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Country Development Strategy Statement

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CAMEROON

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ANNEX I

Cameroon Health Sector Assessment

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I. INTRODUCTION

The focus of this assessment is on the delivery of health services to rural areas in Cameroon. Such a perspective is in keeping with USAID's health program, which is supportive of the Agency's overall objective to increase food production. Special attention has been paid by the authors to the situation in the newly created South and Adamaoua provinces because those were specifically recommended by the Ministry of Health as priority for a USAID health program.

Because of the impact of disease and poor health on productivity and the fact that 70% of the health problems are amenable to cost effective and basic interventions, continued USAID assistance to health improvement in Cameroon is justifiable from a developmental perspective. In addition, by the year 2000, the ratio of Cameroon's consumers to food producers will increase three fold. For these reasons alone, investment to reduce loss of the food producing population due to disease and premature death is an integral part of a balanced development strategy.

II. CAMEROON PRESENT HEALTH SITUATION

The Republic of Cameroon covers 465,402 km² offering an ecological range from desert in the far North to tropical forest in the South. Its population at the beginning of 1986 is estimated at 10,446,400 (based on the 1976 general census) and includes about 93 different ethnic groups. Of this population, one-fifth are officially Anglophones and the rest 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 36% of the total population, this ratio is expected to rise steadily in the next years. Urban centers are expected to continue to grow and will contain over half of the total population within the next ten years. 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 growing steadily younger (55% under 20) due to an increase in fertility (6.5 total fertility rate in 1982) and a decrease in childhood mortality. The population growth is presently estimated at 2.6% per year.

Cameroon belongs to the group of lower middle income countries with a per capita income of 890 U.S. dollars, 1982 estimate. However, an infant mortality rate presently estimated at 105 per/1000 and life expectancy of 52 years are still comparable to those of low income countries. Estimates of mortality in the rural areas make the discrepancy between per capita income and life expectancy more dramatic.

An analysis of morbidity and mortality patterns show a predominance of infectious and communicable childhood diseases. The present system of data collection does not provide reliable epidemiological data on a community level. Existing data usually reflect the situation at the hospital level.

Major causes of mortality include measles, tetanus, acute respiratory infections, and malaria. Diarrheal disease and perinatal death (in particular neonatal tetanus) are under reported.

The major causes of out patient consultation are malaria, intestinal parasites (and in particular hook worm and amoebiasis), skin diseases, throat infections and acute respiratory infections. Sexually transmitted diseases are another major cause of morbidity for 15 to 44 years old patients.

A WHO survey in 1983 and 1984 on diarrheal diseases reported 50% of infant deaths were diarrheal-related and children suffered from 3 to 6 episodes a year. Thirty-five percent of diarrhea incidents are due to rotavirus infection. Outbreaks of cholera occur every 2-3 years. Diarrhea is not only related to diseases like cholera but also to socio-nutritional factors such as inadequate weaning. Poor environmental health, sanitation, and water sources are significant factors contributing to the high incidence of diarrheal disease.

Malaria (*P. falciparum*) is holoendemic, particularly in the tropical forests. There is evidence of recent, progressive chloroquine resistance.

The recent emphasis on the expanded immunization program is believed to have reduced the incidence in whooping cough, poliomyelitis and measles. However, no reliable community based data are available and under reporting of cases is especially high in rural areas.

Other major endemic diseases include tuberculosis, leprosy, and cerebrospinal meningitis. Preliminary mapping of guinea worm disease shows it as prevalent in the North and in some areas of the South. With increasing migration, this easily controlled disease will spread. Guinea worm tends to occur at the height of the agricultural season and frequently incapacitates agricultural workers for up to one full month.

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. Malnutrition is still felt to be a major problem (in particular in Adamaoua province) and is generally due to socio-cultural factors rather than to shortages of food. Due to ethnic, environmental and economic diversity in Cameroon, the epidemiological patterns and the mortality/morbidity profile of the population vary widely from one region to the other.

III. DELIVERY OF HEALTH SERVICES

A. Historical Evolution of Health Policies

1. Government of Cameroon.

At independence, Cameroon inherited a colonial health system characterized by vertical programs and an excessive emphasis on curative facilities (mainly hospitals in urban areas). From independence the government has committed itself to provide free medical care to its constituents. The government of Cameroon has allocated up to 6.3% of its total budget to health. WHO recommends an average of 10%. This decreased to a present rate of 4.6%, but still represents \$12.6 per capita spending in health which places Cameroon at a comparatively high level as compared to other African countries. It is interesting to note that unlike most African countries, Cameroon does not rely entirely on external aid assistance for health investment.

Following the Alma Ata conference in 1978, the government of Cameroon adopted the principle of "Health for All in the year 2000" and consequently the fifth 5 year plan (1980-85) introduced new orientations:

- extension of coverage of health services
- integration of public health services
- priority to preventive medicine
- participation of the community.

This required drastic changes in health strategies and allocation of resources and the MOH was faced with major problems due to institutional and financial constraints.

The past five years can be considered a transition period. Lessons are emerging from experience and measures are being taken to turn the general philosophy of Primary Health care for all into viable programs.

2 USAID Involvement in health in Cameroon

From 1961 to 1985, USAID's total assistance to Cameroon has been \$130 million. This represents both direct and indirect assistance. Initially, USAID's bilateral assistance attempted to respond to a variety of requests from the government. In the 70's, AID's focus shifted towards strengthening of institutional capability.

USAID's support to GRC in health began in the 1960's with the provision of measles vaccine and water supply development. The Mission also helped develop the University Center for Health Sciences (CUSS) which trains most of the nation's doctors, nurses and paramedicals. Support was also given to child feeding programs through PL 480 and the strengthening of health delivery systems. (P.T.H.E. project).

At the beginning of the fifth 5 year plan, confronted with institutional problems and a lack of consistency in GRC's policies in the health sector, USAID adopted a "wait and see" attitude and concentrated on agriculture and education programs in Cameroon. USAID/Cameroon pursued an assistance strategy that was low-keyed and responsive to MOH interests and requests. Since there were no bilateral health programs, USAID has made extensive use of regionally and centrally funded projects to respond to assistance requests. This assistance has covered a wide spectrum of activities to both private and public sector institutions.

The following is a summary of USAID's early interventions in health:

1. Measles vaccine campaign (1965-70)
2. Water Supply Development (1966)
3. North Cameroon Rural Health Services (1975-82). Through a grant to Catholic Relief Services, USAID provided support for the strengthening and expansion of Catholic Mission's health services in North Cameroon. Under this project, community level health workers were trained as auxiliary nurses at Tokombere.
4. Infant mortality study. Through a Yaoundé based regional research institution, IFORD, USAID sponsored a study which identified morbidity incidence and rates of infant mortality in Francophone Africa.
5. University Center for Health Sciences (CUSS). CUSS is developing the capability of health staff in delivery of preventive health services (1973-79).
6. Nutrition advisory services (1979-82). An advisor was provided to the Ministry of Economy and Plan to assist in the formulation of a national nutrition strategy.
7. Mandara Mountains Water Resources (1979-83). The program provided 35 water catchment dams and health education.
8. Practical Training in Health Education (1979-82). PTHE developed a health education training program responsive to the health conditions of rural population.
9. PL 480 pre-school child feeding program (1977-83). The project also provided mothers with health/nutrition information.
10. Strengthening Health Delivery System (SHDS) (1978-82). This regional project focused on training in management of health delivery systems in rural areas.
11. Northern Wells (1980-84). Potable water, sanitation and health education was provided to 92 rural communities.

In the population sector, recent USAID/Cameroon projects have provided technical and financial assistance to various private and government institutions. This assistance has covered a wide variety of activities including support of: demographic data collection and analysis, awareness raising and policy analysis; transfer of microcomputer hardware and software; contraceptive supplies and equipment; training in information, education and

communication skills in family planning and in services delivery; and biomedical and social science research.

B. Present Delivery of Health Services

1. Ministry of Health

a. Organizational Structure of Ministry of Public Health (MOPH)

The organizational structure of MOPH (see Appendix I) as published in 1981, encompasses 4 directorates:

- (1) The Division of Public Health which is responsible for administration of curative medical services offered in urban and rural hospitals and dispensaries,
- (2) the Division of Preventive Medicine and Public Hygiene which is responsible for surveillance, environmental health, immunization, MCH, and control of communicable diseases,
- (3) the Division of General Administration which manages the budget of the MOH and is responsible for procurement of materials and transport;
- (4) the Division of Studies, Planning and Health Statistics which is responsible for short and long range health planning, programming, and evaluation.

The published organization of the MOPH does not reflect the present structure of MOPH. The major changes that have taken place are a result of the new health strategies initiated by the fifth and sixth Five Year Plans. However, no new chart has yet been officially adopted.

Reorganization of services from the colonial system to the present structure has been a slowly evolving process. The reorganization is, however, very positive. The vertical structures previously operating were a major limitation for effective integration of basic health care services. Primary health care was added somewhere half way between curative and preventive services. Duplication was unavoidable and the internal lack of coordination at the central level had major consequences on the delivery of health services in the provinces.

Accompanying the reorganization were changes of people in key positions. Younger staff with more adequate training and field experience were placed in charge of programs. Although difficult to document, this effort is an essential step towards better management.

b. Pyramid of Health

Cameroon is divided administratively into provinces, divisions (departements) and subdivisions (arrondissements). In theory, the organization of health facilities reflects this hierarchy and is usually divided in three tiers:

(1.) Primary care

The large villages in Cameroon are organized as "villages de santé" or health villages. Each village has a "case de santé" supposedly built by the village and staffed by community health workers (CHW). The CHW's receive basic training at the subdivision hospital and manage a village pharmacy on a cost recovery basis. They are theoretically supervised by both the subdivision hospital staff and by the neighbouring health centre staff. Serious illnesses and injuries are referred to the health centre. The "village de santé" constitutes the first contact between the population and the health services.

The Elementary Health Center (EHC) is the smallest government facility and is designed to serve 5,000 people. It is theoretically staffed by five people, headed by a certified nurse (two years training after secondary school), nursing assistants (one year training after primary school), or health workers trained on the job.

The Developed Health Center (DHC) has beds for maternity patients and short term care, and is supposed to have a staff of 11 persons, including a state registered nurse (4 year training), assistant nurses and health aides, a laboratory technician and a sanitary technician. It usually serves over 10,000 people.

(2.) Secondary Care

The subdivisional hospital has basically the same facilities as a DHC but staff includes a doctor and several certified nurses.

The divisional hospital has two general practitioners, one surgeon, one obstetrician and a relatively large nursing and technical staff.

(3.) Tertiary care is carried out by provincial and central hospitals where specialized care is available.

At this stage, operational constraints do not allow this theoretical model to function as conceptualized. Patients tend to choose a health facility based on distance and availability of service.

c. Delivery of Basic Health Care

This section focuses on the first tier of the pyramid of health. As this tier is nearest to the rural population, it is the most critical level to strengthen so as to decrease infant or childhood mortality rates.

The essential activity of EHC, DHC, and subdivision hospitals are out-patient clinics. Major motives for consultation appear to be malaria, diarrhea related diseases, acute respiratory or throat infections, skin diseases, measles (although this is less frequent since immunization coverage improved), sexually transmitted diseases, wounds and infections, back pains, fever, headache, etc. Malnutrition in children is often discovered in relation with another symptom. Patients come for curative services and health centers have essentially developed around such services. Most of the symptoms are amenable to simple and inexpensive measures which do not require sophisticated diagnostic skills and equipment. As such, they can be standardized into cost-effective protocols.

At this stage, most existing facilities, particularly those in the rural areas, are unable to answer patients' demands. A general problem is the insufficiency of drugs supplied to the health centers. This problem is compounded by the fact that both health staff and population have developed habits of over-prescription and often demand drugs that are not essential. A

vicious circle results: if drugs are not available, patients will not show up, and the health staff will invest their interests somewhere else. Thus both the initial investment in the health/facility and the recurrent costs (essentially salaries of underused staff) become not only a waste of much needed resources, but also bring about the loss of credibility for government basic health care services.

At the community level and among many health professionals, the prevalent attitude towards diarrheal disease control is still the use of drugs (sulfamides or antibiotics) and, in case of dehydration, intravenous solutions. Homemade solutions like "eau de riz" (rice water) are commonly used. Most health people have heard of ORT and homemade rehydration solutions but these are not yet integrated in the existing curative routine, nor are the basic aspects of prevention through improved hygiene, water use, and sanitation.

Presently, the government program for immunization is in general carried out in national campaigns. Rural health centers do not have facilities such as refrigerators that would enable them to carry out this function on a regular basis. Rural health centers are only used as vaccination posts where mobile teams will come on a predetermined day. Since there is no existing census of the target population (children and pregnant women in neighbouring communities) the immunization program is limited to people who were informed and willing to bring their families for immunization. Cameroon's Expanded Program of Immunization (E.P.I.) is based on a system in which fixed health facilities are expected to deliver 70% of all vaccinations. Mobile teams are expected to provide the other 30% coverage.

Malaria is also a major problem but chloroquine often runs out. Another drug widely used is injectable quinine (Quinimax). Prophylaxis for pregnant women is said to be not possible in the absence of a regular supply of chloroquine. However since pregnant women do not usually attend antenatal services, the lack of chloroquine is a secondary issue. There are no lists of pregnant women, there is no incentive for them to come to government centers. In spite of a high prevalence of anemia in some regions, iron tablets usually run out. Little attention has been paid to cultural beliefs and customs that will encourage women's participation in such activities or make the MOH's services acceptable to them.

Nutrition and growth monitoring is not well instituted. Acute malnutrition seems fairly common in certain areas and among certain ethnic groups. It is often linked to sociocultural problems such as inappropriate weaning practices rather than to actual shortages of food. Local practices, customs and beliefs are often viewed by trained nurses from a different ethnic origin as "backwards". Little effort has been made as yet to collect information and design educational materials adapted to specific socioeconomic and ecological conditions. Nutrition education is almost non-existent. Growth charts are not available in most health centers. When scales exist, it is usually either the bathroom type scale for adults or the "pèse bébés" for infants.

It is obvious that child spacing could help overcome some problems in mother and child health. However this is not believed to be a need in the under-populated areas of Cameroon, especially the predominantly Moslem North, and would conflict with most existing customs and beliefs. People however are very concerned about sexually transmitted diseases. Addressing this problem is essential. Indirectly, the two issues are related. Operational research to identify target populations and design appropriate messages emphasizing health education is an essential first step.

d. Support systems

(1.) Staff allocation, training and supervision: At the level of basic health care, the primary concern is existing nursing staff. These include state registered nurses, certified nurses, nursing assistants and "matrons". At present, there are two government schools for nursing and midwifery: one in Yaounde for Francophones another in Bamenda for Anglophones. Training for certified nurses is slightly more decentralized with nursing schools in Bamenda, Douala, Bafoussam, Garoua, Bertoua and Ayos. Once trained, staff is appointed by the Ministry of Health at the central level. GRC policy in appointing health workers is based on the assumption that sociocultural mixing should promote national unity and level off regional imbalance. As a consequence, nurses are usually posted to an area they do not know. It can be argued that this has a practical advantage in that the nurses are subject to less social pressure from their patients. However, it often results in misunderstandings with the local population and hence in reduced efficiency in their work.

At present, there is no formalized system for in-service training of existing staff. Technical skills tend to diminish as staff are not kept up to date with new techniques such as ORT. There is a strongly expressed need for increased on-the-job training by nurses, laboratory technicians, and other categories of health professionals.

Due to the insufficient number of trained midwives, 'matrons' are trained in the divisional hospital to perform deliveries at the health centers. This system seems to be well accepted. Most nurses are male and as such have little access to gynecological problems in some areas, especially in the North. Staff supervision is often theoretical since the Divisional Service for Preventive and Rural Medicine does not always have the means of transportation or the budget to carry out its supervisory responsibilities. On the whole there is very little accountability in the system. Personnel decisions rest with the central level and civil servants are seen as impossible to fire.

(2.) Drug Supply: Pharmaceuticals are distributed free of charge to MOPH units. It is common knowledge that the government drug supply system has become increasingly ineffective over the years and blatantly biased towards urban areas and tertiary care facilities. The recent increase in the numbers of basic health facilities has made the situation worse. Health centers are supplied from the divisional level, itself supplied by the provincial level. Until now, drugs were sent to the province from the central pharmacy once a year. The amounts were invariably insufficient, the types of medicine and quantities were standard and based on no ordering system. In some cases, this resulted in stocks of drugs that were completely inappropriate to the needs of the province. In addition it has been estimated that over 30% of medications do not reach the clients.

However, the pharmaceutical situation seems to be improving. The government is now in the process of modifying supply procedures, although no official document exists as of yet on the present policy. The Central Pharmacy has been closed and a National Pharmaceutical Office (ONAPHARM) was created in August of 1985. Deliveries to provinces seem to be more frequent. An essential drugs list for the country does not exist yet but ordering lists for basic health facilities are being introduced. It is still too soon to realize an improvement in the rural areas. When drugs are available, they are

provided free of charge to the patient. While nurses write down their prescriptions in the out patient book, there seems to be no supervised inventory and accounting system. Nurses commonly deliver prescription slips to their patients who must purchase the drugs from a pharmacy.

The government is trying to promote alternatives:

At the village level, village pharmacies have begun and are managed by a community health worker. The chance of success for village pharmacies seem fairly good since the village traditional structure acts as an efficient supervisory system.

Municipalities are encouraged to start pro-pharmacies when no private pharmacy exists. There are only 117 propharmacies at this time. These buy medicine from the Ministry at cost and are run by a nurse under supervision of a doctor. Their margin of profit is limited by law to 10%. However lack of supervision and unethical management often undermine what could, in theory, be a good system. Furthermore, propharmacies are not permitted to open in towns in which there is a private pharmacy and have to close if a private pharmacy opens.

(3.) Other Factors

Most of what has been said for drugs applies to equipment, maintenance of services, and other expenditures required for the operation of health facilities. An almost non-existent management system both at health center level and at supervision level results in a lack of supervision and accountability.

e. Financing of Health Services

The major problem for Cameroon's financing of health services is an overly ambitious investment program and severe under-financing of recurrent costs. In the short term, such a program achieves higher political visibility but in the long run it is counter productive, since facilities cannot be sustained. The imbalance between rural and urban areas continues despite official attempts to reduce it. In 1985 the GRC/MOPH allocated 5.1% of its budget for recurrent expenditures. It seems that the continuing investment program still

does not take into account the recurrent costs. The consequences are in a way limited by the fact that the investment program regularly fails to meet its targets, due to a lack of absorptive capacity rather than to a lack of funds.

The global insufficiency of recurring costs financing is further compounded by a gross imbalance in the allocation of resources. Salaries in 1985 accounted for 72.7% of the operating budget. Data on the further breakdown of non-renewable expenditures were not available. The ratio of non renewable items (without which health facilities cannot operate) to salaries in 1985 was 0.367 which reflects a highly unhealthy situation. The personnel share of operating costs is greater in lower level facilities and can reach 98%. The remaining budget for drugs, medical supplies and maintenance is therefore totally inadequate.

2. Other Government Institutions Involved in Delivery of Health Services

a. National Social Insurance Fund: (Ministry of Labor)

This institution is an important factor in the delivery of health services. Its target groups are the employees of the public and private sectors which constitute approximately 1/4 of the total population. With urban migration it is estimated that this target group will increase in the near future. As this population is concentrated in the urban or industrial areas, the fund at this stage has little impact on rural areas.

The fund's services are intended to complement those of the government. Existing health facilities include:

3 hospitals (MSC) with 120 beds each (plans are underway for extension to 240 beds)

4 MCH clinics for ambulatory care, staffed by at least 8 health professionals including a physician.

Within the context of the sixth five year plan, the fund is planning to expand its services to the North and the South adding hospital facilities. In Yaounde the fund plans to experiment setting up neighbourhood clinic units attached to the existing hospitals.

As in MPH facilities, consultations are free and prescriptions for drugs are given. The fund's health services, both hospitals and MCH clinics, are open to everyone and not just to registered members.

b. Ministry of Agriculture

The Division of Community Development coordinates development activities at the community level. The community development programs usually include 3 sectors: educational action, women in agriculture, and technical action. At the provincial and "departement" level there is a chief of community development. This person is assisted by 3 technical coordinators who, at the "departement" level, work with community development agents trained to carry out each of the activities at the village level. Their primary responsibility is in the provision of improved water sources and sanitation. As an integral part of this program, they emphasize community participation. The Division for Community Development implements its activities through international PVOs, including CARE and Save the Children. The provision of Primary Health Care has become an integral part of their water and sanitation activities. It seems, however, there is little coordination with MOPH staff on the field.

c. Ministry of Social Affairs

Within the context of "responsible parenthood", the Ministry of Social Affairs provides family planning information. This Ministry receives USAID funding for studies intended to better communicate family planning information.

d. Ministry of Women's Affairs

This Ministry is developing its outreach activities which emphasize participation of rural women in the various developmental activities. Many of their programs place great emphasis on preventive health information. This Ministry has a staff of 34 permanent animators and 376 group leaders located in all the provinces who work in the village health centers, women's centers and cooperatives.

3. Confessional Private Sector

More than one third of all health facilities are operated by the private religious sector and most operate in the rural areas. However, the proportion of services rendered is higher as utilization of private services is greater than at government health units. There are two major coordinating organizations: the Federation of Evangelical Churches and Missions of Cameroon (FEMEC) and the Catholic Health Services. Each maintain a medical liaison office in Yaounde. Both organization receive subsidies from MOPH annually. These amount to 1.5% of their operating budgets.

There is great autonomy among the church and mission clinics in their provincial health services. This results in a great diversity of health programs. The health liaison offices in Yaounde work on a consultative basis and are working towards the following strategies:

Health facilities will respond to the population's demand for services.

Services will operate on a cost recovery basis and adapt fees to the socioeconomic context of the catchment area.

Preventive medicine and outreach programmes will be funded where possible using outside donor assistance.

All programs are working towards Cameroonization.

The present document does not pretend to draw up an extensive list of all experiences in integrated basic health care, but will mention briefly projects that seem relevant to further USAID projects in Cameroon.

a. The Presbyterian Hospital in Ebolowa, South Province, is making a concerted effort to integrate preventive medicine into its activities. Over the past 15 years, the hospital maintained a mobile unit to provide some curative care but primarily health education and immunization services in a catchment area 80 miles around the hospital. This mobile unit was maintained from funds and volunteers from the Dutch Government. More recently USAID, through ASHA funds, has supported this effort. This hospital conducts in-service training in preventive medicine for its staff and those in the 7

dispensaries attached to the hospital. The mobile unit is being used to provide the required support and training for outreach dispensary personnel. The recurrent costs of the mobile unit are estimated at 750,000 to 1 million CFA per month (2,500 - 3,000 US dollars per month). The mobile unit staff use cost recovery system where drugs, i.e., chloroquine, antibiotics, etc. are sold. Mothers have to pay 200 CFA for the growth chart for their children.

b. The Tokombere Health Program is based around a hospital and a network of 14 Catholic dispensaries. The program uses medical students and has developed its services to suit the socio-economic conditions of the 55,000 people in the catchment area. Health staff work with villagers to develop their health programs and rely on local leaders to deliver health education. Tokombere has become a training site for Catholic nursing students.

c. The Achatugi Primary Health Care Program, started with six villages in 1977, now provides coverage to over 23 health posts. The program is built around village-identified health workers and traditional birth attendants (TBA) trained for 3-6 months. Monthly refresher training and supervision contribute to making the project a success. The project reports a 40% drop in infant mortality. Six of these health centers are being used as drug distribution depots to 74 Government health posts.

Some lessons can be drawn from these mission health efforts:

- Provision of outreach from hospital works where the facility provides the support and maintenance;
- Use of existing structures i.e. traditional health workers and community leaders is a very effective approach to communities;
- An efficient and effective supervision system can be provided;
- The private sector provides the Government with a support system on which government efforts can base their activities

4. Multilateral Organizations

a. WHO

The aim of WHO since Alma Ata (1978) has been to promote Health for All in the year 2000, the essential strategy for that being Primary Health Care.

However, the lessons learned in Africa since then have led WHO, AFRO (Brazzaville) to start promoting decentralization and concentrating on the operational (or district) level. While there is agreement on the need for decentralization, the MOPH appears to be reluctant to begin since they do not view decentralization as a development policy for Cameroon and do not feel at ease initiating the process alone.

WHO's funding essentially goes to training programs, increasingly through CUSS. Specific programs include immunization (1986 was chosen as the African Year for Immunization and WHO provided technical assistance to organize the national days for immunization in Cameroon), control of diarrheal diseases (supporting an ORT demonstration centre in Yaounde), essential drugs program (providing technical assistance to lay the ground for a local pharmaceutical industry and for a more rational drug supply), promoting inter-sectorial coordination (with the creation of the National Centre for Health Development) etc.

b. UNICEF

UNICEF's regional strategy is the GOBI-FFF package which has been adopted by the MOPH as their own. On the operational level, UNICEF collaborates essentially with the Ministry of Women's Affairs (promoting income generating activities, use of ORT in the "Maisons Familiales" etc.), with the MOPH (supplying vaccines, operating funds, and packages of ORT); and with the Ministry of Agriculture (village water supply).

c. IBPD

World Bank has been working together with Ministry of Health over the past two years in the preparation of a integrated health development project in specific areas of Cameroon. Although the government finally decided not to ask for a commercial loan for a social program, the preparation process has been extremely effective in analysing existing problems and making practical recommendations which has, in turn, increased the awareness and competence of key persons in MOPH.

d. OCEAC: Organization for Control of Communicable Diseases in Central Africa

OCEAC deals with the control of communicable diseases in 11 countries of French speaking Africa. It has inherited the typical vertical structure of research projects and traditionally is not involved directly in the delivery of health services. However OCEAC maintains close links with the services of Preventive and Rural Medicine in the field ("ex-Service des Grandes Endémies") in particular in the field of epidemiological data collection. The data collection system presently in use by MOPH in Cameroon has been designed by OCEAC. It has been slightly modified recently to allow computerization of data to improve their utility for operational purposes (as opposed to research). OCEAC is looking for funding to organize seminars in the field to promote the use of the new data collection forms and to raise awareness of the utility of data collection at all levels of health care.

5. Bilateral organizations

A. USAID

Currently USAID's focus is on developing 3 integrated sectors: health, agriculture, and education with participation of the private sector.

Under the Child Survival initiative, USAID is considering funding two complementary projects. The first, under Pritech plans to begin ORT training and coordination at the national level. The second is the proposed CS/MCH project to follow Pritech's CRT initiative. In addition, the US government's contributions include Peace Corps Volunteers working with communities to implement health related programs.

B. Others

The major contribution in the health field in monetary terms is made by the French government. It consists to a large degree of "substitution cooperation" where French professional health staff occupy positions within the MOPH structure. These posts are usually given to specialists in curative services (e.g. surgery) which do not exist in sufficient number in Cameroon to fill the needs. The French bilateral program has had relatively little impact on basic care in the rural area. The main exceptions to this are the three provinces where the physicians in charge of the Preventive and Rural Services (ex "Grandes Endémies") are French expatriates, as in the Adamoua Province.

A successful bilateral program of basic health care in Cameroon is the German Technical Assistance. For several years GTZ has been financing a primary health care project in the North West Province that incorporates the private sector. This project has been such a success that it is in the process of extension to the South West and is recommended as a model by the MOPH. GTZ started working with the existing administrative structure at the provincial level moving towards the periphery. The structure set up by this project parallels that of the government's and focuses on village health posts directly supervised from Bamenda, but has little relation with existing MOPH health centers.

The Belgian Technical Assistance concentrates its activities in Maroua. This project started in 1981 and will continue until 1990. It supports the delivery of an integrated health program with a cost recovery component. Their activity seems effective for a variety of reasons. In terms of the delivery of services, the project concentrates its activities on training outreach personnel who are in turn supervised very closely by Belgian physicians working at Maroua hospital. The cost recovery component is managed by a person chosen by the community who is based at the health center. Payments are made based on a fee for service for an episode of illness, i.e. a patient pays a sum of approximately 800 CFA when coming to the clinic for a symptom. This fee includes tests, medication, and unlimited visits until cured. The drugs supplied for this project are only for participating health centers, i.e. centers who have made their payments. At present this project is working in 4 health centers.

Other countries involved in financing or implementing (through volunteers in particular) rural health care include the Netherland, Italy, Belgium and Canada (through CUSS).

6. Private Voluntary Agencies

A variety of non governmental organizations, national and international, operate in Cameroon and have a significant role in supporting basic health care in rural areas or dealing with health related issues. It was not possible to dedicate the time needed to a complete investigation of these organizations. Some like the French "Volontaires du Projets" work in primary

health care in the provinces that have been selected for the proposed CS/MCH project and as such should be incorporated by the project design team as existing resources. We chose to concentrate this document on US-based PVOs which have had a long standing relationship with USAID/Yaoundé.

Save the Children and CARE are the key US based PVOs carrying out community level health activities. Both organizations work under the direction of the Ministry of Agriculture, Department of Community Development.

a. CARE

CARE's activities are concentrated in the extreme North of the country and more recently, in the Eastern part of the country. The Wells Project in the North has concentrated its activities on providing water and sanitation as a first activity and has trained animators to provide health education, primary health care activities, and more recently, a weaning project through Manoff International. Within the context of the water and sanitation activities, community participation provided materials, labor, and lodging for the technicians.

More recently CARE began a project in the Eastern Province with MOPH. Under this project CARE trains Community Development Agents who work with Community Health Workers (CHW) and village health committees. Home visits are conducted in families where children aged 0-5 are identified to be at risk. At present CARE is implementing this project in 4 communities and will, following an evaluation, expand to 4 additional villages.

CARE staff view the Northern Wells Project as their most successful initiative in expanding Primary Health Care and preventive health. In this semidesert area the communities themselves identified water as their first need and through this intervention, communities participated and supported primary health care.

At the national level, CARE coordinates their operational plans with Ministry of Agriculture, USAID and CARE staff. To facilitate the functioning of their field level staff, CARE receives an operational fund from the central level and manage it themselves.

b. SAVE THE CHILDREN (Community Development Foundation CDF)

This PV, views its role as that of an intermediary among the community, governmental, and private resources. CDF began its activities in 1978 in Doukoula. Today they are active in 2 additional zones: Ntui in the Centre (near Yaounde) and Yokadoma in the East. CDF provides an integrated program which includes health, nutrition, education, agriculture and women's health. They begin their actions by conducting an assessment of the community's resources which ultimately leads to the creation of a village committee for community development and health.

CDF's outreach activities are implemented by a mobile MCH clinic team of five persons. These include a nun from the local mission, the coordinator for the district hospital, two nurses and a community agent. This team visits the community once every two weeks and provides curative services, weight monitoring, and health education (using locally produced information, and education and communication (IEC) materials from A.M.A). This team is paid a nominal sum by CDF and is also provided the logistical support by CDF. Children under 5 years old are registered and mothers are provided with a monitoring card (growth/vaccination chart).

In addition to fielding a MCH mobile clinic, CDF trains CHW and Traditional Birth Attendants (TBA) for 1-2 weeks. These village level health workers are trained in motivational techniques, identification and treatment of common symptoms, and referral procedures to the health units and are provided with drugs. When communities express an interest, CDF assists them in building a community health center. Such a facility would usually include simple water systems (rain catchment) and latrines. CDF provides the first stock of drugs for the community pharmacy. Subsequent stocks are bought by the community in coordination with the MOPH physician.

Future CDF plans are to be implemented through child survival funds focusing on GOBI-FFF (food, family planning and female health). CDF will monitor 0-5 year old children through a computer program and will also focus on training mothers on ORT remedies.

7. Commercial Private Sectors

a. Traditional Healers

Traditional health providers receive skills which are passed on from father or mother or they may receive their training from recognized traditional health practitioners. In some areas of Cameroon, healers have at least 3 years training. Most traditional healers treat their patients on an ambulatory basis. However, 25% of the healers have homes which serve as their hospitals with 10 to 15 beds each. In one region total bed capacity of traditional health practitioners accounted for half those of MOPH. A study by Dr. Dan Lantum shows that diseases treated by over 50% of healers include: diarrhea, malaria, upper respiratory chest infections (coughs and asthma), and sexually transmitted diseases. Some healers specialize in particular diseases. While many healers work alone, a sizeable sample work in a group practice, referring diseases they cannot treat to others in their group or to modern facilities. The government recognizes traditional healers.

b. Profit Making Clinics (private practice)

MOPH has identified 97 such clinics, situated primarily in Douala and Yaounde. At present these facilities have no direct impact on rural areas. However they are expanding to secondary cities. MOPH authorizes only doctors, nurses and midwives to open clinics.

Polyclinics offer a range of general health, while clinics offer specialized care. Both polyclinics and the clinics provide services to in-and out-patients. Medical consultation "cabinets" offer out-patient services and frequently offer only general medical consultations. Consulting physicians may or may not provide drugs as part of their services. Treatment clinics ("cabinet de soins") are generally run by nurses and provide general medical services.

c. Illegal Private Commercial Sector

This sector includes the shops and kiosks that sell medicines along with other items and petty traders who go from village to village to sell medicines. Although this sale is against the law, it is practised openly and

is socially accepted. Unfortunately these sales promote the common practice of self-medication and a degree of self-diagnosis.

C. Future Perspectives

1. Sixth 5 year plan

In his speech of presentation of the sixth 5 year plan to the National Assembly on July 23, 1986, President Paul Biya stressed several major points:

- He emphasized the need for responsible parenthood in order to avoid the social and economic consequences of an uncontrolled increase of the national birth rate;
- he stressed the need to modernize rural areas in order to limit as much as possible rural exodus;
- he declared that health efforts would concentrate essentially on preventive health and primary health care in order to reach the goal of Health For All in the year 2000.

a. Ministry of Public health

From a present level estimated at 10,446,400 inhabitants the population in Cameroon is expected to rise to 12,243,700 inhabitants by 1991. More exact figures will be provided by the census planned for 1987.

The main orientations of the sixth 5-year plan are the following:

- Improving the efficiency and cost effectiveness of existing health services;
- Developing the health infrastructure by reducing the prevailing geographical imbalance, especially in rural and border areas, and promoting a national network of propharmacies and MCH centres.

In order to gain credibility in public health services, the following activities are recommended: increased delegation of funds to all hospitals and health centers; reorganize services and increase responsibilities of staff; regular drug supply; sale of essential drugs at a moderate cost; development and extension of MCH activities in the routine activities of hospitals and health centers.

The objective of the MCH program is to reduce child mortality from the present levels of 105 to 78 per 1000 live births. The key interventions promoted belong to the GOBI-FFF package which includes growth monitoring, oral rehydration therapy, immunization, child spacing and female education. The target population includes children under five and women from 15 to 49 years of age. (see Appendix 2).

Cameroon has adopted primary health care as the essential strategy to achieve the goal of "Health for All in the year 2000". The National Centre for Health Development established with the support of WHO, will provide the framework for the organization, coordination and followup of the national program of PHC and the optimal use of multilateral, bilateral and PVO aid.

Confessional health facilities will be taken into account in the development of new infrastructure and private initiative will be encouraged, in particular as regards pharmacies. Extension of the national health coverage by the confessional private sector and the CNPS will be a major contribution to that effort.

b. Ministry of Agriculture

The Department of Community Development will be strengthened so as to continue providing services at village level. Such services will be focused on improving the participation of communities in the identification and cost recovery of development activities and maintenance of facilities. In order to accomplish this objective, the plan proposes the creation of Provincial level mobile educational centers.

c. Ministry of Social Affairs

The Ministry of Social Affairs is in charge of studying the feasibility of a social security system to cover the "active but unsalaried" (i.e. not eligible for the National Social Insurance Fund). Such a program should provide health coverage to rural farmers and their families.

Within the context of population and family planning, President Biya's speech emphasizes a more active role for the government to play: "I would like to draw the attention of Cameroonians of both sexes to the economic and social

consequences of an unplanned increase in the 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 responsive parenthood."

d. Ministry of Women's Affairs

The social and health development project promotes women's participation in these fields. The existing pilot project in Fing Biloun Center (covering 3 villages) will be extended to three new centers in the Extreme North, North West and East. Women's participation is recognized as essential to primary health care and preventive medicine in general (in particular immunization) and women's groups will be encouraged to carry out responsibilities in those programs.

2. Analysis and Comments

Policy in terms of the sixth 5-year plan follows the guidelines set up by the fifth 5-year plan emphasizing service to rural areas. The sixth 5-year plan begins by summarizing some of the main problems encountered:

- insufficient operating funding, often responsible for the low level of program execution;
- weaknesses in program design;
- difficulties in administrative and financial management;

Drawing from these lessons, the emphasis is put on increasing the cost effectiveness and efficiency of health services.

As we have seen in previous sections, this approach seems to fit with the facts. It is encouraging that the flaws in the existing situation are given official recognition and that recommendations to address these problems are given priority. Interviews with high level officials in MOPH confirm a general awareness of management problems and a commitment to reduce the prevailing waste of resources.

The total budget for Ministry of Public Health is projected to be \$433 million over the next five years, which represents 3.1% of the plan's overall

budget, as opposed to 4.6% in 1985. However excessive attention should not be paid to this figure since the plan essentially provides a framework and can be modified by the President to adapt to national requirements. As a rule at least 30% of health investments are financed outside of the 5-year plans. Financial analysis should therefore be based on annual budget figures that are officially published in June of each year (the fiscal year in Cameroon runs from July 1st to June 30th). Close attention should be paid to the 1987-88 annual budget. Figures for 1986-87 show no evidence of an effective change in the strategy. Compared to 1985-86 figures, salaries increase faster (+6.7%) than the total operating budget (+4%) and complementary inputs decrease still further (-2.7%). It is hoped that the recommendations of the sixth plan will be made operational by appropriate allocation of resources placed in the next budget cycle.

The degree of underfunding for current activities has been estimated to be 25%. Whether this will continue to be the case is a matter for speculation, but the continuing investment program is not likely to ameliorate the matter. The decision to reallocate resources to the MOPH is obviously a political decision for the national government. If such a decision is not taken, the alternative for MOPH will be deciding for partial cost recovery methods (in itself a political decision since it departs from the free medical care philosophy) or letting the present situation progressively deteriorate. This would also have political consequences.

As we have seen, the problem with recurrent costs is not only a matter of available resources but also a matter of allocation of these resources between salaries and other expenditures. The ratio of complementary inputs (drugs, medical supplies etc.) to salaries in 1985 was 36.7% (the lowest since 1981): if health personnel are to function effectively, this ratio will have to be increased.

As regards more specific technical issues, Ministry of Public Health officials are usually open to suggestions. In addition, many programs are under revision or about to be updated.

a. National Center for Health Development (CNDS)

This center is still in the planning stage. It was planned by the government in collaboration with WHO. Its objectives include:

- operational research in PHC
- multi sectoral coordination
- on job training for physicians and nurses
- coordination within MOPH
- create a national awareness for PHC

CNDS is envisioned as a link between the inter-ministerial council for Health and Social Affairs which is a political organ and the National Committee for Health for All. The latter is envisioned as a technical organ presided over by the Minister of Public Health. The implementation of the CNDS initiative is still not clear. MOPH views CNDS as a unit within the MOPH, while WHO perceives it to be a separate structure. The final direction that this structure will take remains to be seen.

The assumption at government level is that primary health care can be achieved at an affordable cost as long as effective community participation and multisectorial coordination are achieved. Community based programs are the responsibility of Ministry of Agriculture, Department of Community Development. The objective of the primary health care program is to organize "health zones" around a health center which supports and supervises neighbouring "health villages".

One of the goals of the sixth 5 year plan is to decrease the infant mortality rate, which explains the high priority given to M.C.H. activities. However, at this stage, a formal program remains to be designed, updating the traditional MCH approach by selecting the most cost effective interventions to achieve this result.

The general trend in the technical service sectors is towards advocating a greater degree of decentralization. Planners have become weary of exceedingly ambitious programs and appear more interested in indepth preliminary studies and small scale experimental projects that have an operational research component and a multiplier effect. There is also a strong awareness that program design has to take into account the socio-economic realities of the target area, which at national level translates into a high degree of

flexibility in order to adapt to the diversity of Cameroon.

Drug supply is also receiving a lot of attention. The sixth plan announces a substantial increase of government spending for medicines and a revision of its policy. The main objectives of that policy are the following:

- rationalize the nomenclature of drugs used by ministry facilities and come up with a national list;
- rationalize the supply system; for the sake of efficiency the national order should be centralized and purchases abroad scheduled in order to achieve timely deliveries and avoid shortages. At the distribution stage, methods have to be identified so that deliveries of medicine to the provinces are adapted to local epidemiological patterns and pharmaceutical requirements.

The existing data collection system is seen as non-functional and the lack of reliable data is a major worry of the Department of Health and Demography Statistics. They are at present discussing the possibility of establishing periodic data collection sheets adapted to the training and diagnostic capabilities of the staff at different levels of health care. At present there is one data collection sheet for all facilities. It is felt hospitals and basic facilities should have different forms.

Although officials in MOPH remain (understandably) evasive on the subject, several internal planning documents refer to the need to introduce cost recovery systems in the delivery of basic care. The general feeling in the field is that fees for service are acceptable to the population. People already pay for curative services by self medication or attending professional health centers or traditional healers. Suggestions include providing free care in the fields of prevention and control of communicable diseases and adopt a cost recovery system for curative services.

IV. MAJOR ISSUES TO BE ADDRESSED IN USAID'S HEALTH STRATEGY

A. Diversity of approach

As stated previously, Cameroon is characterized by diverse ethnic, ecological, cultural and historical background. As a consequence there is

considerable variation from one area to the other in terms of demography, epidemiological patterns and allocation of health facilities. Project design will have to analyze this situation and develop appropriate operational approaches specific to the target areas.

B. Government of Cameroon's Commitment

Recent changes in MOPH structure and programs and political speeches at a higher level indicate there is a political will to improve the delivery of basic health care. However, this change of policy has to overcome both the inertia of an overly-centralized system and strong pressure from existing interest groups. A USAID project supporting the GRC/MOPH can help override these obstacles.

A serious matter for concern is the existing level of underfunding of recurrent costs in the health budget. The implementation of any health center oriented activity by the USAID project should be based on a commitment by MOPH to fund adequately routine activities. The procedures followed by PVO's, e.g. CARE and Save the Children could be replicated. In these projects the Ministry of Agriculture, Community Development Division allocates its contribution to the project at the beginning of each financial year. Gradually, with planning of all parties involved and with continued policy dialogue at high government levels, the Ministry's share is increased until ultimately the government is responsible for all costs. In this manner, the proposed project becomes an impetus for beginning cost recovery system for community based health activities.

C. Institutional Assessment and Training Need

It is often assumed that training will be the intervention which will improve the delivery of services. In Cameroon, there is frequently an abundance of well qualified personnel. Before embarking on any training program, a thorough assessment should be undertaken outlining which constraints will be amenable to training and which will not. Based on such an assessment, decisions will be made on where investments in training will have the greatest pay-off. Decisions on long-term versus in-country versus on-the-job-training will be identified based on such an assessment.

D. Management Issues

The efficient delivery of basic health care in rural areas is contingent on an effective managerial system. The following section discusses the components of an efficiently run management system in order of priority, as expressed by field staff:

1. Insufficient drug supply

This problem should be broken down into different issues:

The establishment of an essential drugs list adapted to the level of the health care facility is under process and we believe USAID should encourage that approach at the central level.

Procedures for the management of drugs should be clearly established. Decisions should be made with the provincial level as to what drugs should be sold and at what price, if cost recovery trials are to begin. The central level of MOPH should be involved in and kept informed of the process. At an initial stage, the simplest system would be to systematize all drugs orders at the division level. The drugs should be purchased from a provincial warehouse which is supplied by the central level. The establishment of average quantities per health centre (taking epidemiological patterns into account) could be one method of control. It will be necessary to set up a simple accounting and inventory system for the health centre's pharmacy. USAID needs to identify successful experiences from other donors and build them.

2. Staff allocation and training

We believe that a greater awareness of local knowledge, attitudes and beliefs would increase the efficiency of health centre staff. This could be done by incorporating local staff in the health team and to a lesser degree through in-service training.

The recommendations for appropriate management training of health center staff should be integrated into a curriculum for in-service training to be established at the central level in collaboration with relevant Cameroonian institutions. Training at field level should be carried out by provincial and divisional staff: this training team will be previously trained by a central level team using focus group discussions and action based training.

3. Others

Management procedures for health care centres should delegate responsibilities to health center staff, in order for them to achieve sufficient autonomy to respond quickly to immediate needs. However, this should be accompanied by an effective supervision system from the division level. These management procedures will require appropriate resources (in particular vehicles and their operating budget). Procedures at division level should be elaborated at provincial level, in collaboration with a central level team specialized in planning and management of health services. Continuous feedback will be essential between the different levels.

One crucial management tool will be the establishment of an appropriate system of data collection for evaluation and monitoring purposes. Data collected should include relevant indicators for the health status of the population and financial information on the delivery of health services.

E. Primary Health Care .

The key interventions for USAID's Child Survival strategy in Africa are: immunization, oral rehydration, malaria control, nutrition and child spacing. These interventions will require the support and belief of health workers in an integrated approach to health delivery. Health workers are trained in the delivery of curative services. They fear that the implementation of preventive care will result in the loss of their job and of their status in the community. Thus, as a first step, health workers need to be convinced that an integrated approach to health delivery works. For any intervention, the strategy must be based on the target population's existing beliefs and practices.

In nutrition, one notes seasonal shortages in some parts of the country and qualitative diet imbalances. However, existing malnutrition appears to be related more to socio-cultural factors than to about lack of food. In many areas of the South Province, women choose to sell their food produce. The problem is technical: storage and distribution, and improving food preparation practices. The formation of policies to overcome malnutrition will require a comprehensive knowledge of community's food habits, beliefs and practices. In the Northern Province, for example, some ethnic groups have one staple crop, cassava. They tend to eat from one common plate where men eat first, then women and children last. Consequently, children are frequently chronically under-nourished even from a caloric value. Any education and rehabilitation actions must be based on such data.

Child Spacing: in light of the changing policy climate in Cameroon and the emphasis on child spacing in the sixth five-year plan, increased USAID support of population policy development is both timely and appropriate. USAID's continued investment would help sustain the recently created momentum.

Population policy is a slow and delicate process in Cameroon. Within the government, awareness of the population problem is still limited to a few key officials. Nonetheless, in official circles there has been an increased willingness to discuss family planning issues. The public statements of both government officials and religious leaders advocate an active role in the promotion of natural F.P. and modern birth control methods. An economic and intellectual elite has access to modern contraceptives and there appears to be an unmet demand for services among the urban populations.

In the rural areas, especially among more traditional societies (Moslems in the North), and in under populated areas, the populations are much more conservative. As such, the complexity and sensitivity of the issue requires a very cautious approach. However, a good entry point of approaching F.P. could be addressing the problems of Sexually Transmitted Diseases in areas where they are a major health problem.

USAID's assistance to GRC/MOPH within the context of a CS/MCH project should include:-

A better understanding of the motivations and attitudes towards child spacing in order to develop appropriate information, education, communication (IEC) and delivery systems:

Expansion and improvement of the health network to facilitate an integrated delivery of services. USAID's assistance to the policy development process in Cameroon should include increased resource allocation to operational research and to meeting the growing demand for family planning information and services.

Cameroon's child survival strategy will have to address environmental health issues. Sources of water and appropriate disposal of waste need to be an integral part of a community health strategy. A preliminary report on community participation conducted by IBRD shows that one of the first needs identified by communities is a clean source of water. In addition, CARE's experience in the Northern Wells Project has shown that when a community's sources of water are rendered more healthy, then the implementation of other preventive health activities are more readily accepted. Incorporation of such a factor within a primary health context does not necessarily mean building new water sources but incorporating basic water supply and sanitation matters in the health education programs.

Health education is key in terms of delivering preventive services. The design for this intervention will have to be based on a thorough assessment of community based resources, such as social institutions and means of communication. The community's existing attitudes and behaviors will form the basis for the design of this intervention. The acceptance of immunization, ORT, sanitation, improved nutrition and child spacing practices have to be based on such data.

The health education component should be shared, from the design stage onwards with other institutions operating outreach programs.

Traditional health providers

Dr. Lantum's work is significant in demonstrating the level of skills and competence of traditional health providers. An assessment of existing capabilities and institutions in the project's service area must be undertaken and include the range/type of skills and number of healers. This data needs to be incorporated into the delivery of the proposed Child Survival initiative in Cameroon. The ability of healers to influence immunization campaigns and

other preventive health practices is frequently underestimated. Traditional leaders should be included in any proposed health project as colleagues rather than as lower level health workers. Seminars for physicians would do well to include materials on the role of traditional healers.

Policy dialogue: In summary, the USAID rural health project can be instrumental in supporting the GRC at a decisive moment. The current transition period is amenable to the introduction of new concepts and approaches. The main issues to be discussed at central level are the following ones:

effective decentralization of operations to the lowest level of the health care system combined with appropriate management can make a major improvement of the delivery of services to rural people.

the ratio of complementary inputs to salaries should be increased to ensure the health center staff have the means of operating. The institution of a cost recovery system for curative services will allow a reallocation of funds towards preventive care.

coordination, both intersectorial and with other donors and implementing agencies is essential to avoid duplication and improve efficiency.

V. RECOMMENDATIONS FOR AN OPERATIONAL STRATEGY

Two essential points emerge from this assessment and provide guiding principles for a coherent strategy.

There is an obvious need to promote and support basic care in the rural areas if the goal of decreasing infant and child mortality rates in Cameroon is to be met.

The commitment of the new government of President Paul Biya and the attitude of key officials in MOPH appear to indicate increased commitment to improve delivery of services to rural areas. The pragmatic policies being adopted to remedy existing problems indicates definite opportunities for successful bilateral programs in support of integrated basic care activities.

USAID Cameroon has been for the past year discussing a Child Survival/MCH project with the GRC, at the level of both Ministry of Planning and Ministry of Public Health. The components of the project are in line with the Agency's Child Survival program. The sixth 5-year plan of GRC has the same goals: significantly reduce child mortality by the end of the decade. The preconditions stated in USAID's child survival strategy for Africa for the selection of "focus countries" would place Cameroon in a favorable position for receiving such assistance. In rural areas, infant and child mortality rates place Cameroon among the less developed countries. Government commitment is to improving the situation evidents; infrastructure exists and there is no duplication with other donors' activities.

Therefore, it seems that the timing is right for such a project. The following comments are intended to link the present assessment with a mission's strategy in the Child Survival/MCH Project.

A. Design approach strategy

People interviewed strongly suggested that the project should work simultaneously at the central and provincial levels, these two levels of activities being mutually supportive. An exclusively "grassroots" project would not muster the required attention, involvement and support of the central ministry level and the would limit the potential of extending the project to other provinces. However, by the time a centrally initiated project reaches a field operational level it is unlikely it will be appropriate to the specific conditions of the target area or acceptable to the health staff. There is some evidence that strong pressures exist at the central level to maintain the status quo, particularly in the field of drug supply, where interests groups will lobby to make sure the situation does not improve. A project which focuses on improving the delivery of basic health care at the provincial level, while at the same time involving the central level will likely succeed.

The project design team should consider a "rolling" approach to design and implementation, focusing more on the general purpose and objectives (e.g. decrease infant mortality) than on the specific means to be used. This would facilitate testing of alternative health services delivery strategies that could be integrated in subsequent stages of the project. This approach would

also promote decentralization of management, delegation of authority and local participation in the health development process. The implementation of flexibly designed pilot projects maximizes the probability of identifying possible solutions to poorly understood problems. Design, implementation and evaluation should be a repetitive process where design becomes a periodic activity incorporated in the project's implementation. This approach requires a longer term approach and USAID should be prepared to extend the initial 5-year commitment to 10 or 15 years.

B. Collection of background information

As a first step the design team should visit such projects as the GTC funded Achatugi project and the Belgian project in Maroua. The team should meet with the World Bank consultant and counterparts who prepared the IBRD integrated health development project.

The second step would be to carryout an inventory of the existing situation, including institutional assessment of health centres, identification of motivated MOPH staff, identification of private sector programs and PVO activities in the province, assessment of health needs of specific zones, identification of main problems within the health system, and an inventory of available support systems. Based on the assessment, limited areas of operation should be selected within each province.

C. Recommended Stages for Implementation

1. Preparation Stage:

At both central and provincial levels an assessment will be required on what functions are amenable to training and which functions are not being performed because of other factors - i.e. politics, culture, lack of resources.

At the central level elaboration of a training curriculum integrating ORT, immunization, malaria control, nutrition and growth monitoring and child spacing plus basic management skills. This should have two purposes:

design of in-service training for existing staff in the rural areas and curriculum revisions for the health training institutions; review of existing anthropological data on ethnic groups in the two provinces; and elaboration of KAP questionnaires relevant to diarrhoea, nutrition, communicable diseases, child spacing, etc.

At the field level strengthen the support systems to existing health centers, providing them with the basic means to operate, identifying and strengthening the management procedures that promote improved operations. One of the main points to be considered would be a cost recovery drug supply system.

collection of baseline data in the catchment area of the selected health centers that will allow monitoring and evaluation of the project including health status indicators and epidemiological data.

2. Implementation of Child Survival Activities

In-service training of existing staff: A training team should be identified at the provincial level and be backed up by central level team. The continued interaction between provincial and national level will guarantee constant feedback between operations and planning. In a second stage, in-service training could be decentralized to division level.

Implementation of the selected key interventions at health centre level.

Collection of KAP data in the catchment areas (in particular the different existing ethnic groups) and analysis at the central level. This will provide input for the training of community health workers and data for the elaboration of specific health education programs focusing on Child Survival key interventions and of adapted material;

Organization of support systems for outreach activities (supply of transportation, etc.)

3. Support of Outreach Programs from the Health Center to the Villages

On-the-job training of health center staff is essential. Health center staff must be involved from the start of the project. The responsibilities of the health center staffs gradually increases, until they are actually coordinating the outreach programs (health education, immunization, supervision and on the spot training of community health workers, etc.).

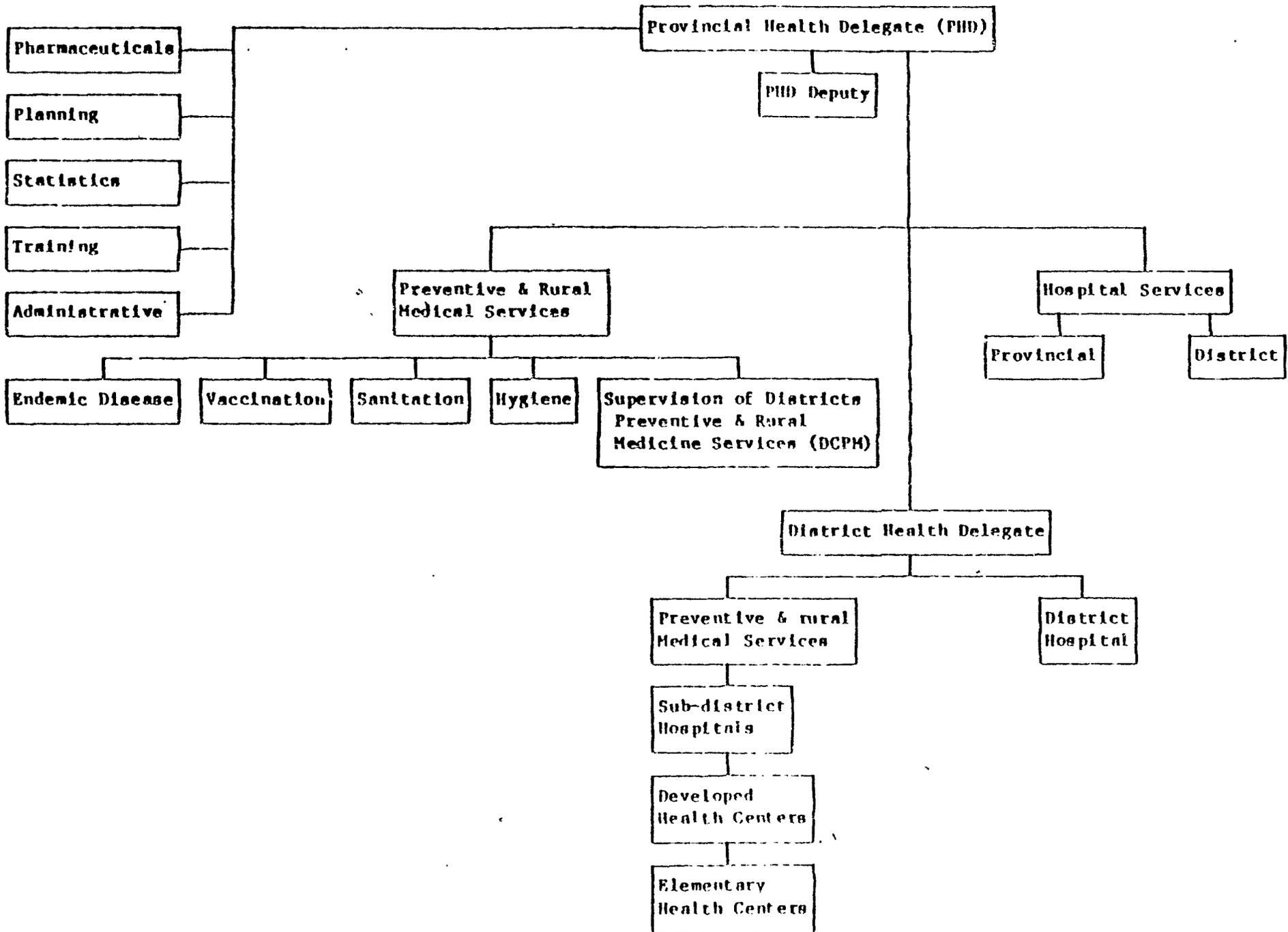
If these stages are a logical chronological sequence, there will be a varying degree of overlapping. Some of these phases may even become simultaneous when the program progressively extends in the provinces. Constant monitoring of activities and periodic evaluations will provide feedback to refine the protocols followed and achieve a methodology adapted to each zone.

Since Adamacua and the South Provinces offer very different situations, this approach will be the most appropriate and if successful, can provide a replicable model for the Ministry of Public Health with unified guidelines for the country and a specific strategy for each area.

The project design team should include a consultant specialized in management of health services and institutional problems, a medical doctor specialized in community health, a social scientist with a background in medical anthropology and health education, and a health economist.

During the design of the project, the team should identify at the central and provincial levels possible counterparts: Cameroon offers a large number of competent people. We would particularly recommend at the central level contacts be made with World Bank (who have been working for 3 years with a MOPH team that gained a lot of experience in the fields of integrated health care in rural areas), UNICEF and WHO, who have been addressing similar issues and training staff in the relevant fields. Counterparts for the provincial subprojects should be chosen in agreement with the provincial services of Preventive and Rural Medicine in order to achieve more effective decentralization.

MOH Organizational Chart - Provincial Level



Projected Target Population for MCH Services 1986/1991 Appendix

par province
Répartition/des enfants de moins de 5 ans
en 1986 et 1991.

Enfants	1986	1991
Province		
Extrême-Nord	280 405	303 156
Nord	98 608	109 223
Adamaoua	68 583	76 478
Est	80 338	89 534
Centre	227 369	360 942
Sud	62 845	69 752
Littoral	281 187	377 975
Ouest	258 185	289 255
Nord-Ouest	218 688	242 018
Sud-Ouest	147 699	169 023
TOTAL	1 784 107	2 092 366

par province
Répartition/des femmes de 15 à 49 ans
en 1986 et 1991.

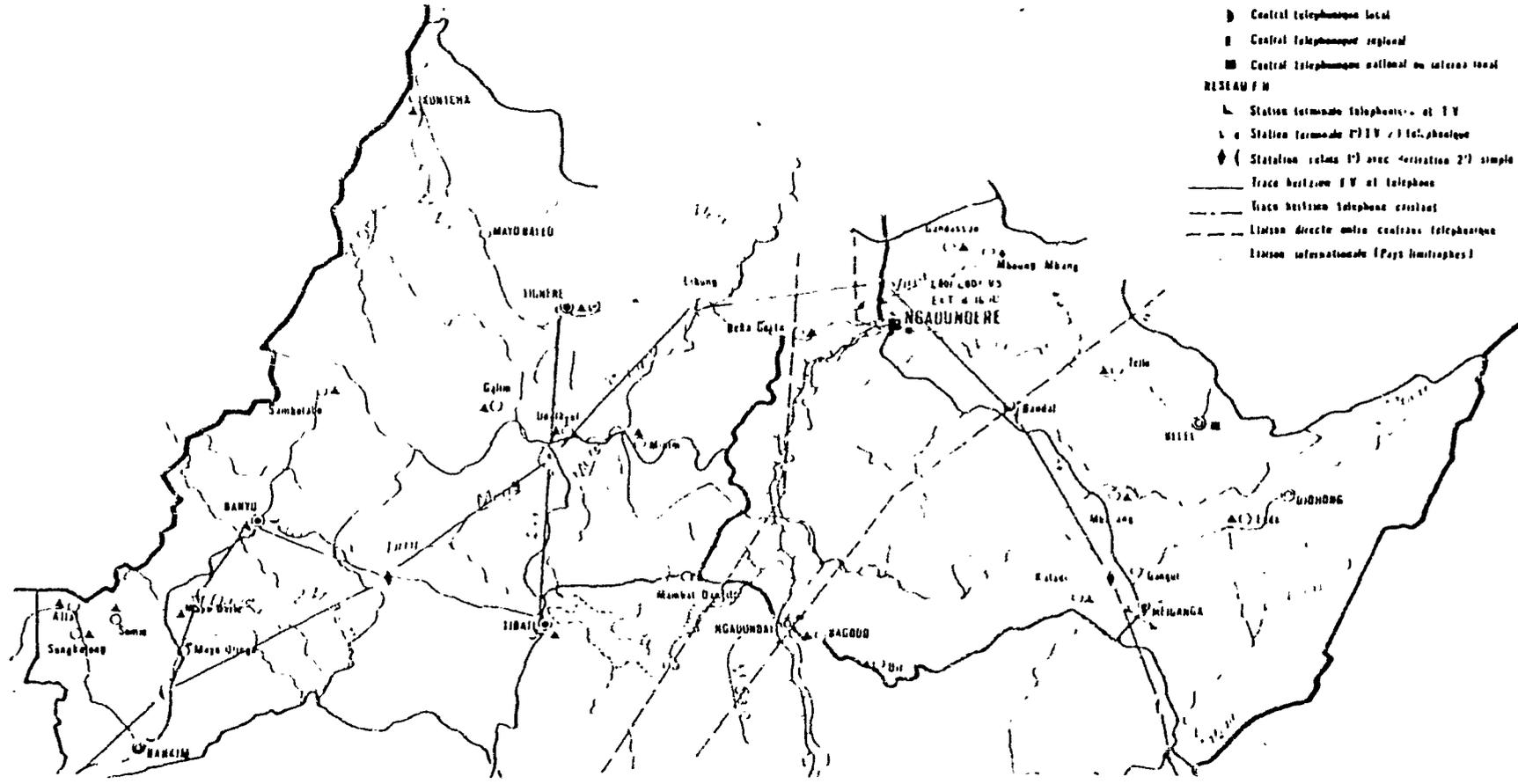
Femmes	1986	1991
Provinces		
Extrême-Nord	443 342	487 225
Nord	155 909	172 690
Adamaoua	108 434	120 915
Est	114 490	127 594
Centre	407 753	509 870
Sud	91 671	101 741
Littoral	404 928	546 672
Ouest	309 499	346 750
Nord-Ouest	283 250	320 106
Sud-Ouest	182 936	218 953
TOTAL	2 508 112	2 942 526

REPUBLIQUE DU CAMEROUN
 Paris Yaoundé Paris
 MINISTERE DU PLAN ET DE L'AMENAGEMENT DU TERRITOIRE
 DIRECTION DE LA PLANNIFICATION

LEGENDE

PROVINCE DE L'ADAMAOUA

- Route principale bitumee
- - - Route principale non bitumee
- Route secondaire
- - - Route en projet
- Chemin de fer
- ABDUCTION D'EAU DES AGGLOMERATIONS
- o Localite pourvue d'adduction d'eau SNEC
- o Localite en cours d'execution
- Localite programme en etude
- o Localite programme etude non debutee
- ▲ Localite avec systeme SCANWATER
- o Localite avec systeme de developpement communautaire
- o Centre ayant aucun programme
- ELECTRIFICATION
- ▲ Localite electriquee
- TELEPHONE
- o Central telephonique local
- o Central telephonique regional
- o Central telephonique national ou international
- RESEAU F M
- o Station terminale telephonique et TV
- o Station terminale F M et telephonique
- o (Station relais 1^o) avec (station 2^o) simple
- Trace horizon TV et telephone
- - - Trace horizon telephone existant
- - - Liaison directe entre centraux telephoniques
- o Station internationale (Pays limitrophes)



G. Y. M. M. M. M.

RÉPUBLIQUE DU CAMEROUN

Paix Travail Patrie

MINISTÈRE DU PLAN ET DE L'AMÉNAGEMENT DU TERRITOIRE
DIRECTION DE LA PLANIFICATION

PROVINCE DU SUD

TELEPHONE

- Central téléphonique local
- Central téléphonique régional
- Central téléphonique national ou international
- RESEAU TV
- Station terminale téléphonique et TV
- Station terminale P1 TV 2° téléphonique
- Station relais 1° avec dérivation 2° simple
- Tracé horizon TV et téléphone
- Tracé horizon télép ne existant
- Liaison directe entre centres téléphoniques
- Liaison internationale (Pays limitrophes)

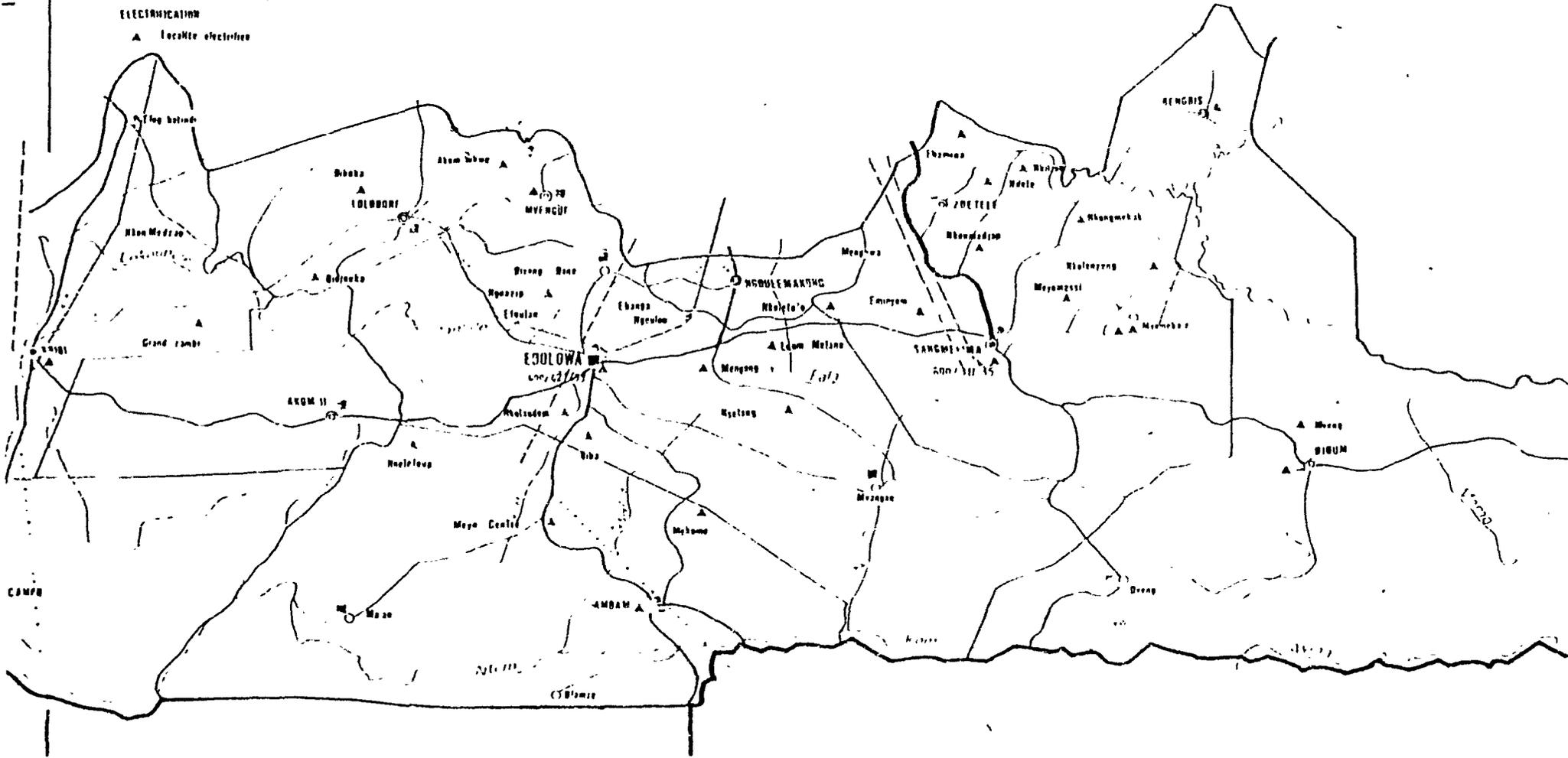
- Route générale bitumée
- - - Route principale non bitumée
- - - Route secondaire
- - - Route en projet
- - - Chemin de fer

ADUCTION D'EAU DES AGGLOMERATIONS

- Localité avec adduction d'eau SNEC
- Localité en cours d'adduction
- Localité programmée au plan
- Localité programmée études non débutees
- ▲ Localité avec système SCARWATER
- Localité sans système de développement communaliser
- Centre rural sans programme

ELECTRIFICATION

- ▲ Localité électrifiée



ANNEXE 6

RECAPITULATIF NATIONAL

PROVINCES	ADAMAOUA	CENTRE	EST	EXT. NORD	LITTORAL	N-QUEST	NORD	QUEST	S-QUEST	SUD	TOT
TYPES. FORM. SAN.											
HOP. DEPT.	3	7	3	6	3	2	1	5	4	3	3
HOP. D'ARRDT.	2	26	9	8	13	5	3	12	11	9	9
HOP. PRIVES	2	4	5	8	9	6	0	6	7	5	5
CSD	5	18	12	14	6	13	11	23	11	16	13
CSE	14	55	32	35	26	13	36	47	21	40	31
PMI	2	11	4	5	4	5	3	3	6	3	4
FORMATIONS SAN. CONFESIONNELLES	15	76	14	30	28	25	6	33	16	36	27
FORMAT. SAN. PRIVES	2	51	25	2	46	3	8	8	45	20	21
AUTRES	12	94	47	24	40	82	15	37	43	33	42
TOTAL	57	342	151	132	175	154	83	174	164	165	157
%	3,51	21,42	9,46	8,27	10,97	9,65	5,20	10,90	10,28	10,34	100

Répartition des formations sanitaires par catégorie
suivant la province en 1985/86 (%)

PROVINCES	ADAMS	CENTRE	EST	E. NORD	LITTORAL	NORD	N. OUEST	OUEST	SUD	S. OUEST	TOTAL
Formations Sanitaires											
HOPITAUX	3,1	20,87	5,42	6,96	24,48	3,6	6,45	8,76	6,45	13,91	100
C S	4,03	23,44	10,5	10,37	7,33	4,52	8,43	13,76	11,84	5,8	100
P M I Maternités	5,89	19,6	11,76	9,8	15,68	3,93	7,85	9,8	3,93	11,76	100
DISPENSAIRES	2,24	20,14	11,19	10,44	28,35	2,24	1,5	3,96	7,17	7,47	100
PHARMACIES PROPHARMACIES	2,96	21,42	4,29	3,8	16,12	2,86	19,04	14,28	5,72	9,53	100

Breakdown of medical and para-medical staff by Province 1985/86

Répartition du personnel médical et para-médical par Province en 1985/86

PROVINCE	Personnel médical et para-médical				Techniciens Supérieurs de la santé				Techniciens de la santé		Infirmiers		Aides-Soignants		TOTAL		
	Médecins		Pharmaciens		Publi		Privé		Publi		Privé		Publi			Privé	
	Public	Privé	Public	Privé	Public	Privé	Public	Privé	Public	Privé	Public	Privé	Public	Privé			
Extrême-Nord	29	11	2	1	5	1	80	-	261	49	309	96	814				
Nord	22	8	3	3	12	-	54	-	225	5	234	6	572				
Adamaoua	17	6	3	3	2	1	34	-	197	24	140	49	476				
Est	25	9	2	2	14	-	23	-	254	23	308	47	711				
Centre	210	62	29	27	79	1	165	7	1027	140	1018	188	2953				
Sud	24	11	6	5	7	-	57	2	197	37	329	57	732				
Littoral	93	101	35	33	22	1	12	2	518	105	543	200	1778				
Ouest	49	30	15	14	14	-	74	3	594	72	812	165	1842				
Nord-Ouest	33	20	4	4	28	1	84	1	422	89	333	206	1225				
Sud-Ouest	37	36	11	10	19	-	118	-	385	43	337	68	1064				
TOTAL	539	294	110	102	205	5	810	15	4080	587	4363	1082	12193				
	833		212		207		829		4667		5445						

Ratio of Medical and para-medical staff
to population 1985/86.

Répartition du ratio population/personnel
médical et para-médical par province en 1985/86.

PERSONNEL MÉDICAL ET PARA-MÉDICAL	MÉDECINS		PHARMACIENS		TECHNICIENS SUPÉRIEURS DE LA SANTÉ		TECHNICIENS DE LA SANTÉ		INFIRMIERS		AIDE-SOIGNANT		TOTAL	
	EFFEC.	RATIO	EFFEC.	RATIO	EFFEC.	RATIO	EFFEC.	RATIO	EFFEC.	RATIO	EFFEC.	RATIO	EFFECTIF	RATIO
Abkhazie	43	43188	3	57567	6	267923	80	11591	310	1573	405	4265	841	2046
Abkhaz	50	20250	5	10252	12	50626	54	11250	230	2641	240	2531	572	1032
Alexandre	23	16371	6	70422	3	140343	34	12427	221	1912	189	2236	476	687
Asie	24	13998	4	113986	14	33996	23	20693	277	1716	355	1340	707	673
Centre	272	7325	56	3550	80	24906	172	11384	1137	1707	1203	1652	2953	675
Est	25	11621	11	5579	7	58109	53	6894	234	1733	336	1053	722	553
Extrême-Orient	114	8643	23	2654	23	72950	127	13212	637	1693	743	2258	1778	943
Ouest	59	16332	29	45372	14	95020	77	17276	666	1932	977	1351	1842	722
Sud-Ouest	53	15359	3	103041	29	28436	85	9738	511	1314	503	1500	1225	673
Nord-Ouest	73	13732	21	53105	19	64263	118	10531	473	2353	405	3015	1054	1145
TOTAL	833	12554	212	49300	207	50521	829	12815	4637	2241	5445	1920	12193	857

People Interviewed

Yaoundé

Madame Passong	Secrétaire d'état à la Santé, chargée des programmes de PMI
Dr. Mafiamba	Technical Adviser No. 1, Ministry of Health Yaoundé
Dr. Bomba Nkolo	Technical Adviser No. 2, Ministry of Health, Yaoundé
Mr. Ngalle Edimo, Samuel	Directeur Planification of Health, Yaoundé
Mr. Mbo-zo Cwende Samuel	Directeur Adjoint
Mr. Bidias Koko Rigobert	Chef de service adjoint des Statistiques Sanitaires et Démographiques
Dr. Prognome Nongho Arida	Directeur Médecine Préventive et rurale MCH
Dr. Martine Combes	Projet de Développement Sanitaire Intégré, Ministry of public Health/World Bank
Mr. Jean Marie Fokam	Chef de Service Planification Santé et Population, Ministère du Plan et de l'Aménagement du Territoire
Mr. Paul Timba Edimo	Chef de Centre Provincial, Caisse Nationale de Prévoyance Sociale, (National Social Insurance Fund)
Dr. Nguewou Zacharie	Médecin Conseil National, Caisse Nationale de Prévoyance Sociale, (National Social Insurance Fund)

Mr. Minkoulou Jean Marie	Chef de Service de l'Education et des Actions Communautaires, Direction du Développement Communautaire
Dr. Ilunga Pitokwela	Représentant OMS
Fr. Sanoko	Représentant adjoint UNICEF
Mr. Charles Bellemans	Chef de la Section de Cooperation, Belgian Embassy
Mr. Jean-Joël Keuzeta	Statisticien, CCFAC
Mr. Hendrik J. Van Dijk	Secrétaire médical, FFMFC
Dr. Darryl J. Candy	Catholic Health Services, Secrétaire médical
Marieke Verhallen	AMA, Chargée d'Etudes Matériel Education pour la Santé
Mr. Onguene M. Pierre	Program Manager, Save the Children
Mrs. Charlotte Johnson Welch	Coordinatrice des Projets Sanitaire, CBF.
Mr. Ellis Brown	Program Coordinator, Peace Corps, Yaoundé Adamoua
Dr. Jean Boulounice	Directeur Provincial Médecine Préventive et rurale (Ngacoundéré).
Mr. Abdou Amadou	Technicien Supérieur en Santé Publique
Dr. Luc Ndounang	Médecien chief des service de partimental de Médecine Préventive et Rurale (Méricanda)

Mr. Souman Joseph
Mr. Dogai Abraham

Centre de Santé Flésseluthécienne, Méicanga

Ms. Ellen Leary

Community Development, Peace Corps, Méicanga

South Province

Dr. Daniel Ftya'Ale

Chief Medical Officer, Hospital Central
d'Enongal

Nieske Heerera

FHC Mobile Clinic/Enodal, Eholowa

Dr. Banemeg Joseph

Provincial Delegate of Public Health, South
Province, Eholowa.

Mr. Mendonga Andjongo

Administrative Section, South Province,
Eholowa

Mme. Ndjeng Therese

MCH, South Province Eholowa

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ANNEX II

CDSS UPDATE

Analysis of the 1980-91 Macroeconomic
Development and Issues.

THAM V. TRUONG
PROGRAM OFFICE
DECEMBER 19, 1986

I. Introduction.

With a credit rating by leading international banks of 35.5 out of 100, Cameroon's credit worthiness is only second to Gabon (37.2/100) in sub-saharan Africa. That relative high credit rating reflects the healthy growth of the economy and the sound economic environment which characterized Cameroon since 1980. Indeed, as indicated in Table I, the annual real rate of increase in the gross domestic product (GDP) was above 10.0 percent from 1980 to 1984. It was estimated at 7.7 percent in 1985 and forecast to be 5.5 percent in 1986. The annual rate of increase in real per capita GDP fluctuated between 12.3 and 7.3 percent from 1980 to 1984. Assuming an annual rate of population growth of 3.2 percent, USAID/Cameroon estimated that the annual rates of increase in real per capital GDP amounted to 4.4 and 2.3 percent for 1985 and 1986 respectively.

The economic environment since 1980 was characterized by (see Table I):

- a moderate rate of inflation with a high of 16.3 percent in 1980 and a low of 6.8 percent in 1983,
- a significant surplus in the balance of trade,
- sustained small surpluses in the Central Government Budget throughout the 1980-86 period,
- a very modest rate of government borrowing which fluctuated between 0.9 and 2.4 percent of GDP.

Given the financial/economic synopsis presented above, USAID/Cameroon has recently learned that the World Bank, a major actor in the development of Cameroon, which has a great deal of input into the 1986-91 Development Plan, will recommend, in its forthcoming Economic Memorandum on Cameroon, that the Government of the Republic of Cameroon (GRC) should take advantage of the country's good credit rating to borrow (especially long-term loans) in international financial markets. That recommendation underscores Cameroon's future need for external funds:

- to sustain rates of investment and of job creation which are sufficiently high to accommodate the annual 3.2 percent population increase and the important rural-to-urban migration,

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Table I: Selected Macroeconomic Indicators.

	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
Real GDP (% change)	14.1	15.2	10.4	10.5	10.4	7.7 ^{1/}	5.
Real Per Capita GDP (% change)	10.8	12.3	7.7	7.3	7.6	4.4	2
Consumer Price (% change)	16.3	14.5	10.2	6.8	11.1	12.0	10
Balance of Trade (\$ million)	3.0	39.3	53.2	55.2	93.5	N.A.	N
Government Budget Balance (FCFA billion) ^{2/}	2.5	4.0	1.4	3.7	1.5	2.7	0
General Government Borrowing (% GDP)	1.3	1.1	1.6	2.4	1.6	0.9	1

^{1/} In its 1986 Annual Report, the World Bank estimated that the growth in real GDP was 8.6 percent for 1985.

^{2/} US Embassy, Yaoundé's reporting cables on central government budget, various years.

N.A. - Not available.

Source: Institute of International Finance, Cameroon: Country Report; January 16, 1986, Washington D.C.

- to increase agricultural productivity to insure food self-sufficiency in the face of rapid population growth and adequate foreign exchange earnings in the perspective of declining oil revenues,

- to build up the social infrastructure (roads, schools, hospitals, water systems and water sewage systems.....) to raise the welfare of all Cameroonians.

In the July 23, 1986 Head of State's Message to the Extraordinary Session of the National Assembly it was stated that the implementation costs of the 1986-91 Development Plan will be in excess of Cameroon's public and private resources. The implementation costs of the Plan was estimated of FCFA 6,000 billion (\$ 17.2 billion at the assumed rate of FCFA 350 per US\$ 1) at constant 1985-65 prices while the contribution of the GPC and Cameroon's private sector was assessed at FCFA 4,602 billion (\$ 13.2 billion). Thus, there will be a shortfall of at least FCFA 1,398 billion (\$ 4.00 billion) in constant 1985-86 prices during the period 1986-91 to implement the Sixth Development Plan. President Biya has called upon public and private foreign investors to fill the financial gap.

To fully comprehend Cameroon's need for greater reliance on external financing/borrowing to foster growth and development in the second half of the 1980s in spite of the solid economic accomplishment achieved by the GPC through sound stewardship of economic resources in the first half of the 1980s, in-depth analyses of the principal economic sectors and the key sectoral policies are called for.

II. Structure of the Economy and Sectoral Policies.

While agriculture remains the backbone of Cameroon's economy, it was the petroleum sector which constituted the engine of growth in the early 1980s. GDP grew at an annual rate above 10 percent during the 1980-84 period spurred by the rapid expansion of oil production. Increases in GDP began to taper off after 1984, however, as oil production peaked in 1985.

II-1. Mining Sector and GRC's Handling of Petroleum Revenues.

With the rapid expansion of oil production in the early 1980s, the mining sector grew from 7.5 percent of GDP in 1980 to 17.5 percent in 1985 (Table II). The consensus appears to be that oil production has peaked in 1985 and at least one-third of proven recoverable oil reserves have been extracted. Oil production is forecast to decline at the approximate rate of 5 percent annually until exhaustion of all known recoverable reserves sometime in the 1990s.

Geological surveys suggest the existence of untapped oil and natural gas reserves at various offshore and inland locations. However, given the depressed market conditions, no further exploration is anticipated in the near future.

Production and foreign exchange earning figures related to the petroleum sector has been notoriously scarce in Cameroon. It has been a deliberate decision from the GRC to withhold these data. However, in a significant departure from past practices, the GRC has recently communicated to the World Bank historical time-series data on actual foreign exchange earnings of the petroleum sector and has authorized the publication of those data in the Bank's forthcoming Economic Memorandum on Cameroon. The GRC's openness in this area was apparently prompted by the need for an exhaustive and realistic analysis of GRC's finances as well as the necessity of full financial disclosure for the purpose of loan application in international financial markets.

GRC's management of petroleum revenues during the 1980-85 period has been lauded for its foresight in keeping the bulk of oil revenues outside the normal budgetary process to avoid wasteful excessive public expenditures and heightened expectations. Indeed, under contractual agreements reached within the joint ventureships between the GRC and foreign private oil companies, GRC's total petroleum revenues included:

1. an in-kind share of approximately 65 percent of the crude oil produced,
2. an income tax of 57.5 percent of the oil companies's gross income,
3. royalties on a sliding scale from 2-12.5 percent of oil exports,

Table II: Composition of Gross Domestic Product (in percent).

	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
GDP	100.0	100.0	100.0	100.0	100.0	100.0
Agriculture, Livestock, Forestry, Fishery	28.7	27.2	27.0	23.2	22.0	21.0
Mining	7.5	11.2	12.1	15.3	16.3	17.0
Manufacturing	8.8	9.7	11.4	11.1	11.2	12.0
Construction	6.0	5.8	5.8	5.6	5.0	5.0
Electricity, Gas, Water	1.2	1.0	1.0	1.1	1.1	1.0
Transport and Communication	6.4	5.8	5.5	4.9	4.6	4.0
Trade	14.3	12.9	11.5	11.9	13.0	12.0
Public Administration	7.1	6.1	6.2	6.6	6.7	6.0
Other Services	14.6	14.7	13.7	14.7	13.7	13.0
Import Duties	5.4	5.7	5.8	5.6	5.4	5.0

Source: World Bank, Proposed Investment in Société Industrielle Laitière Du Cameroun;
Report No. IFC/P-734; May 22, 1986

4. other various taxes and fees related to exploration and exploitation permits.

However, since the advent of oil production and export, only the income tax, royalties and other taxes and fees components of total petroleum revenues (i.e., items 2-4 above) have been incorporated and published in the central government budget. The bulk of total petroleum revenues, which were derived from the production-sharing arrangements, have been kept outside the normal budgetary process for GRC's discretionary use to finance selected developmental projects.

Beside the concern for waste and heightened expectations, the postponement in using oil revenues for investment purposes within Cameroon constituted a sound financial and economic decision. Indeed, given the shortage of skilled labor and limited infrastructure concomitant with strong economic expansion which characterized the early 1980 Cameroon and the high interest rates which prevailed in international financial markets of that time, the investment of oil revenues inside Cameroon would have yielded much lower returns than the use of oil revenues for investment purposes in foreign financial markets.

Finally, given the importance of oil production and exports during the 1980-85 period, the petroleum sector has eclipsed agriculture as the principal source of foreign exchange earnings.

II-2. Agriculture and Agricultural Policies.

The agricultural sector is still the most important sector of the economy in spite of the decline of its relative importance. The share of agriculture, livestock, forestry, fishery in GDP fell from 28.7 percent in 1980 to 21.6 percent in 1985 (Table II).

The bulk of agricultural production in Cameroon comes from small farm families which account for 79 percent of the total population. That traditional agricultural sector (i.e., small producers with less than two hectares per plot, growing food crops in association with cash crops and relying mainly on family labor) produces 65 percent of total agricultural exports (mainly cocoa, coffee and cotton) and the quasi-entirety of Cameroon's food production (mainly plantain, roots/tubers and cereals).

The so-called modern agricultural sector includes large producers who are characterized by an input-mix of imported machines and hired labor and a specialization in the production of palm oil, rubber and bananas. That modern sector accounts for 35 percent of all agricultural exports. The GRC is an important share holder among the large plantations which constitute the modern agricultural sector.

Recent GRC estimates show that Cameroon is presently 90 percent food self-sufficient. Through the widely practiced inter-cropping of food crops and cash crops among small farmers, agriculture has also been playing an important role in ensuring surpluses in the balance of trade since 1980 (Table I). Cash crops (such as cocoa, coffee and cotton), which have been (and still are) mainly produced by small farmers, have always been an important source of foreign exchange earnings for Cameroon.

Indeed, based on government figures presented in the following table, cash crops represented, in terms of FCFA values, 67.8 percent of total exports in 1970-71. Comparable figure for 1974-75 is 70.2 percent. With the advent of oil production and exports in 1979-80, the share of cash crops in total exports declined to 52.2 percent in 1979-80 and 56.7 percent in 1983-84. Nevertheless, those share still accounted for half of all export values in the early 1980s.

In the perspective of the post-petroleum era and in the face of an annual rate of population increase of 3.0 per cent, the challenges confronting the agricultural sector, in the second half of the 1980s, to ensure food self-sufficiency and adequate foreign exchange earnings are enormous for growth in both the food crop sector and the export/cash crop sector have been extremely low. The World Bank estimated that the average annual rate of growth in agricultural production amounted to 1.3 percent during the 1973-83 period while that of population growth was 3.1 per cent. Based on the World Bank figures, the FAO estimated that the rate of increase in per capita food production was +1.4 percent in 1965, -0.5 percent in 1975 and -2.0 percent in 1983.

The decline in the rate of growth in per capita food production since the mid 1970s is not traceable to a repressive price policy since prices of food crops (mainly plantain, roots/tubers and cereals) are, except for rice,

Export Composition in Selected Years (in percent based on FCFA values).

	<u>1970-71</u>	<u>1974-75</u>	<u>1979-80</u>	<u>1983-84</u>
Agricultural Products	67.8	70.2	52.2	56.7
Cocoa	28.4	26.7	20.6	18.4
Coffee	24.0	32.2	22.9	19.6
Others	15.4	11.2	7.7	8.1
Non Agricultural Products	32.2	29.8	48.8	43.3
All Products	100.0	100.0	100.0	100.0

Source: Ministère De L'Agriculture, Bilan De L'Opération Régénération
Café, Cacao Au Cameroun, Direction Des Etudes et Projets, Février
 1986, Yaoundé, p. 12.

uncontrolled. That decline is due to low productivity gains experienced by small farmers involved in food crop production. Low productivity in the food crop sector is traceable to a scarcity of appropriate high yield technologies and inputs and a limited private distribution/marketing system. Those problems are exacerbated by the large number of small producers combined with the quasi inexistence of a functioning extension system and a poor road network.

The deterrent to increases in cocoa and coffee production has been caused, in large part, by insufficient producer incentive granted by low controlled farm gate prices. Even though producer prices were raised by about 40 percent from 1980 to 1986 and price premiums were granted, producers have not responded up to GRC's expectations. However, in spite of those increases in producer prices, GRC's policy during the 1980-86 period was to continue to tax cash/export crop producers and to transfer resources out of the cash/export crop sector. Indeed, the producer price for robusta coffee was, on average, set at 48 percent of FOB export price during the 1980-86 period. Comparable figure for arabica coffee was 44 percent for the 1980-86 period and that for cocoa was 56 percent for the 1980-83 period. It is important to note that the taxing of cash/export crop producers and the transfer of resources out of the cash/export crop sector took place in a period of time where there was a relative abundance of foreign exchange earnings derived from the production and export of oil.

Problems in the export/cash crop sector were further exacerbated by a need to upgrade the road network and the domestic marketing system to insure an expeditious and exhaustive evacuation/processing of cocoa and coffee from remote areas.

While product price is an important policy variable which determine producer's behavior, input price and the relation between input price to output price are also critical policy variables. The GRC does not, however, appear to have either a sound input price policy/subsidy policy or a well-defined agricultural pricing policy which deals comprehensively with both inputs and outputs.

Subsidies on credit and material inputs are either directly or indirectly granted without a clear objective to provide incentives for the expansion of economically efficient activities. The costly fertilizer subsidy, for example, was initially introduced by the GRC as an income support device to encourage the use of fertilizers among small coffee growers with the ultimate objective of expanding coffee production (FYI: It appears that Cameroon has a comparative advantage in the production of coffee). Although fertilizers appear, nowadays, to be a well accepted agricultural input among Cameroonian farmers, fertilizer subsidy is still being granted at a budgetary cost of FCFA 9.72 billion (\$ 24.30 million) in 1984-85. The 1984-85 subsidy rate amounts to 79.1 percent of total delivered cost. IFDC estimates show that, if the current subsidized system continues until 1995, that system will distribute 110,200 mt of fertilizers (64,300 mt in 1984/85) at an estimated subsidy cost of FCFA 16.70 billion (\$ 41.75 million) in constant 1984-85 prices.

In the perspective of dwindling oil revenues, there is an obvious need to reduce the budgetary burden associated with the fertilizer subsidy. A critical review of GRC's subsidy policy is called for.

The lack of policy coordination among the various Ministries also leads to piecemeal policy decisions which fail to produce the desired impacts. While MINAGRI (Ministry of Agriculture) is responsible for the determination of agricultural input prices and, thus, input subsidy, it is MINCOM (Ministry of Commerce and Industry) which sets export/cash crop prices every year. It has been USAID/Cameroon's observation, in the course of the dialogue on fertilizer

issues, that MINAGRI has consistently been dealing with input price/input subsidy policy in complete abstraction of product price policy. Thus, it has been extremely difficult to discuss with MINAGRI the need for simultaneous adjustments in fertilizer subsidy and cash crop prices.

Furthermore, the lack of policy coordination among the various Ministries is one of the principal reasons for, for example, the excessive costs and inefficiencies of the current subsidized fertilizer system. It has been estimated in the IFDC fertilizer report that, through better organization and coordination among various public decision-making units involved in the procurement of fertilizers, THE GRC could lower the cost of importing fertilizers by \$ 35 per ton in 1985. The lack of governmental coordination at the distribution level has also led to excessive storage costs, untimely deliveries of fertilizers and wastes due to storage losses. The improvement of policy coordination among the various public decision-making units involved in the procurement/distribution of fertilizers is a critical issue.

The lack of policy coordination between MINAGRI and MINCOM is also one of the principal reasons for the lack of adequate response from export/cash crop producers to increases in farm gate prices. For, while the ultimate responsibility to boost cocoa and coffee production has been placed under MINAGRI, it has been (and still is) MINCOM which determined farm gate prices for these export/cash crops. There has been no meaningful consultation between MINCOM and MINAGRI on this subject.

Delays in the publication of the 1986-91 Development Plan prevents the full knowledge of GRC's comprehensive program to boost agricultural production. However, the launching of the program of "Promotion Des Exploitations Agricoles de Moyenne Importance (EAMI)" and the initiation of the "Project des Plantations Industrielles (PLIND)" indicate at least, in part, GRC's seriousness in dealing with sluggish growth in the agricultural sector and the ways by which the GRC is going about solving the problem.

The EAMI program was launched in July 1986 by MINAGRI with FAO's support. The objective of the EAMI program is the creation of 3,000 agricultural production units covering an estimated area of 50,000 hectares over the 1986-91 period at a total cost of FCFA 52 billion (\$ 149 million). It is important to emphasize that the EAMI program is focused on the traditional

sector where, as it was pointed out earlier, productivity is low but which produces 65 percent of agricultural exports and the quasi totality of food crops. With FONADER (Fonds National Pour le Développement Rural) as the financial manager of the EAMI program, 32.5 and 53.6 percent of total program cost have been earmarked to facilitate the creation of new plots (clearing the land and building access roads and drainage facilities) and to subsidize credits respectively.

The PLIND project is an initiative of GRC's national export/cash crop marketing board, ONCPB (Office National Pour la Commercialisation Des Produits de Base). While the EAMI program appears to be well defined on papers, the nature and content of the PLIND project are still being discussed with cocoa and coffee exporters. However, attempts are being made to finalize the project by the end of 1986.

Through several meetings with ONCPB's management, the following details of the PLIND project have emerged:

1. ONCPB will require accredited cocoa and coffee exporters to invest in the creation of large scale cocoa and coffee plantations as a condition to preserving their export quotas (FYI: ONCPB grants export quotas to accredited exporters on a yearly basis),
2. Within the PLIND project, the objective set by ONCPB/MINAGRI for accredited exporters is that 30-40 percent of the export quotas should be produced by the exporters themselves by 1991 (FYI: The majority of the twenty two private Robusta coffee exporters, for example, are not at all involved, at this point in time, in the production of coffee. Between the small farmers and ONCPB, the accredited exporters serve as intermediaries for the gathering of coffee cherries in brousse and the processing/storage/transport of coffee beans to Douala),
3. The GRC will assist cocoa and coffee exporters in the creation of PLINDs through clearing of the land, construction of access roads and provision of credit subsidy.

To underscore the importance of the PLIND project, ONCPB has recently announced that the Office will create two new cocoa plantations in the South-West and Center Provinces. The PLIND in the South-West Province will cover 1,000 hectares. The size of the second PLIND located in the Center Province has not yet been determined.

The EAMI program and PLIND project seem to illustrate GRC's future commitment of agricultural development via private ownership. While the GRC has in the past supported quasi-public corporations and parastatals in the promotion of agricultural production, GRC's involvement in the EAMI and PLIND schemes will, with the exception of the two ONCPB's new cocoa plantations in the South-West and Center Provinces, be strictly limited to the provision of incentives to induce small farmers and private investors to create new agricultural production units.

II-3. Manufacturing and Industrial Policies.

Manufacturing industries, the third or fourth largest sector of the economy (see Table II), are mainly involved in either the processing of local raw materials or the processing and assembly of imported raw materials. The major productive activities consist of food processing, beverages and tobacco, textiles, soap products and shoes, metalurgical/mechanical/chemical products, cement and plastics. Most production units are located in Douala, Cameroon's economic capital.

The performance of the manufacturing sector was fairly dynamic during the 1980-82 period going from 8.8 percent of GDP in 1980 to 11.4 percent in 1982 (Table II). That sector stagnated somewhat during the 1982-84 period because of the 1983 drought-induced shortage of agricultural raw materials combined with the increase in labor costs, high interest charges on external borrowing and the rising costs of imported inputs associated with an appreciation of the US dollar vis-à-vis the French Franc.

Beside the problems associated with lack of skilled workers and limited social infrastructure, two additional institutional factors also interfere with the expansion of the manufacturing sector. First, it is the system of administered prices imposed on manufacturing products. Under that system, the GRC sets product price based on estimated cost of production presented by the

manufacturing unit. The GRC's review of cost of production and fixation of administered price are cumbersome and time-consuming. In cases of legitimate imported input price increases, requests for adjustments in product prices could take many months leading to financial losses and hardship.

Second, the GRC's involvement in manufacturing is significant. GRC's share of ownership in the manufacturing sector amounted to approximately 50 percent in 1985 (FYI: Of the remaining 50 percent, about 13 percent are in private Cameroonian hands, 25 percent belong to French investors and 12 percent represent other foreign investments). Given that important ownership, GRC's involvement via its holding company SNI (Société Nationale d'Investissements) in the management of semi-public ventures has led to financial difficulties as SNI has not always been solely using economic and financial criteria in making decisions. It appears that the majority of semi-public ventures are experiencing financial problems and, thus, GRC's subsidy disbursements are significant. A program of financial rehabilitation should be instituted to limit budgetary drains.

II-4. Other Economic Sectors.

Current information on other economic sectors are scarce. The limited data presented in Table II shows that, in relative terms, the construction and electricity, gas, water sectors have been stagnant during the 1980-85 period. That stagnation in the face of a rapid population growth and a significant rural to urban migration points to difficulties in the housing sector and increased pressure on social amenities. GRC's share of ownership in the construction sector amounted to approximately 60 percent in 1985.

The data in Table II also shows the relative reductions in sizes of the transport, communication, trade, and other services sectors. The causes of those economic regressions have not been fully studied. However, it should be noted that a comprehensive system of administered prices is regulating the provision of services in the transport sector and that the GRC sets price ceilings for consumer products at the retail level. Furthermore, the Government's share of ownership in transport/distribution was 59.5 percent in 1985; in the hotel/tourism sector, that share was assessed at 82.0 percent of 1985.

The banking sector has been experiencing serious financial difficulties and needed to be restructured. Those difficulties are traceable to excessively complex and restrictive regulations, undercapitalization and extremely high loan/equity ratio. Its financial viability rests presently on the GRC support via large cash deposits. GRC's involvement in the banking/insurance sector reached up to 60.2 percent of total ownership in 1985.

The relative importance of the public administration sector has also regressed somewhat during the 1980-85 period (see Table II). However, recent World Bank's assessment points to a bloated public labor force and recommends that further hiring of civil servants should be refrained.

III. Fiscal, Monetary and Exchange Rate Policies.

As it was pointed out earlier, GRC's management of public finances is basically sound as the central government budget has been slightly in surplus since 1980 (see Table I). On the revenue side, however, there appears to be too great a reliance on import duties and on taxes/royalties associated with petroleum exports. In the perspective of declining oil revenues, the emphasis should be more on direct taxes (e.g., income tax and turnover tax). It appears that an improved tax collection system is also needed to curtail tax evasion and increase tax revenues.

The GRC's foresight in keeping oil revenues outside the normal budgetary process to avoid wasteful excessive public expenditures is an act of control seldom seen within the African continent. However, the practice of discretionary uses of oil revenues for extra-budgetary financing introduces elements of uncertainty in the budgetary process and problems of accountability. The GRC's recent disclosure of historical time-series data on oil revenues to the World Bank will, perhaps, mark a return to regular budgetary practices.

Being a member of the Central African Monetary Area (CAMA), Cameroon has basically passive monetary and exchange rate policies. Within CAMA, regional monetary considerations impose constraints on BEAC's (Banque des Etats de l'Afrique Central, the Central Bank for Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea and Gabon) decisions vis-à-vis Cameroon.

Within CAMA's regional context, uniform regional interest rates are set by taking account of the diversity in national priorities and developmental levels and of the need to regulate intra-regional capital flows in a region where country members experience different rates of inflation. Thus, uniform regional interest rates appear to be too inflexible to meet the specific needs of Cameroon. Indeed, with regional rates unchanged, nominal interest rates were lowered in 1986 in Cameroon by two percentage points for loans to local businesses in an attempt to spur business growth. Furthermore, to channel more capital into agriculture, given the uniform regional interest rates, the GRC has been putting a lot of financial (as well as management) resources into FONADER to support a subsidized agricultural credit program.

Low ceilings on nominal interest rates in the face of double digit inflation yield low or negative real interest rates which discourage savings. In Cameroon, where the per capita income is slightly above \$800, the rate of saving may not be negligible as it is currently assumed by the BEAC. Indeed credit unions, under AID funded projects, have been successful in mobilizing financial resources in rural areas. Thus, the issue of low-negative real interest rate in the context of savings mobilization should be addressed with greater emphasis and BEAC's assumption on potential savings in Cameroon should be questioned.

Low ceilings on nominal interest rates pose also an important welfare issue. In countries like Cameroon where capital is scarce, the price of capital (i.e., interest rate) should be high. However, as it was pointed out earlier, with low ceilings on nominal interest rates, real interest rates are either low or negative. Thus, for those Cameroonians who have access to commercial bank credit, their use of capital is subsidized since the real cost of capital is low and, perhaps, negative. That subsidy constitutes a transfer of real economic resources from various economic sectors to a privileged group of citizens. In Yaounde, for example, it is quite conspicuous that the bulk of the subsidized capital is used by those who have access to commercial credit to build villas for rental to expatriates. The subsidized capital should, by all means, be used to expand activities other than luxury housing which would bring greater social benefits to the population.

All the issues presented above point to the need to examine in greater details Cameroon's interest rate policy within the context of CAMA.

CAMA is part of the Franc CFA (Communauté Financière Africaine) zone. Thus, Cameroon also belongs to the FCFA zone. Within CAMA's framework (thus, within the FCFA zone), the GRC relinquishes the right to print its own money. Instead, the money supply, thus, the amount of credit available in the economy, is determined each year by National Monetary Committees operating within BEAC. In addition, the GRC is limited in its ability to borrow from BEAC for budgetary and/or developmental purposes. That limit is set, within CAMA, at twenty percent of the tax and non-tax receipts of the preceding year.

The GRC's inability to print its own money and limited ability to borrow from BEAC could be interpreted as restrictive institutional arrangements. However, these two institutional arrangements partly explain the low rates of inflation which prevail in Cameroon. The same conditions prevail in other CAMA countries while African countries outside the Franc CFA (FCFA) zone are plagued with rampant inflation.

As a member of CAMA, thus of the FCFA zone, Cameroon has an extremely passive exchange rate policy. The FCFA-French Franc (FF) parity was set at 50 to 1 since 1946 and has not been revised. There are those who think that, vis-à-vis the FF, the FCFA is overvalued and a devaluation is called for. While the overvaluation of the FCFA vis-à-vis the FF appears to be widely accepted by West and Central African countries of the CFA zone, there is no consensus as to the magnitude of the overvaluation. Thus, it is extremely difficult to find a new FCFA-FF parity which would be acceptable to all West and Central African country members of the CFA zone. It appears that the issue of a new FCFA-FF parity is being studied by the IMF.

IV. GRC's Five Year Development Plans.

In Cameroon, the planning horizon is five years. The Fifth Development Plan covers the period running from July 1, 1981 to June 30, 1986. The Sixth Development Plan sets national priorities and the development strategy for the period going from July 1, 1986 to June 30, 1991. Information on the 1986-91 Plan is sketchy, however, as its publication was delayed for some unknown reasons. The following analysis is based mainly on the July 23, 1986 Head of State's Message to the Extraordinary Session of the National Assembly, various newspaper articles and interviews.

Reviewing past performance, the July 1986 Presidential Message acknowledged that while the rate of economic growth was "acceptable" during the 1981-86 period, the targets set in the Fifth Development Plan were not achieved. The Message did not dwell on factors which gave rise to difficulties of implementation. However, it has been widely accepted that the general caution taken in administering the state budget combined with the lengthy processes of administrative procedures and decision-making explained the implementation delays. Those delays were further exacerbated by the reported widespread payments arrears of the public sector vis-à-vis private contractors. The GRC has, however, recently taken measures to remedy the payment arrears' problem.

IV-1. The 1986-91 Development Plan.

Within the 1986-91 time frame, the July 1986 Presidential Message enunciated the major problems confronting Cameroon. These major problems are high population growth, rural-to-urban migration, urban congestion, rising demand for employment and gradual environmental deterioration. Under the Sixth Development Plan, the solving of those problems will require maintaining a balance between population growth, resource endowment and economic growth/development. To mitigate the rural exodus, the development and modernization of rural areas will be undertaken. To solve the unemployment problem, more jobs will be created and changes in the education system will be made to render the skills acquired by working age persons more adapted to the needs of the economy. The environmental balance will be maintained and, above all, food self-sufficiency will be achieved.

Given the above assessment of problems and tasks, the Sixth Development Plan set the target average annual growth rate at 6.7 percent for the 1986-91 period and proceeded to identify developmental tactics. The focal point of all developmental efforts will be the rural sector to ensure food self-sufficiency for the general population and adequate provision of agricultural raw materials to the agro-industrial sector. Within the rural sector, the modernization of agriculture will be carried out and incentives will be given to expand livestock and forestry activities.

Within the industrial sector, support will be given to small and medium scale enterprises and to local entrepreneurs in an attempt to boost the

formation of local entrepreneurship and local capital. The search for and introduction of appropriate technologies will be reinforced.

All components of the transportation network will be upgraded and expanded to ensure a greater spatial integration of the country, to increase the accessibility of remote regions and to expedite the evacuation and marketing of food and cash crops.

To raise the living standard, efforts will be devoted to achieve an orderly urbanization process, the construction of new housing complexes, the upgrading of existing dwellings, the acceleration of urban and rural electrification programs to meet a demand which is growing at an estimated annual rate of 8.6 percent and the extension of existing water systems as well as the installation of new water systems in provincial cities and villages.

The education system will give greater emphasis to those technical trainings which are most adapted to Cameroon's overall developmental needs. Short-term technical training will be instituted. The decentralization of the university system will be pursued. University programs granting professional degrees will be created.

In the health sector, the foci will be on preventive medicine and on primary health care with the objective of providing health services to the entire population in the year 2000. The provision of social services to needy Cameroonians and to young children will be reinforced. The institution of an appropriate working social security system will be scrutinized.

In the areas of culture and communication, additional efforts will be devoted to establish an infrastructure which will foster growth.

The implementation of all the sectoral programs outlined above will, as it was pointed out earlier, yield an average annual rate of growth of approximately 6.7 percent and, by 1991, the agriculture/livestock/forestry/fishery sector will represent, by GRC's estimates, 31 percent of GDP. The shares of the manufacturing sector and the services sector will be 27 and 42 percent of GDP respectively.

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The implementation cost of the Sixth Development Plan will amount to approximately FCFA 4,148 billion (\$ 11.9 billion) in constant 1982-83 prices or FCFA 6,000 billion (\$ 17.2 billion) in current 1985-86 prices. Given the priority areas identified above, the allocation of those developmental funds will be:

- 26.1 percent for the rural sector,
- 20.0 percent for the upgrading and development of all aspects of the transportation network,
- 17.1 percent for the manufacturing sector,
- 16.7 percent for the social service sector,
- 15.0 percent for the building and upgrading of social infrastructure,
- 4.1 percent for other sectors not identified above.

To finance the implementation of the 1986-91 Development Plan, the GRC will support 42.0 percent of total costs. It is estimated that the local private sector will supply 34.7 percent all funds needed. President Biya called on public and private foreign investors to provide 16.3 and 7.0 percent respectively. Thus, the need for foreign funds will amount to at least FCFA 1,398 billion (\$ 4.0 billion) in constant 1985-86 prices during the next five years.

IV-2. USAID/Cameroon's Comments on the 1986-91 Development Plan

USAID/Cameroon is awaiting the publication of the Sixth Development Plan to undertake detailed critical sectoral analyses. However, based on the preceding cursory and broad description of the Sixth Development Plan, the following general comments can be made.

In enunciating the major problems confronting Cameroon during the 1986-91 period, the July 1986 Presidential Message failed to include government policies as a growth limiting factor. It should be apparent from the analysis in Section II-2 that, unless MINAGRI and MINCOM collaborate to identify a well-defined agricultural pricing policy which deals comprehensively with both inputs and outputs, attempts to increase agricultural production will, in all likelihood, fail. In the industrial and other economic sectors, there is, as it was pointed out in Sections II-3 and II-4, a need to critically reexamine the system of administered prices imposed on manufacturing products and on services to ensure the expansion of those sectors.

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Given JRC's important share of ownership in practically all economic sectors and the related financial problems experienced by the majority of semi-public ventures, the July 1986 Presidential Message failed to deal with the issue of GRC's ownership and the need to institute financial rehabilitation program to assist semi-public ventures.

While the orientation of agricultural export promotion is not clearly enunciated in the July 1986 Presidential Message, it is implicit in the EAMI program and the PLIND project. Indeed, Cameroon's entire cocoa production and the bulk of its coffee production are being exported. Because of limited domestic demands, increments of cash crops under the EAMI program and the PLIND project will also have to be exported. Given the implicit agricultural export orientation, the July 1986 Presidential Message failed to outline an export promotion program.

V. Concluding Remarks.

It should be apparent from the preceding economic analysis and the above examination of the 1986-91 Development Plan that the agricultural sector will be, in the second half of the 1980s and beyond, the engine of growth for the Cameroonian economy. The rapid increase in agricultural output will ensure food-sufficiency for a rapidly growing population, provision of agricultural raw materials for the agro-industry and foreign exchange earnings for a developing economy.

In addition, growth in agriculture will dampen the rural-to-urban migration, thus lessening urban congestion problems. It will also alleviate the unemployment problem.

To induce the rapid increase in agricultural output, the GRC will have to take a harder look at agricultural policies and to be more amenable to undertake timely policy reforms. The need for policy reforms to increase efficiency and reduce budgetary burden will be reinforced by a lack of adequate government revenues due to the projected decline in oil revenues. There is also a need to search for foreign markets for cocoa and coffee. A critical examination of industrial policies is also called for.

To finance agricultural programs and other programs aiming to raise the standard of living in Cameroon, the GRC has directly called upon the participation of public and private foreign investors. It is also very likely that the GRC will have to resort to external borrowing to be able to hold up its commitment to fully implement the 1986-91 Development Plan.

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ANNEX III

POLITICAL OVERVIEW

Cameroon enjoys one of the most stable governments in Africa. Amadou Ahidjo, who had been President from the day Cameroon became independent in 1960, resigned in 1982. President Paul Biya, then Prime Minister, succeeded to the Presidency in accordance with provisions in the Constitution. President Biya received his own mandate in elections in January, 1984. In April, 1984, elements of the presidential security force associated with the former President attempted to overthrow the government, but the Army remained loyal, and quickly put down Cameroon's only coup attempt.

Since that time, President Biya has worked to consolidate his position in the country through the sole legal political party, the Cameroon People's Democratic Movement. The nation's unified labor movement is closely linked to the political life in Cameroon has been a major theme of the Biya government. Both the party and the labor union have been the subject of intensive campaigns to increase their membership, and to make individual members more active, but no one is required to join either organization. Cameroonians participated in 1986 in open elections for leadership positions within the party. Many of the local party elections were contested, with lively campaigning by candidates for the support of the people.

During his tenure in office, President Biya has reorganized his government and appointed new ministers, many with technical expertise appropriate to their ministries. The periodic changes in Ministers have consistently brought about improved performance by the Ministers. Reorganization efforts have been accompanied by a "moralization" campaign to suppress corruption in public life.

In terms of U.S. interests, Cameroon is an African country whose importance is growing. Within Africa Cameroon is widely regarded as a truly independent nation which has managed its affairs effectively. Its record in managing its economic development has earned Cameroon considerable respect. Thus the support Cameroon gives to the U.S. in international fora is particularly useful.

The current state of Cameroonian-U.S. relationship is illustrated by President Biya's recent state visit to the U.S. During the visit President Biya publically announced Cameroonian support for a number of administration

initiatives, including anti-terrorism measures. In Africa, given Libya's influence, this was both an important and useful statement. On the U.S. side President Reagan publically praised Cameroon's pro private sector policies, its economic growth and stability, as well as its independence. An agreement on private investment highlighted the visit, and underscored the growing mutual respect between the two countries.

USAID/CAMEROON PLANNING LEVELS (\$000) FY'S 1988-1990

-LOW OPTION

PROJECT TITLE & NUMBER	LIFE OF PROJECT YEARS	AMOUNT	OBLIGATIONS				MORTGAGE END OF FY 90
			FY 87	FY 88	FY 89	FY 90	
631							
<u>ARDN</u>							
AGRICULTURE MANAGEMENT AND PLANNING	0008	79-88	9,700*	900 (FF)			
NORTH CAMEROON SEED MULTIPLICATION II	0023	82-91	17,783*	1,140	-	1,433	1,570 (FF)
AGRICULTURAL EDUCATION	0031	82-89	43,021	4,000	2,460 (FF)		
NATIONAL CEREALS RESEARCH & EXTENSION II	0052	85-95	39,027	3,455	5,445	5,243	5,400
CREDIT UNION DEVELOPMENT II	0057	86-91	3,200	1,224	410	1,000 (FF)	
TROPICAL ROOTS & TUBERS	0058	86-91	5,800	-	-	1,605	400 (FF)
AGRICULTURE MANAGEMENT AND PLANNING II	0059	88-93	12,000	-	2,690	4,900	2,600
AGRICULTURE INPUTS AND MARKETING	0063	88-93	25,000	-	1,820	2,662	5,050
NATIONAL AGRICULTURE EXTENSION	0064	88-93	9,500	-	1,422	1,700	2,000
AGRICULTURAL EDUCATION II	0066	90-96	11,000	-	-	-	1,500
PD&S				321	300	140	80
<u>HEALTH</u>							
CHILD SURVIVAL/MATERNAL CHILD HEALTH	0056	87-92	9,500	3,010	1,579	1,465	2,300
PD&S				-	-	-	70
<u>EDUCATION</u>							
SUPPORT TO PRIMARY EDUCATION	0033	84-92	31,074*	5,153	3,271	600	440
JICI VOCATIONAL TRAINING	0053	85-90	2,768	552	680 (FF)		
GENERAL PARTICIPANTS TRAINING	0062	89-99	21,000	-	-	-	-
PD&S				50	-	-	80
<u>SDA</u>							
PRIVATE ENTERPRISE	0060	90-94	2,500	-	-	-	-
PVO SUPPORT	0061	88-93	4,000	-	-	-	-
PD&S				195	73		
TOTAL				20,000	20,150	20,748	21,490
							44,936

*PACD'S AND AUTHORIZED LEVELS TO BE AMENDED

*F: Fully Funded.

USAID/CAMEROON PLANNING LEVELS (\$000) FY'S 1988-1990

MEDIUM OPTION

PROJECT TITLE & NUMBER	631	LIFE OF PROJECT		OBLIGATIONS				MORTGAGE
		YEARS	AMOUNT	FY 87	FY 88	FY 89	FY 90	END OF FY 9
<u>ARDN</u>								
AGRICULTURE MANAGEMENT AND PLANNING	0008	79-88	9,700*	900 (FF)				
NORTH CAMEROON SEED MULTIPLICATION II	0023	82-91	17,783*	1,140	-	1,433	1,570 (FF)	
AGRICULTURAL EDUCATION	0031	82-89	43,021	4,000	2,460 (FF)			
NATIONAL CEREALS RESEARCH & EXTENSION II	0052	85-95	39,027	3,455	5,694	5,263	5,400	9,960
CREDIT UNION DEVELOPMENT II	0057	86-91	3,200	1,224	710	700 (FF)		
TROPICAL ROOTS & TUBERS	0058	86-91	5,800	-	-	2,005 (FF)		
AGRICULTURE MANAGEMENT AND PLANNING II	0059	88-93	12,000	-	2,690	5,500	2,800	1,010
AGRICULTURE INPUTS AND MARKETING	0063	88-93	25,000	-	1,820	3,024	5,675	14,481
NATIONAL AGRICULTURE EXTENSION	0064	88-93	9,500	-	1,422	1,910	2,000	4,168
AGRICULTURAL EDUCATION II	0066	90-96	11,000	-	-	-	2,400	12,600
PD&S				321	300	140	130	-
<u>HEALTH</u>								
CHILD SURVIVAL/MATERNAL CHILD HEALTH	0056	87-92	9,500	3,010	1,980	1,840	2,670 (FF)	
PD&S				-	40		70	-
<u>EDUCATION</u>								
SUPPORT TO PRIMARY EDUCATION	0033	84-92	31,074*	5,153	3,231	1,040	1,145	1,260
OICI VOCATIONAL TRAINING	0053	85-90	2,768	552	680 (FF)			
GENERAL PARTICIPANTS TRAINING	0062	89-99	21,000	-	-	1,525	1,500	17,975
PD&S				50	-	-	80	-
<u>SDA</u>								
PRIVATE ENTERPRISE	0060	90-94	2,500				900	1,600
PVO SUPPORT	0061	88-93	4,000		2,000	800	900	300
PD&S				195	73			-
TOTAL				20,000	23,100	25,180	27,240	63,354

*PACD'S AND AUTHORIZED LEVELS TO BE AMENDED

FF: Fully Funded.

-HIGH OPTION

PROJECT TITLE & NUMBER	LIFE OF PROJECT YEARS	AMOUNT	OBLIGATIONS				MORTGAGE END OF FY 90	
			FY 87	FY 88	FY 89	FY 90		
631								
<u>ARDN</u>								
AGRICULTURE MANAGEMENT AND PLANNING	0008	79-88	9,700*	900 (FF)				
NORTH CAMEROON SEED MULTIPLICATION II	0023	82-91	17,783*	1,140		1,433	1,570 (FF)	
AGRICULTURAL EDUCATION	0031	82-89	43,021	4,000	2,460 (FF)			
NATIONAL CEREALS RESEARCH & EXTENSION II	0052	85-95	39,027	3,455	6,494	5,805	6,230	7,788
CREDIT UNION DEVELOPMENT II	0057	86-91	3,200	1,224	710	700 (FF)		
TROPICAL ROOTS & TUBERS	0058	86-91	5,800	-	-	2,005 (FF)		
AGRICULTURE MANAGEMENT AND PLANNING II	0059	88-93	12,000	-	2,690	5,500	2,400	410
AGRICULTURE INPUTS AND MARKETING	0063	88-93	25,000	-	1,820	4,367	6,700	12,113
NATIONAL AGRICULTURE EXTENSION	0064	88-93	9,500	-	1,422	1,500	2,000	4,578
AGRICULTURAL EDUCATION II	0066	90-96	11,000	-	-	-	3,400	11,600
PD&S				321	300	140	130	-
<u>HEALTH</u>								
CHILD SURVIVAL/MATERNAL CHILD HEALTH	0056	87-92	9,500	3,010	2,780	2,515	1,195 (FF)	
PD&S				-	40		70	-
<u>EDUCATION</u>								
SUPPORT TO PRIMARY EDUCATION	0033	84-92	31,074*	5,153	3,231	1,040	1,145	1,260
OICI VOCATIONAL TRAINING	0053	85-90	2,768	552	680 (FF)			
GENERAL PARTICIPANTS TRAINING	0062	89-99	21,000	-	-	2,115	2,900	15,985
PD&S				50	-	-	80	-
<u>SDA</u>								
PRIVATE ENTERPRISE	0060	90-94	2,500				900	1,600
PVO SUPPORT	0061	88-93	4,000		2,000	800	1,200	
PD&S				195	73			
TOTAL				20,000	24,700	27,920	29,920	55,334

*PACD'S AND AUTHORIZED LEVELS TO BE AMENDED
FF: Fully Funded.