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HEALTH/POPULATION SECTOR REVIEW

USAID/CAMEROON -- 2/89

By Vincent W. Brown
Health Management/Planning Consultant
University Research Corporation, MD

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I EXECUTIVE SUMMARY

The following review of the USAID's Health and Population Program has been carried out within the framework of the Government of the Republic of Cameroon's (GRC's)deepening economic crisis, and the preparations now underway within USAID of its Country Development Strategy Statement (CDSS) submission for Fiscal Years 1990 through 1994. It draws on the current analysis of the economy done by the Development Alternatives Inc (DAI) team and the USAID staff. The plans and suggestions for future activities have been analysed and future strategy developed within the framework of the guidelines set forth in Development Fund for Africa (DFA)1.

Background

The GRC covers 465.402 km2 offering an ecological range from desert in the far North to tropical forest in the South. Its population in 1989 is estimated at 10.927 million (based on the 1976 general census) and includes about 93 different ethnic groups. Population projections prognosticate 16.7 million inhabitants by the year 2000. Although the urban population accounts for an estimated 38% of the total population, this ratio is expected to rise steadily in the next years. Population growth rate in the urban areas is estimated at around 7.9% and in the rural areas 3.2%. Population densities vary widely from area to area (from 6.8 inhabitants/km2 in Adamaoua and 8.6 in the South to 95.7 in the West).

The age structure of the population is steadily growing younger (55% under 20) due to an increase in fertility (6.5 total fertility rate in 1982) and a decrease in childhood mortality in recent years. While official statistics for the period since 1985 have not been released, informed sources indicate that during the 1985-87 period infant mortality rose with the most serious increases occurring in rural areas. This suggests that cutbacks in operating costs, inadequate vaccination programs, and inadequate pharmaceutical and ORT supplies are eroding the gains of the past.

1 AID/Washington, "U.S. Assistance for Africa, The Development Fund for Africa (DFA), An Action Plan", December, 1988, Washington D. C.

Morbidity and mortality patterns in both rural and urban areas show predominance of infectious and communicable childhood diseases. Major causes of mortality include measles, malaria, tetanus, acute respiratory infections. The 1983/84 WHO survey reports that 50% of infant deaths were diarrheal-related, due to large part to rotavirus infection, socio-nutritional factors, poor sanitation and water supply, and the neonatal tetanus also remains a serious problem.

Health Sector Analysis in Macro-Economic Context

Cameroon belongs to the group of lower middle income countries with a per capita income of $860, 1987 estimate. However, an infant mortality rate estimated at 105 per/1000 in 1985 (possibly as high as 120 per/1000 in 1989) in the rural areas and life expectancy of 52 years are still comparable to those of low income countries. GRC budgetary allocations for health have, in recent years, constituted as much as 6.3 percent of the government services budget, compared with the WHO recommended average of 10% for low income countries. In 1988/89, however, the health budget has declined to 4.6 percent. With $12.60 per capita spending, Cameroon remains on a high level compared to other African countries.

The USAID believes that because of this very difficult economic/budgetary situation described above, and within the context of the Structural Adjustment Program (SAP) being prepared by the World Bank, there are significant opportunities / possibilities to establish a system for 100 percent payment by the population of basic medicines needed for primary health care, and to make significant management/administrative changes and improvements including Health Information and Management Information (HIS & MIS) systems over the life of the CDSS (FY90-94).

Health Sector Strategy

The Health sector strategy has three major areas of concentration -- Child Survival, Population, and HIV/AIDS. Over the period of the CDSS it will focus on more productive and efficient use of existing resources, development of self-help on the part of the population, and the encouragement of the private sector in order to help assure the sustainability of health sector programs. In carrying out this strategy, the USAID will utilize and build on existing technical assistance resources already in place to take advantage of the heightened interest of the government in better management of existing health programs, decentralization, and its willingness to consider full payment for pharmaceutical and health services by the population.

Child Survival

One of the serious problems in the Cameroon in providing primary health care (especially for woman and children under five) at this time is the lack of essential pharmaceuticals and medical supplies in the GRC's 397 elementary health centers and 146 developed health centers, 57 MCH centers, and 64 dispensaries, not to mention the problem of supplying the country's 173 hospitals. The government, because of high recurrent cost imbalances, has not been able to assure provision of funds to cover these costs. As a result, where in the past a primary health care center might have had 50 to 100 patients a day, in absence of basic pharmaceuticals and medical supplies, only 5-10 or so may use the facility.

The USAID is convinced that if centers could be supplied regularly with 20 essential generic drugs and essential basic medical supplies, over 70% of the diseases could be treated effectively. If these basic curative drugs were available with the concurrent increase in use of the basic level health facilities by mothers and their children, it would make the government's work in preventive medicine (vaccinations, ORT, growth monitoring, child spacing) much more effective.

Experience to date in Cameroon and other sub Saharan countries demonstrates that the rural population will pay for essential medicines and go long distances to purchase them. One solution to this problem would be to develop a sustainable, self-financing system in the short term (next 2 to 3 years) which would provide essential generic drugs to the government's primary health care system at reasonable cost to cover 70% of primary health care illnesses. Such action would make more productive the PHC system for both curative and preventive services.

Therefore, the major thrust of the USAID's Child Survival strategy then will be to establish over the next two to three years, a nationwide renewable medical supply system for the country's primary health care network which would be self sustaining after the initial financing by donors (e.g. USAID, World Bank, UNICEF, and other bilateral donors). Non project assistance would be the mechanism used for the USAID contribution to the revolving fund with major health care policy changes by the GRC the justification for the non project assistance.

To sum up, in the near term (FY90-91) as part of the MCH project's current Child Survival mandate, and by using its resident staff and short term consultant element, a workable self financing medical supply system would be designed and tested in two provinces. The MCH team would then prepare the necessary manuals and training programs (TOT) so that the program could start in late FY 91-92. In FY 92-93, MCH would move nationwide and help with the installation of the system and assure that it was fully sustainable without further external assistance.

Population

The USAID is effectively using centrally funded resources and the Family Health Initiatives II Project. Family planning is also one of the components of the USAID's bilateral MCH/CS project. This assistance has been steadily preparing the government to move ahead in this important area. As the government nears the stage of a public policy statement, or credo on family planning, followed by increased IEC work and movement into national level delivery programs, it is vitally important that the Demographic Health Survey (DHS) requested by the USAID in late 1988 be fielded as soon as possible, hopefully, in fall of 1989, but no later than early 1990.

It is expected that by late 1991 or early 1992 the USAID will be ready to launch a major bilateral Population project.

HIV/AIDS

The government has strongly supported the HIV/AIDS program. The GRC has encouraged the medical community to help, established a special unit in the MOH, and encouraged the initiation of an important Information, Education and Communication (IEC) programs using radio, television and the written media. The HIV/AIDS activity is one in which a vertical program seems advisable, oriented toward prevention focusing on the high risk groups, and the education (IEC) of the rest of the sexually active population.

To sum up, for its Health Sector Program, in FY 90 and FY 91 the USAID will continue to draw on its bilateral and centrally funded programs(using buy-ins where appropriate) at about $3.5 million each year to assist the GRC to continue the development and implementation of its Child Survival/Population/ HIV/AIDS activities.

By late FY 91 or early FY 92, it is expected that the mission will be ready to implement its major "Self Sustaining Pharmaceuticals" non project grant of $10.0 million in cooperation with international and bilateral donors.

In addition, it is expected that by FY 92 the USAID will have obtained sufficient data and experience to launch a major Population bilateral project of $5.0 million over the remaining three years of the CDSS.

The total estimated amount of project and non project assistance required for the Health Sector from FY 90-94 is $28.5 million. Table 6 sets out the CDSS Health Sector Program by Fiscal Year and by project and non project activity.

II. INTRODUCTION/BACKGROUND

The following review of the USAID's Health and Population Program has been carried out within the framework of the Government of the Republic of Cameroon's (GRC's)deepening economic crisis, and the preparations now underway within USAID of its Country Development Strategy Statement (CDSS) submission for Fiscal Years 1990 through 1994. It draws on the current analysis of the economy done by the Development Alternatives Inc (DAI) team and the USAID staff. The plans and suggestions for future activities have been analysed and future strategy developed within the framework of the guidelines set forth in Development Fund for Africa (DFA) (1) and as amplified by Dr. Emmy Simmons (AFR/DP) and USAID discussions.

Since the beginning of the deepening economic crisis in 1987, it has become increasing clear that:

1) GRC resource constraints are having serious adverse effects on the implementation and impact on many of AID's ongoing projects,

2) The Cammeroonian economy cannot return to a sustained growth path without major structureal reforms, and

3) Existing distortions within the economy are already or will in the future prevent AID programs from achieving their planned objectives.

Petroleum earnings are expected to decline gradually until reserves are exhausted toward the end of the century, the agricultural export sector has stagnated during the past decade, and the modern industrial sector cannot survive without high and unstainable rates of protection. Unless these problems are corrected, there is little chance that Cameroon will return to the sustained high rates of growth that were achieved between 1970 and 1985. these findings are consistent with thoses of the World Bank (WB) and the International Monitary Fund (IMF) and the GRC and are the basis for a structural adjustment program currently being negotiated between the GRC and the World Bank.

The USAID Cameroon program in the health sector emphasizes child survival with focus on primary health care. The population program which includes both demographic and health aspects is a high priority. A young and vigorous program with the GRC on HIV/AIDS has started recently. All of these activities focus on self-help with participation of the recipients-community. Opportunities for the private sector participation are stressed as well.

1. AID/Washington, "U.S. Assistance for Africa, The Development Fund for Africa (DFA), An Action Plan", December, 1988, Washington D. C.

The status of these programs, Health Sector strategy and specific recommendations for the future (FY 90-94) are included in sections III and IV below.

III. CURRENT HEALTH (CS/POPULATION/HIV/AIDS) PORTFOLIO
-- Its Relation to Sectorial Needs of Cameroon --

A. Background.

The GRC covers 465.402 km^2 offering an ecological range from desert in the far North to tropical forest in the South. Its population in 1989 is estimated at 10.927 million (based on the 1976 general census) and includes about 93 different ethnic groups. Population projections prognosticate 16.7 million inhabitants by the year 2000. Of this population, one-fifth are officially Anglophones and the rest are Francophones. The official languages are at best, second languages and a major part of the population speaks only their ethnic dialect.

Although the urban population accounts for an estimated 38% of the total population, this ratio is expected to rise steadily in the next years. Population growth rate in the urban areas is estimated at around 7.9% and in the rural areas 3.2%. Population densities vary widely from area to area (from 6.8 inhabitants/km^2 in Adamaoua and 8.6 in the South to 95.7 in the West).

The age structure of the population is steadily growing younger (55% under 20) due to an increase in fertility (6.5 total fertility rate in 1982) and a decrease in childhood mortality in recent years. While official statistics for the period since 1985 have not been released, informed sources indicate that during the 1985-87 period infant mortality rose with the most serious increases occurring in rural areas. This suggests that cutbacks in operating costs, reduced vaccination programs, and inadequate pharmaceutical and ORT supplies are eroding the gains of the past.

Morbidity and mortality patterns in both rural and urban areas show predominance of infectious and communicable childhood diseases. Major causes of mortality include measles, malaria, tetanus, acute respiratory infections. The 1983/84 WHO survey reports that 50% of infant deaths were diarrheal-related, due to large part to rotavirus infection, socio-nutritional factors, poor sanitation and water supply, and the neonatal tetanus also remains a serious problem.

The following Table §copy table page 24 of DAI team draft entitled 1989 Social Indicator Data.)

Table 1

1989 Social Indicator Data
[insert table]

Although the 1978 National Nutrition Survey shows a rate of 22.4% for chronic malnutrition (under 90% height for age) in the rural areas (this is compatible with figures in neighboring countries), acute malnutrition (under 80% weight for height) was found to be only 1.1% for children under five years of age. While malnutrition is still felt to be a problem (in particular in Adamaoua province), it is generally due to socio-cultural factors rather than to shortages of food.

The USAID's strategy is to use existing projects to address the nutrition problem. For example, the MCH/CS bilateral project will emphasize nutrition/gowth monitoring and improved weaning practices as one of the five child survival interventions. In addition under the centrally funded PRITECH project, nutrition is being looked at in connection with the Control of Diarrheal Diseases (CDD) program involving oral rehydration therapy (ORT).

B. Health Sector Analysis in Context of Macro-Economic Situation of the GRC

GRC budgetary allocations for health have, in recent years, constituted as much as 6.3 percent of the government services budget, compared with the WHO recommended average of 10% for low income countries. (2) In 1988/89, however, the health budget has declined to 4.6 percent. With $12.60 per capita spending, Cameroon remains on a high level compared to other African countries. (3)

Nonetheless, budgetary imbalance is characteristic of the national health services due to overly ambitious investment programs skewed toward urban centers, and sever under-financing of non-personnel recurrent costs.

(**2. Cameroon belongs to the group of lower middle income countries with a per capita income of $860, 1987 estimate. However, an infant mortality rate estimated at 105 per/1000 in 1985 (possibly as high as 120 per/1000 in 1989) in the rural areas and life expectancy of 52 years are still comparable to those of low income countries.

(**3. Note: Health budget amounts do not necessarily represent the actual amount spent. While current expenditure figures are not available for the health budget, actual GRC expenditures overall (arrears) have exceeded budgeted amounts by significant amounts in recent years.**)

Insert from DAI CDSS draft page 25

Table 2

Cameroon Health Budgets, 1986 - 1988/89

During the period 1981 to 1985, investments in health infrastructure and services totalled CFAF 2.6 billion, including the construction and rehabilitation of 1,441, hospitals, clinics, pharmacies, propharmacies, and mother and child care centers. In 1986/87 and 1987/88 public investment budgets in health grew markedly. However, only 14 percent of the 1986/87 investment budget was allocated for the construction of primary health centers, while 80 percent financed construction costs of hospitals. In 1987/88 funds for hospital construction grew to 92 percent of investments, the majority of which were earmarked for only two urban hospitals (Yaounde and Douala).

Recurrent costs in the health budget remain low relative to other sectors. However this includes a large allocation earmarked for administrative costs and personnel within the Ministry of Health, and a disproportionate share of personnel costs in rural and primary health care facilities (often as high as 98 percent of recurrent costs per facility).

Since 1986, economic austerity measures have further exacerbated this situation, as budgetary allocations for medications have been reduced by more than 50 percent. Field reports indicate a breakdown in central inventory and management operations, and chronic shortages of basic drugs and clinical supplies, especially in the rural areas.

Prospects for privatization of health services over the short-term are not promising, although new government commitments to cost-recovery (fee for services and medicines) are likely, over time, to improve the prospects for private practitioners. At the present time 40 percent of Cameroon's hospital beds and an undetermined proportion of health services are provided by missionary societies and non-Cameroonian private voluntary organizations, which operate on a fee-for-service basis. A uniform trend toward cost-recovery in health care is likely to transform public expectations regarding free health care that were instituted at independence.

The USAID believes that because of this very difficult economic/budgetary situation described above, and within the context of the Structural Adjustment Program (SAP) being prepared by the World Bank, there are significant opportunities/possibilities to establish a system for 100 percent payment by the population of basic medicines needed for primary health care, and to make significant management/administrative changes and improvements including Health Information and Management Information (HIS & MIS) systems over the life of the CDSS (FY90 - 94). These are discussed in Chapter IV below.)

C. USAID Cameroon Current Health Sector (Child Survival/Population/HIV/AIDS) Program

The USAID feels that the program priorities in the social sector outlined below address the principal social development needs of Cameroon. The primary health care programs which stress child survival including child spacing, the programs to reduce uncontrolled population growth, and the initiatives to stop the spread of HIV/AIDS all have major economic implications for the economy over the long term, and should not be stopped because of the current economic crisis.

The deepening economic crisis offers some major opportunities to encourage and install major self-help measures by the population in the area of primary health care. It has enhanced the interest at senior government levels to carry out major population program, and encourage a more important role in the private sector.

As indicated above, the thrust of the Health sector program does not emphasize capital investments. On the contrary, its objective is to make more cost effective and productive use of existing facilities and services, to lighten the burden on the government through greater cost recovery, and to encourage private sector participation wherever possible.

The USAID's Health Sector program reflects Agency priorities for Child Survival, Population and HIV/AIDS. While in different stages of development, with relatively recent bilateral projects and low pipelines, plus significant use of centrally funded technical assistance, the current bilateral activities focus on DFA strategic objective one: Improving management of African economies by redefining and reducing the role of the public sector and making it more efficient. [underlining added] (4)

Cameroon is in Category I of the DFA countries (5) which includes those with a demonstrated commitment to sound and/or improved economic policies, good potential for economic growth, relatively large populations (over seven million), and capability for managing serious debt or foreign exchange problem . The FY 90 - FY94 CDSS planning for health strongly supports one of the USAID's three CDSS strategy objectives: Increasing the efficiency of the public sector" and sub sector iii "Increased Efficiency and Equity in Providing social services. In the coming months and years, the CDSS Health Sector strategy will emphasize top level policy reform and establishment of even more "performance oriented" targets and benchmarks.

(**4. AID/W/DP, "Development Fund for Africa -- An Action Plan", 12/88, Washington D. C., pages 8, and 11. **)

(**5. IBID, page 8.**)

Highlighting the USAID's Health sector programs be they Child Survival, Population, or HIV/AIDS is the conviction that one of the foremost barriers to progress and effective use of scarce resources are the across the board lack of management skills in the public health field. This may be due to the almost exclusive attention to the technical (nursing, medical and pharmacy subjects) to the exclusion of public health management. In addition, Health Information Systems and Management Information systems are less developed here than in a number of the West African countries.

One of the serious problems is lack of base line data in the health field which will enable the evaluators to measure the forward progress (or lack of it) in the joint GRC/USAID programs. In this context it is vitally important that the Demographic Health Survey (DHS) already requested by the GRC and USAID be carried out as soon as feasible. The base line data obtained from the DHS survey will provide a foundation for measuring progress, and carrying out meaningful mini survey's and other operational research needed to assess the progress of the program and plot future strategies for implementation.

Chapter IV below, "Proposed Health Sector Strategy FY90-94", suggests possible changes in focus, priority uses of modest resources already available or proposed for the future, using a mix of project and non project activities working with other donors to achieve important policy, management and operational changes.

The following paragraphs summarize the Health sector program as of January 1989:

1. Child Survival

The main thrusts of the USAID's Child Survival strategy are to:

- o Strengthen the delivery of basic health services with emphasis on child survival, instituting a cost recovery program, and decentralization -- expanding the decision making authority of the provincial delegates for health.

- o Assure that the rural population has access to health centers which provide an acceptable level of basic health services which include:

  - immunization (EPI),
  - oral rehydration therapy (ORT) as a first choice in controlling diarrheal disease (CDD),

  - prenatal care through health centers and MCH centers,
  - adoption of standardized growth monitoring chart and a set of implementable food and nutrition policies,
  - child spacing should be an integral part of the services offered through all health facilities

- Find a solution to the lack of pharmaceutical and basic equipment and supplies which keep the health centers from operating effectively and reduce dramatically their use by the rural population.

  The integration of preventive and curative services at the health center levels means that the centers must have a dependable supply of pharmaceutical and first aid supplies to treat minor accidents, infections and communicable diseases. As indicated above, the ministry of health's budget for drugs and medical supplies is totally inadequate to meet public demand, thus highlighting the urgent need for workable nationwide self-financing mechanism(s).

The status of the USAID/GRC Child Survival activities supported by bilateral and central funds as of January 1989 is as follows:

- The Maternal Child Health/Child Survival Project has now been operational for nine months. The project has progressed well during this period with the four American team members working to strengthen the delivery of basic rural health services described above in two provinces, the South and Adamaoua. The project stresses improved management, self sustainability and all project activities are designed to minimize recurrent costs. The project is assisting the MOH to design and implement models for cost recovery which can be applied at national level once they have been introduced and tried out successfully in the two provinces. (see Figure 1 for the location of project areas)

  The Chief of Party is located in Yaounde and has direct access to the Director of Preventive Medicine, and other MOH departments as necessary. (This latter point is especially important in terms of the CDSS strategy described in section IV below.)

  The project (631-0056) is scheduled for five years (until August, 1992) with a funding level of $9,500,000. $4,500,000 have been set aside and an additional $1,500,000 is scheduled to be placed in the project in the second quarter of FY 1989 making a total obligation or $6,000,000.

  In addition to the services of the resident team, some 27 months of short term Child Survival technical assistance; is available under the project. The Cameroonian Project Director, Dr. Rene Owona, Deputy Director of Preventive Medicine, is very enthusiastic about the present and future help that this project can provide for help with both the Provincial and national programs.

o The Primary Technologies for Health Care (PRITECH) -- Controlling Diarrheal Diseases (CDD)

The centrally funded project is designed to assist the MOH establish a national policy/strategy for control of diarrheal disease with emphasis on oral rehydration, and its implementation.

In the area of public policy, the sub-project has assisted the MOH to establish a national CDD policy which was issued in late January 1989. This makes the GRC one of the few African countries with a detailed strategy. In addition, other activities under the sub-project included:

- a study of the feasibility of local production of oral rehydration salts(ORS),

- an ongoing training of trainers (TOT), and funding for local trainers from national level to assist ORT training in the provinces.

- Knowledge, Attitude and Practices (KAP) studies and operational research; -- focus groups, managerial problems, etc.

- Information, Education and Communications (IEC) -- technical assistance and full funding of printing (French of Evaluation and Treatment posters including support for pretesting with the Maternal Child Health project.

- Assistance with the costs of supervisory visits from national level.

- Documentation and coordination with other donors.

The principal contact is Dr. Amida Ghogomu, Director of Preventive Medicine. Thus far, the project (936-5927.1 - $550,000) which began in 1986 and runs until September 1989 has been very productive and well received by the GRC. The program will be reviewed in March 1989 to determine future requirements for technical and financial assistance. It is anticipated that this activity will be extended and funded for at least two more years.

o Measles Vaccine Supply

Since 1984 USAID has supplied the MOH with measles vaccine -- 1987, 900,000 doses valued at $138,000; 1988, 450,000 doses at $100,000; and this assistance using USAID funding (698-0421.31) is expected to continue at about $100,000 annually. This vaccine has been very effectively used in Cameroon and is part of the USAID's emphasis on Child Survival. Principal contact is Dr. Ghogomu.

It is expected that Child Survival activities will continued throughout the CDSS period moving to national level with a major non-project proposal to take advantage of self-financing opportunities based on the results of the provincial level activities in FY 90 and 91. (These are described in Section IV below.)

2. Population

The USAID strategy in Population is to assist the GRC in developing its population policy and developing appropriate service delivery programs. Over the long term, the action plan in Population will help the GRC provide safe and effective child-spacing services to greater numbers of Cameroonian couples. The sector purpose is to strengthen the GRC's policy-making capability and personnel base with which to develop family planning services.

Opportunities for the GRC population program only began in the last several years. The first major opening was by the President of the Republic, Paul Biya, who highlighted the need for "responsible parenthood" in his introductory note for the Sixth Five Year plan cited below:

> "We should therefore be more aware of the population phenomenon which is increasing its scope and is becoming more acute everyday in families and towns. This awareness must be concretized:"
>
> > "Firstly by striking the necessary balance between the population, resources and development, and ..."
> >
> > " I would like at this point to draw the attention of Cameroonians of both sexes to the economic and social consequences of an unplanned increase in birth rate. Procreation, albeit a basic human right, can and must be controlled. The purpose, therefore, is not to discard our beliefs, practices and customs in this regard, but rather to increasingly strive for the systematic promotion and institution of planned and responsible parenthood." (6)

Illustrative of the many difficult structural problems caused by Cameroon's 2.7 percent plus annual increase in population is "unemployment". The Sixth Five Year plan notes in section 23.1.6 (page 277) that:

6. VIth Five Year Economic Social and Cultural Development Plan, 1986-1991, Ministry of Plan and Regional Development, "Head of State's Message to the Extraordinary Session of National Assembly", page VIII, Yaounde, Cameroon, August 1986.

"The number of new jobs created annually meet only 40% of labour market needs (and only (20%) are paid jobs). At present, about 250,000 people are estimated to be seeking employment for the first time, and to this figure should be added others who have worked before but are now jobless. ..."

The economic crisis which began in 1987, has only made matters worse. Looking to the economic and social development of Cameroon in the future -- short, medium, and long term --, assisting the GRC and its population reduce its birth rates is of highest priority. The USAID has recognized this need.

The GRC's population program is in its infancy. For example, use of contraception using modern methods is less than 3 percent. (7) Thus far the USAID has utilized four centrally funded population support activities:

a) Training under the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO)

Through 1987, eighty-nine Cameroonians were trained under this project (936-3045) with a AID/W funding level of about $200,000 per year through 1990. USAID/Cameroon and the Chief of Service of External Relations of the Ministry of Health maintain lists of the persons trained. This pool of trained Cameroonians will become vital as the Population program service delivery programs become operational over the next several years.

b) Family Planning International Assistance (FPIA)

This project (932-0955) supports the family planning efforts of the Presbyterian Church hospitals in Cameroon and supplies contraceptives to the MOH for high risk maternity clinics. This project is moving well and demand for contraceptives is said to be increasing. AID/W has provided funding ($139,000 annually) until 1989.

c) Family Planning International (FHI)

This project (936-3041) supports biomedical research on low dose estrogen oral contraceptives and the copper T-380A, IUD. AID/W will provide funds to 1990 at $20,000 per year.

d) Natural Family Planning (NFP)

This project (936-3041) supports the efforts of the Catholic Health Services of Cameroon to promote NFP. The project in 1985 received grant funding of $62,000. The PACD was December 1988.

(**7. Three percent is based on 1978 WFS (Cameroon study findings).**)

e) Family Health Initiatives-II (FHI-II)

In the fall of 1988, the USAID signed a "buy-in" to the Family Health Initiatives-II (FHI-II) project ((698-0462.31) in the amount of $1,200,000 for four years. USAID Cameroon set aside $400,000 in 1988, and plans to set aside $400,000 in 1989 and 1990 respectively. This project has consolidated the mission's population activities. Its objectives are to:

- strengthen the role of the Ministry of Plan in coordinating population efforts,

- assist the Ministry of Plan to develop an official population policy for Cameroon,

- provide for special studies and training in the field of population.,

- provide for management training in areas of program design, monitoring, evaluation and information, and

- prepare the service mininstries (Health, Women's and Social Affaires, and Agriculture/Cmmunity Development) for inititating service delivery programs.

3. Support to Cameroon's HIV/AIDS Control Program

Using AID/Washington central funds, USAID/Cameroon has assisted the National AIDS Control Program in carrying out IEC, studies of high risk groups and supplying condoms. The program is managed by a group of dedicated young Cameroonian doctors and has moved well in a short time. For example, in late January the MOH sponsored a one hour prime time TV program on AIDS and how to prevent it. The program was very well thought out, and direct and explicit about the cause, prevention and fatal results for those contracting the disease. Numerous articles have been published in the daily newspapers and periodicals.

Support to date totals $200,000 pledged through the WHO/Global Program for AIDS (936-5963), $340,000 for technical assistance through the AIDSTECH project (936-5972) and $32,000 for supply of condoms. USAID will provide an additional $200,0000 for this important program in 1989. Support for this activity will continue through the CDSS period.

4. Health Constraints to Rural Production Project
(Schistosomiasis research)

This is a seven year, Africa regional project, begun in 1983 and funded at $7,430,000. The project has surveyed the prevalence and transmission dynamics of all three forms of schistosomiasis in Cameroon. Pilot control studies have been planned.

Twelve Cameroonians are receiving doctoral degrees in the U. S. Eleven of the twelve are fully expected to complete successfully their doctoral work, with only one doubtful. In addition eleven non-Cameroonians are being trained at Tulane University at MPH level.

The national schistosomiasis laboratory provided for under the project has been completed and is operational, as well as the geographical mapping of schistosomiasis in the country. Operating manuals have been prepared.

The PACD for the project (631-0067) is December 31, 1990. It is expected that the project goals will have been 95% achieved by that time and no further funding or extension of time is planned for this activity.

5. Nutrition

AID/W central funds in the amount of $147,000 have supported the Infant Weaning Practices project being implemented with CARE's primary health care program in the extreme; North Province. The project began in 1985 and will continue through 1989. As indicated above, nutrition is not a major priority of the Cameroonian health sector program except for the ORT work where recent research has stressed the strong relationship between adequate nutrition and the debilitating effects of diarrhea, and the nutrition/growth monitoring component of the MCH/CS project.

6. Related Health Activities

The USAID set aside $50,000 as a one time grant for a Health Management Seminar which was held in October 1988. Future management activities will be planned as part of the USAID's Child Survival, Population and HIS/AIDS programs.

Two AID/Science Research Grants were made to two Cameroonian researchers at CUSS --one of $56,000 for onchocerciasis, and another of $139,000 for malaria.

7. Save the Children Federation -- Child Survival Initiative

The Cameroon Field Office of the Save the Children Federation (SCF) plans to continue and expand a major Child Survival initiative in the Far North Province focusing on the following interventions:

- Immunizations
- Oral Rehydration Therapy
- Malaria Control
- Growth Monitoring
- Information system to maximize community participation
- Vitamin A supplements
- Community Water Supply.

In addition to the technical aspects the project will address the following issues:

- Management Systems
- Information System
- Health Care Financing
- Village Health Workers

The proposal, if approved, will continue these activities and involve $715,794 of AID funding from July 1989 to June 1992 and $238,650 of Save the Children Funds. The SCF project has been very successful and its emphasis on management and self financing as well as technical aspects of child survival is very much in line with A. I. D. priorities.

Recently Save the Children and Care have written a joint proposal to USAID for an operational program grant to extend child survival interventions and institute cost-recovery in the extreme North Province of Cameroon. The joint PVO proposal is presently under review at the mission.

D. Other Health Sector Donor Activities (Child Survival/Population and HIV/AIDS)

The following information comes principally from information collected by the UNDP, and additional information obtained from the Ministries of Health, Plan, Social Affaires and USAID contacts with PVOs, bilateral and international donors (e.g. WHO, UNICEF, UNFPA, Save the Children, CARE, Germany, Belgium, and France). (See Annex E, for a listing of other donor activities in the Health and Population Sectors.(8)

In Health in 1986 France was the largest single donor of technical assistance with $42.2 million or 44.5 % of the total amount received from bilateral and international donors. The United States was second with $28.4 million or 30.0% of the total, with West Germany (FRG) third with $8.9 million or 8.4 %. According to UNDP records, in 1986 the Health sector received 12.3% of the total TA of $94.8 million, and Population 0.7%.

See Table 3, "Technical Assistance-Cameroon" by major donor and sector which follows) [insert table 3]

8. Health and Population Sector technical assistance and capital assistance lists in Annex E are taken from UNDP's Development Assistance- Cameroon Annual Report 1986. The annual report for 1987 is not yet issued.).

Most of France's help in the health sector is on the curative side with assistance for hospital care. Germany has concentrated on integrated primary health care in two provinces stressing community participation and self help. Belgium also has a rural primary health care project in one province. The German (GTZ) project is going well, and it has developed some interesting work in designing and setting up non profit community based "propharmacy's" in the areas it is working. The USAID retains close contact with the German and Belgium technical assistance personnel working in the primary health care area.

The principal objective of WHO since the Alma Ata (1978) has been to promote Health for all by the year 2000. This has been made more specific at the Bamako conference in 1987. The strategy for this initiative involves primary health care as a focus on promoting decentralization and concentrating at the operational (or district/arrondissement) level. The new element added at the Bamako conference was to involve the village health committee's, through their representatives at the district level in the self-financing of the operating costs of health facilities at the District level.

The FY 1988-89 WHO technical assistance program was $1.1 million with $1.2 proposed for FY 1989-90. It will provide assistance to the GRC in analyzing its health situation, help resolve management and organizational questions at the primary level, look into health information systems, health education, STD, and other issues of concern to the GRC.

The UNICEF continues to work with the GRC in child survival (especially in the Expanded Program of Immunization (EPI), Control of Diarrheal Diseases (CDC), and Child Spacing. UNICEF collaborates essentially with the Ministry of Social and Woman's Affaires (promoting income generating activities, use of ORT in the "Maisons Familiales" etc.; with the MOH (supplying vaccines, operating funds, and packages of ORT;, and with the Ministry of Agriculture (village water supply). Immunization continues to be a concern since the very successful national campaign in 1987, since the fixed facilities have not been able to keep up, and the level of vaccination coverage is slowly receding.

In addition, UNICEF is working with the World Health Organization is assisting the GRC to implement the Bamako declaration which calls for involving the population at district level in financing and management of health facilities.

In the population field, the USAID and UNFPA are the two major donors, although some help has been received from the World Bank, and Egypt. Population was only o.7% of total external financing in 1986.

In HIV/AIDS in addition to assistance from the USAID and WHO, the French, EEC, and Germans have also made technical and financial assistance available in this important field.

Cameroon has been lucky. The National AIDS Control Program (NACP) is well staffed by competent, young Cameroonians and the National Program has been open to reporting of all cases of AIDS, to sharing information on seroprevalence of HIV, and to cooperating with all donors. The work accomplished in the first year of the NACP is impressive.

With continued support from USAID and other donors Cameroon will be able to ensure an HIV free supply of blood for transfusions, to monitor the prevalence of HIV in both the high-risk and general populations, develop/disseminate appropriate information/education messages, and begin commercial sales of N-Q condoms [free supplies of condoms will be retained at the two GRC STD clinics and to the 225 prostitutes enrolled in a long-term prospective study in Yaounde].

While the various activities appear complementary in nature and are coordinated by the MOH, there is no MOH or Plan donor coordinating committee in health or population which meets regularly to facilitate exchange of information between donors and the government. However, recently the Deputy Chief of Preventive Medicine called together those PVOs and bilateral donors working in primary health care in the field to agree on procedures and timing for the launch of a program of selling health cards for 100 CFA to those using Health Center services. Of the 100 CFA the health center would keep 35 CFA, the intermediate level 15 CFA and the MOH would be reimbursed 50 CFA to cover the costs of producing the cards. This marks a breakthrough in allowing the local centers to keep a percentage of the income from sales.

As part of the Structural Adjustment Program exercise now underway the WB has fielded several technical assistance teams in the social sector concentrating on self-help programs involving community participation. Preliminary talks with the Bank about its interest in establishing a revolving fund for primary health care which would equip the rural health facilities with the generic medicine and supplies needed to deliver basic services which would be self financed by the population was received very positively. This proposal is discussed in section IV below.

IV

Proposed Health Sector Strategy

for
Country Development Strategy Statement (CDSSS)

-- FY 1990 -- FY 1994 --

A. Health Sector Strategy -- Overview

The Health sector strategy has three major areas of concentration -- Child Survival, Population, and HIV/AIDS. Over the period of the CDSS it will focus on more productive and efficient use of existing resources, development of self-help on the part of the population, and the encouragement of the private sector in order to help assure the sustainability of health sector programs. In carrying out this strategy, the USAID will utilize and build on existing technical assistance resources already in place to take advantage of the heightened interest of the government in better management of existing health programs, decentralization, and its willingness to consider full payment for pharmaceutical and health services by the population.

The strategy over the five year CDSS period (FY90-94) is divided into two time periods:

1) Near Term: FY 90, 91 beginning on October 1, 1989 -- a transition period using existing resources already in place to prepare for longer term, new initiatives, and

2) Longer Term: FY 92, 93, 94 beginning FY 92 -- implementation of major self help initiatives nationwide in Child Survival and Population areas which were prepared and tested during FY90 and 91.

The USAID's health sector strategy, which has important long term development implications (e.g. reduction in population growth, and a healthier more productive work force), takes into account the Development Fund for Africa Action Plan, and its performance oriented criteria and potential program flexibility. In addition, the USAID has also developed this strategy within the context of the urgent resource requirements for the Structural Adjustment Program (SAP) now being prepared and negotiated by the World Bank with the GRC in consultation with principal bilateral donors including the USAID. The SAP when agreed and put into operation (perhaps as early as the summer 1989) will dominate resource allocations by the government and donors for the next 3 to 5 years.

While no one can predict for certain how events will unfold, the USAID sector plans which follow are based on the following scenario or assumptions. The economic crisis will continue to deepen for another year (FY 89/90) as the government organizes itself to implement the essential but difficult self-help measures worked out by the World Bank which will have to be met before significant amounts of resources are released. The government will not be able to implement all of these measures simultaneously but will muddle along making slow progress over the next two to three years (FY 91/92/93) until it is able to manage effectively the crisis (FY94). Return to the high growth rates of the period from 1975-85 will be difficult and may not be achieved during the timeframe of this CDSS.

This scenario makes all the more important the measures proposed in the Health Sector Strategy designed to obtain the policy changes necessary to increase the management efficiency of health sector, increase the self-help efforts of the population, and increase the role of the private sector in the priority areas -- Child Survival, Population, and HIV/AIDS project.

As indicated earlier in section III above, the USAID's Health Sector program already reflects Agency priorities for Child Survival, Population and HIV/AIDS. While the program is in different stages of development depending on the sphere of activity, it is characterized by its recently approved bilateral projects and low pipelines plus useful services provided by the selective use of centrally funded technical assistance.

These resources already in place will help the GRC accomplish DFA strategic objective one: "Improving management of African economies by redefining and reducing the role of the public sector and making it more efficient." [underlining added](9)

In addition, the FY 90 - FY94 CDSS planning for the health sector strongly supports one of the USAID's major CDSS strategy objectives: "Increasing the efficiency of the public sector" and its sub sector (iii) "Increased Efficiency and Equity in Providing social services". In both the near and longer term, action plans will be developed to implement the CDSS Health Sector strategy. These plans will emphasize top level policy reform and establishment of "performance oriented" programs including appropriate time phased benchmarks. The following paragraphs outline in more specific terms the USAID's strategy by program elements.

(**9. AID/W/DP, "Development Fund for Africa -- An Action Plan", 12/88, Washington D. C., pages 8, and 11. **)

Put in other terms, the USAID analytical approach started with macro level analysis, and proceeded to identify basic structural problems requiring resolution. Next there has been a careful sector level analysis with focus on subsectors where a flexible mix of project and nonproject level resources made available in conjunction with GRC and other donors can facilitate and make possible improved performance -- e.g. in child survival by making primary health care more productive, and lowering the burden on the government with 100 percent participation by the population in the costs of essential medicines and medical supplies.

Essentially the USAID will be applying a judicious strategy of continuing a base of core sectorial activities of prime importance, while maintaining a flexible stance so that additional resources can be made available to help where performance so warrants.

B. CDSS Health Sector Program Elements -- by sub sector

1. Child Survival

One of the serious problems in the Cameroon in providing primary health care (especially for woman and children under five) at this time is the lack of essential pharmaceuticals and medical supplies in the GRC's 397 elementary health centers and 146 developed health centers, 57 MCH centers, and 64 dispensaries, not to mention the problem of supplying the country's 173 hospitals.

See Table 4 The government, because of high recurrent cost imbalances, has not been able to assure provision of funds to cover these costs. While the reference hospitals in Yaounde and Douala are reported to have received minimal but adequate medicines, the rural health facilities absorbed the majority of the cutbacks. Unfortunately, the outlook for future funds is worse given the GRC's general economic situation.

As a result, where in the past a primary health care center might have had 50 to 100 patients a day, in absence of basic pharmaceuticals and medical supplies, only 5-10 or so may use the facility. By and large prescriptions issued by these government health centers can be filled at the private religious health centers and rural hospitals, which do have the necessary medicines. Often the patient must travel long distances by bush taxi as well as pay cash for the medicines.

Due to shortages of essential materials, and in spite of the governments continued heavy expenditure for salaries under its operating budget (10) (for some 12,000 doctors, pharmacists, dentists, nurses, nurses aides, health and technicians, and investment in the health centers and other service facilities), these facilities are highly unproductive due to lack of medicines and basic medical supplies.(see

(**10. As the amounts budgeted for the MOH continues to decrease, in 1989 an estimated 95-98% will go for salaries leaving only 5% of the government's current budget for supplies, maintenance, and other costs.**)

Table 5) Without any other improvement in management, the regular provision of adequate pharmaceuticals and medical supplies would improve dramatically the productivity of the system and the amount of effective primary health care provided to the community -- perhaps as much as doubling or tripling the number of visits to the center.

The USAID is convinced that if centers could be supplied regularly with 20 essential generic drugs and essential basic medical supplies, over 70% of the diseases could be treated effectively. If these basic curative drugs were available with the concurrent increase in use of the basic level health facilities by mothers and their children, it would make the government's work in preventive medicine (vaccinations, ORT, growth monitoring, child spacing) much more effective.

(N.B. In the near term vaccinations would continue to be provided free for major illnesses, given their cost effectiveness from an epidemiological point of view (e.g. eliminating the necessity of treatment for measles, tuberculosis, whooping cough, diphtheria, tetanus, etc.)

Experience to date in Cameroon and other sub Saharan countries demonstrates that the rural population will pay for essential medicines and go long distances to purchase them. This demonstrates that a program which would solve the medical supply problem would be well received <u>even if the population was asked to pay one hundred percent of the acquisition, plus transportation, plus distribution costs.</u>

One solution to this problem would be to develop a sustainable, self-financing system in the short term (next 2 to 3 years) which would provide essential generic drugs to the government's primary health care system at reasonable cost to cover 70% of primary health care illnesses. Such action would make more productive the PHC system for both curative and preventive services.

The major thrust of the USAID's Child Survival strategy then will be to establish over the next two to three years, a nationwide renewable medical supply system for the country's primary health care network which would be self sustaining after the initial financing by donors (e.g. USAID, World Bank, UNICEF, and other bilateral donors). Non project assistance would be the mechanism used for the USAID contribution to the revolving fund with major health care policy changes by the GRC the justification for the non project assistance.

A restructured ONAPHARM with a capability to function as a wholesaler for the import of these essential generic drugs, would import the drugs and deliver them to its 10 provincial centers. The MOH's Provincial Health offices would pick up the medicines and supplies from ONAPHARM's provincial offices and pay for them at the time of delivery. The first quarterly or semestrial delivery would be provided free, but resupply would require payment to ONAPHARM at time of delivery using the funds collected by the primary health care facilities in selling the pharmaceutical and charging for medical supplies.

In order to obtain significant price savings and quality control, the 20 or so generic drugs and medical supplies would be purchased via UNICEFs supply center in Copenhagen. This source would also assure quality control. Given the large volume of purchase of these pharmaceutical by UNICEF to meet worldwide needs, UNICEF prices are significantly below what might be obtained by ONAPHARM with relatively small orders, or from the private sector for quarterly/semestrial needs, and significantly below the cost of purchase by brand name. ONAPHARM is already mandated to act as a wholesaler in ordering for and selling medicines to the not-for-profit PVOs or NGOs.

This same ONAPHARM wholesaler facility would also be made available to private pharmacies wishing to stock generic drugs, with no government imposed ceiling on the private sector markup. This latter point would encourage private sector pharmacies to stock generic drugs. It could be included in the policy dialogue with the GRC as one of the conditions precedent which must be met in order to qualify for the grant/soft loan for the purchase of generic medicines and medical supplies.

It is expected that as much as $25.0 to $30.0 million would be required to establish the revolving fund. For example, it might be divided between donors as follows:

- USAID (non project grant)	$ 7.5 - 10.0 million
- World Bank (social sector soft loan)	$10.0 - 12.5 million
- Other Donors	$ 7.5 - 7.5 million
Total Required	$25.0 - 30.0 million

[N. B. The USAID considered the possibility of the non project grant directly to the private sector (pharmaceutical), as was done for the fertilizer import non project grant. The private pharmaceutical sector presently imports around 30% of the pharmaceutical and medical supplies used in Cameroon. However, individual private pharmacy imports would be significantly more expensive than ONAPHARM buying through the UNICEF facility. In addition, it might not be profitable to establish commercial pharmacies in some of the isolated areas where the government's primary health care facilities already exist.]

To develop a feasible, pretested nationwide system and develop the training capability necessary for its installation, the GRC and USAID would use the bilateral Maternal Child Health project described in Section III above to develop self-help systems in the two provinces (South and Adamaou) with a view to being ready to go nationwide by late FY 91 or early FY 92. The USAID/GRC MCH project agreement already provides for developing systems in the two provinces which would require payment by the population for medicines and services.

This plan to assure the supply of essential generic medicines to the whole primary health care system and establish a self financing system for the continuous regular supply of these medicines and medical supplies has a very specific and precise objective which is limited to making the existing fixed primary health care system more productive. It is complementary and in no way replaces the broader, longer term "Bamako initiative" programs now being organized under the WHO/UNICEF supported activities at district/ arrondissement level -- i.e. by developing propharmacies and organizing the support of village and district level health committees for broader based health care support.

To sum up, in the near term (FY90-91) as part of the MCH project's current Child Survival mandate, and by using its resident staff and short term consultant element, a workable self financing medical supply system would be designed and tested in two provinces. The MCH team would then prepare the necessary manuals and training programs (TOT) so that the program could start in late FY 91-92. In FY 92-93, MCH would move nationwide and help with the installation of the system and assure that it was fully sustainable without further external assistance.

Another aspect of the Child Survival sub sector strategy which addresses an important area of weakness is that of management, supervision, and administration -- i.e better use of existing resources and reduction of waste. Most administrators in the health field are selected because of the technical skills and may never have had any training in management.

In other cases it is the administrative system in place which must be revamped before significant improvement is possible. Health Information Systems (HIS) and Management Information Systems (MIS) now being developed by the MCH team must be organized so that decision makers can respond promptly to epidemiological challenges, and make sounder operating decisions for vital immunization, ORT, and child spacing programs -- the operation of which are made all the more difficult given the greatly reduced resources available.

Over the next two years (FY 90 and 91) the MCH team will continue its management oriented help at provincial level, and will use this experience to design and test programs which can be successfully applied at the national level -- self help and management systems. The project will be extended through FY 94 to provide help during the transition period from provincial to nationwide self-help programs.

2. Population

As indicated in section III above, the USAID is effectively using centrally funded resources and the Family Health Initiatives II Project. Both resources have been steadily preparing the government to move ahead in this important area. As the government nears the stage of a public policy statement or credo on family planning followed by increased IEC work and movement into national level delivery programs, it is vitally important that the Demographic Health Survey (DHS) requested by the USAID in late 1988 be fielded as soon as possible, hopefully, in fall of 1989, but no later than early 1990. An optimistic time schedule would be to have the results of the survey available, analysed and in the hands of the decision makers by the summer or late fall of 1990.

Not only is this information necessary to design realistic service delivery programs at a national level, the results of the DHS will provide essential base line data upon which benchmarks can be established and progress (or lack of it) can be measured.

Meanwhile, the MCH project will work at provincial level to determine the level of contraceptive demand, and the response if contraceptives to be made available. This foundational work will prepare the way for Information, Education and Communication programs, and contraceptive social marketing efforts involving contraceptive Sales in cooperation with the private sector, once the results of the DHS are known and analyzed.

By FY 91, the government's "performance" -- i.e. public policy population announcements, decentralization of family planning to the district level, field level training, identification of target groups, priority areas of concentration will have been made. The DHS analysis will be available and the stage set for the preparation of a major bilateral population project which would become operational in late FY 91 or early /FY 92 and continue throughout the balance of the CDSS and beyond. While it is premature to make any firm estimate, based on cost of bilateral service delivery oriented activities of this type at least $10.0 million over five years should be planned.

3. HIV/AIDS

USAID feels that over the CDSS period there is an unique opportunity in Cameroon to greatly reduce or stop the spread of the HIV and as a result the number of AIDS cases. However, it is necessary to continue the government's vigorous approach to this problem in spite of the serious monetary constraints -- especially given Cameroon's relatively high rate of sexually transmitted diseases -- higher in the urban areas (12-15% in adults). The results of nine studies (two in the rural areas, and seven in urban areas) showed near zero prevalence in the rural areas and 0.5% and 0.8% HIV positivity in urban survey groups. However, in high risk groups such as "commercial sellers of sexual favors -- prostitutes" from 8% to 12% were HIV positive.

The government has strongly supported the program, encouraged the medical community to help, established a special unit in the MOH, and encouraged the initiation of an important Information, Education and Communication (IEC) programs using radio, television and the written media. The HIV/AIDS activity is one in which a vertical program seems advisable, oriented toward prevention focusing on the high risk groups, and education (IEC) of the rest of the sexually active population. The USAID feels that the organization and implementation should be kept separate from family oriented population programs, and primary health care programs in the rural areas. For example, the Ministry of Health has set up a separate section to deal with HIV/AIDS.

A cost effective system for monitoring the progress or regression of HIV will be developed, and fine tuning the corrective health education messages will be continued and improved over the CDSS period. IEC message content stresses that AIDS is avoidable by the individual -- through abstinence, single partners, reducing the numbers of sexual partners, and use of condoms. While studies show that over 90% of HIV transmission is sexually transmitted, measures are already being taken to test blood donated for transfusions, and to reduce and then eliminate HIV contamination from this source. Public Education also covers the dangers from unsterile needles. and skin piercing intruments.

Regarding the need to slow or stop the HIV transmission by high risk groups, an initial pilot program involving testing, education and supplying of condoms has been initiated. Some 225 prostitutes (who can act as trainers in informing others) from major hotels in Douala and Yaounde are enrolled in the program.

To sum up, in FY 90 and FY 91 the USAID will continue to draw on its bilateral and centrally funded programs(using buy-ins where appropriate) at about $3.5 million each year to assist the GRC to continue the development and implementation of its Child Survival/Population/ HIV/AIDS activities. By late FY 91 or early FY 92, it is expected that the mission will be ready to implement its major "Self Sustaining Pharmaceuticals" non project grant of $10.0 million in cooperation with international and bilateral donors. In addition, it is expected that by FY 92 the USAID will have obtained sufficient data and experience to launch a major Population bilateral project of $5.0 million over the remaining three years of the CDSS. The total estimated amount of project and non project assistance required for the Health Sector from FY 90-94 is $28.5 million.

Table 6

CDSS HEALTH SECTOR PROGRAM (FY 90-94)
($000s)

Project Title	Oblig.to Date	1990	1991	1992	1993	1994	Total (FY 90-94)
I. Child Survival							
-Maternal Child Health (6310056)	6500	2000	1500				
-PRITECH (9365927.1)	550	300	250	200	150	100	
-Measles Vaccine (6980421.31)	240	100	100	100	100	100	
(Proposed Child Survival Bilateral Activities)							
-Maternal Child Health Phase II				1500	1500	1500	
-Self Sustaining Pharmaceuticals (Non Project 1)				10000			
SUB TOTAL (I)	7290	2400	1850	11800	1750	1700	19500
II. Population							
-Family Health Init-II (69850462.31)	800	400					
-Population Services and Policy Support (631____) see ABS '90			1000	2000	1500	500	
(Continuing Population Activities -- Centrally Funded)							
-Training (JHPIEGO)2		200	200	200			
-Service Delivery (FPIA) (2)		130	130	130	130	130	
-Bio Med Research (FHI)2		20	20	20	20	20	
-Demographic Health Survey (DHS) (3)	400						
SUB TOTAL (II)	1200	750	1350	2350	1650	650	6750

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1. Non-Project grant in cooperation with international and bilateral donors-- e.g. World Bank, UNICEF, West Germany, etc. Their contribution $10-20 million.)

2. Contingent on AID/W continued funding.

3. Plus $70,000 taken from USAID/Cameroon Family Health Initiative-II project (69850462.31)

CDSS HEALTH SECTOR PROGRAM (FY 90-94)
($000s)

Project Title	Oblig.to Date	1990	1991	1992	1993	1994	Total (FY 90-94)
III. HIV/AIDS							
-Support to National AIDS Control Program Project (NACP) (4)	748	300	350	400	400	400	
SUB TOTAL (III)	748	300	350	400	400	400	1850
IV. Other Related Health							
-Health Constraints Rural Prod.-Shisto- (6310067)	7483						
(Continuing Centrally funded activities)							
-Infant Weaning Practices (9311010)	147						
-AID/Science (PSTC) (9365542)	225	80	80	80	80	80	
SUB TOTAL (IV)	7855	80	80	80	80	80	400
GRAND TOTAL (I-IV)	17093	3530	3630	14630	3880	2830	28500

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4. Total of $748,000 includes: WHO/GPA, $200,000; AID/W Central Funds, $348,000; and USAID/Cameroon 1989 OYB, $200,000..

C. Responsiveness to Cameroon's Development Needs

The USAID feels that the program priorities in the social sector outlined above address the principal social development needs of Cameroon. There are the primary health care programs which stress child survival and include child spacing, there are programs to reduce the uncontrolled population growth and to stop the spread of HIV to reduce AIDS; all of these have major economic implications for the economy over the long term, and should not be stopped because of the current economic crisis.

The SAP now under negotiation and deepening economic crisis offers some major opportunities to encourage and install major self-help measures by the population in the area of primary health care. They have enhanced the interest at senior government levels to improve management systems, carry out a major population program, and encourage a more important role in the private sector.

As indicated above, the thrust of the Health sector program does not emphasize capital investments. On the contrary, its objective is to make more cost effective and productive use of existing facilities and services, to lighten the burden on the government through greater cost recovery, and to encourage private sector participation where ever possible.

D. Financing -- including Self - Help/Sustainability

Table 6 laid out the expected financial needs by activity over the period FY90-94. (See Page 27) Essentially the priority projects (bilateral, buy-ins, and centrally funded) are already in place and financing needs are reasonably clear for FY 90, and FY91. Projections for Fiscal Years FY 92,93, & 94 are more general in nature and are performance oriented -- i.e. their implementation (described above) will depend on specific policy level, administrative, technical and financial actions taken by the GRC.

Financing of both technical assistance and non project assistance is planned over the CDSS period. The establishment of a $25.0 - 30.0 million multi-donor revolving fund (USAID contribution $7.5-$10.0 million) to provide essential generic drugs for the governments fixed primary health care facilities will lead to a sustainable self-help system under which the population will pay for 100% of the cost of the replacement and recurrent costs for these essential medicines and supplies. The following table outlines the financial needs over the CDSS period by type of assistance, activity and fiscal year:
(Detailed justification and benchmarks for activities described above and listed in the table will be provided in the USAID's Action Plan(s) which will be prepared later in the year.) [See Table 6]

V. USAID Health Sector Management and Administration

The USAID's current Health sector portfolio contains three major health bilateral activities, one African Regional Population activity, three centrally funded population activities, AID/SCI research grants, PRITECH, the HIV/AIDS program (which is a mixture of funding from AID/Wand USAID/Cameroon) as well as other elements. In addition the USAID is responsible for health programs in the Central African Republic (CAR) and Equatorial Guinea (E.G.).

The Office of Education and Human Resource Development through its Health, Population and Nutrition Division (HNP) is responsible for these activities. The HNP division is managed by a senior direct hire Health and Population Officer who has been in the Cameroon for five years and will leave during the summer of 1989. He is assisted by a Project assistant -- a very competent Cameroonian. In addition there is secretary assigned to the Division.

At present the HNP office is very busy. The office is well managed and copes very well with its Child Survival, Population and HIV/AIDS activities including a major health research project in schistomiasis which will end in 1990. The work involves not only the Ministry of Health but also the Ministries of Social and Woman's affairs, Plan and Agriculture.

Close contact is also maintained with WHO, UNICEF, UNFPA, and the World Bank on health sector activities, as well as PVOs (Save the Children, and CARE), and major bilateral donors working in the USAID's field of action -- Germany, Belgium, and the French. The government has no formal coordinating mechanism in the health sector (child survival, population, HIS/AIDS, etc.). This makes the informal coordination with other bilateral and international organizations particularly important -- although time consuming.

The use of the full range of A. I. D. resources -- centrally funded services (an estimated $550,000 annually), buy-ins, and bilateral funding-- has been very effective in the health field, and enabled the mission to respond to critical GRC technical assistance needs. However, if there were not the careful orchestration and program planning by the USAID direct hire health officer, these multi disciplinary technical resources would be wasted. As it is they have been very effective in moving the government's thinking and programs along in the right direction in spite of the growing financial constraints.

Future health sector activities will involve decentralization, self-help, community participation, multi donor cooperation, IEC/CSM, multi disciplinary surveys (DHS, mini surveys, focus groups, operational research with a view to effecting public policy so that any policy and/or structural changes needed to increase the effectiveness of public health services can move ahead.

To carry out the CDSS plans described in Chapter IV above and manage or maintain the current portfolio, at minimum a senior level U. S. direct hire health/pop officer will be required. Even then, the US direct hire (Gary Leinen's) replacement (he or she), may not be able to handle the program load in their initial year without some additional help. Given the expected expansion in population sub sector, there is an a priori need for a PSC population officer to provide additional technical, administrative and management help as this activity grows from regional testing to a major nationwide program.

To reiterate the problem in more program terms, the thrust of Health Sector program with innovative self help, management, programs , non project assistance promoting policy level decisions affecting policy structure will require more careful management by an experience USAID direct hire health/population officer. Opportunities are great, put will require firm but sensitive direction.

For example, as the program moves into the service delivery phase the population program will require coordination between three ministries (Ministry of Health, Ministry of Social and Women Affairs, and Ministry of Agriculture. As mentioned above a GRC coordinating mechanism in the Presidence of Plan for population will need to be created with senior level government support. Contraceptive social marketing drawing on the marketing strengths of the private sector offer opportunities for chloroquine tablets - malaria; ORS Salts for CDD, condoms for at risk groups to reduce the HIV/AIDS threat.

Lack of adequate USAID management will put at risk the substantial progress, and foundation building work already carried out or under way.

To sum, up the present USAID direct hire Health/Pop officer should be replaced this summer by a senior Health/Pop officer with experience in Africa. Given the complexity of the Cameroonian program, there should be several weeks overlap, if at all possible. In addition, budget permitting a PSC should be hired to help carry on the growing work in the Population field.

If it is not possible to maintain the direct hire health/population officer, the health sector program described above should be reduced significantly to allow for proper administration and management control.

VI. Monitoring and Evaluation

Highlighting the USAID's Health sector programs be they Child Survival, Population, or HIS/AIDS is the conviction that one of the foremost barriers to progress and effective use of scarce resources are the across the board lack of management skills in the public health field. This may be due to the almost exclusive attention to the technical (nursing, medical and pharmacy subjects) to the exclusion of public health management. In addition, Health Information Systems and Management Information systems are less developed here than in a number of the West African countries. This makes monitoring and evaluation of health sector activities of special importance.

One of the serious problems is lack of base line data in the health field which will enable the evaluators to measure the forward progress (or lack of it) in the joint GRC/USAID programs. In this context it is vitally important that the Demographic Health Survey (DHS) already requested by the GRC and USAID be carried out as soon as feasible. The base line data obtained from the DHS survey will provide a foundation for measuring progress, and carrying out meaningful mini survey's and other operational research needed to assess the progress of the program and plot future strategies for implementation.

Each major health activity will have its own annual action plan with specific benchmarks by fiscal year, so that the USAID management can measure specific strengths and weakness of its CDSS program in the health sector and make the necessary adjustments. In addition, apart from these regular annual, biennial or as-needed evaluations of the specific health sector activities, given the uncertainties around the results of the Stabilization Adjustment Program agreement expected to be signed in the summer of 1989, the USAID will include an assessment the health sector in its overall review of the CDSS in January 1990.

Annex B

List of Persons Contacted

I Government of the Republic of Cameroon (GRC)

- Ministry of Plan (MPAT)

  Alphonse Tabi, sub Director of Human Resources
  Madame Fuller, Assistant Chief of Service for Health and Population
  Jean- Marie Fokam, Chief of Health and Population

- Ministry of Health (MOH)

  Dr. Amida Ghogomou, Director, Preventive Medicine
  Dr. Owona, Deputy Director, Preventive Medicine

- National Pharmacy Office (ONAPHARM)

  Dr. Dobo Beye Casimir, Pharmacist, Director

II International Organizations and Other Donors

- World Bank (WB)

  Dr. Raymond Rabeharisoa, Resident Representative

- UNDP

  Lee Merores, Deputy Resident Representative

- World Health Organization (WHO)

  Dr. Malouba, Resident Representative

- UNICEF

  Dr. Sanoko, Senior Program Officer

- UNFPA

  Pierre Ongenue, Program Officer

III Non Profit Organizations (NGOs)

- Save the Children

  Tim Manchester, Director

IV USAID

Jay P. Johnson, Director
Ellsworth Amundson, Deputy Director
Robert W.Schmeding, Office Director, Education, Human Resource Development Division
Gary Leimen, Health/Nutrition/Population Officer
George Vishio, HNP Project Officer
Norman Olson, Supervisory Program Officer
Robert Shoemaker, Superviory Project Development and Evaluation Officer
Gerald Hensley, Controler

V. AID/W

Emmy Simmons, Senior Economist, AFR DP
Gary Merritt, Chief, Population and Public Health Branch Africa TR
Ebbe Fessenden, Cameroon Desk Officer
Alan Getson, Project Development Officer, AFR Bureau

VI USAID Contractors

- Maternal Child Health/Child Survival Project

  Malcom Bryant, MB, MPH Project Coordinator, HIID Cambridge, U. S. A.
  Dr. James C. Sonnemann, MD, MPH, Chief of Party
  Robert de Wolfe, Management Trainer

- Control of Diarheal Diseases Project

  Ms. Robbin Steinwand, PRITECH Representative, Cameroon

- Health Constraints to Rural Production

  Dr. Raoult Ratard, MD, MPH, Chief of Party (Tulane)

- Development Alternatives Inc. (Jan/Feb 1989)

  Dr. Roger Poulain, Chief of Party
  Dr. Nicolas Kulibaba, Anthropologist/Sociologist
  Dr. Eric Nelson, Economist

- The Futures Group (TFG), Washington D. C.

  Dr. Ken Yamashito, Population Research Director
  Maurice I. Middleberg, Deputy Director Options for Population Policy Project

Annex C

Documents Consulted

1. Cameroon, Republic of (1986). Sixth five year ecnomic, social and cultural development plan, 1986-1991. Ministry of the Plan and Regional Development, Yaounde.

2. United Nations Development Programme (1987). Development Assistance Cameroon, Annual Report 1986.

3. _____. Health Sector Analysis, 1987.

4. USAID Cameroon, Country Development Strategy Statements 1986, & 1987 (update).

5. AID/W, Development Fund for Africa, Action Plan, Wash., D.C., 1988

6. USAID Cameroon, Project Papers for:

   a. Maternal Child Health/Child Survival Project (631-0056)

   b. Primary Technologies for Health Care (PRITECH) -- Controlling Diarrheal Diseases (CDD)

   c. Family Health Initiatives-II,(FHI-II) (698-0462.31)

   d. Health Constraints to Rural Production Project (Schistosomiasis research) (631-0067)

7. Save the Children/Yaounde. Project Proposal -- Child Survival Inititatives, 1988.

8. ONAPHARM [illegible]

ANNEX D

OTHER DONOR ACTIVITES IN HEALTH AND POPULATION

(Source: UNDP: "Development Assistance
Cameroon, Annual Report 1986, Table I & Table III)

TABLE I

EXTERNALLY FINANCED TECHNICAL ASSISTANCE PROJECTS AND ACTIVITIES, 1986

(in thousands of US dollars)

Country Receiving Assistance CAMEROON

ACC Sector 08 - Population

(1) Project/Activity (Title and Number)	(2) Source of Assistance	(3) Project Duration 19- 19-	(4) Total Donor Commitment to the Project	(5) Disbursement or expenditures in 1986 or latest financial year	(6) Nature of Assistance
Family Health international 932-0537	USAID		85	16	Research on no-estrogen and copper IUD.
International Foundation for family life promotion	USAID			38	Support for natural family planning.
Margaret Sanger Center 932-0651	USAID			57	training in New York for nurse-midwives instructors.
Family planning international assistance 932-0955	USAID	4/81-5/87	320	210	to provide family planning commodities and services.
Research for awareness of population impact RAPID II	USAID	7/83-6/87	332	170	nationwide survey on family size and family planning, transfer of technology.
		D-1	SECTOR TOTAL	USAID... 491	

TABLE I

EXTERNALLY FINANCED TECHNICAL ASSISTANCE PROJECTS AND ACTIVITIES, 1986

(in thousands of US dollars)

Country Receiving Assistance CAMEROON ACC Sector 08 - Population

(1) Project/Activity (Title and Number)	(2) Source of Assistance	(3) Project Duration 19- .19-	(4) Total Donor Commitment to the Project	(5) Disbursement or expenditures in 1986 or latest financial year	(6) Nature of Assistance
Education des populations à la parenté responsable et amélioration des conditions de vie familiale et communautaire CMR/85/P01, Phase II	UNFPA/ILO	1985-1987	282	65	Education et recherches sur le comportement démographique des populations. 1 CTP, 1 expert national en démographie, 1 expert national en organisation, consultants.
Unité de planification de la population CMR/80/P02	UNFPA/ILO	1984-1986	316	85	Mise en place d'une unité de planification de la population au MINPAT. 1 Expert, équipement, bourses.
			TOTAL UNFPA....	150	

D-2

TABLE 1

EXTERNALLY FINANCED TECHNICAL ASSISTANCE PROJECTS AND ACTIVITIES,1986
(in thousands of US Dollars)

Country Receiving Assistance CAMEROON ACC Sector 10 - Health

(1) Project/Activity (Title and Number)	(2) Source of Assistance	(3) Project Duration 19 19	(4) Total Donor Commitment to the project	(5) Disbursement or expenditures in 1986 or latest financial year	(6) Nature of Assistance
ıst Water Project (PN 03) Phase III)	CARE-CANADA CIDA	1986-1989	1,621	622 (7/86-6-87)	Materials, Equipment, Personnel, Training for Rural Wells Construction and Health Education in East Province.
›rthern Wells Project 'N 06)	CARE-CANADA USAID	1984-1987	1,386	578 (7/86-6/87)	Materials, Equipment, Personnel, Training for rural Wells construction and water sanitation education in three departments of Extreme-North Province.
›proved Weaning Practices 'N 09)	CARE-USA/ MANOFF Int'l.	1985-1987	93	74	Materials, equipment, personnel, training in support of better weaning foods growth monitoring health education in the Extreme North Province.
			SECTOR TOTAL CARE	1,274	

TABLE I

EXTERNALLY FINANCED TECHNICAL ASSISTANCE PROJECTS AND ACTIVITIES, 1986

(in thousands of US dollars)

Country Receiving Assistance CAMEROON ACC Sector 10 - Health

(1) Project/Activity (Title and Number)	(2) Source of Assistance	(3) Project Duration 19- 19-	(4) Total Donor Commitment to the Project	(5) Disbursement or expenditures in 1986 or latest financial year	(6) Nature of Assistance
Information on public health and traditional medicine	IDRC	1986-1989	66	11	Expanding the services of a documentation centre on traditional and modern medicine.
YOKO Water	CRS	1984-1986	18	4	financial support of a wells digging and prevention health programme in Yoko.
Water Supply Mayabat	CRS	1984	35	14	Provide potable water to a leper village in the Central Province.
Village Water SA'A	CRS	1985	18	18	Financial support for the implementation of a workshop for pre-fabricated materials.
Primary Health CARE	CRS	1984-1988	250	51	Support to coordinating Body of Catholic Health Services.
Mullah Water Supply	CRS	1984	62	11	Provide potable water to populations of Mullah in the North West Province.
CeDAC Sanitation	CRS	1986-1989	578	220	Financial support to CeDAC for a program of wells and latrins digging in the South Province.
			SECTOR TOTAL CRS...	318	

TABLE I

EXTERNALLY FINANCED TECHNICAL ASSISTANCE PROJECTS AND ACTIVITIES, 1986

(in thousands of US dollars)

Country Receiving Assistance CAMEROON

ACC Sector 10 - Health

(1) Project/Activity (Title and Number)	(2) Source of Assistance	(3) Project Duration 19- 19-	(4) Total Donor Commitment to the Project	(5) Disbursement or expenditures in 1986 or latest financial year	(6) Nature of Assistance
Northern Wells II 631-0051	USAID	8/84-6/87	820	-	To provide permanent potable water sources in Northern Cameroon and teach hygienic water usage and easte disposal practices to the user population
Program Development and Support 631-0510	USAID	CONTINUOUS	-	400	Fund the design of the Child Survival statistics capability within the Ministry/ Maternal Child Health Project. Short-term research.
Health constraints to rural development 698-0408.1	USAID	8/83-12/90	7,353	933	To develop a schistosomiasis research center in Cameroon.
Central Hospital at 4'Nongal and Metet Hospitals (Ebolowa) 938-1349	USAID	1986	-	350	Funds for construction and repair of facilities, supplies development and operations.
Combatting childhood communicable diseases 698-0421	USAID	-12/88		108	Train senior management and supervisory health personnel to combat and provide simple treatment for childhood diseases as well as diarrheal diseases and malaria.

TABLE 1

EXTERNALLY FINANCED TECHNICAL ASSISTANCE PROJECTS AND ACTIVITIES, 1986

(in thousands of US Dollars)

Country Receiving Assistance CAMEROON ACC Sector 10 HEALTH

(1) Project/Activity (Title and Number)	(2) Source of Assistance	(3) Project Duration 19 19	(4) Total Donor Commitment to the project	(5) Disbursement or expenditures in 1986 or latest financial year	(6) Nature of Assistance
Oral Rehydration Therapy	USAID	86-88	320	320	Support Save the Children Federation program in oral rehydration therapy.
JHPIEGO Mother/Child Health (932-0604)	USAID			200	Training in obstetrics and gynacology for physicians and family planning for midwives and nurses.
Infant Feeding Study (931-1010)	USAID	6/81-9/87	147	61	Study cultural habits to promote breasts feeding in support of better infant health and reductic of malnutrition.
PRITECH (936-5927)	USAID	86-87	300		Child survival estimates.
			TOTAL USAID	2 372	
Basic health care in the North West and South West Provinces	FRG		2 500	2 500	Advisers, material
Basic health care in the Littoral Province	FRG		700	700	
				3 200	

TABLE 1

EXTERNALLY FINANCED TECHNICAL ASSISTANCE PROJECTS AND ACTIVITIES, 1986
(in thousands of US Dollars)

Country Receiving Assistance CAMEROON ACC Sector 10 HEALTH

(1) Project/Activity (Title and Number)	(2) Source of Assistance	(3) Project Duration 19 19	(4) Total Donor Commitment to the project	(5) Disbursement or expenditures in 1986 or latest financial year	(6) Nature of Assistance
Health Sector Support	FRANCE			3 395	59 medical staff
Village water, Ekondo Titi	UK			7	Investigations visit prior to planning water supply for single village
Design studies for water supply for four towns	UK	12 months			Study and design prior to construction.
Volonteers for hospitals	BELGIUM	1986		132	29 volonteers
Training for nurses	EGYPT	1986		5	
Seminar on immunization	UNDP/WHO	1986	13	13	Training for health staff
Health sector support:HH11	UNICEF	1986	479	479	Assistance for vaccination campaign and other MINSANTE programmes
Analysis of health situation CAE/HST/001	WHO	1986		11	Scholarship for Documentation technology in France

TABLE 1

EXTERNALLY FINANCED TECHNICAL ASSISTANCE PROJECTS AND ACTIVITIES, 1986
(in thousands of US Dollars)

Country Receiving Assistance CAMEROON ACC Sector 10 HEALTH

(1) Project/Activity (Title and Number)	(2) Source of Assistance	(3) Project Duration 19 19	(4) Total Donor Commitment to the project	(5) Disbursement or expenditures in 1986 or latest financial year	(6) Nature of Assistance
Health systems organization based on primary health care CAE/PHC/001	WHO	1986	45	22	Sundry activities
Training health personnel AF/CAE/HMD/001/RB/86	WHO	1986	360	310	Seminars other training cours for MINSANTE Staff
Mother and Child Health CAE/MCH/001	WHO	1986	56	24	Purchase of 2 vehicles for MFOUNDI division
Developpement du bien-être familial	UNFPA/WHO	1986		10	Purchase of contraceptives for NGONGA training Centre
Expanded Programme of Immunization CAE/EPI/001/RB/86	WHO	1986	71	53	Purchaseand transportation of equipment and training
Fight organist disease vectors CAE/VBC/001	WHO	1986	14	14	Purchase of vehicle for use in yellow fever affected areas
Fight organist parasital diseases	WHO	1986	15	10	Local purchase of biltricine
Fight organist leprong CAE/LEP/001	WHO	1986	8	7	Purchase of leprosy drugs (Lamprène)

Table 3

CAPITAL ASSISTANCE FINANCED BY EXTERNAL SOURCES, 1986
(in thousands of US dollars)

Country Receiving Assistance CAMEROON ACC Sector 10 - HEALTH

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Title or Project/Activity	External Source (s) of Capital Assistance and date Committed	PU/PR- If project is co-financed list each source separately under Column 2	Amount Committed (US $ Equiv.) Loans/ Credits	Grant	Equity	Amount disbursed in 1986 or the latest complete financial year	Comments (Grace period, interest rate, location of project, etc...)
Health component of South-East Benoué Project:122/C/DPL/86/CAE	FRANCE	PU		29		29	3rd instalment
Funding of Community Water Supplies	HELVETAS	PU		150		150	South West; West; North West provinces