAGEOISE DU MFOUNDI	O.M.S.	MOB/MSP	MSP/DELEGUE PROV. DR.LOUIS PHILIPPE T. Tél: 23-20-87
14 -!	EDUCATION A LA VIE FAMILIALE	O.M.S.		MSP/MINEDUC/DS/SD/MHR Dr BEKOE Tél:

.../...

15	INTEGRATION OF F.P. IN AGRIC. EXT. C.M.	FNUAP	FNUAP	MINAGRI DCD Mme MBIDE Tél: 22-34-48
16	CMR/89/PO3 (UPP) UNITE DE PLANIFICATION DE LA POPULATION.	FNUAP	BIT	MINPAT DP RESP. PIM FOKAM OU KADDOUM Tél : 23-00-20
17	CMR/89/POI, SANTE FAMILIALE : RENFORCEMENT DE L'OFFRE DES SERVICES DE P.F. A TRAVERS LES STRUCTURES DE P.M.I.	FNUAP	O.M.S.	MOH/MSP/DS/PMI CENTRALE Dr. MOLU Tél: 22-25-33/23-36-53
18	WOMEN AND DEVELOPMENT	FNUAP	BIT	MINASCOF/DPS/ Mme NJOCK Tél : 23-40-15 post. 205
19	PROMOTION ET COORDINATION I.E.C. EN MATIERE DE POP. CMR/88/PO6	FNUAP	FNUAP	MINFOC, JEAN PAUL NANGA Tél: 23-40-75
20	EDUCATION A LA VIE FAMILIALE POUR LES TRAVAILLEURS ORGANISES.	FNUAP	OSTC	SOMBES Tél:
21	EDUCATION DES POP. A LA PARENTEE RESPONSABLE ET AMELIORATION DES COND. DE VIES FAMILIALE ET COMM.	FNUAP	BIT	MINASCOF Mr MBENA Tél:
22	POPULATION POLICY DEVELOPMENT	FNUAP	FNUAP	U P P - MINPAT
23	CAMNAFAW	I P P F		Mme GRACE WALA
24	PRESBYT. HEALTH CENTRE BAMEUDA	MATERNEL CHILD-WELFARE		
25	NATURAL F. PLANING	U.S.A.I.D.	IFFIP (INTERNATIONAL FEDERATION FOR FAMILY LIFE PROMOTION	CATHOLIC HEALTH SERVICE MVOLYE Tél : 22-17-46 SR ABOMO

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APPENDIX D

Debriefing Memorandum: From Mr. Pape Gaye and Dr. James Lea to Dr. David Awasum, Director of the Division of Family and Mental Health, Ministry of Public Health, and Mr. Richard Greene, Chief of the Health/Population/Nutrition Office, USAID/Cameroon

MEMORANDUM

DATE: 7 December, 1990

FROM: Dr. James Lea, INTRAH Director  
Mr. Pape Gaye, Regional Director for  
Francophone Africa

TO: Dr. David Awasum, Director  
Department of Family and Mental Health  
Ministry of Public Health

Mr. Richard Greene  
HPN Officer  
USAID/Cameroon

RE: INTRAH Site Visit, 2-7 December, 1990

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From 2-7 December, 1990, Dr. James Lea, INTRAH Director, and Mr. Pape Gaye, Regional Director for Francophone Africa, visited Yaoundé at the invitation of the MOPH and USAID/Cameroon. The purpose of the visit was to introduce INTRAH and to explore possibilities for collaborative assistance to the MOPH under USAID/Cameroon's FHI-II project and the prospective bilateral Integrated Family Health Project (IFHP).

The following activities were completed by the INTRAH team:

1. Briefing meetings were held with the Director of Family and Mental Health and with the HPN Officer and Population Coordinator at the USAID mission.
2. Documents pertaining to USAID-sponsored MCH/FP activities were reviewed, including reports and project proposals by SEATS, JHPIEGO, PCS; MOPH documents on the reorganization of primary health care and integration of child spacing into all PHC services; and a summary of the PID for USAID's prospective bilateral IFHP, planned for FY 92-97.
3. Courtesy visits were paid and discussions held with representatives of other international donor agencies and A.I.D Cooperating Agencies working in Cameroon, including UNFPA, SEATS, the Population Council, PRITECH and the Peace Corps. A formal meeting was held with CAMNAFAW, the family planning association of Cameroon.
4. Observational visits were made to MOPH and NGO service delivery sites in the Yaoundé area: the Maternité Principale, Djoungelo Hospital, and the PMI Centrale.
5. Work sessions were held with Dr. David Awasum and Mr. Mbofung LUCAS Mfuh to discuss possible next steps in developing and implementing MH/CS training development.
6. Exit briefings were held with the Director of the DFMH and with the Population Coordinator at USAID.

On the basis of discussions with USAID/Cameroon and the DFMH, the INTRAH team suggested a series of next steps, illustrated by the attached "Tentative Timeframe for INTRAH Training Assistance to MOPH/DFMH." (It is emphasized that the Tentative Timeframe is for purposes of illustration only; actual activities, dates and durations will be jointly planned following technical assessment of training and service delivery resources and needs in Cameroon. Detailed work plans will be finalized when the availability of INTRAH and MOPH personnel and other resources, as well as funds from an FHI-II buy-in, is determined.)

On the basis of this visit, it is assumed that INTRAH assistance will focus on the following areas and will be largely supported by a mission buy-in from FHI-II funds, for which a PIO/T has already been sent to AID/W.

- (a) technical assistance for the preparation of a national MH/CS service delivery policy, including medical standards, and clinical method protocols
- (b) technical assistance for the preparation of a core curriculum for in-service training and selected sub-curricula
- (c) training of a cadre of clinical preceptors to provide practicum training at selected clinical sites in support of in-service provider training
- (d) other activities to begin the development of stronger national capabilities and capacities for training and supervising providers of MH/CS services within the PHC system.

These activities, to be carried out during the final nine months of the mission's FHI-II project, will lay the foundation for the major effort planned for the development of training capabilities and the training of providers, supervisors and other personnel in the context of the MOPH reorganized PHC program and the mission's IFHP.

It is anticipated that during the IFHP, INTRAH will function as the major assistance resource for the development of in-service training capabilities, especially the development of national, provincial and sub-divisional training teams and the training of MH/CS service providers, supervisors and other personnel in the national PHC system.

When the dates of a technical assessment visit have been proposed and approved, a detailed scope of work for that visit will be prepared by INTRAH and submitted to USAID/Cameroon. INTRAH expects to submit the scope of work during the week of 24 December.

The INTRAH team deeply appreciates the hospitality and assistance of USAID/Cameroon and of the DFMH which made this initial site visit highly productive and quite pleasant. INTRAH looks forward to contributing to the exciting new initiatives being undertaken by the MOPH and the USAID mission in Cameroon.

- Attachments:
- (1) Tentative Timeframe
  - (2) Rationale for Development of In-Service Curricula and Service Policy/Medical Standards

FY 91: FHI-II

FY 92: IFHP PY 01

FY 93: IFPH PY 02

Jan-Mar    Apr-Jun    Jul-Sep    Oct-Dec    Jan-Mar    Apr-Jun    Jul-Sep    Oct-Dec    Jan-Mar    Apr-Jun

ESSENTIAL EVENTS

1. Assessment and planning for policy and standards	x---x									
2. Assessment of in-service training needs and resources	x---x									
3. MH/CS policy/standards/protocols development		x-----x		x						
4. In-service curricula development	x-----x									
5. Training clinical preceptors			x--x    x--x							
6. Project/subcontract development				x						
7. Development of national training team (TOT, materials, etc.)				x-----x	----->					
8. Development of provincial/sub-divisional teams						x-----x	----->			
9. Technical support to training teams					x-----x		x----->			
10. Develop training teams' self-renewal plans and capacity								x-----x		
11. Training of service providers, supervisors, others					x-----x					----->

\*NOTE: This timeframe is for purposes of illustration only. Actual dates and duration of activities will be jointly developed following technical assessment of current resources and needs.

**APPENDIX E**

**Background Paper for the Guidelines for a Draft  
National Population Policy: Republic of Cameroon**

REPUBLIC OF CAMEROON

BACKGROUND PAPER

FOR THE GUIDELINES FOR A

DRAFT NATIONAL POPULATION POLICY

Yaounde, September, 1990

## OUTLINE

- I. Introduction.
- II. The Demographic Setting.
- III. Implications of Current Rapid Population Growth.
- IV. Checking Population Growth: The Issues.
- V. The Institutional Framework; the Need for Coordination.
- VI. Monitoring and Evaluation; Data Collection and Research

## 1.. Introduction.

### 1.1. Historical Background

1.1.1. The Republic of Cameroon, like so many Sub-Saharan African countries, found at Independence, that the country, with a population of only 5.5 million, needed many more people to make full use of its economic potential and that, as quickly as possible. Moreover, several regions were very sparsely populated. The first national Governments followed therefore pro-natalist policies aiming at increasing the population. A series of measures were taken, especially very generous family allowances for each additional child. They were in agreement with the spirit of the former colonizer's legislation to stimulate the birth rates, which in the "Metropole, were of course inspired by totally different demographic circumstances than the ones prevailing in Cameroon. The 1920 French law prohibiting the import, sales or promotion of contraceptives was not only kept 'intact' but it was the basis of the law of 1969 (No.29/69) which reconfirmed the banning of contraceptives. In addition, traditional family (size) ideals, in the first place stemming from a reality of extremely high infant mortality, were emphasized. Infant mortality started to decline but the family ideals remained unchanged until very recently.

1.1.2. The country's potential for rapid demographic growth was underestimated when the goal of ten million people at the end of the century was proclaimed. As we know, that goal was attained thirteen years ahead of schedule! The end of the century will bring the population of Cameroon, instead of to ten million, to more than fifteen million.

1.1.3. In the 1980's, some changes in official and private thinking regarding population growth and ideal family size began to appear. A report to third congress of the National Cameroonian Union by the then Head of State and National President of the NCU, Ahmadou Ahidjo, signaling a concern about the impact of rapid demographic growth on the realization of development objectives, was misunderstood by a great part of government officials and the population, as witnessed by two interpretations of the same speech, the one completely the opposite of the other, in the official press during the following days'. Nevertheless, that same year, law No. 80/10 of 14 July, (also, like the 1969 law, referring to the regulation of the profession of pharmacist) opened the possibility for the sales, of contraceptives.

Gubry, P., 1988, "Cameroun: d'un natalisme nuance vers un anti-natalisme modere?", in Cahiers de Sciences Humaines, 24 (2) 185-198.

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1.1.4. The sudden and severe economic crisis which appeared in the middle of the decade, accelerated this change in official thinking on population growth and development. In August 1986, while presenting the sixth five-year development plan to Parliament, the Head of State, H.E. Paul Biya made a strong plea for bringing population growth in balance with the country's resources, lest development objectives would be seriously compromised: by the straightforwardness of his words in the sense that, while respecting individual rights, the traditions and customs of the people, natality had to be brought under control, this time no conflicting interpretations of his remarks were possible.

1.1.5. In the meantime, several changes had been taking place. A National Fertility Survey<sup>2</sup>, carried out in 1978, had shown that fertility levels and fertility ideals in the country were high, at the same time indicating a serious problem of sterility, which - if brought under control - would raise fertility levels even further. In 1984, a Population Planning Unit had been created within the Ministry of Planning and Regional Development<sup>3</sup>, with as main tasks, to assure the incorporation of demographic considerations into development planning and to assist Government in preparing a national population policy. A National Population Commission consisting of the Ministers, or their representatives, of key ministries, was created in 1985.

1.1.6. A Needs Assessment mission was sent in 1983 by UNFPA which is currently financing several population projects from, family planning services to information, education and communications (IEC) activities. The World Bank undertook an in-depth 'Population, Health and Nutrition Sector Review' in 1986; an agreement for a social-dimensions-of-adjustment project was signed between Government and the Bank in August, 1990. This project, financed by some ten donor agencies, contains comprehensive population and health components, which should have a major impact on the future course of population dynamics in Cameroon. In the private sector, a Cameroon affiliate of the International Planned Parenthood Federation (IPPF), started in 1987 the promotion of family planning under the name of the Cameroon National Association for Family Welfare (CAMNAFAW).

<sup>2</sup> In the framework of the World Fertility Survey Program, which lent technical support, and with financing from the United States Agency for Development (USAID).

<sup>3</sup> with financial support from the United Nations Population Fund (UNFPA) and with technical support from the International Labour Organization (ILO). The UPP continues to function with support from both organizations.

## 1.2. The Present Situation

1.2.1. There are many indications that there is a growing demand for family planning services, mainly in the cities. These indications unfortunately are mostly negative : increasing numbers of teen-age pregnancies (outside of marital union), a recrudescence of illegal abortions, infanticide and abandoning of children. On the positive side is the almost daily references to child spacing in the interest of mothers and children, to responsible parenthood, to family planning methods and the services providing them.

1.2.2. Total contraceptive use however, is estimated to be still very low since thus far there are only a few public or private sector services available. Unfortunately, little is known about that contraceptive practice, which requires none, or only a doctor's prescription; there is no data on the total of condom and pill sales in the country, which could yield a (very) rough estimate about use. It is likely that contraceptive use among the city dwellers and especially the younger generations among them, is catching on. As it is equally likely, that in the countryside, the practice of contraception is negligible, be it only that, even if there were a demand, access to services and/or contraceptives is seriously limited under the present circumstances.

1.2.3. In the meantime, modernization is causing breast-feeding periods to become shorter while sterility according to national medical experts, is declining, both phenomena having a positive influence on fertility. Indeed, the total sum may well be that fertility in Cameroon is on the rise.

## 2. The Demographic Setting

### 2.1. Population Trends and Perspectives

2.1.1. A generally accepted estimate for 1950, puts the population of Cameroon at 4.5 million. The population growth rate at that time was under 2 percent per year. It was 'modest' in comparison with many other African countries and was about the same as that of Poland. The components of growth in Cameroon however were quite different from those in Poland: in the latter country, the birth rate was 30 per thousand and the death rate, 10 per thousand; in Cameroon, the birth rate was 46, and the death rate 26 per thousand. These differences in the composition of the growth rate are of considerable consequence for future growth.

2.1.2. Fertility, and therefore the birth rate, went up steadily since 1950; the death rate, being far above its lower limits, continuously went down. The joint effect of both movements was an increase in the annual growth rate; this rate not only became higher but the pace with which the population was growing accelerated. In the period 1950/55 the population grew at an average of 1.94 per year; for the period 60/65 that rate was 2.01, for 1970/75 it was 2.29 and for 1980/85: 2.71 percent per year<sup>4</sup>. According to the latest census results the population of Cameroon must, at present, be growing at a rate of about 3 percent per year. Where it took a good 35 years for the population to double at the growth rate of 1950/55, it is now taking only a good 23 years; at present, it takes only three years to add one million people to the country's population, (it being understood that international migration is negligible).

2.1.3. The total fertility rate (TFR) is estimated to be at least 6.0 but a more detailed analysis of the 1987 census results, eventually supplemented by a Demographic and Health Survey<sup>5</sup>, will be needed. The population projections made by UPP, assume for the base year 1987, a crude birth rate of 43.2 per thousand and a crude death rate of 14 per thousand<sup>6</sup>.

2.1.4. Although there is a growing concern among the authorities and the public at large, about the impact of rapid demographic growth on economic and social development, a decline in the growth rate cannot be expected for some time to come. While in Poland a decline in fertility had an immediate effect on the growth rate, in Cameroon this cannot be the case. In fact, with a death rate of 10 per thousand in the fifties, Poland was approaching the lower limits of mortality already. Therefore, when mortality could hardly decline any further, fertility declines had an immediate effect on the growth rates. Cameroon is only recently approaching somewhat these lower limits of mortality but, at an estimated life expectancy of 53-54<sup>7</sup>, it still will take some time before these limits are reached. Furthermore, there are no firm signs of a decline in fertility.

<sup>4</sup> United Nations, 1989, World Population Prospects, 1988

<sup>5</sup> Recent information indicates that a standard DHS survey will be undertaken by the Department of the Census, to be financed by USAID, and with the technical support of the Institute for Resource Development in Washington, D.C.

<sup>6</sup> MINPAT/UPP, 1990, SITUATION ET PERSPECTIVES DEMOGRAPHIQUES DU CAMEROUN, forthcoming.

<sup>7</sup> UPP, 1990, *ibidem*.

2.1.5. As in most African countries, vital statistics and other demographic information are still imperfect and therefore, most data is the result of "best possible estimates"; another consequence of the lack of firm demographic information, is the existence of several estimates of basic data, especially in relation with population projections, which show, the further they go, differences of importance (Annex 1). The United Nations projections seem, even in their high variant, on the low side. It may well turn out that the World Bank's fertility estimate is best approaching reality but as said before, not unless the full 1987 census data and their degree and specificity of under-registration are released, the answer remains unknown. In this paper, UPP's projections are taken as a guideline for discussions, unless otherwise indicated.

2.1.6. Within ten years the population of Cameroon will have reached 15.5 million in twenty year will stand at 20.3 million according MINPAT/UPP's medium variant projection. Assuming that mortality decline would continue its observed trend over the next thirty years and fertility would drop from an average of 6 children per woman to about 4, the population of Cameroon would be over 26 million people by the year 2020.

## 2.2. Age Structure

2.2.1. By now, it is common knowledge that Cameroon has a young population. Many times over the public has been informed of this fact and figures are forwarded in different forms according to the needs of the argument under consideration. The population under 15 years of age is 46-47% ; the population under 20 years make out 56% of the total and 64% of the total population is under 25 years of age.

2.2.2. Less well known is the fact of what causes a population to become younger or to grow older. Contrary to common belief, it is fertility, which determines mainly the form of an age structure; changes in mortality have little influence on its shape. Inversely, in the absence of significant in- or out migration, an age structure which is becoming younger, as seems to have been happening between the first and the second population and housing census, would indicate that fertility is on the rise. If this impression is corroborated by more detailed analysis of the 1987 census, the fertility assumptions adopted for the population projections are probably too low which would result in higher population figures for the coming years.

### 2.3. Density, Distribution and Urbanization

2.3.1. With only 24 inhabitants per square kilometer, Cameroon seems to have no population problem at all. The country can, and will be much more densely populated in future. But it should be remembered that in spite of the image of a sparsely populated country, pockets of relatively high density do exist like in several departments in the western part of the country or in the Mandara mountains in the north. The exhaustive study of the Food and Agricultural Organization, FAO, carried out in the early 1980's, emphasized the notion of "population carrying capacity". The study relates the productivity of the soil and the climatological conditions, with total food production, which, translated into calories, indicates the number of persons a given territory can support on a sustainable basis. Obviously then, the carrying capacity per square kilometer varies enormously from region to region but also even within certain agro-economical regions.

2.3.2. It should also be recalled that in the past, the locus of human settlements, their patterns and their extension are not a function of sheer chance but did find their origin in ecological, geographical, economic and cultural circumstances. If some regions today are sparsely populated, it is because their attraction was not as big as that of other regions. In almost all documents referring to national population policies, a mention is made in the sense of finding "a more equitable distribution of the population over the national territory". Seldom, if ever, this objective is backed up by a comprehensive study of the costs in economic and psychological/cultural terms, which attaining such an objective would attain, not to mention the cost-effectiveness of such an enterprise.

2.3.3. On the other hand, most of the developing countries, lack plans and directives, concerning industrial settlements, which in turn, in most cases, can influence the shape of human settlement patterns. Another, unfortunate, factor influencing the distribution or redistribution of the population is of a political nature: political unrest in the country or in neighboring countries are determining the growth of cities or regions: In Cameroon, the troubles of the recent past in Chad, have led to a extremely rapid growth of Kousseri and its surrounding area. The growth rate of Kousseri between the two censuses is estimated by the Census Department at over 14% per year, a situation which is hard to visualize, as it means a doubling of its population in just five years!

2.3.4. There was very little change in the population distribution in the period 1976-1987. The Extreme Northern, the North-Western and Western provinces gained proportionally at the expense of the other provinces. At the same time it seems useful to remind the proportions of these three provinces: almost one fifth of the total population of Cameroon lives in the Extreme North and well

over one quarter of the population lives in the two other provinces of the North-West and West.

2.3.5. The urbanization process is accelerating. In 1987, 30 percent of the total population was living in the 37 cities of 10,000 inhabitants or more. Some of these cities were showing an extremely rapid growth: Bamenda almost 8 percent per year, Bertoua 10 percent, Tiko and Kumbo over 9 percent and Mbouda 8 percent per year. All these cities are doubling in size in between seven and eight years, an enormous challenge for any city authority.

2.3.6. By the end of the century, in spite of the still rural character of the country, half of the population or more will be living in urban areas. This fact implies that also more than half of the population will be increasingly exposed to the influences of 'modernization', adopting different attitudes, not in the least in the areas of demographic and social behavior.

2.3.7. In conclusion, if sparse population density were a problem, this would mainly reside in the fact that the provision of social and infrastructure services is complicated and costly. The more urgent population problem is the speed with which the population is growing and the implications are manifest in a more pronounced form in the rapidly growing urban conglomerations. In short, at present, not 'density' but 'growth' is the important population problem.

2.3.8. The implications of the accelerating urbanization process for housing, infrastructure, employment, and social services such as health and education, are attracting more and more the attention of development agencies. Major solutions of the population-and-development problems of developing countries have to be found, in the next decades, in the adjustment of the urban physical, economical, social, and cultural environment to these waves of people being added every year. In more dramatic terms: the population battle will have to be fought in the cities in the first place.

2.3.9. For some time now, development thinking about the effects of rapidly growing cities has been changing and the almost universal pessimistic conclusions of several decades ago are making place for more optimistic and positive assessment of the phenomenon. It is believed that the speed with which the urbanization process is taking place has the positive effect of 'dragging' more people, more quickly, into the development process than would have been the case when all these thousand rural migrants would have stayed in their villages. These positive effects would be more evident among the 'second-generation' migrants, as they would from a young age on, have had more access to health and education and even employment, albeit in the informal sector, than their parents or kin in the rural areas, where unemployment and underemployment are problems for which solutions are even more difficult to find. It will be clear that in this school thought, there is no place for 'stemming-rural-exodus'

programs, which, it must be added, are internationally notorious for their failure.

### 3.. Implications of Rapid Population Growth

3.0.1. The rapid growth of population is affecting virtually every sector of social and economic life of the country. Its impact is exacerbated by the severe economic crisis the country is suffering from. Since 1986, not only is GDP per capita declining, but GDP is declining in absolute terms in Cameroon. This phenomenon is finds its origin in the first place in the economic crisis which struck the country suddenly. But it is also a simple matter of mathematics, that when the population is growing at 3 percent per annum, any growth in GNP, lower than 3 percent, will diminish per capita income. As indicated earlier, it is not likely that the population growth rate is coming down soon, even if fertility would start to diminish. [ironically, a profound economic crisis may cause mortality rates (especially infant and child mortality) to go up, which would cause the population growth rate to become lower. With a sharp decline in health expenditures per capita as witnessed in several Sub-Saharan countries, such a increase is quite possible.]

3.0.2. Crisis and demographic growth are also endangering the educational levels of the population. Net enrolment primary education rates for boys and girls are estimated at around 75 percent of the corresponding school-age population. Catering for the growing cohorts of potential school kids and at the same time closing the gap, to attain full enrolment, will be an especially difficult task.

3.0.3. Crisis and demographic growth is furthermore exposing the human resources and employment problems in a brutal manner: here again, growing cohorts (at some 250,000 per year) of young job-seekers who have ever more difficulty in finding an opening in the employment market on the one hand, growing contingents of adults, being dismissed because of the economic difficulties in enterprises and public services. [the 'parasol' secretaries in front of public buildings are showing that the 'informal sector' is not confined to manual labor only].

3.0.4. As a last example of the impact of demographic growth the case of food-security can be cited. Although food might appear to be abundant in Cameroon, for some it is not, or not of the right kind. The economic crises was partially caused by the sharp drop on the international markets of several agricultural export products; food production is not increasing rapidly enough to meet the future demands and self-sufficiency in food might be lost soon. (Annex 2)

3.0.5. In order not to further compromise the already endangered development goals, population growth has to be brought in balance with the country's real possibilities and resources.

#### 4. Checking Population Growth: The Issues

##### 4.1. Public and Private Support

4.1.1. Following the lead of the Head of State, Cameroon's Government is now consciously trying to curb population growth and to bring down the prevailing high fertility levels. The public at large is becoming more aware of the advantages of child spacing and family planning. Public and private services are starting to offer contraceptive advice and the means to practice contraception or child spacing.

4.1.2. The declaration of a national population policy becomes no a matter of urgency as all those in the private and the public sector have to join forces to attain Government's goal of checking population growth and thus fertility. There must be a clear Government's position, known to all and a institutional framework must exist within which, all organizations and institutions concerned with population activities, can find themselves with the knowledge of Government's decisive approval and backing. The institutions should be technically capable and receive clear mandates, within the context of a multi-sectoral national population strategy.

##### 4.2. Mortality and Fertility

4.2.1. Mortality: Population growth in Cameroon is determined only by fertility and mortality levels. The reduction of mortality is a common goal pursued by all. Success or failure depend largely on the quality and the coverage of medical services, especially of 'community based' primary health services, including concerted activities in health education. A decline in infant and child mortality, if not an absolute condition, plays a very important role in the acceptance of child spacing methods and in the decisions on family size.

4.2.2. Fertility: In order to bring the country's population growth in line its resources, a substantial decline in present very high fertility levels should take place and this in a reasonably short time to maximize its impact: the slower the decline, the higher the growth rate remains and the higher the ultimate population will be.

4.2.3. Determinants: There are several factors which determine fertility levels. In the literature these are known as the 'proximate determinants of fertility'<sup>8</sup>. They are seven: the marriage pattern, contraceptive prevalence and effectiveness, post-partum infecundability, induced abortion, sterility, spontaneous abortion and frequency (and timing) of intercourse. The first four of these factors exercise the greatest influence on fertility outcome.

4.2.4. Population programs will direct their attention to any, several or all of these proximate determinants to bring about changes in fertility behavior:

the legislator may change the law and raise the minimum age of marriage for boys and girls. In the case of countries like Cameroon, where that minimum age is established at fifteen years for girls, there would be good health reasons for putting the minimum at a higher age, as the World Health Organization now advises women not to become pregnant before the age of eighteen. Already twenty years ago, Ansley Coale demonstrated the enormous effect on the overall level of fertility, of raising by a couple of years the girl's minimum age at marriage. In Cameroon the mean age of girls at first marriage is low, at just over 20 years.

the future course of fertility will mainly depend on the contraceptive prevalence and effectiveness. This factor will be discussed below with more detail. Prevalence of modern contraception is low, probably not more than 5 %

postpartum infecundability is achieved by breastfeeding. Apart from sound health reasons, promoting breastfeeding will have a positive impact on birth intervals. Everywhere in Cameroon, the period of breastfeeding is becoming shorter. This has been one of the main reasons for a seriously suspected rise in fertility.

The incidence of induced abortions is high and rising in the cities, according to medical sources, but few data are available; a clear sign of unmet demand for contraceptive services. Combatting induced abortions, especially among young girls should form part of, and a reason for family planning programs.

<sup>8</sup> The pioneer in this field has been John Bongaerts of the Population Council, New York; see among others: Bongaerts, John, 1978, "A Framework for Analyzing the Proximate Determinants of Fertility", Population and Development Review, 4 (1) pp 105-132. see also: Bongaerts, J., O. Frank and R. Lestaeghe, 1984, "The Proximate Determinants of Fertility in Sub-Saharan Africa" Population and Development Review 10 (3) pp 511-538.

Sterility has been a problem of importance in Cameroon. According to medical sources it has much diminished since 1978, date of the national fertility survey; this would together with shortening breast feeding periods, be another factor causing an increase in fertility.

Spontaneous abortion is a medical and physical problem which in fertility surveys may be overestimated, as frequently, induced abortions are presented as having been 'spontaneous

The frequency of intercourse is having a minimal effect on fertility but the timing becomes a key element in the birth spacing 'natural' methods, which catholic missionary health services are offering.

#### 4.3. Activities directly influencing fertility

##### a) Access to contraception

4.3.1. The most important factor directly influencing fertility is contraceptive use and effectiveness. Although no recent data are available, it is generally accepted that the acceptance and practice of modern contraception is very low. Referring to the 12 years old data of the National Fertility Survey, a figure of 3 percent is often quoted but this percentage refers to all methods; the percentage regularly using modern methods was less than one percent.

4.3.2. The still high maternal mortality and the high incidence of induced abortions are indications of unmet demand. This unmet demand is likely to be higher in cities than in the countryside. The number of available services where contraceptive advice and means can be obtained, is still very low; Yaounde has four locations where such services are provided but a 'center pilot' foreseen for Douala has still not opened.

4.3.3. The demand for primary health services including (or specially?) MCH services in the rural areas is great but services have deteriorated and seem now to the point of having a serious credibility problem. Together with the low population density of most of the rural areas, family planning services do probably well by concentrating in a first phase, on the big cities and secondary towns, where because of the concentration of the population, the input would be more cost-effective.

##### b) the overall effectiveness of services

4.3.4. This problem is intimately related to the delivery of primary health services and MCH care. As long as the primary health

services are not operating as should reasonably be expected, to offer family planning services would be counterproductive. In addition, at the start of a national program, the country may benefit from the experience of other countries, so that some of the possible pitfalls can be avoided.

4.3.5. It has been the experience in other countries that the way a woman is received and treated is very important for her acceptance or continuation of contraception. Sometimes little attention is paid to the opening hours of the clinic, which may not be the most convenient ones for a particular group of women. The upkeep and maintenance of the facilities. Adequate and timely supervision should be assured and care taken that the local nurse or nurse-assistant is not burdened by the obligation of filling out detailed statistics on information which might be better and quicker be obtained by small check-spot surveys.

c) Increasing the demand for services.

4.3.6. Where activities for creating demand for family planning are concerned in Cameroon today, this seems to turn out a problem of sailing between Scilla and Charibdis: on the one hand there is the need to create a great demand for services so as to reach the goal of fertility reduction as quickly as possible. On the other hand there is the real danger of creating a demand, where there are no services to satisfy them.

4.3.7. To obviate this dilemma, one could think of nation wide IEC programs on methods, which do not need medical assistance, such as prolonged breastfeeding, or the use of condoms or of sex education programs in schools. Child spacing could form part of general health education activities, if they can be followed up. Different government institutions could make an important contribution by incorporating family planning in their extension programs such as programs for rural women. Enterprise medical services, should without exception, provide to their workers the information and the means to contraception.

4.3.8. However if specific targets are set for a certain level of contraceptive prevalence to be reached at a given time, the implications of such targets should be calculated in terms of acceptors, clinics, medical personal etc. and it should be decided whether those targets are realistic. A reduction of the current fertility rate by 50 percent by the year 2,000 as suggested by some, will be impossible to realize under the demographic and health conditions of Cameroon today.

4.4. Activities indirectly influencing fertility

4.4.1. Fertility levels seldom decline without a previous decline in infant mortality. Fortunately, infant mortality, although still high in Cameroon at about 94 per thousand, is declining.

Accepting for the moment UPP 's estimates of the CBR and CDR, some 457,000 babies were born in 1987 and some 148,000 people died. In the same year, 43,000 babies died before reaching their first birthday. This is 29 percent of all deaths in 1987. Again primary health services are the crucial condition for bringing down both: infant mortality as well as fertility. Therefore, in IEC activities family planning messages should be combined with health, especially child care messages.

4.4.2. Also maternal and child health are influenced by fertility behavior. Birth intervals are strongly correlated with infant mortality (annex 3). Child spacing will therefore have the double effect of improving the health of mothers and children and of reducing fertility. In the North of the country, apparently, still high levels of primary and secondary sterility exist. It is likely that this problem must be reduced before the ideas of child spacing or a limitation of family size would be generally acceptable; it might also be difficult to introduce the OMS norms of no pregnancies before 18 or after 35 years and have them accepted by the population.

4.4.3. Maternal mortality in Cameroon is about fifty times as high as in industrialized countries, indicating lack of prenatal care and medical assistance at birth. The age of the mother at the moment of giving birth, birth intervals and the number of live-born children are all related to maternal mortality. It is on these findings that OMS based its advise against having babies after the age of 35.

4.4.4. The dispersed rural population and the rapid increase in the target group population of children under five and women 15-49 years, makes the expansion and the improvement of services in quality-and efficiency, a particularly serious challenge to public and private health services. This target population is in the next ten years, increasing on average by some 150,000 women and children per year.

#### 4.5. Women in Development

4.5.1. The situation of women is an important indirect factor through which changes in fertility can operate. The correlations between level of education attained by women and the number of children they have, as well as the correlation between the number of children of a woman and her occupational status (especially for work outside the house) are well known.

4.5.2. In Cameroon, the enrolment in primary school is almost equal for girls as for boys, but girls are seriously lacking behind as of secondary education. Furthermore, drop-out rates for girls in primary education are higher than that for boys. Prolonged education for girls should push up the medium age at first marriage, with its known effects on fertility

4.5.3. In spite of the equality of the sexes guaranteed by the Constitution, women are legally and traditionally often in a situation of dependence. This should be a fruitful domain for investigation by lawyers and sociologists. The improvement in the status of women should make them more susceptible to changing attitudes towards child bearing and family formation.

4.5.4. Finally, the participation of women in the conception and execution of (community based) development programs and projects, should contribute to their full personal development and make them more conscious of alternative ways of performing their roles as individual, as spouse and as mother.

## 5.. The Institutional Framework; the Need for Coordination.

5.1. Cameroon counts many government and private institutions and organizations, which are addressing, some in a narrower others in a broader sense, the different population issues. Several international organizations are also engaged in population activities in the country. There is however, at present, a lack of coordination of all efforts displayed and not all who are doubtlessly making very useful contributions have the same views on how the problems should be solved.

5.2. The National Population Commission met, since its creation in 1985, just once, on which occasion a great variety of some 130 recommendations were formulated. The calculation of the financial implications for implementing these recommendations would have made an interesting and revealing exercise.

5.3. ~ During the intervening years, Government has sharpened its thinking about population problems affecting the country, ministerial structures have been modified, public opinion about population issues has developed and family planning services are more and more demanded and offered.

5.4. In the context of the Social Dimensions of Adjustment Project, signed between Government and the World Bank, Government commits itself to formulate a National Population Policy. This policy is now being drafted. Its adoption by Parliament should follow in a near future. In order for this policy not to remain a dead letter, a clear and decisive position, for all to be known, is needed from Government to assure an effective policy implementation in the pursuit of its objectives.

5.5. To be prepared for this moment, the time seems to have come to review the terms of reference of the National Population Commission and its Inter-Ministerial Committee, their composition and the periodicity of their being convened. Ministries which are not yet represented in these bodies and which should play a role in fostering Government's population policy, should be represented. Certainly the

time has also come for admitting in the Commission, the non-governmental organizations, religious groups and private sector institutions involved in the various population activities.

5.6. The Commission should make ample use of its prerogatives to establish ad-hoc sub-committees, to address specific aspects of the population problem, recognizing the expertise in various fields available in the country.

5.7. A great need for better coordination in the field of population is already felt. Not only should the different activities of a same kind, e.g. population communications, legal aspects of human reproduction, contraceptive services, sex education in schools, biomedical research be coordinated, but close links should be established between the different areas of action and research, especially between the family planning services and educational, research or other activities.

5.8. Finally, in its efforts to bring the present rapid population growth under control Government is assisted by many external donor agencies. Naturally, they do not all have the same vision on how best to solve the population problem. Government should therefore promote a regular exchange of ideas and experiences between national and international agencies to come to an effective coordination of all activities, ultimately pointing into one and the same direction. The National Population Commission and its President should play an assertive role here.

6.. Monitoring and Evaluation: the need for improved data collection and research in the population sciences.

6.1. The effectiveness of the population policy implementation requires a regular assessment of performances against the stated objectives. This is the more important as, in the first years, the implementation of the policy will meet with considerable constraints. The very first constraint is, that in spite of several sources of demographic information, there is no solid set of basic demographic parameters: in reality, the current level of fertility in the country is a matter of more or less considerate speculation; estimates range from a low 5.5 to a high 7.0, an enormous difference yielding widely varying population projections and making target setting, particularly in the context of a population policy, extremely hazardous.

6.2. The situation is aggravated by the fact that more than three years after a population census was taken, its results are not yet released. To assess the validity of basic demographic parameters, the results of the post-censal survey, conducted to evaluate the quality of the information collected and the degree of coverage, are of particular interest. These results are not available either. So

in fact, many for a population policy indispensable estimates come from the 1976 census and the national fertility survey, conducted in 1978. The rest of the available information is originated by partially complete statistical systems (only 50% of the hospitals send their data in) or ad-hoc (non-national) surveys.

6.3. There is fairly much demographic expertise available in the country and several institutions engage in demographic studies. Unfortunately, there seems to be little consultation or exchange of data and/or experience taking place, maybe because there is lack of a mechanism to foster such an exchange on a regular basis.

6.4. There clearly need for more solid basic demographic information, for coordination among institutions and experts and for data collecting systems which could provide information expediently and on a regular basis. The system of permanent household surveys being set up in the framework of the structural adjustment program, should also offer an opportunity for regularly collecting demographic information on the most important variables. Open discussions on and assessment of demographic analytical studies should take regularly take place with a broad participation of national experts, wherever they serve.

In the meantime, plans for a national 'Demographic and Health Survey', should be vigorously pursued. Finally, Government should prepare a five year Human Resources Training Needs Program, to continuously improve national demographic expertise.

6.5. Much attention should be given to the promotion of social sciences and other 'population' related research. The several institutions which have in the past proven their research capability: CUSS, ISH, CRED, IFORD as well as the Census department and the Statistical Office, should be commissioned with research projects to support population strategies.

Yaounde, 1990

ANNEX 1Cameroon: Population Projections 1990 - 2020

from different sources  
(in 000's)

Source:	1990	2000	2020
United Nations:			
Medium variant	11,245	14,787	24,016
high variant	11,245	14,854	26,044
World Bank:	12,000	16,702	27,653
MINPAT/UPP	11,500	15,404	26,128

Cameroon: Estimated Demographic Parameters

from different sources

Source:	TFR	CBR	CDR	e°	r
United Nations (1985/90)	5.79	41.8	15.8	51.0	2.60
World Bank (1990)	7.0	48.0	13.0	56.0	3.2
MINPAT/UPP (1987)	5.95	43.2	14.0	53.4	2.92

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Annex 2Nutrition and Food Production

## The State of Nutrition

The nutritional status of population depends of course on the availability of foods and on the diet composition. In the particular case of children, who do not decide on their own diet, above factors plus additional social and cultural characteristics of mainly their mothers, play a role.

For most, familiar with Cameroon, it is unthinkable that there could be a food shortage of any kind, at any time and the general conclusion is then that cases of mal-nutrition must be a) sporadic, b) occurring only among children, if at all, and c) exclusively due to poor habits of the mothers. Yet, the reality is quite different.

The 1978 national nutrition survey indicated that cases of malnutrition indeed do occur mostly among children: 22 percent of the rural and 19 percent of urban children between 3 months and 5 years old suffered from chronic malnutrition; malnutrition among mothers, as measured by low birth weight of babies, was about 20 percent. Male adults may escape the statistics and/or in reality: either because many surveys conducted to investigate the general state of nutrition of a population concentrate on the vulnerable groups of women and children, or, because societal and cultural norms reserve for the men (and often already for boys) a preferential treatment within the family, in respect to the quality and quantity of food they receive.

Like in the case of the level of fertility in Cameroon, the published data refer to 12 years back, when a national nutrition survey was conducted, on which most of the information on the state of nutrition in Cameroon are based.

The 1978 National Nutrition Survey found that the prevalence of chronic undernutrition among pre-school children was 21 percent although severe acute undernutrition, at 1.1 percent of all children seems not to indicate a problem. However, in several regions, more than 20 percent of all live-born children had a weight at birth of under 2,500 gram, indicating the mothers were undernourished<sup>9</sup>.

<sup>9</sup> Quoted from: The World Bank, 1987, Population, Health and Nutrition Sector Review.

Among the causes of infant mortality, classified by major groups, 'nutritional illnesses' came in third place in 1979 with 8 percent of all causes; infectious diseases caused over half of all infant deaths (57%) and respiratory diseases were the cause of 22% of infant deaths.

On the other hand, malnutrition appeared as one of the principal causes of child mortality. In 1979 it came in second place with 12 percent of all child deaths, after measles with 34 percent and before malaria with 10 percent<sup>10</sup>.

Some caution in using the figures is called for: in the first place: data refers to more than ten years ago; in the second place: they are based on hospital statistics which reflect only part of all the deaths occurring: many more children may have died from malnutrition outside a hospital and thus, are not reported in these statistics; and thirdly, only half of all hospitals were sending in their statistics.

#### Food Availability

A report prepared for the Ministry of Planning and Regional Development, indicates that present food self-sufficiency, at providing 96% of the total needs, is "precarious"<sup>11</sup>. Food production is not showing a noticeable increase: population does!

The annual growth in agricultural and food production diminished considerably as compared with the decade 1971-1980 when annual growth for both categories was close to 2 percent. In the first quinquennium of the 1980 's, annual growth dropped to half of one percent for agricultural output and to 0.6 percent per year for food production. Unless the annual growth rate of food production could be raised considerably and rapidly, the state of food self-sufficiency could quickly deteriorate.

<sup>10</sup> Dackam Ngatchou, Richard et alii., 1986, Survie et développement des enfants au Cameroun, a report prepared for Unicef.

<sup>11</sup> MINPAT, 1986, Plan alimentaire à long term

Annex 3.

Infant Mortality Rates by Birth Interval Since Last Surviving Child, around 1980; selected countries.

	< 2 years	2-4 years	4 years +
Benin	109.7	107.3	79.1
Cameroon	127.6	74.0	63.5
Ghana	98.9	57.8	44.0
Ivory Coast	110.7	106.6	67.1
Nigeria	97.6	71.3	45.7
Senegal	105.2	105.4	80.8

Source: Cochrane, S.H. and Samir M. Farid, 1989, Fertility in Sub-Saharan Africa, Analysis and Explanation, The World Bank Discussion Paper # 43, Washington D.C.; data taken from table 7.6

APPENDIX F

Descriptive Brochure of the Cameroon National  
Association for Family Welfare (CAMNAFAW)

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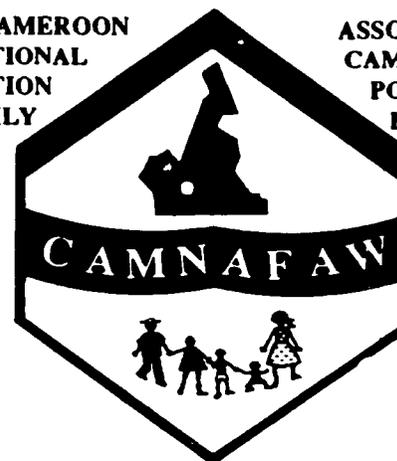


**A happy family is a  
Well planned Family**

**Plan wisely  
Choose freely  
Serve voluntarily**

**CAMNAFAW**

**CAMEROON  
NATIONAL  
ASSOCIATION  
FOR FAMILY  
WELFARE**



**ASSOCIATION  
CAMEROUNAISE  
POUR LE  
BIEN-ETRE  
FAMILIAL**

**Immeuble EX-SOCADA  
Rue du Cinéma le CAPITAL  
B.P. 11994 - Yaoundé  
Tel: 22-03-04/**

**Une famille heureuse est une  
Famille bien planifiée**

**Planifier sagement  
Choisir librement  
Servir volontairement**

**CAMNAFAW**

1st President and Founding Member of CAMNAFAW.

... Therefore the well being of the family especially that of its main pillars the

father and mother is essential for the optimal development of its members and by extension the whole family."

*Prof. B.T. NASAH*



**PROF. B. T. NASAH**

1er Président et Membre Fondateur de la CAMNAFAW.

... Ainsi, le Bien-Etre de la famille, surtout celui des piliers, à savoir le père et la mère est essentiel pour un développement optimum de ses

members et par extension, de la famille tout entière.

*Prof. B.T. NASAH*

## HOW DOES CAMNAFAW FUNCTION?

CAMNAFAW is composed of voluntary members out of which a body of members is elected every two years. An Executive Committee (EXCO) comprising:

- 1 President and Vice
- 1 Secretary General and Assistant
- 1 Treasurer and Assistant
- 6 Advisers.

This EXCO meets once a month to monitor the execution of their activities and to make necessary decisions such as recruitment and training of personnel.

The General Assembly is held every two years.

The Secretariat is manned by permanent paid staff who are responsible for running the daily activities of the Association. Our Secretariat Head Quarters is presently in Yaounde.

## COMMENT FONCTIONNE LA CAMNAFAW?

Notre Association est composée des membres volontaires qui élisent tous les deux ans parmi eux un Bureau Exécutif comprenant:

- 1 Président et son Vice
- 1 Secrétaire Général et son Adjoint
- 1 Trésorier et son Adjoint
- 6 Conseillers.

Le Bureau Exécutif se réunit une fois par mois. Il prend des décisions et s'enquiert de leur exécution et de la situation d'avancement des activités de l'Association.

Le Secrétaire Général convoque l'assemblée générale tous les deux ans.

Le Secrétariat de l'Association est assuré par un staff salarié et permanent qui est responsable de la réalisation des activités courantes de l'Association. Le siège actuel de l'Association se trouve à Yaoundé.