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# USAID/CAMEROON

Health Sector Assessment

October 1992



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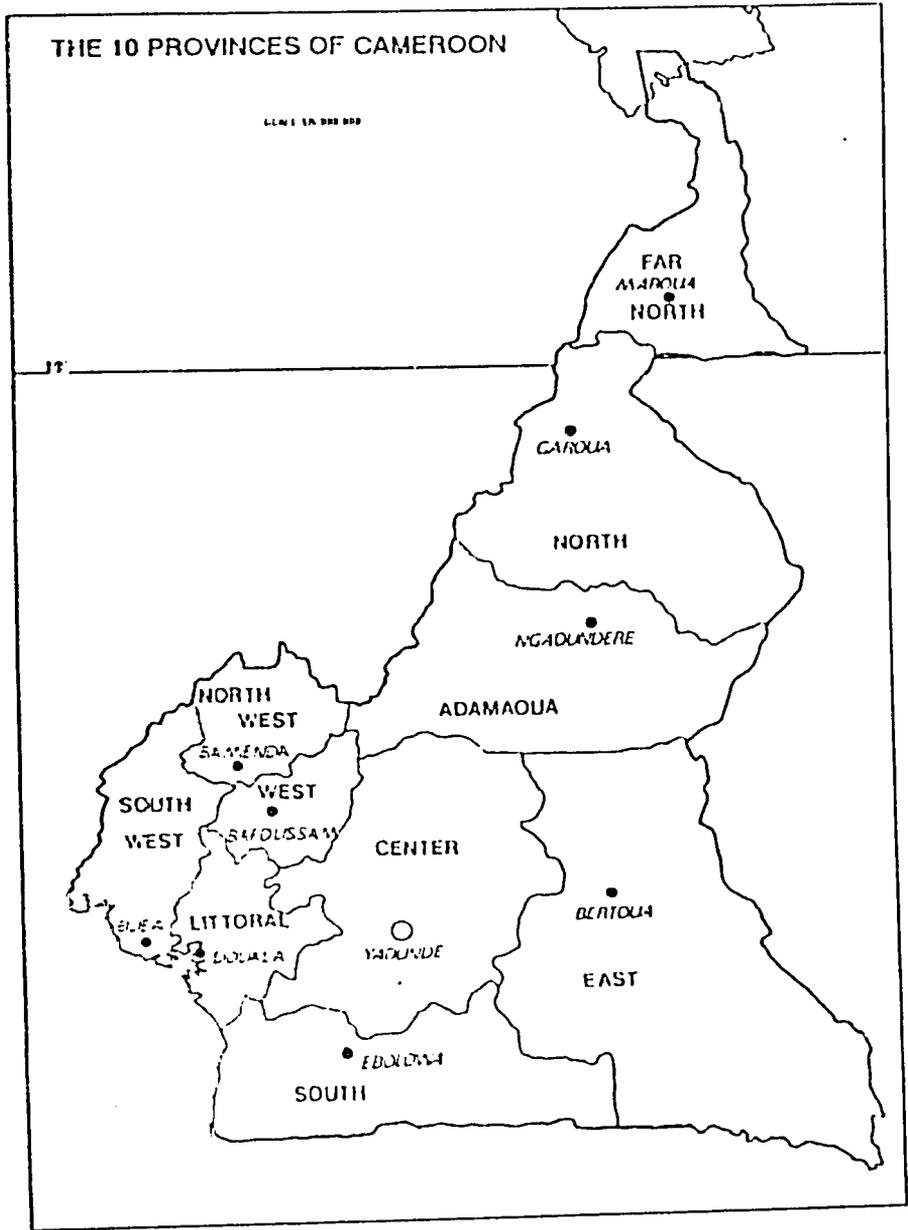
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## ACRONYMS

A.I.D	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSTECH	AIDS Technical Support Project
ARI	Acute Respiratory Infections
BCG	Vaccine for Tuberculosis
CDD	Control of Diarrheal Disease
CHW	Community Health Worker
CMR	Child Mortality Rate
CSM	Condom Social Marketing Program in Cameroon
CS	Child Survival
CUSS	Cameroon University Center for Health Sciences
DFA	Development Fund for Africa
DFMH	Directorate of Family and Mental Health
DHS	Demographic and Health Surveys (R&D/POP Project)
DPRH	Directorate of Preventive and Rural Health
DPT	Diphtheria, Pertussis, and Tetanus Immunization
EC	European Community
EHRD	Office of Education and Human Resources Development
FCFA	Franc de la Communauté Financière Africaine
GDP	Gross Domestic Product
GRC	Government of the Republic of Cameroon
GTZ	German Technical Cooperation
HCRP	Health Constraints to Rural Production
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HPN	Health, Population and Nutrition
HPNO	Health Population Nutrition Officer
IEC	Information, Education, and Communication
IMF	International Monetary Fund
LOP	Life of Project
MAR	Monthly Activity Report
MCH	Maternal Child Health
MCH/CS	Maternal Child Health/Child Survival
MOPH	Ministry of Public Health
NACS	National AIDS Control Service
NFH	National Family Health
NGO	Non-Government Organization
ONAPHARM	National Office of Pharmaceuticals
OR	Operations Research
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PACD	Project Activity Completion Date
PHC	Primary Health Care
PHD	Provincial Health Delegate
PID	Project Identification Document
PP	Project Paper
PRITECH	Technology for Primary Health Care Project
PSC	Personnel Services Contractor
PSI	Population Services International

<b>PVO</b>	Private Voluntary Organization
<b>RHDS</b>	Reform of the Health Delivery System
<b>R&amp;D/H</b>	Office of Health, AID/W
<b>R&amp;D/POP</b>	Office of Population, AID/W
<b>SAP</b>	Structural Adjustment Program
<b>SDA</b>	Social Dimensions of Adjustment
<b>STD</b>	Sexually Transmitted Diseases
<b>TA</b>	Technical Assistance
<b>TAACS</b>	Technical Advisor in AIDS and Child Survival (AID/W Project)
<b>UNFPA</b>	United Nations Fund for Population Activities
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development (Mission)
<b>WHO</b>	World Health Organization

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## EXECUTIVE SUMMARY

### A. MACRO-ECONOMIC SITUATION:

For more than two decades following independence in 1960, Cameroon enjoyed stable economic growth fueled principally by earnings from coffee, cocoa, and (beginning in 1978) oil production. However, export earnings experienced a steep downturn beginning in 1986 which has resulted in an estimated 24% decline in the GDP and a severe recession which has continued to this day. This economic decline is unlikely to be reversed in the absence of a successful structural adjustment reform effort.

### B. HEALTH SECTOR ENVIRONMENT AND CONSTRAINTS:

During Cameroon's growth years, the Government of Cameroon allocated as much as 6 percent of the national budget to the health sector which permitted the funding of drugs and many of the critical recurrent costs of delivering rural health services. During this period infant mortality declined steadily from approximately 150 per 1000 live births to less than 90 per 1000 by 1986.

However, as a result of the economic downturn, the Ministry of Public Health (MOPH) budget has registered a sharp decline since 1986, dropping from a high of 26.75 billion FCFA in 1986/87 to 22.76 billion FCFA in 1990/91. Prior to the economic crisis, over 30 percent of the health budget was allocated to the rural health services (subdivision hospitals, health centers, and village health posts). In 1988, as a result of the worsening economic crisis, the budget for rural health care was cut by 50 percent and health facilities lost most of their operating budgets. The supply of medications to rural facilities, already inadequate, virtually ceased. Insufficient funds were available for supervision, in-service training, and the maintenance of a functional health information system. These continuing financial problems have been exacerbated by inefficient health budgeting, planning, and resource allocation practices. MOPH personnel, like other Cameroonian civil servants, have outdated job descriptions, work in a system without incentives and sanctions to encourage accountability, and lack the resources to perform their jobs properly. Health center utilization, which is already low, has worsened. As a result, primary health care (PHC) and rural health services has ceased to function in a coordinated, effective fashion in the country.

The economic crisis has also adversely affected private health services. Both of the country's large religious health delivery networks are operating under severe financial constraints and have had to reduce services. The private for-profit sector has experienced dramatic reductions in clients and income.

The weaknesses of the public health system are manifest in the low coverage rates for preventive services. National vaccination coverage for measles remains below 40 percent and less than 25 percent of the nation's children are completely vaccinated. The oral rehydration therapy use rate is only 20 percent. Despite over 100 pharmacies in the country selling contraceptives, contraceptive prevalence is estimated at 4 percent. Poor preventive and curative health services are jeopardizing the long-term downward trend in infant mortality experienced by Cameroon since 1960.

### **C. HEALTH SECTOR REFORM - GRC RESPONSE TO CONSTRAINTS IN THE HEALTH SECTOR:**

In response to deteriorating conditions, the MOPH initiated health sector reform beginning in 1989, several years after the onset of the country's severe economic crisis. Health sector reform has proven to be a long process involving operations research, policy formulation, and implementation of new programs in pilot regions. Progress in improving health conditions in pilot zones is already apparent in 1992 and will begin to have nationwide impact over the next five years. The key events in the MOPH's health sector reform program are as follows:

- the testing by the MOPH of a revised PHC policy beginning in 1989;
- the authorizing of public health facilities to establish community-managed revolving fund drugstores in 1990;
- the formal adoption in 1992 of a new PHC policy based on cost recovery called the Reorientation of PHC; and
- the authorization in late 1992 for specially-approved public hospitals to retain 50 percent of their revenues from fees for services (formerly not available for local use).

The Reorientation of PHC is based on the following principles: community co-financing of health services; community co-management of health facilities; decentralized health planning; and full integration of services.

Other important health sector reforms since 1989 include the adoption of a National Population Policy, the design and approval of family planning medical standards, and the creation of a national committee to coordinate and monitor health programs. The MOPH also began work on reforming the pharmaceutical sector and the national health information system.

### **D. USAID AND OTHER DONOR SUPPORT FOR HEALTH SECTOR REFORM:**

The Reorientation of PHC program is being implemented in large areas in all ten provinces, with plans underway to expand the program to every division in the country. USAID supports the program in Adamaoua, South, and Far North provinces. UNICEF, Germany, France, Belgium, Switzerland, and the European Community (EC) fund the implementation of the program in other areas of the country. Other important donor efforts are:

- German Technical Cooperation (GTZ) and European Community (EC) support for pharmaceutical sector reform.
- USAID and GTZ support to design a new national health management information system (HMIS).

- USAID and United Nations Fund for Population Activities (UNFPA) assistance for family planning programs.

**E. ECONOMIC ANALYSIS OF THE MOPH'S REORIENTATION OF PHC PROGRAM:**

Analysis indicates that the MOPH's Reorientation of PHC program is capable of addressing the major constraints affecting the health sector. The program is based on the premise that the GRC does not presently have, nor will it have in the near future, sufficient budgetary resource to finance health care services. The strategy's cost recovery approach divides the cost of health care between the government and the population. The government will continue to fund health worker salaries, pre-service training, and other inputs which are currently provided despite the economic recession. Based on the population's demonstrated willingness and ability to pay for health services, the community is asked to fund the key recurrent costs associated with the delivery of PHC services. In addition, the health system will be made less costly and more efficient by stressing the full integration of health management systems and health services.

**F. CONSTRAINTS IN THE IMPLEMENTATION OF HEALTH SECTOR REFORM AND OPPORTUNITIES FOR HEALTH DEVELOPMENT FOR 1993 - 1997:**

Although implementation of the MOPH's Reorientation of PHC program has been positive to date, important constraints will need to be addressed over the medium and long term. These constraints include:

- the lack of a legal framework for community participation in the delivery of health services.
- the need to remap health administrative zones in order to establish functional health districts.
- the need for improving supervision, health information, and drug logistics systems.
- the lack of quality care at reference hospitals.
- limited understanding and acceptance of the new system by health committee members, health workers, and the population at large.
- lack of effective coordination between public and private health facilities.
- the need to expand the new system to underserved areas.

The major health donors are committed to addressing these issues in their ongoing, provincial-based, PHC projects.

However, there are important constraints which cannot be addressed by existing donor projects because of lack of resources. These include the need to renovate hospitals and health centers; the lack of a PHC program for Yaounde or Douala, the nation's two largest urban areas; and the lack of a national health equipment maintenance program.

Beyond basic primary health care, donors as a group are interested in helping to strengthen the MOPIH's health coordinating committee, to reform the pharmaceutical sector, to continue work on a national HMIS, and to support the integration of critical maternal and child health interventions into the PHIC delivery system and into private sector health facilities.

In the area of policy reform, the MOPIH needs to approve operational guidelines for both the management of revolving-fund drugstores at public health facilities, and the local management of fees for services by public hospitals. In addition, the MOPIH needs to revise its present profit-sharing program for consulting physicians, and to formally establish new health districts in each province.

#### G. RECOMMENDED USAID ROLE IN THE HEALTH SECTOR FOR 1993 - 1997:

Over the next 5 years, USAID's major objective in the health sector should be to further the development of a financially and institutionally sustainable PHIC system to provide basic preventive and curative services to the population, focussing on women and children. USAID would achieve this objective by collaborating with other health donors to implement the MOPIH's Reorientation of PHIC Program. Broad donor support for the Reorientation of PHIC would begin to address the major constraints identified in the health sector: the lack of financing, inefficient health delivery systems, and ineffective health services.

Consistent with USAID's prior assistance and with other donor inputs, the assessment recommends that USAID support the MOPIH's new PHIC program through two complementary but distinct interventions: a project which will address the identified constraints to the delivery of quality community co-financed and co-managed health care in South, Adamaoua, and Far North Provinces (USAID's area of support); and a project which will support the integration of quality maternal child health/family planning and AIDS information and services into community co-financed and co-managed health facilities, private sector health facilities, and social marketing efforts.

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# CAMEROON HEALTH SECTOR ASSESSMENT

## I. MACRO-ECONOMIC OVERVIEW

A nation of 12 million people, Cameroon is endowed with rich natural resources and a well-educated and bilingual workforce. For nearly two decades following independence in 1960, the country enjoyed stable economic growth fueled by earnings from agricultural products, principally coffee and cocoa. During this period, the gross domestic product (GDP) increased at an average annual rate of 5.2 percent from 320 billion FCFA in 1970/1971 to 1,800 billion FCFA in 1980/1981. The substantial expansion of oil production beginning in 1978 further accelerated the growth of the GDP to 8 percent annually from 1980/1981 to 1985/1986, with per capita income reaching \$800.

Since 1986, however, Cameroon has endured an economic recession which has resulted in an estimated 24 percent decline in GDP. The decline in the world price of oil (approximately 40%), which began in 1986, and the subsequent steep reduction in the world prices of cocoa and coffee (approximately 54% and 39% respectively), beginning in 1987 and continuing up to the present, have cut export earnings by almost one-third. This drastic reduction in export earnings has plunged Cameroon's economy into a deep recession and liquidity crisis which will not disappear in the absence of a major structural adjustment reform effort.

According to USAID Cameroon's Action Plan for 1990-1992, "there is little cause for optimism regarding the Cameroonian development environment. This environment is an extremely difficult one in which maintaining zero growth should be viewed as a very significant accomplishment."

### Cameroonian Approach to Structural Adjustment:

Beginning in early 1988, the GRC began discussions with both the International Monetary Fund (IMF) and the World Bank regarding the stabilization and structural adjustment of its economy. With the support of two IMF Stand-by Agreements approved in 1988 and 1991, and a World Bank Structural Adjustment Loan approved in July 1989, the GRC began to undertake actions aimed at 1) curtailing the growth of public expenditures; 2) strengthening and broadening revenue collection; 3) reforming the civil service; 4) liberalizing the trade regime; 5) liquidating, privatizing, and restructuring the parastatal sector; and 6) restructuring the commercial banking sector. Although some progress has been achieved in selected areas such as banking reform and privatization of parastatals, the overall performance of the structural adjustment program has been poor. In September 1992, the World Bank blocked disbursement of the third tranche of the Structural Adjustment Loan because of arrears in the GRC's payments to the IMF and the World Bank.

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## I. HEALTH SECTOR ENVIRONMENT AND CONSTRAINTS

### A. Health Sector Operational and Policy Constraints

During Cameroon's growth years (1960 -1985), the GRC allocated as much as 6 percent of the national budget to the health sector which permitted the funding of drugs and many of the critical recurrent costs of delivering rural health services. During this period infant mortality declined steadily from approximately 150 per 1000 live births to less than 90 per 1000 by 1986.

However, as a result of the economic downturn, the MOPH budget has registered a sharp decline since 1986, dropping from a high of 26.75 billion FCFA in 1986/87 to 22.76 billion FCFA in 1990/91. Prior to the economic crisis, in excess of 30 percent of the health budget was allocated to the rural health services (subdivision level hospitals, health centers, and village health posts). In 1988, because of the worsening economic crisis, the budget for rural health care was cut by 50 percent and health facilities lost most of their operating budgets. The supply of medications to rural facilities, already inadequate, virtually ceased. These financial problems, which have continued, are exacerbated by inefficient health budgeting, planning, and resource allocation practices. MOPH personnel, like other Cameroonian public servants, have outdated job descriptions, work in a system without incentives or sanctions to encourage accountability, and lack the resources to perform their jobs properly. Health center utilization, which is already low, has worsened. As a result, primary health care and rural health services have ceased to function in a coordinated, effective fashion in the country.

The weaknesses of the public health system are manifest in the low coverage rates for preventive services. Only about one-quarter of the nation's children are completely vaccinated, the oral rehydration therapy (ORT) usage rate is less than 20 percent, and the contraceptive prevalence rate for modern methods is 4 percent.

The following are identified operational and policy constraints of the Cameroonian health sector:

**Health Personnel System:** There are an estimated 12,000 public health workers in the country including approximately 729 medical doctors; 44 dentists; 49 pharmacists; and 10,000 nurses, health technicians and nurse assistants. This personnel is unevenly distributed in favor of urban areas with the result that rural health facilities often lack minimal staff. In addition, there exists a law which assigns women civil servant to the localities where their civil servant husbands live. The net effect in the health sector is a preponderance of women nurses and midwives of health facilities in large cities.

The National Medical School (CUSS) graduates about 50 medical doctors a year. Due to the national budgetary crisis, many of the country's 40 paramedical training schools have been closed. If these schools do not reopen there will be a lack of paramedical workers in the health system by the end of the decade. Other problems in health personnel are lack of clear job descriptions, lack of accountability, insufficient career development, inadequate supervision, lack of delegation of authority even at the

highest levels, lack of in-service training, and oftentimes late payment of salaries. In addition, there is a lack of disciplinary sanctions even in cases of repeated absences from work. Health worker morale is low and relations between the health workers and their clients are poor. As a consequence of these problems, overall health worker performance is poor.

**Rural Health Services:** Cameroon has 185 hospitals, 742 health centers, and 105 specialized health facilities. Despite a relatively large number of health facilities, there is an overabundance of structures in favor of certain regions (Center and South) and other areas where there is little access to health care. In many cases subdivisional hospitals are no larger, better equipped, or better staffed than health centers. Rural health services are hampered by the lack of essential drugs, laboratory equipment and reagents, and other expendable supplies. The lack of community-managed or private pharmacies in rural areas limits the availability of pharmaceuticals to the inadequate supplies of free drugs furnished periodically to MOPH facilities. Clinical practices are characterized by the prescription of inappropriate medications (e.g., injectable quinine for malaria and anti-diarrheals rather than ORS for childhood diarrhea), over-medication, little follow-up of illnesses, and lack of coordination of the various services offered at health facilities. Logistical systems work poorly and result in frequent stock outages of drugs, vaccines, and other essential supplies such as refrigerator parts. Preventive programs such as childhood immunizations, ORT, nutrition monitoring and promotion, child spacing, and pre-natal and post-natal care are absent from many health centers. The little supervision that exists in the health system is hampered by the lack of supervision guidelines and protocols, little follow-up of findings, and inappropriate attitudes on the part of supervisors. The net result is a rural health system which is non-functional.

**Medical Referral System:** The medical referral system lacks clear guidelines for identification of at-risk patients and there is no follow-up or feedback on referred patients. In addition, reference facilities lack laboratory, surgical, radiology and other equipment required to permit quality secondary care to be delivered. Due to a lack of confidence in primary health care centers, patients often bypass these structures and utilize hospitals as dispensaries in the belief that these facilities are more likely to have drugs and other supplies.

**Health Information System:** The present national health information system (HIS) is functioning poorly. Data is incomplete (only 42% of the expected reports for 1989 were received) and of low quality. Data analysis is rudimentary and late (the annual HIS report for 1990 has not yet been published). The system has six required HIS forms (a monthly health facility activities report, a weekly health facility infectious disease report, a monthly divisional epidemiologic report, and monthly health facility reports on leprosy/tuberculosis, trypanosomiasis, and vaccinations). Moreover, additional forms are required by various donor projects. In North-West province 24 HIS forms are theoretically completed and sent to the central MOPH. As a result, little data is analyzed, fed back to health facilities, or used for decision-making at any level.

**Pharmaceutical Procurement:** There currently exists no functioning structure designated as responsible for the provision of drugs to public health facilities. ONAPHARM, the parastatal mandated by law to fulfill this role, has been unable to procure significant

quantities of drugs for the last two year. Public health facilities are therefore required to procure drugs from several private (both for-profit and non-profit) sector distributors operating in Cameroon or import them directly from foreign sources. Recent studies indicate that these distributors do not provide a consistent supply of the drugs required by PHC services (i.e., essential, generic drugs in bulk packaging). There is also concern that, at the prices charged by these suppliers, segments of the population will be unable to afford them. Although there is an national essential drug list classified by pharmacological family and health facility level, there are too many authorized pharmaceuticals (e.g., 149 for central and provincial hospitals, and 74 for health centers) and specialty drugs on the list. In addition, the list is neither officially signed nor widely distributed to health facilities. Traditional drugs are not properly controlled by the health care system. Finally, there is a significant flow of unlicensed pharmaceuticals into Cameroon, mostly covertly imported from Nigeria.

**Public/Private Sector Coordination:** Cameroonian private health providers include religious hospitals and clinics, employee-based health facilities, and some for-profit clinics and hospitals in large urban areas. Despite the severe financial constraints facing the public health sector, little attention is focussed on the integration of these resources into the national health care system. As a result, there is duplication of services (e.g., some religious and public health facilities next to each other), there are no consistent medical standards and procedures, and there is no plan to effectively address underserved areas with available resources from the public and private sectors.

**Health Planning:** The MOPH produces annual health plans and is the process of finalizing a national health policy for the country. However, health planning exercises to date have been hampered by too many objectives, no prioritization of activities, few linkages of activities with available resources, and little monitoring and evaluation of plans. In addition, there is little health planning at the provincial, divisional, and sub-divisional levels. Finally, there needs to be improved coordination of national and donor inputs into the health sector.

## B. Health Sector Financing Constraints

Cameroon is considered to be a lower middle income country based upon a per capita income of \$500 (1987 estimate). However, Cameroon's health indicators are more indicative of lower income countries. This poor performance in the health sector has prevailed despite relatively high public expenditure levels for health (\$12.60 per capita in 1988/89 as compared to many Sub-saharan countries with levels consistently lower than \$5 per capita).

Although GRC budgetary allocations for health grew during the 1970s and the early 1980s, they did not grow as fast as overall government spending. As a result, the percentage of the national budget devoted to health has fallen from approximately 6 percent in 1968/1969 to a current level of only 4.5 percent for the 1991/1992 budget. This is well below WHO's recommendation that lower income countries devote 10 percent of their national budgets to the health sector. Not only has GRC budget allocations for health as a percent of the overall GRC budget fallen steadily in recent years but the current economic crisis has necessitated a drop in overall government spending. As a result, the GRC recurrent health budget has dropped from 27.8 billion

FCFA in 1986/1987 to 24.36 billion FCFA in 1991/92. The table below summarizes recent trends in the GRC recurrent health budget.

#### Recurrent Health Budget, Cameroon 1983-1991

Year	National Budget	Health Budget (CFAF billions)	% Health
83/84	520	22.89	4.4
84/85	620	23.02	3.6
85/86	740	26.75	3.6
86/87	800	27.81	3.5
87/88	720	25.62	3.6
88/89	600	23.98	4.0
89/90	600	25.87	4.3
90/91	550	22.76	4.1
91/92	545	24.36	4.5

The GRC investment budget for health totaled a mere 2.6 billion FCFA during the period 1981-5. Investment spending increased markedly in 1985/86 to 7 billion FCFA and in 1986/87 to 8 billion FCFA. Investment spending fell drastically in the 1988/89 and 1989/90 budgets to approximately 3 billion FCFA a year, representing no more than 1 percent of total GRC investment spending. Historically, most health investment spending has been consumed by hospital construction. In 1987/88 only 14 percent of investment was spent for construction of primary health care centers. Hospital construction grew to 92 percent of health investment spending in 1988/89.

#### Health Investment Budget, Cameroon 1985-89

Year	Nat. Investment Budget	Hlth Investments (Billions FCFA)	% Health
1985/86	310,000	7,736	2.5
1986/87	340,000	8,008	3.4
1987/88	250,000	5,014	2.0
1988/89	225,000	2,265	1.0

Within the GRC recurrent health budget, personnel costs currently consume over 80 percent of the total. This rate increased from approximately 70% in the early 1980s. This leaves little for non-salaried operating costs. For instance, in the 1989/90 budget only 2.1 billion FCFA (192 FCFA per person) was allocated for drugs within the total recurrent health budget and less than 40 million FCFA (.1% of the recurrent health budget) was allocated for building maintenance. With fixed personnel costs, there appears little hope for improvement in the situation.

**Composition of the Recurrent Health Budget (Billion FCFA)**

Line Item	1987/88		1988/89	
	Amount	%	Amount	%
Personnel (Salaries)	19,936	77.8	19,824	82.7
Other Personnel Expenses	325	1.3	277	1.2
Health Services	4,179	16.3	3,124	13.2
Building Maintenance	49	0.2	34	0.1
Scholarships	237	.9	236	1.0
Other Expenses	<u>878</u>	<u>3.4</u>	<u>430</u>	<u>1.8</u>
Totals	25,622	100.0	23,976	100.0

Moreover, detailed analysis of the 1989/1990 budget indicates a lack of correspondence between budgeted funds and monies actually expended. For instance, of the 2.1 billion FCFA allocated for drugs in 1989/90, only 400 million FCFA (19% of budget) was actually spent. Only 28% of the 3.2 billion health investment budget was expended. Data indicates that the ratio of expenses to allocations is the highest for personnel and lowest for investment. Similarly this ratio is highest for allocations to central health directorates and facilities, and lowest to rural health centers. Part of these discrepancies can be explained by the relative greater liquidity of central treasuries as compared to those in rural areas.

**Expenditures of 1991/92 Health Budget (Billions FCFA)**

Item	Allocation	Expenditures	Percent
Personnel	19.5	18.54	95
Non-Salaried Costs	4.9	2.89	59
Investment	3.2	.89	28
Total	26.6		

**Resource Allocation Within the Health Sector**

The current operating procedures of the Ministry of Finance currently prohibit the creation of new line items within the MOPIH operating budget and do not allow the increase in any budget line item from the previous year. According to the Directorate of Administrative Affairs within the MOPIH, these rules severely limit the ability of the MOPH to alter current resource allocation to better reflect MOPH policies and programs.

A shrinking budget and high, almost constant, personnel costs have combined to reduce the percent of the MOPH operating budget available for programming according to policies and strategies. Personnel costs currently absorb in excess of 80 percent of the MOPH allocated recurrent budget and a greater percent of actual expenditures. These high personnel costs are in part due to the rapid expansion of the civil service that took place in the first half of the 1980's.

Although the MOPH has managed to slightly reduce personnel costs over the past three years, it would appear that dramatic reductions in this line item will be difficult to achieve. The MOPH has currently undertaken a personnel audit in an attempt to reduce the level of salary fraud. Although recruitment has been greatly reduced and most national nursing schools closed, it will be difficult for the MOPH to effect any significant reduction in the number of health personnel in the near future. An audit is an encouraging step but it is not clear that any reduction in personnel costs would not result in an identical, corresponding reduction in the overall MOPH operating budget. Therefore, a reduction in personnel expenditures may not necessarily increase the funds available for non-personnel items.

Part of the budgetary problem is due to the fact that GRC resource allocations are made by means of ministry vouchers which have to be redeemed at local treasuries. Some provincial treasuries are chronically short of cash and cannot provide payments in support of any government service. In addition, because of the financial crisis and the government's inability to pay its bills, private suppliers often refuse to accept the MOPH's purchase orders. This would mean that resource allocation, even correctly done, has an unknown effect on actual spending within the health sector. Moreover, without a functioning national health management information system, the allocation of resources within line items (which is carried out by the responsible technical directorate) is performed in the absence of reliable data and with no objective criteria.

**Cost Recovery:** In a law enacted in 1963, the GRC authorized fees for services at all public hospitals in the country. Except for a small portion retained by practicing physicians for profit-sharing, all revenues collected as a result of this law must be remitted to the national treasury. Thus, none of these funds is available to fund operating costs at hospitals or to improve services in any way.

### **Effect of the Economic Crisis on the Private Health Sector**

The ongoing economic crisis has had a major negative impact on Cameroon's private health sector. Both of Cameroon's major missionary health networks, the Federation of Evangelical Missions in Cameroon (FEMEC) and the Catholic Health Services Foundation (Ad Lucem), are currently experiencing serious financial difficulties. Together these two networks provide health services to greater than 20 percent of the population.

FEMEC's health facilities receive support from four sources: contributions from Cameroonian member churches, donations from overseas, contributions from the MOPH, and cost recovery revenues. As a result of the economic crisis, contributions from members churches are down as much as 50 percent compared to previous years, budgetary support from the MOPH has been reduced by approximately 70 percent, and cost recovery revenues have declined significantly due to lower utilization of health facilities. While no facilities have been forced to close, several hospitals are experiencing serious financial difficulty. Many facilities have had to lay off employees and reduce services as a result of reduced incomes.

due to lower utilization of its facilities, increased numbers of patients who are unable to pay for care, and greatly reduced MOPH support. To make matters worse, in 1990, Ad Lucem initiated an ambitious construction program which it did not have sufficient funds to complete. The foundation has still not completely recovered from this financial setback.

Private for-profit clinics in Yaounde have also experiencing serious economic problems linked to the economic crisis. Utilization has significantly decreased with several major clinics reporting less than five new patients a day. Reduced incomes have forced private clinics to lay off personnel (by as much as 80 percent), severely limited the range of drugs available for treatment, and postponed repayment of debts. The financial status of private health clinics has been made worse by major clients (such as the GRC) not paying their bills. In an attempt to increase utilization and income, clinics have reduced fees to patients by as much as 85 percent.

### III. DESCRIPTION OF THE HEALTH SECTOR

#### A. Demographic Trends

According to official demographic projections from the 1987 National Population Census, the total population of Cameroon reached 12 million in mid-1991, compared to 7.7 million registered in the 1976 census. With an average annual growth rate of 2.9 percent, Cameroon's population will exceed 15.5 million in the year 2000. Cameroon has a total fertility rate of 5.8 live births per woman, which has remained fairly steady since the 1976 census. The crude birth rate is estimated at between 42 and 45 births per 1000 population, a high rate even by African standards. Urbanization is increasing rapidly, and the proportion of the population living in urban areas has increased from 20 percent to over 40 percent since the early 1960s. The Census projects that about half of the Cameroon population will live in urban areas by the year 2000. The 1991 Cameroon Demographic and Health Survey (DHS) measured the modern contraceptive prevalence rate at 4 percent. According to a national fertility survey conducted in 1978, the infertility rate is high at 17 percent.

#### B. Health Indicators

Since 1950, dramatic improvements have occurred in the health status of the Cameroonian population. The crude death rate has declined from 27 deaths per 1000 population to 14 per 1000 according to the 1987 National Population Census. During the same period, life expectancy at birth rose from 35 to 54 years. Infant mortality has similarly declined from 170 deaths per 1,000 live births to approximately 90 per 1,000, and child mortality from over 250 deaths per 1,000 children under age five to approximately 160 per 1,000. Despite important declines in child and infant mortality rates over the past 40 years, evidence indicates that infant and under five mortality rates are reaching a plateau (the annual rate of decrease being almost halved from that of the previous decade). In addition, present infant and child mortality rates are high when compared to other African countries at comparable levels of GDP per capita.

According to the Cameroon DHS, approximately 80 percent of pregnant women

receive at least one prenatal consultation with a health professional, and approximately 60 percent of births are protected against tetanus by means of injections received by the mother during pregnancy. A relatively high proportion of births (63.8%) take place under the supervision of a health professional, generally a midwife or a nurse (55% of cases). Nonetheless, maternal mortality is high at an estimated 420 per 100,000 live births.

Morbidity and mortality among infants and children in Cameroon are largely preventable and generally caused by illnesses whose early diagnosis and treatment could substantially reduce mortality. The most important among these are malaria, measles, tetanus, diarrhea, pneumonia, and meningitis. According to a MOPH study, 2,153 deaths were recorded during the first six months of 1990 among both children and adults. The major causes by order of importance were as follows:

1. Malaria
2. Measles
3. Meningitis
4. Pneumonia
5. Anemia
6. Diarrhea
7. Broncho-pneumonia
8. Malnutrition
9. Hypertension
10. Tetanus

In addition to these principle causes of death, the MOPH reports that tuberculosis, leprosy, filariasis (including onchocerciasis), schistosomiasis, and cholera are also endemic. Childhood vaccination coverage is low by African standards: 38% vaccinated against measles and only 27% completely vaccinated. Only about 5 percent of childhood diarrhea cases are treated at home with oral rehydration salts. Overall use of oral rehydration salts or homemade salt-sugar solution at home to treat diarrhea is approximately 20 percent.

Cameroon reported its first AIDS case in 1985. A total of 1,052 AIDS cases have been reported in Cameroon as of April 1992, almost equally distributed between males and females. The main mode of transmission is heterosexual and the epidemic is primarily affecting the young, sexually-active population (70 percent of the cases are in persons between the ages of 20 and 39 years of age). The overall seroprevalence of Human Immuno-deficiency Virus (HIV) in the sexually-active population is less than one percent but appears to be rising. Surveillance studies in pregnant women in urban areas (a high risk group) have shown an increase in HIV seroprevalence from 0.9 percent in 1989 to 1.3 percent in 1990 and 2.2 percent in 1991.

Current evidence points to the possibility that nutrition in Cameroon may be deteriorating. In 1985, 13% of babies were born with low birth weights. Daily food intake, on average 2,028 calories per day, is slightly lower than in 1965. The daily diet of most Cameroonians shows a deficiency of protein. In addition, there are pockets of iodine and vitamin A deficiencies among the populations of northern Cameroon.

### C. Public Health Infrastructure

Administratively, the Ministry of Public Health (MOPH) is composed of a private secretariat to the Minister, an Office of the Inspector General, two Technical Advisors, a Central Administration, and External Services. The Central Administration consists of the following six directorates: Hospital Services; Preventive and Rural Health (DPRH); Family and Mental Health (DFMH); Pharmacy; Planning, Studies, Statistics; and Administrative Affairs. All directorates report to the Secretary General who heads the Central Administration. The Inspector General and the two Technical Advisors receive instructions directly from the Minister. The External Services of the MOPH comprise the following:

- Provincial Delegations of Public Health
- Divisional Services of Public Health
- Sub-divisional Services of Public Health
- Health Facilities and Special Services

The Provincial Delegations of Public Health are headed by Provincial Health Delegates (PHDs), who are the representatives of the Minister in their respective provinces. As such, the PHD is the chief medical officer in charge of overseeing all provincial-level public health services -- delivery of curative care, administration, health planning, and preventive medicine activities and programs. The director of the provincial hospital reports directly to the PHD.

At the divisional level, the representative of the Minister of Public Health is the Divisional Chief Medical Officer who is responsible for managing the divisional hospital and supervising the medical staff of sub-divisional hospitals. Overseeing all preventive activities in the division, as well as the health centers and health posts, is the Divisional Chief of Preventive and Rural Medicine. Both officers report directly to the Provincial Health Delegate.

At the sub-divisional level, the representative of the Minister of Public Health is the medical officer in charge of the sub-divisional hospital. Finally, there are primary health care (PHC) coordinators appointed at the provincial, divisional, and sub-divisional levels.

**Tertiary Care:** Tertiary care is carried out in four large referral hospitals located in Yaounde and Douala. In addition, each provincial capital has a full service hospital offering specialty care. General hospitals without specialty services are located in the divisional and sub-divisional capitals. However, sub-divisional hospitals frequently resemble upgraded health centers.

**Primary Health Care:** Primary health care is delivered through a network of health centers and village health posts. Health centers are defined as either elementary (defined to serve approximately 5,000 people) or developed (serving 10,000 people and including some maternity and in-patient beds). In practice, there is little distinction between the two types of facilities. There are approximately 742 public health centers in the country. For village health posts, communities contribute resources and build health units out of local materials. Community health workers (CHWs) are selected by the

village and trained at the sub-divisional hospital. The community is responsible for their remuneration. The government considers the health posts to be outside of the public sector.

**Other Facilities:** There are approximately 59 maternal child health centers in the country, many of which are attached to provincial hospitals. In addition there are approximately 23 women's centers managed by the Ministry of Social and Women's Affairs which conduct income generation, counseling, and health programs targeted at women.

**Ministry of Agriculture:** The Ministry of Agriculture's Community Development Division conducts development activities at the community level. This division actively supports women in development and water and sanitation programs. PVO-implemented health projects often use community development animators to promote primary health care at the village level.

**Ministry of Women's and Social Affairs:** This ministry supports and implements programs on responsible parenthood. Within this context, the ministry conducts family planning information, education, and communication activities and sex education in secondary schools.

#### **D. Private Health Infrastructure**

Non-profit religious organizations make an important contribution to the delivery of health services in Cameroon. There are approximately 25-35 Protestant hospitals, 15-20 Catholic hospitals, and several hundred health centers, small dispensaries, and mobile clinics which are supported by these hospitals. There are two major coordinating organizations: The Federation of Evangelist Missions in Cameroon (FEMEC) and Catholic Health Services (Ad Lucem Foundation). The distribution of these health facilities in the country is uneven. For instance, in West Province, religious-supported health facilities form a health network parallel to that of the MOPIH while in North province there are only two religious dispensaries outside of the provincial capital.

In addition, there are 30 to 50 private and parastatal businesses which operate health facilities for their employees. There are also a small number of private for-profit clinics in Yaounde and Douala and in several other larger cities.

Finally, there are approximately 225 private pharmacies operating in Cameroon. Most of these pharmacies are supplied by four large drug wholesalers. The GRC has set standard markups for wholesale and retail sales of pharmaceuticals.

### **IV. HEALTH SECTOR REFORM - THE MOPIH'S RESPONSE TO CONSTRAINTS IN THE HEALTH SECTOR**

#### **A. Primary Health Care**

In response to deteriorating conditions, the MOPIH initiated health sector reform beginning in 1989, several years after the onset of the country's severe economic crisis. Health sector reform has proven to be a long process involving operations research, policy formulation, and implementation of new programs in pilot regions. Progress in

improving health conditions in pilot zones is already apparent in 1992 and will begin to have nationwide impact over the next five years. The key elements are outlined below:

**1. Testing of a Revised Primary Health Care Policy**

In 1989, the MOPH began testing a revised PHC program based on community co-financing and co-management of health services. Under this pilot program, called the Reorientation of Primary Health Care, communities participate in the delivery of health care by paying for essential drugs and fees for services, and by co-managing with health center staff the local utilization of these revenues. USAID, the German Technical Agency (GTZ), and the Belgians began testing this program in five provinces.

**2. Drug Financing Law of 1990**

As a result of the successful operation of donor-supported community-managed drugstores at public health facilities, the National Assembly passed legislation authorizing public health facilities to establish community-managed revolving fund drugstores in which all receipts are retained locally. This important legislation provides the legal basis for USAID and other donors to develop sustainable medical supply systems under PHC projects. As a result of this legislation, revolving-fund pharmacies are being launched to provide regular supplies of essential drugs to health facilities. Surplus revenues from these pharmacies are used to finance some of the operating costs of delivering health care.

**3. Formal Adoption of New PHC Policy Based on Cost Recovery (1992)**

In 1992, after two years of pilot testing community co-financing and co-management of health services, the MOPH formally adopted this approach as national policy. According to the new strategy, the national health system will be reorganized in such a way that local communities will begin to take some responsibility for health care. Each statutory subdivision of the country will be organized as a health district which will receive technical and administrative support from the divisional and provincial levels. The health district, rather than the statutory division, now becomes the major planning and implementation unit for health services, a major decentralization of health administration. Within the health district, health areas will be established in zones surrounding functional health areas and community health committees will be created at the level of the health center. Each health center will have a drugstore and other cost recovery mechanisms which will be managed by the community health committee. These revenues will permit the funding of important recurrent costs of the PHC program. A summary description of the system is provided in Annex B.

The Reorientation of PHC is based on the premise that the GRC does not presently have, nor will it have in the near future, sufficient budgetary resources to finance health care services. The strategy's cost recovery approach divides the costs of health care between the government and the population. The government will continue to fund health workers' salaries, pre-service training, and other inputs which are currently provided despite the economic recession. The community will fund the key non-salaried recurrent costs associated with the delivery of PHC services. In addition, the health system will be made less costly and more efficient by stressing the full integration of health management systems and health services.

#### 4. August 1992 Hospital Financing Law

In August 1992, the GRC National Assembly amended the 1963 health financing law to permit specially approved public hospitals to retain 50 percent of their revenues from fees for services (i.e., hospitalization, deliveries, consultations, surgery, etc.) Formerly, public hospitals were required to send all revenues not disbursed to physicians for profit-sharing directly to the national treasury. This legislation will provide hospitals access to significant revenues which can be utilized to maintain equipment and infrastructure; purchase supplies; train staff; extend profit-sharing to non-physicians; and to fund other operating costs. The MOPH plans to begin implementation with national and provincial hospitals where there are existing financial management systems. In combination with the 1990 law authorizing revolving fund pharmacies, this legislation will permit dysfunctional public health hospitals to improve their services sufficiently to attract clients and serve as viable secondary care centers. The possibility of future legislation allowing hospitals to retain greater than 50 percent of their revenues will depend on the results of this measure.

A complete list of legal measures in support of primary health care reform is included as Annex C.

#### Donor Support for the Reorientation of PHC Program

The MOPH's Reorientation of PHC strategy is being implemented in large areas in all ten provinces with plans underway to implement the program in every division in the country. Similar to other major health donors, USAID has provided important support for this new initiative:

##### 1. USAID

- Since 1989, the USAID Maternal Child Health/Child Survival (MCH/CS) Project (PACD 1993, life of project funding \$11.5 million) has supported the introduction of the Reorientation of PHC Program in Adamaoua and South Provinces. Implemented through a contract with the Harvard Institute of International Development, the project has developed a comprehensive PHC training program consisting of modules on community mobilization, the establishment of community health and community management committees, the delivery of integrated and rationalized health care, the management of a drug logistics system, integrated supervision, and other related topics. The project supports long- and short-term technical assistance, in-country training, commodity support, operations research, and participant training. By the end of 1992, the MCH/CS Project will have introduced community co-financed and community co-managed health services into approximately 50 health areas in the two target provinces.

According to the November 1991 evaluation of the project, progress has been achieved in identifying health areas; designing training manuals; organizing and training community health and management communities; and establishing cost recovery, logistics, supervision, and health information systems. As a result curative, preventive, and to a lesser extent, promotive services are being provided under the new system - a marked improvement over baseline conditions. However, weaknesses in management,

supervision, and information collection have resulted in operational problems in the cost recovery system such as drug outages at health centers, the unauthorized sale of drugs on credit, and the incomplete preparation of control forms.

The team further stated in its report that, while health personnel and the public generally accept the new system, they have difficulty understanding the new administrative procedures. In addition, authorities need to clarify the legal basis for community health committees and their relation to MOPH structures. Major conclusions were that (1) the operational problems encountered can be rectified through improved health systems management and (2) decentralization of health services and the community co-management and co-financing of health care are appropriate mechanisms for delivering health services. Finally, the team recommended that USAID provide follow-on assistance to the MOPH for continuation and expansion of its new PHC program.

- The USAID's Reform of the Health Delivery System (RHDS) Project (PACD 1993, life of project funding \$2.6 million) supports the implementation of the Reorientation of PHC in four divisions of Far North Province. The project is jointly implemented by Save the Children and CARE International, both of whom have a long experience of working in the province. Progress has been made in designing drug logistics, financial management, supervision, and health information systems. Since inception, the RHDS Project has worked closely with the MCH/CS Project, drawing on the latter's training modules and operational guidelines. An initial eight community co-managed and co-financed health centers were launched in September 1992.

## 2. German Technical Cooperation (GTZ)

The GTZ has been implementing the the Reorientation of PHC in the Northwest, Southwest, and Littoral provinces since 1989. Progress has been made in establishing provincial drug logistics systems which procure essential drugs internationally and assure their delivery to over 140 community co-financed and co-managed health centers in the three provinces. Provincial supervision and health management information systems have also been established. Finally, GTZ has helped the MOPH to develop and implement a provincial health committee in Northwest Province which oversees the provincial drug logistics system, programs surplus cost recovery revenues, and establishes health priorities for the province. Similar provincial committees will be established in Southwest and Littoral provinces. A recent evaluation of the program indicates that additional work is needed to improve the performance of health district teams, to improve the range and quality of services provided by health centers, and to strengthen reference hospitals. The present project terminates in December 1992. GTZ has proposed a three year extension with a life-of-project funding of \$6 million.

3. Belgian Cooperation: Belgian Cooperation is implementing the Reorientation of PHC program in Diamere Division of Far North Province. Under this assistance, Belgian Cooperation has established ten community co-financed and co-managed health centers which charge their patients flat consultation fees for each new episode of illness, regardless of the severity or type. In addition, Belgian Cooperation has established a revenue-sharing system in which health centers with larger catchment area populations support health centers with smaller catchment area populations. The present project period is from 1991 to 1993 with a life-of-project funding of approximately \$2 million.

4. **French Cooperation:** In 1991, French Cooperation launched a \$2.7 million project over three years to implement the Reorientation of PHC program in North Province. This initiative includes institutional support to the Provincial Health Delegation and assistance to the Provincial Hospital in Garoua.

5. **UNICEF:** UNICEF is providing approximately \$1.5 million for the period 1991-1995 to implement the Reorientation of PHC in 158 health center catchment areas in East, Center, and West provinces. The first community co-financed and co-managed health centers under this project opened in November 1991. This project, modelled after UNICEF's Bamako initiative (a cost recovery program similar to the Reorientation of PHC), does not include support for referral hospitals.

6. **European Community:** As part of a proposed \$12 million health program, the European Community plans to support the implementation of the Reorientation of PHC in parts of East, Center, West and Far North provinces where there is presently no donor assistance. This program will likely be implemented by GTZ/Cameroon.

7. **Switzerland:** The Canton of Jura in Switzerland is funding the introduction of the Reorientation of PHC in the division of Mefou, Center Province.

## B. Health Systems

**Pharmaceutical Sector:** In 1992, the World Bank financed a study of the pharmaceutical sector which concluded by recommending the closure of the bankrupt ONAPHARM, the national drug procurement and distribution agency, and its replacement by an autonomous wholesale purchasing board. The MOPH has indicated its general endorsement of this recommendation.

**Coordination and Institutional Support of the Health Sector:** To improve coordination of actors and interventions in the health sector, the MOPH in 1991 formally created a "technical committee for coordination and monitoring of health projects and programs," composed of representatives of each of the MOPH's central directorates and provincial delegations, the Ministries of Plan, Finance, and Social and Women's Affairs, health donors, and non-governmental organizations. The committee is mandated to meet at least semi-annually to coordinate projects and programs and monitor their progress. In addition to the central committee, sub-committees on PHC, maternal and child health, essential drugs, health information, and the national immunization program have been created. All of these sub-committees have met, at least informally, within the last six months of this writing. These committees are viewed by the donors as promising structures to better coordinate health sector initiatives.

**Development of a National Health Management Information System:** In 1991 the MOPH began work on design of a national health management information system (HMIS). This HMIS will provide timely data for decision making for the MOPH's new Reorientation of PHC Program. In addition, the HMIS will collect and analyze management, budgetary, and other data on all public and private health sector activities in Cameroon. The design of system will be the responsibility of the MOPH's new technical coordinating sub-committee on health information which is headed by the Directorate of Studies, Planning and Statistics.

## Donor Support for Health Systems Development

**Pharmaceutical Sector:** In 1992, the European Community provided GTZ approximately USD 800,000 to establish an essential drugs procurement body in Southwest province. This non-profit entity procures low-cost essential drugs internationally for PHC projects and non-governmental health programs. At present, this procurement entity is utilized by all provinces, except those supported by UNICEF, to resupply essential drugs to community co-financed and co-managed health centers and hospitals. UNICEF has established a drug procurement entity in Cameroon, linked to its UNIPAC procurement organization, which resupplies the community co-financed and co-managed health facilities in its project area.

As part of its proposed \$12 million health sector program, the European Community (EC) plans to assist the MOPH in developing a new pharmaceutical and distribution system for the country. Under the EC proposal, ONAPHARM would be replaced by an autonomous pharmaceutical agency with three regional outlets. In addition, the ten provincial health committees would have authority, if the national procurement agency was inefficient, to procure drugs internationally. The present GTZ-implemented drug procurement body in Southwest Province would constitute one of the three regional outlets proposed under the EC project.

**Health Management Information:** USAID through the RD/Health-funded Technical Advisors in AIDS and Child Survival (TAACS) Project (PACD 1994, life-of-project funding \$500,000) is providing the MOPH with a long-term epidemiologist to assist in the design of the national HMIS. GTZ is actively supporting this effort with technical assistance, and funding for in-country training and field testing of HMIS forms.

**Institutional Support to the MOPH:** In 1992, French Cooperation placed a long-term technical advisor in the office of the Minister of Public Health to assist the MOPH in the areas of donor coordination, health administration, and health financing. In addition, as part of its proposed health sector program, the European Community in 1993 plans to place two long-term technical advisors in the MOPH to provide guidance on health policy and budgeting, and the pharmaceutical sector.

### C. Family Planning/Maternal Child Health:

Since 1990, Cameroon has made significant progress in establishing an institutional framework for the expanded delivery of family planning information and services. In particular, progress has been achieved in the following areas:

- The development of a national family planning service delivery policy. This policy authorizes all health centers and hospitals in the country to include family planning services as part of integrated primary health care. The policy also authorizes all levels of health care providers (including village health workers and nurse assistants) to participate in the delivery of services. In addition, the policy approves a full range of modern family planning methods including injectable contraceptives, norplant, and voluntary surgical contraception.

- The design of a national family planning in-service curriculum. This curriculum is being used to train health service providers from public and private sector health facilities.
- The inclusion of contraceptives in the MOPIH's official essential drug list.
- The development of nationwide contraceptive social marketing program which presently sells two brands of condoms and is preparing the launch of oral contraceptives.

In addition to policy measures aimed at expanding access to quality family planning information and services, the Cameroon National Population Commission officially adopted a National Population Policy in July 1992 to establish a national consensus on population matters. The policy outlines a well-conceived, broad-based program which addresses trends in fertility, mortality, and migration; the status of women; educational opportunities; health status; employment; and the environment. In addition, the policy supports the need for reproductive health education and the integration of family planning into primary health care services. Although it does not set specific targets for fertility reduction, the policy underscores the need to realign population growth with the availability of resources, and emphasizes the link between population and development. The impact of this policy will be to increase both donor and government commitments to family planning, maternal and child health, demographic data collection, primary education, and the environment.

#### Donor Support for Family Planning

**Family Planning:** USAID's National Family Health (NFH) Project (PACD 1996, life-of-project funding of \$8.05 million) supports the integration of family planning and maternal health services in community co-financed and co-managed health facilities and in private sector clinics and hospitals. Project strategies include the integration of contraceptives into community-managed pharmacies, and the expansion of PHC supervision and information systems to permit monitoring of family planning and maternal health interventions. As a result of these efforts, the number of family planning service sites and the number of contraceptive users has more than doubled in the past 18 months in Cameroon.

In addition, USAID supports the Cameroon Social Marketing Program, implemented by Population Services International (PSI), by means of four separate projects: a \$200,000 grant from RD/POP's Family Planning Services Expansion and Technical Support Project, a \$400,000 child survival grant from FHA/PVC, an \$800,000 grant from the RD/Health AIDSCAP Project, and through provision of condoms and oral contraceptives from the USAID National Family Health Project. With this support, the Cameroon Social Marketing program is marketing two brands of condoms and is planning the launch in 1993 of oral rehydration salts, oral contraceptives, and sexually-transmitted diseases treatment kits.

In 1992, USAID through the RD/POP OPTIONS Project also provided technical assistance, commodity and local cost support for the design of Cameroon's National Population Policy.

Finally, through the RD/POP Family Planning Operating Research Project A.I.D. supports four operations research projects in Cameroon.

The United Nations Fund for Population Activities (UNFPA) is the only other large donor in the population sector in Cameroon. Between 1987 and 1991, UNFPA supported the 1987 National Population Census; the delivery of family planning services in eight MCH clinics in Yaounde and Douala; development of the National Population Policy; and targeted IEC programs with the Ministry of Women's and Social Affairs. During its 1993-1996 funding period, UNFPA plans to support the population unit of the Ministry of Plan to oversee coordination and implementation of the National Population Policy, provide additional funding for integration of family planning into MCH clinics, and continue its support for IEC programs implemented by the Ministry of Women's and Social Affairs.

International Planned Parenthood Foundation (IPPF) also provides support for the Cameroon National Association for Family Welfare (CAMNAFAW). CAMNAFAW conducts family planning training and IEC activities and provides commodity support including contraceptives to public sector MCH clinics.

#### **Maternal Child Health:**

**Control of Diarrheal Diseases (CDD):** In 1990, the MOPH authorized a national CDD policy which provides case management guidance to health providers and family caretakers, and bans the use of anti-diarrheal drugs at health facilities.

**Breastfeeding:** In 1992, the MOPH conducted a multi-sectoral workshop to design a national breastfeeding policy and plan of action. Both documents have been finalized and will be submitted to the Minister of Public Health for signature.

**Immunizations:** Under the Reorientation of PHC program, childhood immunizations are an integral part of the under 5 care and outreach programs conducted by health center personnel. As a result of this clinic-based vaccination strategy, the MOPH is now deemphasizing mobile vaccination teams as a means to achieve vaccination coverage.

#### **Donor Support for Maternal Child Health**

**Control of Diarrheal Diseases:** Since 1988, USAID, through the RD/Health PRITECH Project (annual funding: \$250,000, PACD 1993) has supported the National Control of Diarrheal Diseases (CDD) Program. In conjunction with the MCH/CS Project, PRITECH has developed a CDD curriculum for service providers working in community co-financed and co-managed health facilities. PRITECH has also worked closely with the MCH/CS and other PHC projects to design supervision protocols and health information indicators to be used in integrated PHC supervision and health information systems. Finally, PRITECH has assisted the MOPH to train CDD trainers, design IEC materials, and develop CDD medical standards.

**Immunizations:** UNICEF is providing approximately USD 1.5 million from 1991-1995 to support the National Expanded Program on Immunization (EPI). This support includes procurement of vaccine, cold chain equipment, vaccination supplies, and the funding of training and other local costs.

In addition to the above, the German, French, Belgian, USAID, and UNICEF PHC projects provide support for the basic child survival interventions (vaccinations, CDD, and malaria treatment) as part of overall funding for integrated PHC services in their project areas.

#### D. AIDS

Established in 1987, the Cameroon National AIDS Control Service (NACS) consists of an operational unit and six technical sub-committees. At the end of 1992, the NACS will complete its first medium-term AIDS program. In order to promote the integration of AIDS control activities into the national health system, the MOPH in 1991 placed the NACS under the direct supervision of the Directorate of Preventive and Rural Health.

##### Donor Support for AIDS Control

Since 1987, the NACS has established programs in the following areas: reducing the sexual transmission of HIV, sentinel surveillance of HIV and sexually-transmitted diseases, reducing the spread of HIV through blood transfusions, reducing perinatal transmission of HIV, and reducing the morbidity and mortality associated with AIDS. Following is a brief summary of the major donor contributions for 1992:

**EC:** Support for blood transfusion and screening; information, education, and communication (IEC) activities in schools; and training for laboratory personnel (approximate value \$1,400,000).

**Canadian AID:** Development of a program to promote in-country production of testing kits (approximate value \$800,000).

**USAID:** Support for AIDS counseling, quality assurance for HIV testing, sentinel surveillance, social marketing, high risk group education, and condoms (total value \$600,000).

**France:** Support for blood transfusions and screening; training; renovation of hospital laboratories; and procurement of testing kits, equipment and supplies (approximate value \$500,000).

**WHO:** Support for administrative costs, technical assistance, and training (approximate value \$500,000).

**GTZ:** Support for training of laboratory workers, epidemiologic surveillance, counseling, program planning, socio-cultural research, and AIDS education (approximate value \$300,000).

## **E. Design of National Health Sector Policy by the MOPH**

In 1992, the MOPH began work on the design of a national health sector policy. The first draft of this policy emphasizes the major health reform efforts initiated since 1990 including support for the Reorientation of PHC, expanded cost recovery in health centers and hospitals, and rehabilitation of the national pharmaceutical sector, the development of a national health management information system, and the strengthening of maternal child health/family planning care as key component of integrated PHC services. The MOPH expects to finalize the document and issue a formal health sector policy statement in 1993.

## **F. Donor-Supported Health Programs in Other Areas**

USAID is funding a Pilot Project for the Control of Onchocerciasis in South Province (PACD 1994, life-of-project funding of \$423,000) to develop a sustainable strategy to distribute ivermectin, a highly effective onchocerciasis control drug, to high risk populations. This project aims to integrate onchocerciasis control into the Reorientation of PHC program by emphasizing a clinic-based approach to ivermectin distribution, by selling ivermectin at community pharmacies, and by amending PHC supervision and information systems to include data on onchocerciasis. Other donors involved in ivermectin distribution include Helen Keller International and the River Blindness Foundation.

Through its Health Constraints to Rural Production II Project (PACD 1993, life-of-project funding \$650,000), USAID is also assisting the MOPH to develop an affordable model for the control of schistosomiasis in highly affected areas. The chief output of this project will be a manual which outlines the procedures and the costs of integrating schistosomiasis control into a community co-financed and co-managed health district. GTZ is also supporting schistosomiasis control in Cameroon.

France and Belgium have both provided assistance to improve the management of the large specialty care (tertiary) hospitals in Yaounde and Douala. France has helped the Laquintinie Hospital in Douala to improve its management and to establish a revolving fund drugstore. The Belgians constructed the Yaounde General Hospital in 1988 with the intention of providing quality care to patients who would otherwise seek to be evacuated to Europe for treatment.

## **G. The World Bank**

### **1. The Structural Adjustment Program and the Health Sector**

The World Bank's Structural Adjustment Program does not propose a detailed program for health sector reform. However, it does include a variety of measures to improve health sector performance. These include:

- formulating an operational strategy to prevent any decline in existing levels of coverage.

- improving quality of care and recovering costs where possible.
- promoting preventive and PHC in rural areas.
- establishing permanent household surveys to measure social conditions.
- improving the quality of care and management at referral hospitals.

On the basis of this general guidance, almost all major health sector projects can be considered to be consistent with the Structural Adjustment Program, particularly those supporting the Reorientation of PHC and maternal child health/family planning.

## 2. World Bank Social Dimensions of Adjustment Program

In order to protect the most vulnerable groups of the population in the course of the structural adjustment program, the World Bank in 1990 developed the Cameroon Social Dimensions of Adjustment (SDA) Program. The principal objectives of the program include:

- protection of the disfavored segments of the population, particularly groups directly affected by the economic crisis and the adjustment program.
- greater participation of poor groups of the population in the process of recovery.
- direct assistance to the health sector.

While it does not represent a coherent program of social sector reform, the SDA Program has been an effective mechanism to mobilize donor funding in the areas of health, population, education, employment, and women in development. Many of the leading health sector donors have identified their PHC projects as contributions to the SDA, including GTZ, France, the Belgian Cooperation, and USAID (i.e., the Reform of the Health Delivery System Project). The adoption by the GRC of a National Population Policy in 1992 was considered as an important achievement in support of the SDA Program.

## 3. World Bank Funding in the Health Sector

The World Bank is presently funding a series of studies on the health sector which may lead to the future design of a major health sector loan program. Approval of the loan would be contingent upon the following actions by the MOPII:

- finalization of its health sector policy document;
- development of an overall budget framework which summarizes present and planned GRC and donor financing in health; and
- elaboration of an overall health sector action plan which incorporates existing and planned donor and GRC funded health programs.

The World Bank supports the Reorientation of PHC Program and its principles of integrated service delivery, decentralized health planning, and community co-financing and co-management of health services. A recent World Bank consultant wrote that "contrary to what takes place in other developing countries, the health donors in Cameroon fully cooperate with each other and share the policy of the MOPH."

According to the World Bank, one of the major objectives of the health sector policy document will be to formalize the effective prevailing practices of the MOPH, particularly in the area of PHC. The findings of the World Bank's studies will provide information to help refine national policies on health infrastructure, pharmaceuticals, human resources management, and financial administration.

In the population sector, the World Bank is implementing a USD 1 million grant from the Japanese government to support population policy development and family planning service delivery. In addition, the World Bank is financing a study of the operation of the MOPH's Directorate of Family and Mental Health.

## V. ECONOMIC ANALYSIS OF THE MOPH'S REORIENTATION OF PHC PROGRAM

As part of the design of the National Family Health Project in June 1991, the Project Paper team conducted a comprehensive economic and financial analysis of the community co-financed and co-managed PHC program in South and Adamaoua Provinces. The major findings of this analysis are outlined below:

**The Reorientation of PHC Approach:** The Reorientation of PHC Program is a promising approach put forth by the MOPH as a means to achieve previously unmet health objectives during a period of economic hardship. The reoriented PHC system is designed to target government resources to specific inputs (e.g. personnel, central supervision) and cover other costs (e.g., pharmaceutical supplies, health center and district supervision, etc.) through community financing.

**Willingness and Ability to Pay:** Cameroon has an average per capita income of \$800, more than double many of its African neighbors, including some that have had positive experiences with health sector cost recovery. A study completed by the Ministry of Plan in 1983 found that the average household in Cameroon spent 5,726 FCFA (\$22) per year on health care. An October 1990 household survey, administered to 768 households in Adamaoua, found that the average expenditure per episode of illness was 4,393 FCFA (\$16.90). The average amount paid per episode of illness was 671 FCFA (\$2.58) for transportation, 2,133 FCFA (\$8.20) for medications, and 1,589 FCFA (\$6.11) for consultation.

While these findings demonstrate that households in Cameroon do pay for health services, it should be noted that the Reorientation of PHC program with its "co-finance" (cost recovery) component is being introduced at a time when the country is suffering from 4 years of economic crisis. Though most of the population may indeed be able and willing to pay for health care, overall health center utilization - at government, mission and private health facilities - has declined quite dramatically since 1988, and particularly since 1989.

It would be reasonable to assume that a portion of the decline in health facility attendance is attributable to the economic crisis. This indicates that when income levels change people are sensitive to increased costs (direct health costs, indirect opportunity costs, and access costs of transportation, gifts, etc.).

In a study of the effects of user fees and improved quality of health care on health facility utilization in Adamaoua, the MCH/CS Project found that people were significantly more likely to use community co-financed and co-managed health centers than other health centers. In addition, contrary to previous studies which have found that the poorest quintile is most hurt by the imposition of user fees, this study found that the probability of the poorest twenty percent of the population seeking care increases at a rate proportionately greater than the rest of the population. Travel and time costs involved in seeking alternative sources of care are too high for the poorest people and thus they appear to be benefitting from local availability of drugs more than others.

The health sector care providers in Cameroon must try to weather the economic crisis while providing the most cost-effective services possible to the greatest number of people. The Reorientation of PHC program is one way that the MOPH is attempting to do so. However, the financial stringencies faced by the government and households may necessitate revision of cost-recovery targets, and/or greater donor commitment for aspects of the PHC co-finance system until Cameroon's economy resumes growth.

**Financial Responsibility of Government and Community within the PHC System:** The PHC co-finance system in Adamaoua and South provinces became operational in January 1991 following the completion of financial and logistics management training, village sensitization, and procurement of drugs. A consultation fee of 200 FCFA was introduced to cover outreach activities and improvements in the health center. Prices charged for the drugs represent the local replacement cost of the drug item, plus a mark-up which covers other costs associated with the operation of the PHC system. As a result of all these costs to be covered by the community, the mark-up placed on the purchase price of all drug items sold to patients is 160 percent. The MOPH has decided not to restock any pharmacies which become decapitalized through community mismanagement. Categories of recurrent expenses for which MOPH, donors, and the community are responsible appear in Annex F.

In order for the community to cover its portion of the costs associated with PHC system, a critical minimum number of patients is necessary in order to raise revenue to cover the health center's fixed costs associated with the system. Revenues are generated through drug sales, consultation fees, maternity services, preschool and prenatal consultations, and fees for wound dressings.

Irrespective of patient volume, costs such as the pharmacy clerk's salary, supervision, refresher training, motorcycle maintenance, and maintaining the cold chain must be met. The estimated total of fixed costs per health center is 84,350 FCFA (US \$325) per month. Health centers in the South Province would break-even at 63 new cases per month. If we assume a health center utilization rate of 25 percent of the population with one new case a year, 63 new patients requires a catchment area of 3,000.

**Pricing and Availability of Drugs:** Drugs need to be procured at a price sufficiently low to enable mark-ups to cover designated fixed costs and outreach activities and still attract patients. After experimenting with local suppliers, the provincial health delegations of South and Adamaoua are reverting to international procurement of pharmaceuticals to reduce costs and to maintain regular supplies.

**Limited Reliance on Government for Health Center Recurrent Costs:** Since in recent years the government has proven to be unreliable in terms of meeting various recurrent cost commitments in the health sector, the PHC system has been redesigned to target government resources to specific items, such as personnel costs. The community is now responsible for covering such costs as pharmaceutical supplies, supervision, vehicle maintenance, fuel for outreach activities, maintenance of cold chain for vaccines, and salary of the pharmacy clerk. However, the level of cost recovery expected of the community may be too ambitious for the economic circumstances of Cameroonian households at this time. Should the results of the co-finance efforts indicate that the proposed levels of cost recovery are too high for the community to support, line item amounts could be strategically reduced to ensure that the most essential items are covered.

**Financing Health Care for Indigents:** The macroeconomic situation could continue to worsen or the FCFA could be devalued, making the price incurred at the health center represent a greater portion of the household budget. While some households will be able to increase their health budget, other households may not and might normally be forced to reduce use of health services. The percentage of the population considered "indigent" may increase as available resources decline. The PHC system has been designed, however, to have the capacity to respond to community-specific problems through a community health committee created at each health facility.

The health committee determines priorities and policies of the health center including such issues as the definition and provision of services to indigent persons. The community members are encouraged to decide among themselves how to solve such problems as lack of liquidity among some of its population. The health committee has the flexibility to decide to use a portion of health center "profits" as a pool for members of the community unable to pay the health fees, or to devise some community-specific solution.

**Using Pricing Strategies to Promote Use of Cost-effective Medications and Contraceptive Supplies:** While the initial pricing strategy used in the co-financed health facilities is based on a flat mark-up of all products, this strategy is being revised to include a system of cross-subsidies. The new pricing strategy will achieve revenue targets by charging larger mark-ups on the less expensive and the less critical medications and lower mark-ups on the more expensive and more vital drugs. Development of a pricing strategy which encourages users to adopt the most cost effective appropriate methods of contraception could also be employed.

## VI. CONSTRAINTS IN IMPLEMENTATION OF HEALTH SECTOR REFORM AND OPPORTUNITIES FOR HEALTH DEVELOPMENT FOR 1993 - 1997

### A. Primary Health Care

Implementation of the MOPH's Reorientation of PHC has begun in pilot areas of all ten provinces. Since programs were initiated at different times, progress has not been uniform. However, in most programs the following has been achieved in some measure:

- Health zones have been identified;
- Community health committees have been established;
- Health workers have been trained in the delivery of integrated services;
- Decentralized health planning has begun;
- Provincial cost recovery systems (including the sale of drugs and fees for services) have been established which finance the resupply of drugs and some important recurrent costs of PHC;
- Provincial medical supply systems have been established to assure the resupply of essential drugs and client and health information forms to participating health centers.
- IEC programs have been conducted to inform target populations about the new PHC system.

Evaluations and reviews have identified the following important constraints which need to be addressed over the next five years to assure continued progress:

1. **Lack of a legal framework and administrative procedures for community participation in the delivery of health services:** The MOPH needs to complete the work which has already begun on developing a legal basis for community health committees at the levels of the health center, the hospital, the health district, and the province. This legal framework should provide the administrative procedures for these committees. In addition, it should define the relationships among the committees and between them and the MOPH. This framework should also provide procedures for programming excess cost recovery revenues collected at community co-managed and co-financed health facilities, mechanisms to assure profit sharing between the larger and smaller health center areas, and guidelines to develop community programs to provide health care for indigents.

**Probable Donor Support:** USAID and GTZ through their PHC projects are presently assisting the MOPH to finalize the legal framework.

**2. Health districts need to be remapped in order to establish effective health administrative units:** The operational planning and management unit of the Reorientation of PHC is the health district. At the beginning of the program, the MOPH considered the administrative subdivision as equivalent to the health district. However, program implementation has indicated that most subdivisions have neither the infrastructure (i.e., an equipped reference hospital, vehicle) nor the qualified personnel to effectively plan, supervise, and coordinate activities within its catchment area. In June 1992, the MOPH conducted a conference on this matter and concluded that the definition of the health district needed to be revised and new health districts needed to be identified in every province.

**3. The quality of care at reference hospitals needs to be improved:** The MOPH needs to establish functioning reference hospitals in each health district. In order to accomplish this, the following actions are required:

- The expansion of hospital pharmacies to include essential drugs for secondary care;
- The strengthening of laboratory services;
- The provision of essential medical equipment and the establishment of local programs to assure equipment maintenance;
- The implementation of financial management procedures to locally manage revenues generated from fees for services (as mentioned above, the GRC has authorized specially-approved hospitals to retain 50% of their revenues collected from fees for services);
- The improved administration and organization of hospital services.

**4. Newly established provincial health management systems are weak:** The regularity and quality of supervision need further improvement. Medical logistics systems still have problems assuring regular supplies of drugs in some areas. The effective analysis and feedback of health information are still not at acceptable levels. Additional training and monitoring of these systems are necessary to make them fully operational.

**5. The quality of preventive and curative services at health centers needs to be upgraded:** Despite the improvements in PHC achieved by Reorientation of PHC in some areas of the country, preventive, curative, and outreach activities at health centers need strengthening. In particular, diagnostic and treatment practices are weak, laboratory services are often unavailable, and outreach activities are infrequently conducted. To improve services, a quality assurance program needs to be developed. Such a program would establish quality of care indicators, train health workers to improve performance, and upgrade supervision and health information collection at the level of the health center.

**6. The population neither fully understands nor fully supports the MOPH's new PHC program:** The population is poorly informed about the Reorientation of PHC. In addition, health committee members do not fully understand their roles in co-managing health facilities. Finally, health workers are not universally supportive of the new

program. In order to improve the situation, tailored IEC materials and programs need to be developed and targeted at health workers, community health committee members, and the population as a whole.

**7. Coordination between public and private sector health facilities needs to be strengthened:** Private health centers and hospitals are important sources of health care for the population. In order to effectively utilize these resources, the MOPH needs to involve private health facilities (chiefly missionary in rural areas) in the Reorientation of PHC. This could be done by arranging these health facilities to provide the full range of preventive and curative services to their catchment area populations, and by enrolling private health sector organizations in provincial supervision, health information, and medical logistics systems. In almost all cases, private health organizations are strongly interested in increased cooperation with the MOPH in the delivery of health care.

**8. Community co-financed and co-managed health services need to be expanded to underserved areas:** PHC projects need to establish additional community co-financed and co-managed health facilities in order to bring basic services (i.e., essential drugs, immunizations, prenatal and under-five care, etc.) to underserved areas. In addition to increasing the population's access to basic health services, the development of new community co-financed and co-managed health facilities would make health districts more efficient by lowering the unit costs of supervision and drug logistics. Additional community co-financed and co-managed health facilities would also strengthen the financial viability of provincial cost recovery systems.

**Probable Donor Support to Address Constraints 2 - 8:** The existing donor-funded PHC projects will need to address the above constraints in their project-supported areas. In provinces where there are more than one donor (i.e., the Far North, East, Center, and West provinces), the provincial health delegation will need to assure that activities are coordinated. The PHC donors have expressed satisfaction with the Reorientation of PHC program and their willingness to continue to support program implementation over the next 3 -5 years. A listing of the locations of each of the PHC projects is included in Annex E.

**9. Community co-financed and co-managed PHC programs need to be initiated in the large urban areas of Yaounde and Douala:** In 1992, a World Bank consultant designed a strategy to deliver sustainable PHC services to Yaounde and Douala. According to the report, the cost of such a program would exceed \$10 million.

**Probable Donor Support:** There is no identified donor to finance this program at this time. A potential future donor is the World Bank if a health sector loan program can be negotiated with the GRC.

**10. Many health centers and referral hospitals throughout Cameroon are in need of renovation:** Although Cameroon's health infrastructure is better than in other African countries, there are many health facilities in disrepair. In general, donors began their PHC projects in health areas where there were functioning health facilities. In order to provide full PHC coverage in their provinces, donors will need to fund the renovation of health facilities.

**Probable Donor Support:** GTZ and the European Community will fund the renovation of a selected number of health facilities in their project-supported provinces. However, there is no identified source of funding for the renovation of health facilities in the other four provinces. Again, a potential source of funding for this activity would be through a World Bank health sector loan.

**11. A national program in health equipment maintenance needs to be established:** Health equipment at hospitals and health centers is constantly breaking down. Repair efforts are hampered by the lack of trained technicians and spare parts. A World Bank study on the subject has proposed the establishment of regional maintenance units, the training of hospital-based technicians, and the inclusion of spare parts in revolving fund medical supply systems.

**Probable Donor Support:** The initial stocks of spare parts and the training of technicians could reasonably be funded by existing PHC projects. However, cost recovery revenues would have to be used to purchase replacement spare parts. The establishment of regional maintenance units would be more costly and require separate financing.

**12. Ongoing disease-specific intervention activities need to be integrated into provincial PHC programs:** Donors have launched targeted programs to combat schistosomiasis and onchocerciasis. These targeted program have begun as self-contained activities, separate from the MOPH's Reorientation of PHC program. Recurrent cost funding for these activities are not included in cost recovery schemes.

**Probable Donor Support:** Donors in highly endemic areas will begin integrating these interventions into their PHC programs over the next 5 years.

## **B. Health Systems**

**1. Coordination of health programs and donors need to be improved:** With six donors involved in the implementation of the MOPH's Reorientation of PHC program and at least ten other donors involved in different aspects of the health sector, it is essential to have effective coordination of health programs and projects. In 1991, the MOPH officially created a technical committee to coordinate and monitor health programs and projects with subcommittees in PHC, essential drugs, HMIS, MCH/FP, and AIDS. This committee has begun to improve the coordination of MOPH programs. However, long-term technical assistance is required to make the committee an active force in the health sector. Coordination is particularly crucial in PHC where donors have developed parallel training, information, and management instruments which need to be harmonized.

**Probable Donor Support:** The MOPH would like the major health donors to take turns providing long-term advisors to the health coordination committee. The German and French have both expressed interest in providing an advisor beginning in 1993.

2. **The MOPH needs to develop and implement a national health management information system (HMIS):** In 1992, the MOPH created the HMIS sub-committee of the health coordination committee and charged it with the task of creating a national HMIS. To date, this committee has developed a set of health indicators and a draft health facility data collection instrument which is ready for testing.

**Probable Donor Support:** The USAID TAACS Program will provide long-term technical assistance through 1994. In addition, GTZ will continue to support the design of the national HMIS under its PHC program.

3. **The provision of essential drugs needs to be assured:** Mechanisms need to be developed to assure the regular supply of pharmaceuticals to provincial-based PHC programs and for secondary and tertiary hospitals.

**Probable Donor Support:** In 1993, the European Community is expected to fund and begin implementation of the pharmaceutical sector project described in Section V. In the meantime, the PHC programs will obtain their drugs either through the GTZ-managed pharmaceutical procurement body operating in Southwest Province or through the drug procurement services of UNICEF/Cameroon.

## C. Family Planning/Maternal Child Health

### Family Planning

As described in Section IV, the national family planning program has made excellent progress in developing medical standards, designing training curriculums, training service providers, and designing IEC programs and materials. To date, family planning information and services have been introduced into 44 health facilities. The 1992 National Population Policy has provided a consensus for the expansion of family planning information and services nationwide. The major program constraints are listed below:

**Constraint:** Family planning information and services need to be integrated into all community co-financed and co-managed health facilities in the country. This involves integrating contraceptives into provincial medical supply logistics systems, including family planning data in health information forms, and assuring that integrated PHC supervision includes family planning.

**Constraint:** The Directorate of Family and Mental Health needs to be strengthened in order to effectively plan the expansion of family planning services in both the public and private sectors; to assure that newly-developed medical standards and training materials are used to standardize family planning services nationwide; to assist the provinces to integrate high quality family planning services into their PHC programs; and to develop additional IEC materials and programs.

**Constraint:** Family planning information and services need to be integrated into private non-profit (religious), employee-based, and private for-profit health facilities in the country.

**Constraint:** The Population Unit of the Ministry of Plan needs assistance in planning and coordinating the execution of the newly-enacted National Population Policy.

**Probable Donor Support for Family Planning/Population:** UNFPA has pledged support to the Population Unit of the Ministry of Plan to design and implement a plan of action for the National Population Policy. In addition, UNFPA has expressed interest in continuing its support for family planning IEC and service delivery activities.

USAID is funding the National Family Health project which will provide institutional support for the Directorate of Family and Mental Health, and assistance for IEC, service delivery, and private sector activities. Under this project, USAID also provides support for the social marketing of condoms and oral contraceptives.

Finally, the major PHC donors are now interested in funding the integration of family planning information and services into their provincial-based service delivery programs.

#### **Childhood Vaccinations:**

With UNICEF support, the MOPH has established a national expanded program on immunization (EPI) which provides training, logistic, and material support for childhood vaccinations. The percentage of the nation's children who are completely vaccinated is a relatively low 35%.

**Constraints:** Vaccination coverage rates need to be increased nationwide. IEC programs need to be reinforced to improve compliance with vaccination schedules and to combat false rumors about vaccination safety. In addition, PHC programs need to assure that all community co-financed and co-managed health facilities provide clinic-based and outreach vaccination services for their catchment area populations. Finally, adequate financing needs to be found to assure annual purchase of vaccine stocks. Vaccines are not presently included in the cost recovery system.

**Probable Donor Support:** UNICEF is committed to continue its support of the national EPI and to purchase the bulk of vaccines required for the country. The PHC donors (including UNICEF) will need to continue to support routine vaccination activities at community co-financed and co-managed health facilities. Finally, the MOPH and the major donors will need to determine how expected shortfalls in vaccine will be financed.

#### **Control of Diarrheal Disease (CDD):**

With USAID support, the national CDD program has conducted training, logistics, and IEC activities. Home use of ORS for childhood diarrhea is a relatively low 5%.

**Constraints:** Home use of ORS to treat childhood diarrhea needs to be increased. IEC efforts need to be strengthened to increase acceptance of ORS. Plans to socially market ORS should be pursued. CDD activities need to be fully integrated into all community co-financed and co-managed health centers.

**Probable Donors:** USAID will be providing one additional year of support to the National CDD program under its PRITECH Project. Beyond 1993, there is no identified support of the National CDD Program. Community co-financed and co-managed health facilities will continue to provide CDD services as part of their integrated PHC programs. Provincial PHC logistics systems will continue to assure the resupply of ORS to health facilities.

#### **Acute Respiratory Infections (ARI) and Breastfeeding:**

There is presently no national ARI program to provide guidance to PHC projects in ARI diagnosis and treatment. A draft national breastfeeding policy and plan of action has been developed but not authorized.

**Constraint:** National ARI and breastfeeding programs need to be operational to assure that private and public sector health facilities provide high quality ARI and breastfeeding services.

**Probable Donor Support:** Under the National Family Health Project, USAID will provide some support for the development of the National ARI and breastfeeding programs.

#### **D. AIDS:**

The National AIDS Control Service has launched programs in the following areas: HIV and STD sentinel surveillance, AIDS counseling, IEC, health worker training, blood testing, and education and condom promotion for high risk women and STD patients.

**Constraints:** All of the above areas need continued support. Because of Cameroon's low HIV seroprevalence, priority should be given to targeting high risk groups with education and condom promotion.

**Probable Donor Support:** In 1993, WHO and the NACS will design Cameroon's 2nd medium-term AIDS plan. At that time, commitments for future donor support will be made. It is likely that USAID, GTZ, WHO, and the EC will continue to be the key donors in support of the program.

#### **E. Policy Reform:**

Since 1990, the GRC has adopted the following important policy reforms: authorization for public health centers to establish revolving fund pharmacies, authorization for approved hospitals to retain 50% of revenues generated by fees for services, and a new PHC strategy based on cost recovery (the Reorientation of PHC). The following additional policy reform measures will need to be adopted over the next 5 years. These proposed reforms are all supported by the MOPIH.

- A supporting text for the 1990 drug financing law to provide guidance on the management of revolving fund drugstores at public health facilities.

- A supporting text for the August 1992 hospital financing law to establish the procedures for public hospitals to apply for the right to retain 50% of their fees for services, and to establish guidelines on the local management of these funds by community health committees.
- A MOPH decree to revise the present profit-sharing program for consulting physicians. This text would expand profit-sharing to other health workers and involve the community in the management of the program.
- A MOPH decree to officially establish new health districts in each province. These new districts, to be determined in conjunction with local officials, would have adequate referral hospitals and health staffing.
- A MOPH decree which would establish or authorize the creation of an autonomous organization(s) to import essential drugs.
- A MOPH decree to establish the definition, legal framework, and procedures for community health committees at each level of the PHIC system.
- The official adoption of a national health sector policy document.

**Probable Donor Support:** The major donor-supported PHIC projects will continue to work closely with the MOPH to achieve policy reform through their policy dialogue efforts and targetted operations research. In further support of policy reform, the European Community is planning to provide long-term technical advisors to the MOPH in the areas of pharmaceutical policy and health financing and budgeting.

## F. Health Sector Constraints Linked to Government-wide Reform

### 1. Resource Allocation Within the Health Sector

Within the GRC recurrent health budget, personnel costs currently consume over 80 percent of the total. This leaves little for non-salaried operating costs. One possible mechanism of increasing the funds available for health sector operating costs would be to realign the MOPH budget by reducing the personnel line item. However, the elimination of public sector jobs is a politically-charged issue that is beyond the scope of bilateral health sector donors like USAID to achieve. Furthermore, the reduction of health sector employees during a period of structural adjustment is controversial due to the need of safeguarding the vulnerable populations against further hardships. Furthermore, as mentioned in Section II, it is unlikely that any reduction in the numbers of health personnel will result in a corresponding increase in the funds for operating costs. Reallocation of the MOPH budget without touching personnel costs (the predominant item) would have little overall effect.

### 2. The MOPH Budgeting Process

Like the overall GRC budget, the annual MOPH budget has little relation to actual expenditures. MOPH annual budgets do not correspond with available funds in the treasury. In addition, a large percentage of budget credits cannot be used. Because

the GRC does not pay its bills in a timely fashion, many merchants both within and outside Cameroon will not accept MOPH purchase orders, which makes procurement of essential supplies difficult. Finally, allocation of resources within line items are made in the absence of objective criteria.

Reform of the MOPH budgeting process is necessary. However, to be effective, this must be linked to overall reform of the GRC budgetary process.

### 3. Human Resources Management by the MOPH

The MOPH, like the civil service as a whole, suffers from poor human resource management. As mentioned in Section II, there are no mechanisms to either encourage good performance or discourage poor performance. There is universal agreement that the entire civil service personnel system needs to be reviewed and overhauled.

Although they cannot reform the civil service system as a whole, donor-funded PHC projects can contribute to improvements in human resources management within the MOPH in a number of important ways. PHC projects can conduct operations research to test mechanisms to make public health personnel accountable to community health committees. In addition, donor projects can continue efforts to strengthen supervision, improve job descriptions, and to track health worker performance. Finally, the donors can encourage the MOPH to revise the existing profit-sharing mechanism for consulting physicians by expanding this program to other personnel and involving the community in setting disbursement levels based on performance.

### 4. Increased Resource Allocation to the Health Sector:

At present, the MOPH budget represents about 4% of the national budget which is a low allocation even by African standards. In order to increase GRC allocations to the health sector, governmental revenue would need to increase or a decision would need to be made to increase the health sector's share of the existing budget. The former would depend upon improved economic performance. The latter would depend on the GRC's decision to restructure the entire budget in support of structural adjustment.

Without increased resources for non-salaried operating costs, the MOPH will be unable to improve curative programs, such as those for tuberculosis, which are too expensive to be included in cost recovery schemes. Without increased resources for its investment budget, the MOPH will be unable to renovate health facilities in provinces where there is no donor support for this item. In addition, new construction of health facilities to improve access to care will be impossible.

## VII. RECOMMENDED USAID ROLE IN THE HEALTH SECTOR FOR 1993 - 1997

Over the next 5 years, USAID's major objective in the health sector should be to further the development of a financially and institutionally sustainable PHC system to provide basic preventive and curative services to the population, especially women and children. USAID would achieve this objective by collaborating with other health donors to implement the MOPH's Reorientation of PHC program. Broad donor support for the

Reorientation of PHC would begin to address the three major constraints in the health sector: lack of financing, inefficient health delivery systems, and ineffective health services. The Reorientation of PHC would:

- increase financing in the health sector by implementing comprehensive cost recovery measures.
- improve efficiency by delivering integrated preventive and curative services, strengthening the link between primary and reference care, improving supervision and health information management, and assuring better coordination between public and private sector health facilities.
- increase the effectiveness of the health services by assuring the local availability of essential drugs, and the delivery of key maternal child health/family planning services in every health center and hospital in the country.

Given the ongoing economic crisis in Cameroon, the Reorientation of PHC is an appropriate strategy to deliver health services to the population for the following reasons:

- it does not assume that GRC support to the health sector will increase in the near future.
- it increases resources to the health sector by privatizing health financing (i.e., community contributions through cost recovery measures).
- it promotes the private sector delivery of services (and improved efficiency) by privatizing the sale of drugs at public health facilities (through community health committees); by enlisting private sector facilities in a global health coverage strategy; and by establishing drug logistics, supervision, and information systems linking the public and private sectors.
- it addresses the issue of providing health care to indigents by helping to establish and implement locally-managed indigent policies and assuring the local availability of affordable, essential drugs.

Consistent with USAID's prior assistance and with other donor inputs, the assessment recommends that USAID support the Reorientation of PHC through two complementary but distinct projects: The MCH/CS II Project, which will strengthen and expand community co-financed and co-managed health services in South, Adamaoua, and Far North provinces; and the National Family Health Project, which will support the integration of high quality maternal child health/family planning services into community co-financed and co-managed health facilities as well as those in the private sector. Descriptions of these two projects are provided below.

**MCH/CS II Project:** The project will have two major components: strengthening health management systems and expanding access to health care. Under the former component, the project will upgrade supervision, provincial medical supply logistics, financial management, and health information systems in the target provinces. In

addition, a quality assurance program will be established in the three target provinces. Finally, operations research will be conducted to identify feasible mechanisms to improve the performance of health personnel and community health workers.

In order to expand access to health care, the project will strengthen existing community co-financed and co-managed health facilities, expand services to new health areas, and strengthen care in referral hospitals.

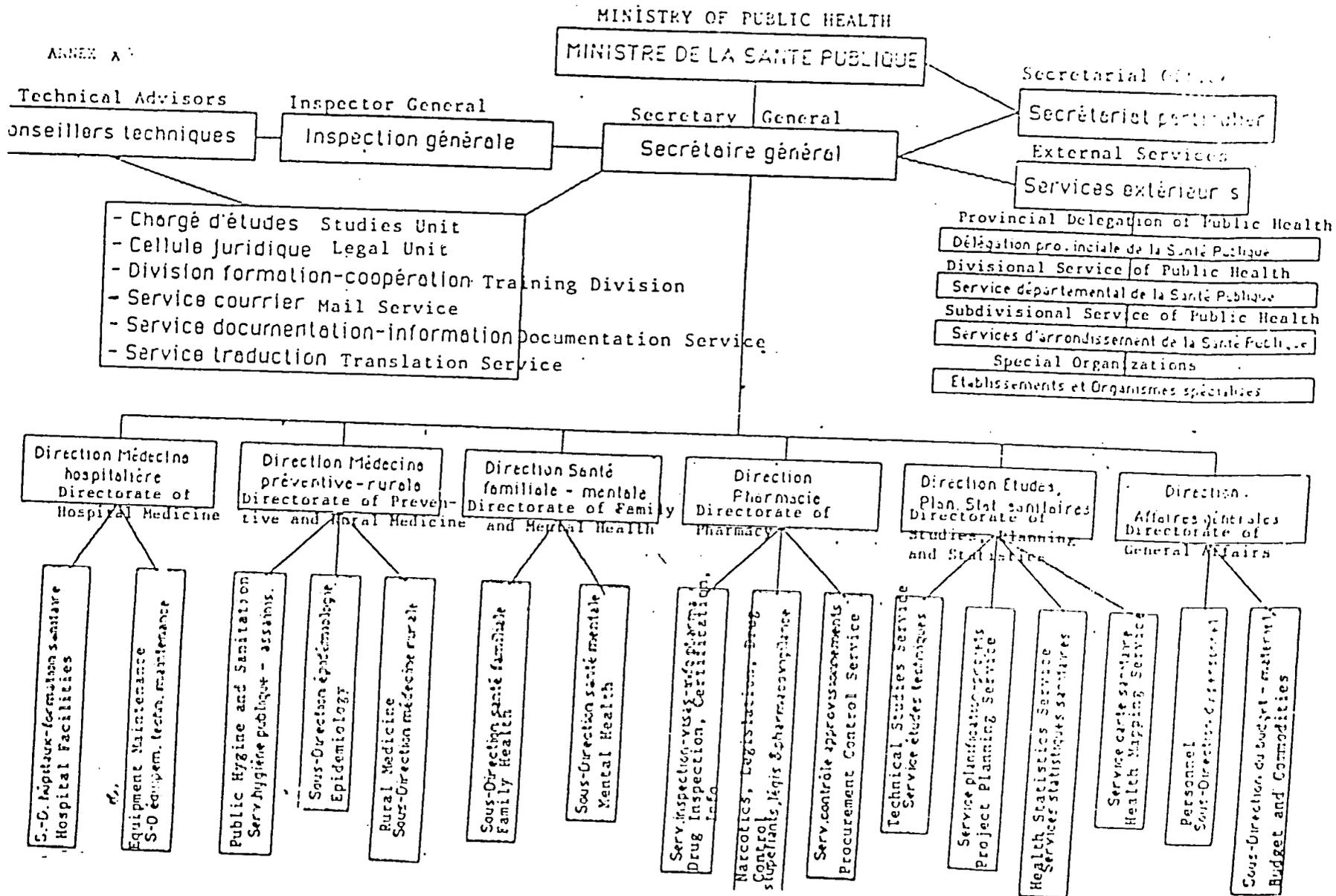
**National Family Health Project:** Initiated in 1991, the project will increase the effectiveness of the MOPH's Reorientation of PHC program by introducing family planning and key MCH service into community co-financed and co-managed health facilities. The project will also introduce these services into private for-profit, religious and para-public health facilities. In addition, support will be provided to the Cameroon social marketing program to promote the community-based distribution of key MCH technologies such as contraceptives and oral rehydration salts. Finally, this project will be amended to include support for priority AIDS control activities which are linked to ongoing social marketing and IEC efforts.

These two projects would be USAID's only form of assistance to the health sector. USAID's present support of schistosomiasis and onchocerciasis control activities would be integrated into the MCH/CS II Project. Support for AIDS would become an integral component of USAID's National Family Health Project. Finally, USAID would continue to promote the control of diarrheal diseases as a part of community co-financed and co-managed health services, but would phase out its direct support to the National CDD Program.

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# *ANNEXES*

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## ANNEX B

### DESCRIPTION OF THE MOPH'S REORIENTATION OF PHC PROGRAM

In 1989, the MOPH conducted a national assessment of the existing PHC program and developed a revised PHC strategy. This strategy, entitled "the Reorientation of PHC" follows closely both the UNICEF's Bamako Initiative and WHO's strategy of delivering PHC in three phases. The plan conforms to the administrative division of the country into provinces, divisions, and subdivisions. A description of the system is provided below:

Community/Village Level: The existing village health posts, community health workers, and village health committees will be maintained but will be placed under the supervision of health center staff.

Health Center Level (Health Area) (Population 3,000-15,000): A community health committee will be elected to represent the concerns of all the villages in the health center's "catchment area." The health committee will select a subcommittee responsible for managing the health center and pharmacy. This management subcommittee will consist of community representatives and health center personnel, and will be overseen by the chief medical officer of the subdivision.

The health center will be reinforced to serve as the focal point of PHC in the area. The health center will provide fully integrated services consisting of child survival interventions, prenatal consultations, treatment of acute and chronic diseases, health promotion, and collection of health information. The health center will provide patients continuous care during each episode of illness or risk. Each health center area will be defined and mapped.

The health center will establish a pharmacy stocked with essential drugs and other essential health supplies. The community-managed pharmacy will sell drugs at low prices but still make a profit sufficient to cover many of variable recurrent costs of the health center. Fees for consultation, prenatal care, well baby care, wound dressing, and deliveries will also be charged at health centers.

Sub-Divisional Level: The subdivision will be divided into health areas (health centers and their catchment areas). The subdivision (health district) will be the functional management unit of the new health system. A health district team (including public health and PHC specialists) will be responsible for coordinating all PHC activities throughout the subdivision. The subdivisional hospital will serve as the referral hospital for the health centers in the subdivision. A subdivisional health committee will be created consisting of representatives from the different health area committees. The sub-divisional health committee will form a management sub-committee responsible for overseeing the subdivisional hospital and pharmacy.

Divisional Level: The divisional health team will conduct technical and administrative supervision of the subdivisions.

Provincial Level: The provincial health team will provide technical and administrative supervision to the divisions. The provincial hospital will serve as the referral hospital for the subdivisional hospitals. A provincial health committee will be created consisting of representatives from the sub-divisional health committees. The provincial health committee will form a management sub-committee responsible for overseeing the provincial hospital and pharmacy, and the provincial drug depot.

## ANNEX C

### Complete List of Legal Measures in Support of Health System Reform

1. A ministerial decree in 1963 authorizes all health facilities to charge fees for services. According to this decree, the funds generated must be returned to the treasury except for a percentage which can be retained by consulting physicians as incentive payments.
  2. The MOPH is restructured by ministerial decree 89/011 in January 1989 creating six central directorates and organizing the provincial health system to reflect the administrative divisions of the country.
  3. In June 1990, the Minister of Public Health signed a letter circulaire which authorizes the creation of community health and management committees at the village, health center, and the subdivisional levels.
  4. In December 1990, the GRC legalizes the operation of revolving fund drug stores at public health facilities (GRC law 90/062).
- Future Action: A supporting text is required to provide guidance on the management of revolving fund drug stores.
5. In December 1990, the GRC enacts a law which simplifies the creation of private associations.
  6. In an official letter signed in 1992, the Minister of Public Health instructs all community health committees to obtain official authorization for their existence by petitioning the Division Administrator.

Future Action: A legal framework is required in order to define the roles, procedures, and interrelation between community health committees at the health center, health district, and the provincial levels.

7. In March 1992, the GRC declares the Reorientation of PHC as Cameroon's official PHC policy in a letter circulaire entitled "Declaration de Politique Nationale de Mise en Oeuvre de la Reorientation des Soins de Sante Primaire (Declaration of National Policy of Implementation of the Reorientation of Primary Health Care)."

Future Action:

- A MOPH decree is required to establish new health districts in each province. These new districts, to be determined in conjunction with local officials, would have adequate reference hospitals and health staffing.

- The MOPH needs to officially adopt a national health sector policy document which will include the Reorientation of PHC Policy.

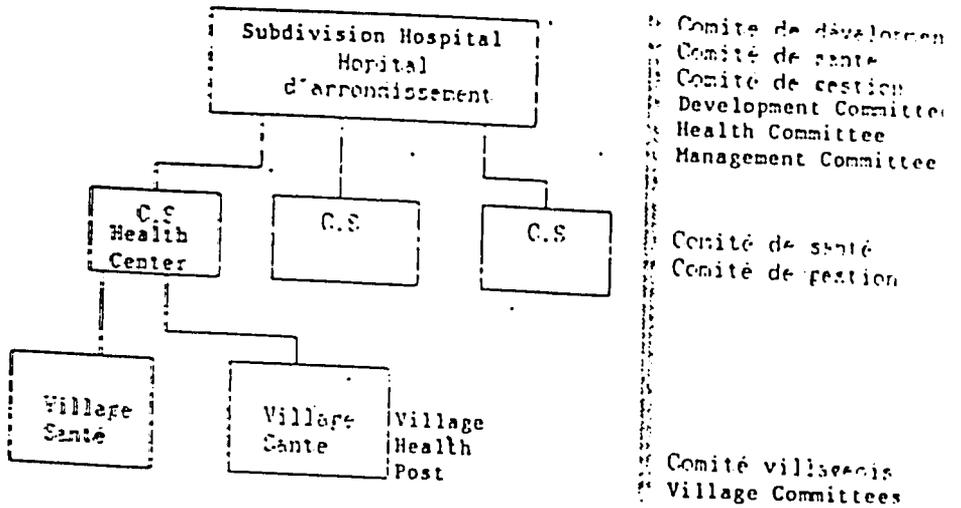
8. In August 1992, the GRC passes legislation authorizing specially approved public hospitals to retain 50 percent of their receipts from fees for services.

Future Action:

- A supporting text is required to establish procedures for public hospitals to apply for the right to retain 50% of their fees for services, and to establish guidelines on the local management of these funds by community health committees.
- A MOPH decree is required to revise the present profit-sharing program for consulting physicians. This text would expand profit-sharing to other health workers and involve the community in the management of the program.

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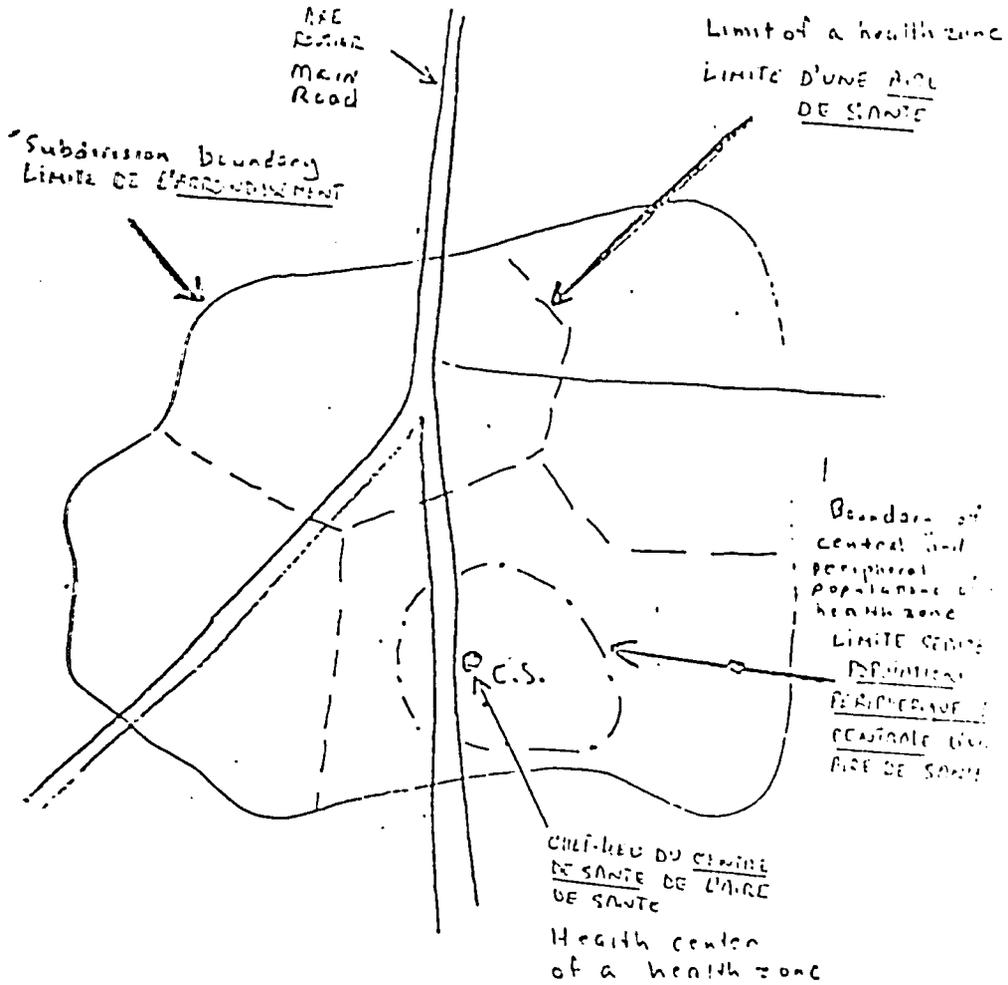
HEALTH DISTRICT STRUCTURE  
INCLUDING HEALTH COMMITTEES



Organigramme structurel d'un district de santé  
et structures de dialogues correspondantes.

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DIVISION OF A POLITICAL SUBDIVISION (HEALTH DISTRICT)  
 INTO HEALTH AREAS



Subdivision d'un arrondissement  
 en aire de santé.

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ANNEX E

MAJOR DONOR SUPPORT TO THE HEALTH SECTOR 1993-1997

1.	<u>Primary Health Care</u>	<u>Donors</u>
	Northwest Province	GTZ
	Southwest Province	GTZ
	Littoral Province	GTZ
	Centre Province	EC, UNICEF, SWISS (Leke Division)
	West Province	EC, UNICEF
	East Province	EC, UNICEF
	North Province	France
	Adamaoua Province	USAID
	South Province	USAID
	Far North Province	USAID, Belgium (Diamare Division), EC, (Logone and Chari Division)
2.	<u>Health Systems</u>	<u>Donors</u>
A.	National HMIS	USAID (until 1994), GTZ
B.	Pharmaceutical Sector	EC/GTZ, UNICEF
C.	Institutional Support	EC, France, Donor-funded PHC Projects
3.	<u>Maternal Child Health/Family Planning</u>	<u>Donors</u>
A.	Family Planning	USAID, UNFPA, PHC Projects
B.	Immunizations	UNICEF, PHC Projects
C.	Control of Diarrheal Disease	PHC Projects
D.	Acute Respiratory Infections/ Breastfeeding	USAID, PHC Projects
4.	<u>AIDS</u>	<u>Donors</u>
		WHO, USAID, GTZ, Canada, France, EC

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ANNEX F  
DELINEATION OF RESPONSIBILITIES FOR RECURRENT COSTS  
OF PRIMARY HEALTH CARE SYSTEM

MOPH

- \* Salaries of Health Workers
- \* Pre-Service Training
- \* Supervision for central to provincial levels
- \* Production of national MIS reports

DONORS:

- \* Contraceptives
- \* Vaccines

MOPH or DONORS

- \* Depreciation of Health Infrastructure
- \* Depreciation of vehicles
- \* Operations Research
- \* Health equipment
- \* Health education material
- \* In-service technical training

COMMUNITY:

- \* Salary of pharmacy clerks
- \* Per Diem for Logistics Resupply
- \* Transport for PHC logistics
- \* Administration for cost recovery system
- \* Vehicle maintenance
- \* Pharmacy maintenance
- \* Maintenance of cold chain
- \* Transport of vaccine
- \* Loss and waste of drugs
- \* Motorcycle maintenance
- \* Motorcycle depreciation
- \* Supervision-sub-division to health team
- \* Supervision-Division to sub-division
- \* Supervision-Province to division
- \* Supervision-Health center to CHW
- \* Provincial Emergency fund
- \* Expendable supplies
- \* Printing of forms
- \* Office supplies
- \* Refresher training for health workers
- \* Essential drugs

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ANNEX G

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