

PD-ABS-510

Jan 90740

Submitted to:

AID/Office of Population  
Family Planning Services Division  
Rosslyn, Virginia

**PRELIMINARY COUNTRY ASSESSMENT**

**CAMEROON**

**October 30-November 3, 1989**

Prepared by:

Gael O'Sullivan  
Faustin Yao  
SOMARC/The Futures Group  
1101 14th Street, N.W.  
Washington, D.C. 20005

Under Contract No. USAID/DPE-3051-Z-00-8043-00

## CONTENTS

I.	EXECUTIVE SUMMARY .....	1
II.	COUNTRY SITUATION .....	3
III.	OBJECTIVES .....	8
IV.	PUBLIC SECTOR CONTACTS .....	9
V.	NGO CONTACTS .....	12
VI.	PRIVATE SECTOR CONTACTS .....	16
VII.	CURRENT MARKET SITUATION AND INFRASTRUCTURE FOR A SOCIAL MARKETING PROJECT .....	19
VIII.	PROGRAM CONSTRAINTS .....	28
IX.	CONCLUSIONS AND NEXT STEPS .....	30

### APPENDICES

- A. List of Persons Contacted
- B. Schedule of Cost for TV Advertising
- B. List of Languages in Cameroon
- D. Schedule of Costs for Radio Advertising

## I. EXECUTIVE SUMMARY

A SOMARC/Futures Group team composed of Africa Deputy Managers Gael O'Sullivan and Faustin Yao visited Cameroon from October 22 to November 3, 1989. During the first week of the visit, the team attended the WHO-sponsored conference on AIDS Information, Education and Communication. The second week of the visit was focused on assessing the potential for a SOMARC/TFG project in Cameroon.

The team's objectives for this preliminary assessment included: (1) determining the Government of Cameroon's (GOC) interest in implementing a social marketing project; (2) examining current family planning service delivery efforts; and (3) assessing the private sector skills and resources required to implement a contraceptive social marketing (CSM) project.

All the officials contacted in the Ministry of Health (MOH) expressed strong interest in a CSM program for Cameroon. In addition, the MOH requested that the team examine the feasibility of adding maternal and child health (MCH) products such as anti-malarials and oral rehydration salts (ORS) to the project.

Current family planning service delivery efforts in Cameroon are minimal; the MOH has only recently focused on providing contraceptives through its clinics. Similarly, in the non-governmental organization (NGO) sector, there are very few programs promoting family planning.

The private sector, through approximately 175 pharmacies, offers a wide range of condoms, spermicides, orals, IUDs and injectables, but prices are high for the average low-income consumer and sales are limited. The private sector is relatively sophisticated in terms of distribution and promotion. It appears that the necessary marketing infrastructure and resources exist for a CSM project in Cameroon.

A number of potential program constraints were identified, including: low awareness and use of contraceptive methods (1-2 percent estimated prevalence); strong influence of the Catholic and Muslim authorities; weak purchasing power among the program's target market; advertising and tax policies of the government; and low level of knowledge among retailers concerning correct use of different contraceptive methods.

Despite these potential constraints, the team feels that on the whole the market potential in Cameroon is promising and recommends that SOMARC/TFG return to Cameroon in early 1990 to conduct a more in-depth assessment and to propose a project design model including contraceptives and MCH products. With the GOC's support for social marketing, a sophisticated private sector, and significant unmet need (per 1978 fertility survey), it appears that a social marketing project could assist the GOC in achieving its health and population goals.

## **II. COUNTRY SITUATION**

### **Background**

Cameroon is a country of 11 million people, with both Anglophone and Francophone regions due to its colonial ties to the British and the French. The country is divided into ten provinces, and further divided into departments and then arrondissements at the local level (see Figure 1).

Cameroon is a large country, covering 476,000 square kilometers. The north is semi-desert, and includes the vast Maroua plain. Further south and to the west are the savannah uplands--the Ndop plain and the Bamenda grasslands area. To the east and south is a dense, fertile forest area; almost one-half of the country is covered by forest, but only about one-third of this is exploited. In the coastal area crops such as cocoa, coffee, and rubber are cultivated. Thanks to a network of rivers and estuaries, a hydro-electric power infrastructure exists which provides an impetus for industrial growth.

### **Economy**

The backbone of the economy remains agricultural products, however, and about 70 percent of the labor force worked in the agricultural sector as of 1980. Cocoa and coffee account for approximately 65 percent of total exports, although cotton, tobacco, rubber and timber are also important. Cameroon enjoyed a positive balance-of-payments situation until 1983, with an average annual growth rate of 5-7 percent from the mid-1970s until 1982. While Cameroon has suffered severe economic setbacks over the past few years due to the collapse in world prices for oil, coffee and cocoa, the Cameroonian economy remains stronger than in many neighboring countries. This is due in part to its natural resources, which include bauxite, iron, timber, oil and natural gas. Cameroon's food production has been rising faster than population growth, despite the setbacks caused by the droughts of the 70s and early 80s, and the country is close to self-sufficiency in food.

The industrial sector is assuming greater importance and there are a number of manufacturing efforts underway. In addition, the Government of Cameroon is currently negotiating with the donor community to establish a duty-free zone in Douala.



The per capita GNP in 1987, according to the 1989 PRB Data Sheet, was \$960. However, the economic situation has deteriorated significantly over the past two years due to the problems noted above. Inflation averaged 11.8 percent per year between 1980 and 1985.

### **Political Situation**

Cameroon's colonial history includes being ruled by Germany until World War I. Then the country was divided and ruled separately by Britain and France under the mandate system of the League of Nations. In 1945, each part became a Trust Territory under the supervision of the United Nations.

An anti-colonial unification movement developed in French Cameroon in the 1950s under the Union des Populations du Cameroun (UPC). When the French handed over power at independence in 1960 to the Head of State, El Hadj Ahmadou Ahidjo and his Union Camerounaise, the UPC actively opposed the new government and there was open rebellion in the west of the country. After suppressing this uprising with the help of the French, Ahidjo focused on unifying the French and British parts of Cameroon.

British Cameroon was being administered as a part of Nigeria, and in a 1960 referendum the northern part of British Cameroon voted to remain in Nigeria, while the southern part agreed to federate with the Francophone Republic of Cameroon. The country continued as a federation with domination by the Francophone region until 1972. Then, in another referendum, the population voted to create a single state called the United Republic of Cameroon.

In 1982 Ahidjo resigned and handed the presidency over to his deputy Paul Biya, who continues to rule the country.

Yaoundé, the capital, serves as the government and administrative center of the country, while Douala, with its seaport, continues to serve as the most important commercial center in Cameroon.

## **Social Situation**

The Cameroonians are a very diverse people, with some 130 different ethnic groups included in the population. The Semitic groups in the north (Arab, Chadic and Foulbe) are mostly Muslim, although the majority of the people in the north are non-Muslim and collectively are known as Kirdi. Other ethnic groups include the Bantu, the pygmies, Bassa and Pahouin-Beti. While French and English are the official languages, there also are about 19 local languages commonly used, especially Pidgin.

The population is distributed unevenly, with concentrations in the west, the south-central region and the savannah zone in the north. There is a fair amount of migration from the rural to urban areas, with approximately 42 percent of the 1989 population considered urban and about 58 percent rural. The Anglophone region in the North-West and South-West accounts for about one-fifth of the population and one-tenth of the surface area of the country, while the Francophone area dominates the rest of the country.

Besides Islam, other major religions in Cameroon include Catholicism, a variety of Protestant religions (such as Presbyterian and Baptist) and traditional religions such as Animism. The Islamic influence is strongest in the north, and the Protestant churches are very strong in the Anglophone western regions. Catholicism is widely practiced throughout the country.

Cameroon's population is increasing at a rate of 2.6 percent annually, which means that by the year 2000 Cameroon will have 14.5 million inhabitants. By the year 2020, the population is expected to reach 23.5 million. Life expectancy at birth is approximately 50 years.

As of 1987, there were about 1.7 million women of reproductive age in Cameroon. Literacy for women aged 15 and older reached 55 percent as of 1985, while the comparable rate for men was 68 percent.

Maternal and child health issues are considered a priority within the Ministry of Health, and there are a number of efforts currently underway to combat the major causes of infant and child mortality, such as diarrhea and malaria. Infant mortality is relatively high at about 128 per 1,000, with the largest proportion of deaths occurring when the mother is either under 20 or over 40.

Infant mortality rates are higher among unmarried women than married women, and are also higher among women in polygamous rather than monogamous unions.

The last fertility survey was conducted in 1978 and there is little recent data on the demographic and family planning situation in the country. A DHS survey is planned for 1990, however, which should provide a comprehensive update in this area.

The 1978 survey showed that on average, women marry at about 17 years of age, with an even lower average of 15 in many of the Muslim areas. The average number of children desired by a woman during her lifetime is 8, while fertility is 5.9. About 16.5 percent of all births occur among women under 20, and another 16.8 percent occur among women over 35 years of age. The average interval between births is 2.5 years and increases as a woman becomes older.

As far as contraception is concerned, 28.8 percent of the women surveyed in 1978 knew of a modern method and fewer than 3 percent were current users of either a modern or traditional method. The rates of knowledge and use are much higher among women with at least a secondary education, and among women living in urban areas. Catholics and Protestants also had higher knowledge and use rates than Muslims and Animists.

The methods with the highest rates of awareness were the pill (21 percent), periodic abstinence (21 percent), the IUD (19 percent), condoms (14 percent) and withdrawal (14 percent). Among users of modern methods, the pill and the condom were cited most often.

One of the most important findings of the 1978 survey in terms of the implications for social marketing in Cameroon is that 75 percent of the women surveyed expressed a desire to receive more information about ways to plan their families. The goal of most women is to space rather than limit births.

### **III. OBJECTIVES**

Staff members Gael O'Sullivan and Faustin Yao of SOMARC/TFG visited Cameroon from October 22 to November 3, 1989. During the first week of the trip, the team attended the WHO-sponsored conference on AIDS Information, Education and Communication.

The second half of the visit was focused on assessing the potential for a SOMARC/TFG project in Cameroon. Because of the team's one-week time constraint, the main objective of this visit was to conduct a preliminary assessment for a social marketing project. A second SOMARC/TFG visit will be planned to conduct an in-depth feasibility study if the recommendations in this report are accepted by USAID/Yaoundé and the Government of Cameroon.

Specifically, the team's objectives were to:

- o Assess the level of interest in the MOH for social marketing of contraceptives and MCH products
- o Examine the current level of effort through public sector family planning service delivery mechanisms
- o Contact all relevant NGOs to learn about their programs and identify potential areas of collaboration
- o Examine the private pharmaceutical sector to identify potential management and distribution organizations and to assess the marketing environment for contraceptive products.

#### **IV. PUBLIC SECTOR CONTACTS**

##### **A. Government of Cameroon (GOC)**

The SOMARC/TFG team met with a number of officials at the Ministry of Health (MOH), including Professor Lazare KAPTUE, Inspector General of Health (in effect, third highest ranking official of the MOH) and President of the National Committee on AIDS Prevention. The team discussed the official position of the MOH regarding family planning in general and the potential role of social marketing in particular. The MOH expressed a strong interest in examining the feasibility of social marketing for both family planning and MCH promotion.

##### **B. GOC Official Policy**

Until recently, the GOC has openly advocated a pronatalist population policy. There is no policy intervention to reduce the rates of population growth and fertility. The GOC's view is that authoritarian and artificial measures to limit births are inefficient and the population problems need to be addressed within the framework of socioeconomic development. Population growth and size are therefore expected to be indirectly affected by activities to reduce morbidity and mortality. The official policy aims to educate individuals to make responsible decisions regarding the size of their family. Agencies and individuals can practice family planning/child spacing within the general framework of responsible parenthood. In other words, family planning/child spacing is acceptable and may be encouraged within the context of maternal and child care, for health and welfare purposes.

Recently, however, a combination of factors such as the general economic crisis, which has reduced the country's resources, and the pressure of donor agencies and countries have somewhat altered the official position. A national population policy is currently being drafted which will recognize the importance of active family planning/child spacing. An indication of that openness is that in 1983, the GOC opened a pilot family planning clinic in Yaoundé, and Responsible Parenthood is coined as the official philosophy within which family planning must be practiced. This philosophy has a number of implications. First, as in many African countries, it precludes the very idea of family size limitation. Second, it means that although child spacing is an acceptable policy, it must

be practiced within a family environment. Family planning messages must therefore be carefully designed and targeted toward couples (legally married or in some form of socially approved union).

### C. Family Planning Activities

Understandably, the official position of the GOC has had an adverse effect on the development of family planning activities in the country. Public sector family planning activities are exclusively confined to maternal and child health clinics in large cities and at the University Teaching Hospital for clinical cases. In this context, family planning is not an activity per se. Women and sometimes couples are informed about contraception and the availability of contraceptive methods when they come to the health centers for other reasons such as pregnancy surveillance, child health care, child immunization, etc. There is therefore no active and large-scale information campaign.

The MOH has just started a 3-year project financed by UNFPA involving four Maternal/Child Health centers in Yaoundé, including the PMI Centrale. The goal is to reach 800 acceptors in each of the four pilot centers each year, all methods combined (pills, IUD and injectables). At the PMI Centrale, for the first three months of the project for which data are available, the result is as follows:

Methods(a)	August 89	September	October	Total
Pills(b)	10	11	7	28
IUD(c)	10	2	1	13
Injectable(d)	12	12	13	37

#### Notes

(a) Excluding condom and spermicide users

(b) Pills are: Femenol, Trinordiol, Triella

(c) IUDs: CuT 200, CuT 220, CuT 380 A

(d) Injectable: Depo-Provera, Noristerat

The UNFPA project will have a youth-oriented IEC component, partly in response to the growing problem of teenage and school children pregnancies. However, it is unclear what form this IEC activity will take.

#### **D. Policy Issues**

It appears that, while donated contraceptives may be sold commercially, there may be some taxes and duties that would apply. The MOH suggested that these issues be explored with the Ministry of Commerce. Any pricing restrictions would also be enforced through commerce. Government policies on advertising indicate that brand advertising of nonprescription products is permissible; it is unclear whether a generic campaign promoting orals, for example, would be allowed.

#### **E. Contraceptive Social Marketing Potential**

From the GOC official point of view, a contraceptive social marketing program will be a welcome proposition and will most likely meet with official approval. First, the government is currently drafting a national population policy that will acknowledge the importance of child spacing/family planning in the social and economic development process. Child spacing is viewed as a strong contributor to social welfare. Second, with the country facing an economic crisis, like many other countries, the government's financial resources for health delivery systems are strained. Therefore, any effort to supplement government actions is welcome, especially if the project is designed as a cost-recovery scheme operating through private sector initiative, which seems to be the new orientation. Third, a social marketing program has already been approved in the country for condom promotion to prevent the spread of AIDS. The official position in that respect is that the Cameroonian market is large enough to accommodate more than one social marketing program. Furthermore, contrary to the social marketing program now operating in the country in the two major urban centers, the SOMARC project will potentially be national in scope and will involve more than condoms, to include a larger contraceptive mix and possibly MCH products. Finally, another social marketing program will greatly enhance the national AIDS prevention campaign and supplement GOC efforts in this area even if the social marketing condom is positioned essentially as a child spacing product.

## V. NGO CONTACTS

- A. The International Planned Parenthood Federation (IPPF) has developed a project paper in 1989 and a national Family Planning Association (CAMNAFAW) has been created. An executive committee of the Association has been set up but no family planning activity has actually taken place.
- B. Different church groups organize family planning activities in church-operated hospitals. The Presbyterian Church organizes family planning activities at the Djungolo Hospital in Yaoundé, and at the Bafia and Mbalmayo hospitals. The Djungolo Hospital has the most elaborate program. It started as an FPIA project in 1980, with FPIA providing products, training, personnel, salary and equipment. The project has reached about 2,000 clients, including about 45 percent pill users, 40 percent IUD users and 15 percent users of other methods. The Djungolo program organizes daily counseling sessions on its premises and 2-3 times a week outside of the hospital. The sessions involve an average of 20-25 persons each time. Patrons are mostly women but the Djungolo Hospital strongly promotes male involvement, to the extent that many of the sessions actually involve couples. An effort is also being made to involve social workers of the Ministry of Youth and Sports with the objective of reaching both in- and out-of-school youths.
- The Presbyterian Church organizes similar activities in other cities such as Bafia and Mbalmayo, where an average of 30 new clients turn up every month in each city. Apart from the pill (CFA F 300/3 cycles) and the IUD (CFA F 1,000), all other contraceptive products are distributed free of charge. It is interesting to note that according to the manager of the Djungolo program, the majority of clients say they use the facilities not primarily for health reasons but rather for economic reasons.
- C. Save the Children Federation Inc. has initiated three primary health care projects in Cameroon (East, Center and North). With the Population Council, Save the Children has already trained 47 traditional birth attendants who have been provided with first-aid kits. There are plans to train more TBAs and nurses in contraceptive technology and in IEC. In the North and Center, traditional birth attendants have been trained in community-based distribution of family health products. Given its strong community mobilization approach and the prospect

of consolidating its CBD and training components, Save the Children could be a strong partner for the Cameroon social marketing project in promoting community marketing. Through its network of trained traditional birth attendants and nurses, the program could reach large areas with nonprescriptive products including MCH products, and even oral contraceptives in some limited cases through certified nurses trained by the program. Save the Children, like many NGOs operating in the rural areas, has a wealth of experience in health promotion using simple but efficient IEC materials and interpersonal communication. This experience could be useful especially in the early phases of the project to launch a generic family planning campaign to motivate the rural population.

- D. CARE International has initiated projects in the extreme north and the east of the country. The thrust of its action is child survival with a strong nutrition emphasis. The organization has produced very elaborate health promotion IEC materials with a very strong interpersonal component. CARE's action is usually based on ethnographic studies which helps the organization to understand the local communities before devising the educational materials and determining the best ways of approaching the local population.

Even though CARE's activities do not include family planning and child spacing, the organization could be a good collaborating agency, should a Cameroon social marketing program decide to include MCH products in the product mix.

- E. The USAID-funded SESA (Santé Infantile dans le Sud et l'Adamaou) project has five different components: oral rehydration therapy, nutrition, malaria prevention, immunization (EPI) and child spacing. The goal of the child spacing component is to provide information and contraceptive products to patients. According to the program officer, however, the child spacing component has been less successful than initially planned. Distribution data were unavailable to the team; however, the following are levels of stock of USAID-donated products at the time of the visit:

OC:	Lo Femenal	3,600	cycles
VFT:	Conceptrol	14,400	units
IUD:	CuT 380 A	200	units
CONDOM:	Sultan	24,000	units

The SESA project, which started in January 1989, operates three offices in Yaoundé, Ngaoundéré and Ebolowa. The project is planning to extend over 20 pilot zones in the two provinces it covers with an integrated health intervention orientation. It also is planning to introduce a cost recovery scheme in its operation by selling its products. In addition, the project is also planning to step up its family planning components by training between 15 and 20 medical doctors and a number of nurses to provide family planning services, including IUD insertion, with the help of JHPIEGO. In keeping with the GOC's official orientation, the project is not contemplating active promotion of family planning.

The training and cost recovery aspects of SESA's family planning component make the project a potentially important collaborating agency for a Cameroon Social Marketing Project. That collaboration will be even more interesting should the project decide to include MCH products such as ORS, anti-malaria products and even weaning foods.

- F. Ad Lucem is a Catholic-based NGO that distributes pharmaceutical products in a number of African countries. Since Ad Lucem buys its products in large quantities from France, Belgium and West Germany, and because it is a nonprofit organization, Ad Lucem is able to sell its pharmaceutical products at the lowest prices in Cameroon. The NGO sells its products to church-related health clinics, hospitals and other health centers. AD LUCEM operates warehouses in Bali and Douala and employs four pharmacists.
- G. Pritech is a USAID-funded effort under the MOH to combat diarrheal disease. Cameroon has been implementing a national level effort for several years to reduce mortality and morbidity through the proper use of diarrheal medicines, proper case management and proper treatment at home.

One of the main objectives of the Pritech project is to improve the availability of ORS in the private sector. Several studies have examined possibilities for local production of ORS, but to-date product is only available in the private sector through Ad Lucem. UNICEF provides the ORS used in the public sector, and continuity of supply has been a problem.

A national media campaign has recently been developed for the diarrheal disease program, and the information to be given on ORS will be very general since it is not guaranteed that

consumers will have access to the product. It appears that a social marketing program that includes ORS could help alleviate this supply and accessibility problem, and the next SOMARC/TFG visit should explore this area further.

- H. The Institut de Formation et de Recherche en Démographie (IFORD) is an intergovernmental training and research institute in demography for western and central Francophone African countries. The institute has extensive experience in large-scale national level demographic research as well as specific topical research in population issues (fertility surveys, migration studies, etc.). The institute has seven professionals (demographers, statisticians, sociologists) who are lecturers and researchers and a large student body trained in field research which can be used for surveys as research assistants. At the time of the team's visit, the institute was being equipped with new computer facilities which should enhance its research capabilities. However, it does not appear from discussions the team had that the institute has much experience in qualitative research such as focus group studies.

## **VI. PRIVATE SECTOR CONTACTS**

The SOMARC/TFG team met with the four largest pharmaceutical wholesalers in Cameroon: Laborex, Campharm, GPC and Pharmacam.

### **A. Laborex**

This is the oldest and largest importer and distributor of pharmaceutical products in Cameroon. Laborex is a locally owned subsidiary of a multinational firm based in Paris. Additional Laborex subsidiaries are located in the Congo, Gabon, Cote d'Ivoire, and Senegal.

In Cameroon, Laborex's headquarters are in Douala, with satellite offices in Yaoundé, Garoua and Bafoussam. While the team was unable to meet with the Managing Director, M. Michel Philippe, SOMARC/TFG did meet with the Deputy Director of the Yaoundé office, M. Raymond Azegue.

Laborex, like the other pharmaceutical wholesalers, imports its products directly from France. The firm does not manufacture any products of its own. Likewise, the company has no exclusive distribution arrangements for any contraceptive products; all the leading wholesalers carry similar products. Laborex's scope of activities is limited to importing and distributing products to all the pharmacies in Cameroon. Additional clients include some of the private mission hospitals and clinics.

Laborex has a staff of 'telephonistes' who call all the pharmacies each day to take orders. Orders also can be placed by either calling or coming to the Laborex office. Deliveries are usually made the same day an order is placed, using the firm's fleet of trucks. There is no charge for delivery within the major cities. In the rural areas, pharmacy owners usually come to the nearest Laborex warehouse to pick up their orders.

Hundreds of different products are promoted through the Laborex network, and in the contraceptive area the firm sells a number of condoms, spermicides, orals, IUDs and injectables. An important advantage exists for Laborex and the other firms in this market in that they can buy their products from France using the CFA, the local currency, which is tied to the French franc.

Therefore, the foreign exchange constraints which often exist in other markets do not apply in Cameroon for French products.

### **B. Campharm**

This is a new firm founded in 1987 in Douala. Campharm recently opened a second office in Yaounde, and future plans include expanding to other parts of the country as well. Campharm is 90 percent Cameroonian-owned, with 10 percent of the company owned by British interests.

According to the Director of the Yaounde office, M. Auguste Tameze, Campharm is second in volume of sales behind Laborex. The Campharm network covers about 65 pharmacies in the Douala area and about 45 pharmacies in the Yaounde region.

Campharm follows many of the same practices as Laborex in that the firm imports products from France and wholesales to pharmacies and some mission hospitals. Campharm does not manufacture, nor does it represent any international drug companies. It has a similar telephonist system for ordering and uses its own vehicles for product delivery. All the ordering procedures are computerized. The standard payment system allows 30 days credit, except in the case of clients who pay COD due to credit problems.

Campharm sells a wide range of ethical and para-pharmaceutical products, and its contraceptive line includes orals, condoms, spermicides, IUDs and injectables. The best-selling products are Stediril pills (Wyeth), Manix Futur condoms (6-pack, from Laboratoire Degan), and Polygnax vaginal caps (6-pack, from Innotech).

### **C. GPC (Groupement des Pharmaciens Camerounais)**

This firm is owned by a group of Cameroonian pharmacists and has its headquarters in Douala. Additional offices are located in Bamenda, Yaoundé and Ngoundéré. The SOMARC/TFG team met with Mme. Félicité Edimou, the head of purchasing in Douala, and also met Mme. Grace Ekeki, the Managing Director.

GPC operates much in the same manner as Laborex or Campharm. The company imports products directly from France and distributes to pharmacies and hospitals via its own fleet of trucks. Its ordering system is computerized.

Like the other distributors, GPC carries many ethical and para-pharmaceutical products. Its best-selling contraceptives are Stediril pills (Wyeth), Supratex condoms (12-pack, from Group Pil), and Pharmatex ovules (10-pack).

#### **D. Pharmacam**

Pharmacam is a two-year old Cameroonian-owned firm. The company is reportedly experiencing some financial difficulties and therefore is not performing as well as its competitors.

The SOMARC/TFG team met with the Marketing Director in the Douala office, Dr. Pierre Sopngui. Pharmacam also has offices in Maroua and Bafoussam, and its headquarters are located in Yaoundé.

Again, Pharmacam operates like the others in terms of importing and distributing products, and does not manufacture or represent specific drug companies. Pharmacam's product line includes a number of different orals, condoms, spermicides and IUDs. In addition to supplying pharmacies, the firm also sells to the Regie National des Chemins de Fer, the national railroad authority.

## **VII. CURRENT MARKET SITUATION AND INFRASTRUCTURE FOR A SOCIAL MARKETING PROJECT**

There are no recent studies that provide information about the potential target market for a social marketing program in Cameroon. Nevertheless, it is estimated that there is 1-2 percent prevalence of modern contraceptive methods, and the SOMARC/TFG team was able to obtain some sales estimates from the private pharmaceutical sector. These data indicate that the total size of the current contraceptive market might include annual sales of 50,000 cycles of oral contraceptives and 500,000 units of condoms.

To better define the target market for a SOMARC project, during the next SOMARC/TFG visit the team will work with existing data to arrive at estimates of the number of married women of reproductive age who are currently not contracepting but who would like to either delay or prevent future pregnancies. In addition, SOMARC programs typically reach low-income women in urban and semi-urban areas.

The scope of this visit covered contraceptives only, and during the next SOMARC/TFG trip the team will also examine the current situation and market opportunities for the social marketing of MCH products such as ORS, chloroquine and weaning foods.

### **A. Products**

Cameroon follows many of the same regulatory practices as other Francophone countries in controlling the importation and pricing of pharmaceutical products. In general, the market is heavily regulated by the government.

The SOMARC/TFG team met with Dr. Moustapha Thomas Lapnet, Pharmacy Director at the Ministry of Health, who has recently been appointed to this post after an internal reorganization of the MOH. Dr. Lapnet explained that, to introduce a new contraceptive product, the manufacturer must submit a technical dossier requesting approval from the MOH. The Ministry of Commerce and Industry is responsible for assigning a price, and Dr. Lapnet indicated that contraceptives may be exempt from taxes.

According to Dr. Lapnet, donated contraceptives could be sold commercially, but the intent to sell must be clearly noted on all documentation. If the SOMARC program were to sell donated goods, Dr. Lapnet suggested that the program obtain a letter from the MOH stating that the products meet the highest standards for quality assurance. This is especially important because of concerns in that past that donated condoms have not met high-quality specifications. Dr. Lapnet is unaware of any laws prohibiting brand advertising of para-pharmaceutical products, but indicated that advertising of ethical products is not allowed in the mass media.

The following is an illustrative listing of the best-selling products in the market. Most products are imported from France; there are few U.S. products in the market. The pricing scheme and manufacturer/distributor are also indicated. It should be noted that prices of the same product sometimes vary by distributor, especially when stockouts occur, which happens quite often.

As part of the next SOMARC/TFG visit, the team will investigate the possibility of working with some of these existing brands versus using USAID-donated goods in the project.

To convert the following prices to U.S. dollars, an estimate of 6 French francs to the dollar and 310 CFA to the dollar should be used.

### 1. Oral Contraceptives

<u>Manufacturer/Brand</u>	<u>Price to Wholesaler</u>	<u>Price to Retailer</u>	<u>Price to Consumer</u>
<u>Wyeth</u>			
Stediril - 21 pack	4.16 FF	286 CFA	415 CFA
Stediril - 3 cycles	10.15 FF	693 CFA	1,010 CFA
Minidril - 21 pack	4.39 FF	305 CFA	445 CFA
Minidril - 3 cycles	10.32 FF	706 CFA	1,030 CFA
Adepal - 21 pack	285 CFA	354 CFA	515 CFA
Adepal - 3 cycles	708 CFA	885 CFA	1,290 CFA
Trinordial - 21 pack	300 CFA	363 CFA	530 CFA
Trinordial - 3 cycles	743 CFA	928 CFA	1,355 CFA

<u>Manufacturer/Brand</u>	<u>Price to Wholesaler</u>	<u>Price to Retailer</u>	<u>Price to Consumer</u>
<u>Schering</u>			
Miniphase - 21 pack	6.85 FF	468 CFA	685 CFA
Miniphase - 3 cycles	15.99 FF	1,089 CFA	1,590 CFA
Millianovlar - 21 pack	3.80 FF	259 CFA	380 CFA
Millianovlar - 3 cycles	6.81 FF	470 CFA	685 CFA

## 2. Condoms

### Group Pil

Supratex - 12 pack	15.41 FF	1,608 CFA	1,850 CFA
Supratex - 6 pack	7.09 FF	741 CFA	855 CFA

### Innotech

Innotex - 12 pack	16.38 FF	1,706 CFA	1,965 CFA
Innotex - 3 pack	4.71 FF	489 CFA	560 CFA

### Eyis

Maximum - 3 pack	3.00 FF	378 CFA	435 CFA
------------------	---------	---------	---------

### Degan

Manix Contact - 12 pack	1,016 CFA	1,230 CFA	1,475 CFA
Manix Futur - 6 pack	601 CFA	727 CFA	870 CFA
Manix Futur - 12 pack	1,202 CFA	1,454 CFA	1,740 CFA

## 3. IUDs

### Schering

Nova-T	5,179 CFA	6,266 CFA	7,510 CFA
CopperT-200	3,937 CFA	6,063 CFA	7,265 CFA

#### 4. Spermicides

<u>Manufacturer/Brand</u>	<u>Price to Wholesaler</u>	<u>Price to Retailer</u>	<u>Price to Consumer</u>
<u>Pharmalac</u>			
Pharmatex -			
12 Comprimes	24.48 FF	1,657 CFA	2,415 CFA
Cream	21.25 FF	1,475 CFA	2,150 CFA
10 Ovules	22.57 FF	1,530 CFA	2,230 CFA
20 Ovules	39.50 FF	2,679 CFA	3,970 CFA

#### 5. Injectables

##### Upjohn/Belgium

Depo-Provera	944 CFA	1,083 CFA	1,580 CFA
--------------	---------	-----------	-----------

##### Schering/Germany

Noristerat	1,182 CFA	1,476 CFA	2,152 CFA
------------	-----------	-----------	-----------

In addition to the above products, there is a new condom called Prudence being sold commercially as part of the national AIDS prevention program. This is the Sultan Non-oxynol 9 product which is sold in packs of 4 for 50 CFA (US\$0.16). According to PSI, the project implementing agency, 200,000 units were sold during the launch month in October, and another 200,000 units were sold during the first half of November. The program's first-year sales goal is to sell between 1 million and 1.5 million condoms. The project is initially focusing on Douala and Yaounde, with distribution to pharmacies, bars, nightclubs and hotels. Promotional activities include point-of-purchase materials and consumer giveaways such as t-shirts and key chains. The target market consists primarily of high-risk groups such as prostitutes and their clients, STD patients, transport workers and bar personnel.

#### B. Pricing

The average price to the consumer for a cycle of pills is \$1-2, and the average unit price for a condom is about \$.45. Condoms are mostly sold in 6 and 12 packs, however, thus the cost to the

consumer totals about \$2.70 for a 6-pack and \$5.40 for a 12-pack. Spermicides are relatively expensive, at about \$6.50 for a box of ten. IUDs are very expensive, with retail prices averaging \$20-25. The markups at the wholesale and retail levels vary a lot, as the information above indicates. Theoretically, wholesalers have a 15 percent markup and retailers have a 25 percent margin, but in practice these levels are rarely respected.

Wholesaler margins for oral contraceptives, for example, range from 20 percent to 35 percent. Condom markups can range from 20 percent to 100 percent, and IUDs range from 20 percent to 55 percent. At the retail level, pill margins average 45-50 percent, condoms average 15-20 percent, and IUDs average 20 percent markups.

Since there is a lack of current data on the target market and household incomes, it is difficult to estimate what the appropriate pricing levels would be for a social marketing project. It is clear, however, that due to the current economic crisis in Cameroon, purchasing power has diminished considerably. From the team's interviews with pharmacists, it appears that the current retail prices are high for the average consumer. In fact, the current clientele at the pharmacy level tends toward well-educated middle and upper class consumers.

### C. Distribution

There are 176 pharmacies in Cameroon, with 50 in the Douala area and 45 in the Yaounde region. All pharmacies in this network are served by at least one of the major wholesalers. Sales of contraceptives are restricted to this network, with the exception of mission hospitals and the Prudence condom network in bars, hotels, etc. Condoms and spermicides could be offered through outlets beyond pharmacies, but it is unclear whether ethical products such as the pill could be marketed through other networks.

During the next visit the SOMARC/TFG team will identify additional distribution possibilities for at least the nonprescription products.

A prescription is needed to obtain the pill, IUD and injectable, and this seems to be enforced at most pharmacies. There are approximately 200 private physicians in the country.

The SOMARC/TFG team visited four pharmacies in different parts of the country: Douala, Yaounde, Bamenda and Bandjoun. While the types, brands and prices of contraceptives sold varied somewhat between the four regions, all the pharmacists and clerks interviewed obtain their products from the major wholesalers discussed above. Frequent stock outages were mentioned several times as one of the main problems in selling contraceptives.

Medical detailers do visit these pharmacies, but no one recalled any recent promotional activities for contraceptives. The SOMARC/TFG team noted the presence of small stickers for Innotex and Manix condoms on the cash register in one pharmacy, but aside from that the only point-of-purchase materials on display were for products other than contraceptives.

These individuals also expressed similar opinions about the profile of their typical consumer and their interest in participating in a social marketing program. As for the current clientele, most pill users are women who are well educated and middle to upper class. In Bamenda, there are a fair amount of female college students who purchase oral contraceptives. Condom users, on the other hand, include men of all ages and some women, but the majority of purchasers are younger men. The market for IUDs, spermicides and injectables is too small to establish a definite profile.

When asked if they would be interested in stocking social marketing products, the retailers said they would be willing to participate if the products were of good quality and the prices competitive.

#### **D. Promotion**

##### **Trade Promotion**

As noted above, the only trade promotion activities observed in the pharmacies were a few stickers for various condom brands. For ethical products, the pharmaceutical manufacturers usually employ local individuals to detail to physicians. Sometimes representatives are also sent to Cameroon from Europe to launch new products.

## **Consumer Promotion**

There appear to be no mass media campaigns or consumer promotions directed to potential users with the exception of the new Prudence condom effort for AIDS prevention, which includes some giveaways such as t-shirts.

## **Advertising**

There are a few advertising agencies in Cameroon, including affiliates of Lintas and McCann-Erickson and a local organization affiliated with the government called Cameroun Publi-Expansion (CPE). The SOMARC/TFG team did not have time to interview them; this will be a priority during the next visit.

## **Television and Radio**

Cameroon has a relatively strong network of television and radio stations, as well as print media. The television and radio stations are state-controlled, and for ethical products no brand advertising is allowed, but it is unclear whether method-specific advertising would be permitted. There appear to be no legal restrictions to brand advertising of nonprescription contraceptives on television and radio. Most of commercials observed by the SOMARC/TFG team were of high production quality, and many promoted beer or automobiles.

Television, which began in 1985, reaches the majority of the country, and 85 percent of the population is estimated to have access to this medium. The cost of purchasing a set is prohibitive, however, for many low-income people. Programming is offered throughout most of the week in either French or English.

Media time is expensive for television, with costs for advertising about \$800 for a 15-second spot, \$1400 for a 30-second spot, and \$2066 for a 60-second spot (see Appendix B, Schedule of Cost for TV Advertising).

Radio is also a very effective medium for reaching a large audience, and the AIDS control program has recently aired messages promoting the use of condoms.

There are one international radio station, one urban station, and ten provincial stations in the entire network. The languages used vary, with 59 percent of the broadcasts in French, 22 percent in English and 19 percent in local languages. Broadcasts are offered practically all day until 11:00 PM on the provincial stations, and the Yaoundé station broadcasts from 5:30 AM until 1:00 AM.

It should be noted that language appears to be a problematic issue in terms of reaching a large national audience. English and French are not understood by everyone, and in daily communication many people use the various local languages such as Pidgin, Douala, Bassa, Ewondo and Fulfuldé. There are about 19 local languages, most of which are used on the various provincial radio stations (see Appendix C, List of Languages in Cameroon).

The cost of radio advertising in English and French is more than double the cost of advertising in local languages. For a 30-second spot on one station, the cost is about \$85 in an official language and \$35 in a local language. The same spot broadcast on seven stations would cost \$207 in an official language and \$85 in a local language (see Appendix D, Schedule of Costs for Radio Advertising).

### **Print Media**

There is a wide range of print media, including the state-owned Cameroun Tribune newspaper, which accepts advertising and is published daily in French (circ. 70,000), bi-weekly in English (circ. 10,000), and includes a weekend edition (circ. 4,000). There also is a monthly called Les Nouvelles du Cameroun, published by the Ministry of Information (circ. 2000).

The private press includes Le Combattant (daily, 10,000 copies), Le Messager (bimonthly, 10,000 copies), and L'Effort Camerounais (bimonthly, 15,000 copies). There are many other publications, including a number of sports and specialty newspapers and magazines, many of which appear on an irregular basis.

Print media is not as popular as radio and television, which is due in part to its limited distribution and the problem of illiteracy.

## **Other Media**

There is outdoor advertising such as billboards and store signs in Cameroon. It is unclear whether cinema advertising exists. Traditional means of communication such as songs, dance and theater are still very much in use, especially in rural areas. A social marketing program could also use some of these techniques to disseminate messages to the target audience.

### **E. Additional Components of a Social Marketing Program**

Two other areas must be explored in the next visit. First, since all SOMARC projects are based on market research, the local capabilities for both qualitative and quantitative research studies will be assessed. It appears that there are some research organizations in Cameroon, but most seem to be experienced in the social sciences, not marketing. Second, the local capacity for printing of packaging and other materials will be evaluated. This will probably not pose a problem, given the relatively sophisticated nature of the Cameroonian market.

## **VIII. PROGRAM CONSTRAINTS**

### **A. Social**

1. Certainly a baseline study will give a better picture of the situation but it appears that given the history of family planning in the country, the low level of contraceptive knowledge is a major constraint for a contraceptive social marketing.
2. The multiplicity of languages can be a constraint for program implementation in terms of message design and dissemination. Not only do messages have to be designed taking local, regional and ethnic differences into consideration, but the multiplicity of languages will greatly increase the communications budget in a market where media cost is already high.

### **B. Religious**

1. There appears to be a strong Catholic influence in the country, especially in the decisionmaking apparatus. Knowing the Catholic Church's opposition to modern methods of child spacing, a strong public relations campaign may be needed to ensure that the project is accepted.
2. There is also a strong Muslim influence in the northern part of the country. Even though Islam as a religion is not as opposed to family planning per se, local cultural interpretation may hamper efforts to promote the very idea of family planning and furthermore the selling of contraceptive products in retail outlets.

### **C. Resources Needed in Private Sector**

1. Though the team did not have enough time to investigate all possibilities, availability of research institutions to carry out marketing research needed in the program may be a constraint.

2. Retail personnel (pharmacy assistants and salespersons) at the retail level may need training in contraceptive technology given the level of contraceptive use in the country. Such training is even more important in outlets not currently carrying contraceptives.

#### **D. Policy**

There may be government restrictions in the areas of taxes, duties, pricing or advertising that could impact on the program's ability to reach a large audience with low-priced products.

#### **E. Economic**

Given the current economic crisis in Cameroon, purchasing power among the program's target may be weak. This issue will be explored further through research.

## **IX. CONCLUSIONS AND NEXT STEPS**

### **A. Conclusions**

The time constraint under which the team had to work did not make it possible to investigate major issues beyond identifying them, or pursue discussions with key actors. Following are some of the key issues arising from the visit.

1. Given the level of socioeconomic development achieved by the country, family planning activities in comparison appear to be embryonic. Public sector activities are confined to major medical facilities and are performed under the framework of Maternal and Child Health Care. Nongovernmental activities are scattered and lack coordination despite an obvious effort, especially by religious-run health centers, to coordinate programs.
2. The official GOC position about child spacing/family planning is evolving positively and there appears to be a genuine willingness to expand services and support a contraceptive and MCH social marketing program. Officials do acknowledge that there is an unmet need and that there is a large demand for both information and services. Thus, a contraceptive social marketing program is an appealing proposition for officials who see it as a welcome supplement to governmental efforts, given the crisis situation facing the country. Furthermore, this proposition takes on extra significance at a time when the donor community (e.g., The World Bank) is insisting on cost recovery.
3. Cameroon has a strong, dynamic and sophisticated private sector with pharmaceutical distribution companies covering the national market. Some of them have a lot of experience in dealing with the national market and have established working relationships with sister companies in other countries in the subregion.
4. The team did not visit other consumer goods distributors. The next SOMARC/TFG team should include that in its scope of work.

5. The marketing situation for contraceptives can be summarized as follows:

- o Methods are readily available throughout the country
- o Prices are very high
- o Distribution is limited to major centers
- o There is little or no promotion
- o There is no commercial advertising of ethical products.

Pending a more in-depth assessment, the SOMARC/TFG team has concluded that a contraceptive social marketing program is feasible in Cameroon. The potential constraints discussed above are not insurmountable and opportunities are encouraging. With the GOC's support for expanded family planning activities, a sophisticated private sector, and significant unmet need (per the 1978 fertility study), a social marketing program could have a positive impact on the health and population situation in Cameroon.

#### **B. Next Steps**

1. SOMARC/TFG team visit in February 1990 for in-depth assessment. Key areas to investigate:
  - o Distribution, including consumer goods distribution
  
  - o Capacities for
    - . Research
    - . Training
    - . Advertising
    - . Printing and packaging
    - . Public relations
  
2. Conduct feasibility study for MCH products: ORS, anti-malarials, and any other products designated by GOC
  
3. Outline structure of program
  
4. Design timetable of activities
  
5. Develop illustrative implementation budget.

**Appendix A**  
**LIST OF CONTACTS**

## LIST OF CONTACTS

### USAID

Mr. E. M. Amundson  
Deputy Mission Director  
Tel: 23-05-81

Mr. George Vishio  
HPN Office

Mr. Brian Ames  
Private Sector Officer

### Ministry of Health

Dr. Lazare Kaptué  
Inspector General & President  
National AIDS Committee  
Tel: 22-44-19

Dr. Neba Awassoum  
Directeur Santé Familiale  
Tel: 22-44-19

Dr. Andela Assomo  
Médecin Chef, PMI Centrale, Yaoundé  
Tel: 23-36-53

Dr. Roger Ntounga Salla  
Chef de Service  
Service de Lutte Contre le SIDA  
Tel: 22-20-23

Dr. Moustapha Thomas Lapnet  
Directeur de la Pharmacie  
Tel: 23-32-59

Dr. Suzanne Molu  
PMI Centrale, Responsable du Projet FNUAP  
Yaoundé  
Tel: 23-36-53

## Distributors

Mr. Raymond Azegue  
Directeur Adjoint  
Laborex, Yaoundé  
Tel: 23-06-90

Mr. Auguste Tamaze  
Pharmacien Directeur  
Campharm, Yaoundé  
Tel: 23-36-58

Mme. Felicité Edimon  
Director of Purchasing  
GPC, Douala  
Tel: 42-53-68

Dr. Pierre Sopngui  
Commercial Director  
Pharmacan, Douala  
Tel: 42-08-98

## NGOs

Mr. Tim Manchester  
Director  
Save The Children  
Tel: 23-10-07

Dr. Eleonore Suemo Fosso  
Health Coordinator  
Care International  
Tel: 23-20-54

Mr. Robert De Wolfe  
Training Coordinator  
SESA Project  
Tel: 22-44-19

Ms. Robin Steinwald  
Pritech Project  
Tel: 22-44-19

Dr. Victor Kanga  
Directeur General  
Ad Lucem Foundation  
Tel: 22-03-18

**Mr. Antoine B. Houehougbe**  
**Research Coordinator**  
**IFORD**  
**Tel: 22-24-71**

**Mr. Steve Chapman**  
**PSI**  
**Washington DC**

**Appendix B**

**SCHEDULE OF COST FOR TELEVISION ADVERTISING**

**SCHEDULE OF COST FOR TELEVISION ADVERTISING**

**PUBLICITE DE MARQUE SUR ECRAN**

Durée (en s)	15"	20"	30"	45"	60"
Prix	240.000	320.000	420.000	520.000	620.000

Troisième tranche ou tranche spéciale (10 percent les samedi, dimanche et jours fériés)

**AVANT ET APRES UN EVENEMENT**

Durée (s)	15"	20"	30"	45"	60"
Prix	320.000	460.000	520.000	620.000	720.000

**AVANT ET APRES LES INFORMATIONS DU SOIR**

Durée (s)	15"	20"	30"	45"	60"
Prix	260.000	360.000	460.000	560.000	660.000

**Appendix C**

**LIST OF LANGUAGES IN CAMEROON**

## LIST OF LANGUAGES IN CAMEROON

### PRINCIPALES LANGUES NATIONALES UTILISEES SUR LES ANTENNES DE LA RADIO POUR LA PUBLICITE

#### STATION DE YAOUNDE

Ewondo  
Bassa  
Bafia  
Bamiléké

#### STATION DE DOUALA

Douala  
Ewondo  
Bassa  
Bamiléké

#### STATION DE BAFOUSSAM

Bafoussam )  
Dschang ) Bami-  
Bamoun ) léké  
Mboh )

#### STATION DE BERTOUA

Maka

#### STATION DE BUEA

Bakweri  
Bankwa  
Bakossi

#### STATION DE MAROUA

Foulfouldé  
Toupouri  
Arabe choa  
Haoussa

#### STATION DE GAROUA

Foulfouldé  
Haoussa  
Arabe choa  
Toupouri

#### STATION DE NGAOUNDERE

Foulfouldé  
Haoussa  
Toupouri  
Arabe choa

#### STATION DE BAMENDA

Mungaka  
Ngemba

#### STATION D'EBOLOWA

Bulu  
Ewondo  
Fang

### LANGUES VEHICULAIRES AU Cameroon

1. Pidgin: véhiculaire dans les provinces du Nord-Ouest, Sud-Ouest, Littoral et Ouest.
2. Douala: voisinage immédiat de son aire propre (c.x. Bakoko).
3. Bassa: les trois aires Bakoko qui jonchent l'aire Bassa.
4. Ewondo: surtout parlé par les originaires de Yaoundé. Le petit Ewondo est utilisé dans l'Est et le Mbam.
5. Fulfuldé: plaine du Diamaré, de Maroua à Garoua et à Ngaoundéré. Véhiculaire dans l'Adamaoua, le Nord et l'Extrême-Nord.

6. Haoussa: les abords du Nigéria.
7. Wandala: les Monts Mandara et de département du Mayo-Sava.
8. Hanuri: frontière du Nigéria (Mora).
9. Arabe: véhiculaire dans le département du Logone et Chari.
10. Bamoun: département du Noun.
11. Bangangté: département du Ndé.
12. Féfé: département du Haut-Nkem.
13. Dschang: département de la Menoua.
14. Mbouda: département du Bamboutos.
15. Bandjoun: département de la MIFI.
16. Bafia: département du Mbam dans le Centre et voisinage immédiat.
17. Batanga: département de l'Océan.
18. Bulu: véhiculaire dans le Sud.
19. MPO: département de la Boumbo avec le Kozime.

Source: Atlas linguistique du Cameroon cité dans Recherche sur la famille Camérounaise - Vol. I, p. 32 - MINASCOF - Mars 1988.

Voici la liste des langues locales suivant les provinces.

Centre: Ewondo - Eton - Mengissa - Bamvelé - Bassa.  
Extrême-Nord: Fulfuldé - Mafa - Arabe choa - Haoussa.  
Littoral: Mbo - Bassa - Pidgin.  
Ouest: Bamoun - Mbouda - Dschang - Feté - Bangangté - Badjoun - Batié - Bafoussam.  
Nord-Ouest: Pidgin.  
Sud-Ouest: Pidgin.  
Nord: Fulfuldé - Fali - Mboum - Doayo - Guidar.  
Est: Mango Ewondo.  
Adamaoua: Fulfuldé - Baya - Mboum - Dourou - Tikar.  
Sud: Bulu - Ntumu.

Au total: 35 langues locales dont 29 différentes.

Source: Recherche sur la famille Camérounaise - Vol. I, p. 47.

### La publicité à la T.V.:

Ce n'est pas encore la ruée des annonceurs vers la télévision. Toutes les publicités sont permises sauf celles des liqueurs, des produits pharmaceutiques et du tabac. En revanche, contrairement à d'autres pays, on fait ici la publicité des bières.

La publicité de la CRTV ne transite pas par l'agence nationale Cameroon Publi-Expansion.

40

**Appendix D**

**SCHEDULE OF COSTS FOR RADIO ADVERTISING**

41

**SCHEDULE OF COSTS FOR RADIO ADVERTISING  
LOCATION D'ESPACE A RADIO CAMEROON EN FCFA (1988)**

	Durées (en secondes)					
	Langues officielles			Langues nationales		
	30"	45"	60"	30"	45"	60"
1 station	25.000	32.000	45.000	10.000	13.000	15.000
2 stations	30.270	39.000	51.000	12.600	16.000	20.900
3 stations	35.000	44.950	59.000	15.000	18.000	23.920
4 stations	40.250	50.150	64.950	17.700	20.500	26.510
5 stations	45.300	55.800	70.100	18.000	22.350	30.000
6 stations	50.700	60.770	76.840	21.700	24.900	53.050
7 stations	62.000	70.000	83.000	25.000	30.700	40.100

4/2