

**CASE STUDY OF THE PSI  
SOCIAL MARKETING PROGRAM  
IN CAMEROON**

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## LIST OF ABBREVIATIONS

AIDSCAP	AIDS Control and Prevention project
AIDSCOM	AIDS Technical Support project's communication component
AFSU	Association des Soeurs et Freres Unique
CAMNAFAW	Cameroon Association pour la Bien-etre Familiale
CAMTRIX	faculty of medicine
CAPP	provincial drug procurement and distribution warehouse or depot
CAR	Central African Republic
CBD	community-based distribution
CCLS	Commission de Controle et de Suivi de la Lutte contre le SIDA
CDC	Cameroon Development Corporation
CHP	Cameroon Health Project
CMI	Centre Medicale Integre
CNLS	Unite de Lutte contre le SIDA
CSW	commercial sex worker
CYP	couple year of protection
DHS	Demographic and Health Survey
FAC	Agence de la Cooperation Francaise
FCFA	Franc de la Commununaute Financiere Africaine
FEMEC	Federation des Eglises et Missions Evangeliques du Cameroun
FEP	Africaines Femmes et Progres project
FESADE	Femme, Sante, et le Developpement project
FP	family planning
GOC	Government of Cameroon
GPA	Global Program on AIDS (WHO)
GTZ	German Technical Cooperation
HFPP	Cameroon Health and Family Planning Project
HOSPICAM	Cameroonian pharmaceutical distributor (later named GROUPE SANTE)
IEC	information, education, and communication
IMF	International Monetary Fund
IPAD	Institut Pan-Africain pour le Developpement
IRESKO	Institute des Recherche et des Etudes de Compartiment Humaine
KAP	knowledge, attitudes, and practices
LOA	Letter of Agreement
LOI	Letter of Intent
MCH	maternal/child health
MOH	Ministry of Health
MOP	Ministry of Plan
MOPH	Ministry of Public Health
NAC	National AIDS Committee

OC	oral contraceptive
ORS	oral rehydration salts
PMI	protection maternelle et infantile (or MCH)
PMSC	Program Marketing Social of Cameroon
PMT	Medium Term Program
PNLS	Programme Nationale de Lutte contre le SIDA
PSI	Population Services International
PVO	private voluntary organization
RPHC	Reorientation to Primary Health Care
SFPS	Sante Famiale pour le Prevention de SIDA
SIDALERT	"Caution AIDS"
SM	social marketing
SOW	Scope of Work
SWAA	Association des Femmes d'Afrique Face au SIDA
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

## EXECUTIVE SUMMARY

### Purpose and Objectives

This is a case study of the Population Services International (PSI) Social Marketing Program in Cameroon under the Cameroon Health and Family Planning Project (HFPP) (681-0005). The detailed objectives of this case study are to provide an in-depth analysis of the following project elements:

1. The stages of development of the social marketing program in Cameroon compared with those of other subregional and worldwide programs.
2. The performance of the program with respect to the expected accomplishments compared with that of other subregional and worldwide programs.
3. The success of the program in preventing HIV/AIDS by increasing the use of condoms and decreasing risky sexual behavior in Cameroon and in the subregion.
4. The contributions and missed opportunities of the social marketing program in meeting the demand for family planning (FP) and reproductive health services and products.
5. The strategies and practices, including those related to contraceptive logistic management, that made a critical contribution to the program and that merit the attention of other social marketing programs and AIDS prevention activities.
6. The gaps and strengths of the linkages established with other FP and health programs and the critical elements that should be pursued to achieve greater linkages and overall impact.
7. The limits of the social marketing program in addressing population and health problems in the region compared with other experiences worldwide.
8. The lessons learned from the Cameroon experience compared with other experiences in Africa and worldwide.
9. Strategic steps that need to be taken to improve social marketing operations in Central Africa with respect to the existing regional linkages and market.

## **Report Format**

This case study examines the development of HIV/AIDS in Cameroon and the impact that various interventions, including those of PSI, have had on the spread of the epidemic. It is not an evaluation, as such, of PSI's activities in isolation, or as would be carried out as part of a social marketing program.

The report includes sections on (1) the structure and changes in Cameroon's public health sector, (2) the history of HIV/AIDS in Africa and the disease's epidemiology in Cameroon, (3) current AIDS and STD knowledge and preventive practices, (4) the history of the PSI program in Cameroon and a comparison with other African programs with respect to condom sales and family planning practices, (5) family planning activities in Cameroon, and (6) the activities of other organizations which contribute to the fight against AIDS in Cameroon.

## **The Impact of Cameroon's Social Marketing Program**

The first case of AIDS in Cameroon was identified in 1985. Since then, more than 9,600 cases of AIDS have been reported, and the problem is growing rapidly. This level is grossly underreported. Officially, 5.5 percent of Cameroon's 14 million people are HIV-positive, but the actual figure is probably double, making the actual number of HIV-positive people in Cameroon over 700,000. This means that Cameroon has a much larger HIV/AIDS problem than is recognized, especially compared to neighboring countries; it is not dissimilar to that in Cote d'Ivoire.

The pattern of HIV/AIDS has changed in Cameroon. What started as primarily a male disease has now altered, such that the ratio of male to female cases of AIDS is virtually equal. This clearly shows that HIV/AIDS is a heterosexual disease and that women have an increasing role in the spread of the virus.

Despite its relative wealth and its commercial development over the last 20 years, Cameroon has not put the necessary resources into the fight against HIV/AIDS. Although there was some positive action in the early years of the epidemic, this action has not been really effective in changing people's behavior, nor is the surveillance satisfactory. Further, the population's perception of HIV/AIDS is one of denial of its existence or of its relevance to their lives. Several interventions have taken place over the last 10 years, but these activities tend to have been initiated mainly in the private sector. PSI began a social marketing program in 1991, following a short activity introduced by DKT in 1989. PSI's operation has been running for six years with commendable success, given the lack of sufficient or regular funding and other difficulties.

In many respects, the development of Cameroon's overall country program to fight HIV/AIDS cannot be described as successful. Several factors have contributed to this lack of success. Many

attribute it to Cameroon's economic crises and lack of committed personnel at the central level over the past three years. Nevertheless, some positive activities have been developed by provincial public sectors, PSI, and others. This case study examines the development of these various interventions and assesses the impact of the social marketing (SM) program on the country's fight against the HIV/AIDS epidemic.

### **National Activities from 1985 to 1997**

With the first identified case of AIDS in 1985, the Government of Cameroon (GOC) quickly took an active role. The Ministry of Public Health, with financial support and encouragement from major organizations based in Yaounde, established a National AIDS Committee to monitor the progress of the disease and coordinate the activities of various NGOs. However, the impact of these activities was somewhat limited and has not continued. Since 1994, the little action that has taken place has been in the form of ineffective information, education, and communication (IEC) activities.

Four individuals have held the Minister of Health position in the last three years. These changes in management have resulted in a lack of leadership and motivation and have left several central-level operational decisions pending. Although there are dedicated health professionals working in the provinces, mostly to good effect, bureaucracy and lethargy is rife at the central level. The decentralization program for primary health care, launched in 1989 and approved in 1992, is working in some aspects of health care and efforts are being made to integrate services within newly created health districts.

A cost-recovery system has been introduced into the primary health care system. The cost-recovery system is composed of two levels. The first is a medical supply warehouse that sells drugs, medical supplies, spare parts, and other items to health facilities. Profit margins are set to recover the costs of the provincial health management system (drug supply, supervision, and health information), maintenance of vehicles, and other items. The second level involves service fees and drug sales at the health facilities. Profit margins are set to recover the nonsalary recurrent costs of health facilities, including resupply of essential drugs, the vaccination program, outreach activities, and facility maintenance. The systems were functioning satisfactorily until the devaluation of the Central African Franc (Franc de la Communauté Financière Africaine [FCFA]) in 1996. This dramatically increased the costs of essential drugs and other imported medical commodities, which in turn has caused the price of drugs and medical supplies to increase by 50 percent at public health facilities and more at private pharmacies. As a result, the rural population who were just beginning to enjoy access to affordable drugs and medical supplies are now unable to use facilities because of high prices.

Donors play a growing role in supporting the health service. Donors have severe reservations about giving funds directly to the GOC because of corruption and mismanagement. Instead,

donors prefer to fund NGOs specializing in specific sectors (health education, family planning education, and management training) and often specific provinces. This method can work, but has produced very segmented programs that do not provide a coordinated approach to meeting the country's overall needs. Sometimes, several NGOs are conducting similar types of activities to those that may have already been completed. Hence, it appears that old programs are being repeated without reviewing past experiences. This has been found to be the case in primary health care, family planning, management information systems, contraceptive logistic registers, and diarrheal control by oral rehydration therapy. It is also particularly true for AIDS/STD prevention in which PSI is the only operation working nationally, other than the public sector.

USAID-funded AIDS control and prevention projects from between 1987 and 1996 provided assistance to the Ministry of Public Health (MOPH) to implement components of the Medium Term Plan (PMT) of the Programme Nationale de Lutte contre le SIDA (PNLS). The plan called for focusing on three high-risk groups: commercial sex workers (CSW), students, and the armed services. Baseline and impact evaluation research indicate that the work done with CSW's has had some effect in changing behavior among this group and their clients. These CSWs are by definition at high risk and, acknowledging the risks they run, have started to use condoms more frequently. In addition, some have abandoned their commercial sex profession for income-generating activities such as sewing, small-scale restaurants, and trading consumer products. Unfortunately, these CSWs have been replaced by recently unemployed female office workers and students.

Some behavior change has occurred among students, particularly female students. Although students are better educated and better informed than CSWs on means of contracting and avoiding AIDS, their risky behavior continues. With regard to members of the armed services, their number of occasional partners has declined, but this decline is offset by an increased use of prostitutes.

### **Dissemination of Data**

Some small-scale knowledge, attitude, and practice studies were conducted by PSI as well as pre- and post-test national baseline studies under the USAID-funded family planning project. The United Nations Population Fund (UNFPA) and World Health Organization (WHO) have also funded baseline studies to assess the impact of their programs. These studies include sections on behavior change among the general population and high-risk populations. Although the sample sizes of these studies are smaller than that of the Demographics and Health Survey (DHS), last conducted in 1991, they have provided guidelines as to where and what type of strategies are necessary to effect behavior change. However, no recent national information exists on behavior change among the general population. A second DHS survey is scheduled to start in January 1998 with the preliminary results expected to be available by June 1998. The MOPH, donors, and health professionals acknowledge that, at present, the only indicator that some behavior

change is occurring is the increasing volume of condoms sold by PSI. What is unclear is whether this increasing use is among the general population or among high-risk groups. A further question to be asked is whether condoms are being used for AIDS/STD prevention or for contraception since both men and women are now concerned about the costs of caring for and educating children.

In the early 1990's, the MOPH, with assistance from USAID, initiated some vigorous IEC activities. Radio and television spots were common. A CSW theater group performed in Douala and Yaounde and traveled to the provincial capitals. These activities explained the modes of AIDS/STD transmission and instilled fear of an early death. However, studies showed that the population doubted the reality of AIDS and the level of denial remained high. Although few public sector IEC activities have occurred during the last two to three years, people are beginning to discuss the possible existence of HIV/AIDS. This change is the result of an increase in deaths among relatives and friends. Early detection of HIV is poor and most cases are discovered simultaneously with full-blown AIDS when people go to hospitals and health centers.

In Cameroon, the actual state of the epidemic is grossly underreported by the GOC at the central level. In all probability, the number of HIV-positive cases is at least twice the number of reported AIDS cases. Regional data sent to the central level on the number of AIDS cases are not fully represented in the official statistics. Although some parts of the country have systems for testing and confirming samples, no testing of negative results occurs and in some provinces, testing centers retain positive samples for long periods of time. Regional centers do not receive statistical information and many practitioners are ignorant of the state of the epidemic in their locality.

Although a national policy on HIV/AIDS exists, this policy is in letter only and is not really effective in practice.

STD's are rife and a very high level of syphilis is reported among pregnant women. Because of the continuing high incidence of STDs among the general population, most people believe that they can obtain a cure for their ailment fairly readily, at a cost. Cameroonians possess little knowledge of the association of STDs with AIDS. This attitude is highly detrimental to the progress of preventing HIV/AIDS. It is believed that some progress could be made in behavior change if the association between STDs and AIDS was given programmatic attention.

The blood transfusion service, a once voluntary system that was discontinued by donors because of fear of AIDS, now relies on blood sources from relatives of needy patients. This is affected by the recently introduced cost-recovery system; people will only be tested prior to giving blood for their relatives if they can afford to pay for these tests. In many cases, it is believed that blood donations are not fully and systematically tested for HIV.

PSI's program began by taking over a project initiated by DKT in 1989. The program has not

been without its difficulties. PSI experienced some difficulties with the original distributor, resulting in protracted legal battles. Although stock and bank accounts were frozen, the sale of condoms to the consumer was not affected. However, stock and supply of condoms to the wholesale trade was disrupted.

Funding for the SM program has been intermittent and unreliable. The program has never had a period when sufficient funds were committed from one or more donors for a reasonable period of time. This lack of sufficient funding has meant that PSI has had to spend time seeking funding and has been unable to plan far enough ahead to sustain the momentum of the program. In addition, this lack of funding has meant that the program has been unable to afford costly mass-media promotions, which have yielded success in other markets. In the absence of any real mass-media communication by the National AIDS Committee (NAC), most of PSI's work has had to be done on the ground with a very limited sales force. Reliance is placed on the ability of the wholesale trade to force distribution through retail points of sale once PSI makes initial contact. Although this process appears to be working reasonably well, sales penetration will eventually be limited unless additional resources are put behind the program.

### **PSI's Contribution to Cameroon's Social Marketing Program**

By recognizing the problems inherent in the environment, PSI has succeeded in getting closer to the MOPH. In a political country such as Cameroon, this is essential if the PSI program is to receive support in fighting AIDS. The MOPH has signed new protocols that will hopefully prevent the recurrence of the commercial legal problems, it is committed to assisting PSI wherever possible. But, in order to maintain this positive relationship, PSI's management will have to have continued proactive contact with the MOPH.

PSI has carried out a successful program. The achievement of a 0.75 per capita rate of condom sales puts the program in third place in the West and Central Africa region, behind Cote d'Ivoire and Burkina Faso. It is generally acknowledged by other NGOs in Cameroon that the PSI condom program has been effective. Given the potential demand and likely use by the Cameroonian population, much more could be achieved with proper support from donors. PSI is the only national organization working in the private sector and, given the chance, could contribute substantially to the fight against AIDS.

The extension of the PSI program into areas other than condoms has the advantage of using sales force resources. However, since the oral contraceptives (OC) and STD kit were restricted to pharmacy distribution, this advantage is not as great as it would be if these products were distributed in the open market.

PSI's OC activity started well but has been unable to reach its full potential because physicians do not necessarily prescribe the SM brand first. When a woman returns to a pharmacy to replenish

her supply of OCs, she normally asks for and is given the initial brand prescribed, thus perpetuating the situation. Similarly, because of the profit from sales of commercial brand condoms, the pharmacists are reluctant to promote the SM brand. In addition, stocks were blocked during PSI's legal problems.



## LESSONS LEARNED

1. Social marketing programs work best when sufficient funding is made available for a reasonable period of time<sup>7</sup> at least three years in one tranche.
2. Social marketing programs need to establish and maintain consistent contacts with public sector ministries if they are to avoid in-country commercial difficulties and fully support National AIDS programs.
3. Social marketing programs work best when they have a marketing program rather than just sales and distribution functions.
4. HIV/AIDS programs need to be designed and implemented through a national strategic approach. The efforts of donors, private voluntary organizations (PVO) and NGOs should not be vertically operated in small pockets of diverse parts of the country. Emerging potential sources of HIV/AIDS development in specific areas of a country need to be monitored and acted on at an early stage.
5. HIV/AIDS programs should be integrated with STD programs, especially with regard to communications. This communication becomes more important as programs mature and begin to focus more on the general population.
6. Continued mass media and/or public relations activities are essential for several years of a program, so that the initial impact is not lost, forgotten, or deemed as being irrelevant to the general population.
7. Although "fear tactics" may be one approach to increasing the impact of the AIDS message, programs need a sustainable approach that introduces notions of care and support to those people contracting the disease.
8. Sound statistical data is crucial to keeping health professionals aware of the extent of the epidemic and to being able to adapt programs as the epidemic proceeds. This is true for both in-country data relating to testing and nationally based consumer information.
10. Countries cannot be treated as separate geographic entities with regard to HIV/AIDS because of the transient nature of the population. Continuing work needs to be done on a regional basis to provide aid and assistance where the problems are seen as greatest.
11. Before the social marketing of oral contraceptives is started, sufficient preparation should be given to identifying private for-profit medical and pharmaceutical professionals who are willing to support affordable contraceptives. Otherwise, the social marketing of OCs cannot be fully successful, particularly in terms of encouraging doctors and pharmacists

to recommend the SM brand and encouraging the government to support OC sales outside of traditional outlets.

In the absence of free trade of OCs on the open market, PSI has an opportunity to work more closely with health centers that are not participating in the Reorientation to Primary Health Care (RPHC). This includes public- and missionary-run health facilities.

12. An STD kit appears to be a useful adjunct in the fight against these widespread diseases. Again, it is necessary to gain the active support of physicians and pharmacists where there may be vested financial interests in not recommending such a treatment. In addition, widespread publicity would help overcome trade lethargy.

# 1. BACKGROUND ON AIDS

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## 1.1 Methodology

This case study of the Population Services International (PSI)/Cameroon program was conducted between July 6 and August 20, 1997, by a three-person team: a social marketing expert, a reproductive health and policy expert, and an HIV/AIDS expert. The team saw this as an opportunity to assess the impact of social marketing in a complex socioeconomic environment.

In Washington, the team leader met with representatives from Population Services International and DKT International to discuss these organizations' social marketing contribution worldwide and, in particular, in Africa. In addition, in-person or telephone interviews were held with representatives from PSI/Tanzania and PSI/Guinea, DKT Ethiopia, the AIDS Control and Prevention project (AIDSCAP), the U.S. Bureau of the Census, and Macro International, Inc.

Based on the reporting requirements of the Scope of Work (SOW), each member of the team was responsible for data collection and analysis of different elements. Some data was collected prior to the four-week visit to Cameroon, and some analysis was done in the field, with further detailed analyses conducted after completion of the mission.

Fieldwork was carried out in Cameroon between July 16 and August 16, 1997. Starting in Douala, the team visited PSI's warehouse, met with its staff, and conducted visits. The team also met with Ministry of Public Health (MOPH) representatives including the Delegate and Provincial Coordinators for the National AIDS Committee (NAC) and the Family Health Division. Meetings were also held with directors of public sector district hospitals, nongovernmental organizations working in AIDS prevention and counseling and PSI distributors. The second week was spent in Yaounde, the political capital, meeting with the Director of Community Health at the Ministry of Public Health. Following this meeting, the team received an overview of the AIDS and family planning programs from meetings with major donors involved in AIDS prevention and family planning. Thereafter, each team member conducted meetings in their areas of expertise with PSI, government representatives, NGOs, or private for-profit organizations. The third and fourth weeks were spent traveling to the provincial capitals of Bertoua in the East Province, Bamenda in the Northwest Province, Maroua in the Far North Province, and Garoua in the North Province. In the provinces, the team met with groups similar to those met in Douala and Yaounde and visited public and private rural integrated health centers. Prior to leaving Cameroon, the team presented its initial findings to the PSI Country Representative and his staff in Douala. The team also conducted a detailed briefing for USAID at the REDSO/WCA office in Abidjan, Cote d'Ivoire.

## **1.2 AIDS Worldwide**

In 1983, the causative agent, HIV-1, was identified as a virus that slowly destroys the body's immune system. Several variants of this virus have since been identified and HIV-2, another variant known to cause AIDS, was discovered in 1986. HIV-1 is far more common than HIV-2 worldwide. Because of the potential impact of this disease on the health of developing countries, the World Health Organization (WHO) began the Global Program on AIDS (WHO/GPA) to provide technical leadership, planning, and coordination of AIDS prevention and control, and to conduct AIDS-related research. USAID has been deeply involved in this program since its inception, having committed more than \$100 million to it. In addition, USAID has allocated nearly \$200 million for bilateral HIV/AIDS prevention and control programs and has supplied nearly one billion condoms for HIV/AIDS prevention in Africa.

As studies on the development of HIV/AIDS progressed, the major modes of transmission were identified as (1) sexual contact, (2) exposure to HIV-infected blood or blood products (through transfusion of unscreened blood or use of unsterilized needles or syringes for intravenous drug use, or medical interventions), and (3) transmission from HIV-infected mother to child before or during birth. Approximately 75 percent of HIV infections worldwide are transmitted by sexual contact, 10 percent through intravenous drug use, 10 percent perinatally, and 5 percent through blood transfusions. Epidemiological studies also indicate that STDs are important cofactors in facilitating sexual transmission of the HIV infection. Approximately 90 percent of HIV-infected people live in developing countries, especially in sub-Saharan Africa.

Several well-known reasons for the rapid spread of the epidemic in developing countries include interrelated social factors such as poverty, society and culture, and in particular, migration, prostitution, war, insufficient health services, inconsistent or troublesome economic and legal status of women, and lack of information in the general population.

One of the early and continuing major concerns around the world is the development of HIV/AIDS in East Africa, particularly in Uganda, Kenya, and Malawi. Not surprisingly, other African countries paid attention to the progress of the epidemic in these countries and in 1985 the first case of AIDS was identified in Cameroon.

## **1.3 African Seroprevalence**

In monitoring the progress of the disease, HIV seroprevalence studies identify the origin of HIV infection and the groups of people that have the highest levels of infection. Not surprisingly, in most cases urban populations show greater incidence than rural populations. Figures 1 and 2 show HIV-1 seroprevalence across Africa for high-risk and low-risk urban populations. These data are clearly related and indicate the extent of transmission of the disease: where there is a high seroprevalence rate in an apparent low-risk population, it is likely that the disease will have

progressed further into the general population.

These two figures clearly show that not only is East Africa a region of high prevalence, but West and Central Africa are also regions with high prevalence rates according to 1997 data. In particular, Cameroon has high seroprevalence in the high-risk urban populations but, according to official statistics, only moderate seroprevalence in low-risk urban populations. In comparison, the Central African Republic (CAR) has high prevalence rates in urban populations, and Mali, Niger, and Chad have lower prevalence rates.

Using data from the U.S. Bureau of the Census, Table 1 shows the prevalence rates for selected Central African markets. High prevalence rates can be clearly seen in the urban areas, particularly in the CAR. Unfortunately, some of these data are not recent; they refer to the early 1990s. For comparison, more recent data is shown for Cote d'Ivoire and Mali. These data continue to show high prevalence rates.

**Table 1**

**HIV Prevalence Rates In West and Central Africa**

	Urban		Rural		
	Low Risk (%)	High Risk (%)	Low Risk (%)	High Risk (%)	
Cameroon	5.7	45.3	2.9	9.0	1992/4
Chad	4.1	-	-	-	1992
CAR	16.0	31.0	6.5	-	1994
Niger	1.3	12.6	1.4	-	1993
Nigeria	6.7	29.1	-	-	1995
Cote d'Ivoire	12.5	77.0	3.3	-	1996
Mali	4.4	55.5	3.4	52.8	1995/3

Source: the U.S. Bureau of the Census 1997.

Although high rates are found in the high-risk urban populations in all of these countries, the prevalence within the defined low-risk populations is one of the indicators of the progress of the epidemic into the general population. In particular, at 5.7 percent in the low-risk urban population, Cameroon's rates are believed to be underestimated compared to those of other countries.

Insert Figure 1



## 1.4 AIDS Growth

The growth of declared numbers of AIDS cases is shown in Figure 3 for selected Central African countries. Congo, Central African Republic, Chad, and Gabon have smaller populations than that of Cameroon. Therefore, as a comparison with a country with a similar size population, data for Cote d'Ivoire is shown. Although Cote d'Ivoire and Cameroon have similar size populations, the number of cases officially declared in Cameroon is about one-third that of Cote d'Ivoire. Congo, probably because of its proximity to Zaire and East African countries, shows a relatively large number of AIDS cases.

Insert Figure 3

## **1.5 AIDS Per Capita**

Obviously, population size affects the number of AIDS cases reported. Figure 4 shows the number of cumulative AIDS cases per capita over the last 11 years.

Insert Figure 4

The high prevalence of AIDS cases in Congo is indicated at about 4 cases per 1,000 population. The number of AIDS cases in Cote d'Ivoire continues to climb but the number of cases in the CAR, which is adjacent to Cameroon, has leveled off in the last three years. This leveling is probably due to misreporting of cases rather than to a cessation in the development of AIDS in that country. Somewhat surprisingly, data from Cameroon is close to those of Chad at about 650 cases per million population but, the true figure is probably much higher. The epidemic is treated seriously in Cote d'Ivoire and data collection is good. The same cannot be said of Cameroon for a variety of reasons.

Although both media reporting and epidemiological studies of AIDS have focused on East Africa in the past, it is believed that the AIDS epidemic in Cameroon is of prime importance in the Central African region. For all of Africa, intra- and international migration is a key contributor to the spread of HIV/AIDS, but the issue of migration is particularly crucial in Cameroon. Douala is the main port of entry to Cameroon, the CAR, and Chad, and both Douala and Yaounde, the administrative capital, attract many people seeking work. Many of these migrants return periodically to their own countries to visit wives, families, and friends, and those who have been sexually active while in Cameroon may have become infected and carry the virus back to their local community. In addition to business travelers, some tourists, military personnel, and police, those engaged in transport and others who move from one area to another all contribute to the spread of HIV/AIDS in Cameroon and nearby countries.

STDs also have an extremely high incidence in Cameroon, and are a major factor in the heterosexual spread of HIV/AIDS. Further, many African societies often accept relationships with several partners, another major factor in the heterosexual development of the disease. In Cameroon, polygamy is an accepted norm in some provinces, but it is the unofficial polygamy and free sexual practices of both male and female Cameroonians that encourage the spread of the epidemic.

Thus, with regard to HIV/AIDS, Cameroon is not only important because of the problems it faces for its own population, it is also key to the spread of the epidemic to and from other neighboring Central African countries.

## **2. BACKGROUND ON CAMEROON**

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### **2.1 People**

Cameroon is a central African country of approximately 13,937,000 inhabitants where 66 percent of the population resides in rural areas. Cameroon is often described as "Africa in miniature," because its population represents over 230 different ethnic groups, which are divided into six major groups. The major groups are Fang, Bamileke and Bamoum, Douala, Hausa and Fulani, and Bete and Etondes. The Fangs live in the Northwest; Bamilekes and Bamoums in the West Province; Douala in Littoral Province; Hausa and Fulanis in Adamaoua, North, and Extreme North Provinces; the Betes in the South and East Provinces; and the Etondes in the Center Province. Its colonial legacy has left Cameroon with two official languages: English and French. English is spoken in the Southwest and Northwest Provinces. French is spoken elsewhere. Islam is practiced in the three northern provinces, Christianity in the rest of the country, and different forms of traditional African religion are practiced throughout the country.

Education in public schools is free. School enrollment was good until the economic crisis.

### **2.2 Economy and Political Perspectives**

The population's economic activities include agriculture, livestock, and fishing. Douala is the main port city and the import and export center. Yaounde is the administrative capital where government and the international communities have their offices. The other provinces are mainly agricultural, varying from forestry in the East; cotton and rice in the North; and cocoa and coffee in the Center, Northwest, and West Provinces. The Bamilekes, who are originally from the West Province, are the dynamic commercial group of the country. They have relocated throughout the country and created business opportunities.

Since the early 1970s, Cameroon enjoyed a developing economy due to its natural resources and its oil revenues. Oil revenues contributed significantly to investments in infrastructure such as new airports, hospitals, and roads. Reduction in the price of oil on the world market, along with corruption and mismanagement has resulted in a decline in external trade since 1986. The 1994 devaluation of Cameroon's currency, the Central African Franc (Franc de la Communauté Financière Africaine [FCFA]), has meant a 50 percent increase on all imported commodities. Cameroon is now a visibly poorer country, with poverty felt at all levels.

However, prospects for an economic recovery in Cameroon appear promising. According to discussions with the World Bank and recent economic U.S. commercial trend reports, the Cameroon economy is reviving itself following the 1994 devaluation of the FCFA and in rising expectation of the Chad/Cameroon pipeline project. A 3.3 percent growth of the GNP in FY 95

was topped by a five percent increase in FY 96. Forecasters anticipate a further five percent increase in the GNP for the current fiscal year with inflation held in check at 3 percent.

On July 24, 1997, Cameroon signed a Letter of Intent (LOI) to implement an Enhanced Structural Adjustment Facility with the International Monetary Fund. These measures are expected to bolster confidence in the economic resiliency of the country. In addition, they will assist Cameroon to regain lost credibility within the donor community. USAID closed its operation in Cameroon partly because of lack of economic growth and fraudulent elections. Swiss, British, German, and Canadian cooperations have all reduced their financial assistance and presence in the country.

Because this is Cameroon's Fifth Structural Adjustment Program since 1988, it is viewed as the country's last chance with the International Monetary Fund to demonstrate that it is serious about economic development in the country and about meeting the basic social needs of its population. Serious results will mean moving beyond transforming theories and forming nonfunctional committees into active committees. It will also mean controlling corruption.

If Cameroon does not meet the conditions agreed to in the LOI, it will not benefit from the debt release program. These conditions are as follows:

- C Including petroleum revenues in the national budget,
- C Improving the tax revenue collection system,
- C Privatizing parastatal functions and reducing the number of civil servants,
- C Developing and implementing a forestry code, and
- C Increasing the health budget by allocating seven percent of the national budget to health in 1997 and ten percent by 2000.

Within the area of social dimensions to the Structural Adjustment Program, the objectives outlined are as follows:

- C Increasing the literacy rate by extending schools in the northern region,
- C Continuing to expand Reorientation to Primary Health Care (RPHC), and
- C Reducing infant and maternal mortalities.

If achieved, these measures will provide evidence to donors, as well as to nationals, that the

economic crisis is turning in a positive direction.

A more pressing issue is that of the political environment in Cameroon. Political strife continues to be a factor. The presidential election took place in October 1997, extending the Paul Biya regime another seven years. These were the second official multiparty elections. The first election in 1992 was characterized by international observers as being fraudulent. The recent October 1997 elections were also classified as fraudulent and were boycotted by the opposition parties because the government refused to create an independent electoral commission.

Paul Biya came to power in November 1982. Then President Ahidjo resigned because of ill health and transferred the power to Biya, who was prime minister. Biya inherited a swelling national budget. However, four years into his regime, an economic crisis began. The president and his allies argue that falling commodity prices and depreciation of the U.S. dollar are to blame. Donors and nationals forcefully argue that the crisis has been fueled by years of corruption and a dysfunctional judicial system. During the team's visit, German Technical Cooperation (GTZ) pointed out that of the 11 million FCFA provided for RPHC, 6 million FCFA cannot be accounted for. The Biya regime instituted an anticorruption commission in 1995.

### **2.3 Demographics**

Population Reference Bureau data for 1994 provides the following demographic indicators. Cameroon's population is growing at a rapid annual rate of 2.8 percent. This growth is propelled by a total fertility rate of 5.9, which is high, yet lower than the 6.9 children per woman reported by the World Bank in 1988. Women make up 32 percent of the labor force, distributed as 64 percent in agriculture, 4 percent in industry, and 32 percent in services. Women of childbearing age (15-49) constitute 22 percent of the total population. According to a Cameroon World Health Organization Report of 1993, "Behavior and Sociocultural Determinants Affecting Acceptance of and non-Acceptance of Artificial Contraception Among High-Risk Women in Cameroon," women obtain multiparity by 27 years of age, which confirms the finding of several USAID-funded studies that the average age of clients at family planning clinics is 26.

The contraceptive prevalence rate for modern methods has been low and slow to increase over the past 13 years. The 1978 Cameroon World Fertility Report found that 36 percent of women knew of a modern contraceptive method: 14 percent knew of condoms and 21 percent knew of oral contraceptives. By the time of the Cameroon Demographic and Health Survey in 1991, 73 percent of married women could name a method, with 44 and 49 percent knowing of condoms and oral contraceptives respectively. However, only 4 percent were actually practicing a form of modern contraception. Twelve percent were practicing traditional fertility control methods. Postpartum abstinence was the most prevalent. Abstinence, withdrawal, and prolonged breast-feeding were also common. Another method of traditional fertility control is polygyny. In Cameroon, as in other countries in Africa, polygyny provides the husband with another sexual

partner, thereby decreasing the chances that the abstinence will be violated and sexual relations resumed prematurely. The Billings Ovulation Method is widely practiced in Cameroon.

There is a high level of maternal mortality (550 per 100,000) and death from abortions and abortion complications. Teenage pregnancies are common and represent 21 percent of high-risk cases seen at the Central Hospital High-Risk Clinic (WHO, 1993).

Cameroon is part of the recognized subfertility and infertility belt of West and Central African countries. In Cameroon, the Central, South, and East Provinces have more childless women than other provinces. Few national studies have been conducted on this topic, but several regional studies have been completed that found that marital instability is the major cause of infertility. In addition, men and women with multiple sex partners have a higher risk of becoming infertile. The relationship between marital instability and STDs, infertility, and now AIDS has not been the focus of mass information, education, and communication (IEC) messages. Therefore, Cameroonians, especially those in urban zones, have "deuxieme bureaux," or men with more than one legal wife or girlfriend. Posters urge the population to "stay fidel."

Prostitution is widespread and overt in Douala and Yaounde. Around paydays prostitutes travel from Douala to rural towns to meet their clients. These rural towns include Boto-Limbe, where Cameroon Development Corporation (agriculture plantations employing 15,000) is located in the Southwest Province, or the numerous forestry mills near Bertoua, East Province. In the East Province, the situation is critical because young girls (9-10 years old) learn the traditional tricks of the trade that they assume protect them from STDs. These girls compete with older women for clients. In other provincial capitals, high school girls are sought after by older men. These girls may become infected and in turn transmit STDs to their male peers. In the Northwest Province, Ministry of Public Health (MOPH) staff are working with male students to develop IEC messages for female classmates on STDs/AIDS.

#### **2.4 Background on the Health Sector from 1985 to 1996**

During Cameroon's growth years (1970 to 1985), the Government of Cameroon (GOC) allocated as much as 6 percent of the national budget to the health sector, permitting the funding of drugs, personnel, and many of the critical recurrent costs of delivering rural health services. However, since 1986, as a result of the country's economic downtrend, the MOPH budget has registered sharp declines, dropping from a high of US\$ 5,350 million in 1986 to US\$ 4,800 million. Prior to the economic crisis, over 30 percent of the health budget was allocated to the provincial health services and drugs were provided free at government health facilities. In 1988, because of the worsening economic crisis, the budget for rural health facilities dramatically decreased. As a result, primary health care and rural health services ceased to function in a coordinated, effective fashion.

The National AIDS Control Program and the Condom Social Marketing Program were both launched in 1988 to 1989. Prior to the launch of these programs, the blood supply was essentially unprotected against HIV contamination and AIDS education activities were limited. Further, there was little consumer demand for use of condoms either as a way to prevent sexually transmitted diseases or to avoid unwanted pregnancies.

## **2.5 Cameroon Government Health Policy**

Developed in 1989 and formally adopted in 1992, Reorientation to Primary Health Care (RPHC) is Cameroon's health policy. The policy is gradually creating a decentralized and integrated national health system based on providing a minimum package of PHC services through health districts. The policy empowers local communities by including them in the co-financing and comanagement of health facility services.

Health facilities in the country's 10 provinces have now been organized into health districts, linking health centers to hospitals and hospitals to large reference hospitals. The three fundamental elements of a health district are as follows:

- (1) A health committee composed of the community and health center staff.
- (2) Several health centers covering a specific, delineated area with a population of approximately 5,000 to 10,000 people in rural areas.
- (3) A district hospital is the referral point for health centers in the area. This district-level facility provides technical support, monitors implementation of plans, and supervises health facilities within the district. The district hospital does not serve a specific population as do the health centers or CMI's.

Provincial hospitals act as referral points and provide technical support for the health districts. They assure the coordination, training, supervision, provision of supplies, monitoring, and evaluation of health districts. The provincial-level facility takes on a specific role in operational research and technical support, such as maintaining and repairing equipment and vehicles in the districts.

### **2.5.1 Financial Support**

Financial support for the RPHC strategy comes from the sale of drug supplies and cost-recovery systems. A 1990 Cameroonian law permits MOPH facilities "to recover the costs related to the sale of generic medicines." In the absence of a national procurement system, provincial drug procurement and distribution warehouses or depots (CAPP) have been established in all ten

provinces. At present, each provincial depot procures its own drugs from private drug distributors or orders them from overseas. There is, however, a proposed European Union intervention to develop a national procurement system.

USAID/Cameroon had supported three provinces (Adamoua, South, and Extreme North) in establishing the RPHC, but the abrupt closure of the mission and the withdrawal of direct aid to Cameroon has resulted in a decline in earlier successes. UNICEF carried out a follow-up plan, which provided initial stocks for reorienting health centers, but because of the absence of regular training activities and supervision, activities have not continued in a structured manner.

### 2.5.2 Donor Contributions

With a declining health budget, the MOPH is virtually dependent upon assistance from donors to implement the RPHC strategy in Cameroon's ten provinces. The MOPH's priorities for donor assistance in the areas outside of the communities are training MOPH staff to improve planning and management capabilities, renovating health facilities, and procuring initial stock of essential drugs.

The donors assisting the GOC to implement the RPHC in selected provinces are the Belgians in the Far North Province; Agence de la Cooperation Francaise (FAC) in the North province; GTZ in the Northwest, Southwest, and Littoral Provinces; and the World Bank in the Central, West, and East Provinces. Adamaoua and South Provinces have been virtually abandoned. WHO has been providing some support to the CAPP in the South Province. Only the Extreme North Province has managed to reorganize and identify donors to pick up former USAID districts. Also in the province, local populations viewing the benefits of the RPHC in some districts have pooled their funds together and financed start-up costs in their areas.

The levels of effort and the degree of success of the RPHC vary from one province to another and sometimes within the same province. At the provincial level and in districts where the level of commitment of personnel is high, the strategy has not only taken off, but is in full operation.

## 2.6 Organizational Structure of the Ministry of Public Health

It is important to understand the complexities of the public sector administration of the health service with which Population Services International (PSI) has to work. The latest MOPH organizational structure is outlined in Appendix D. The MOPH is now composed of a Private Secretariat to the Minister, an Inspector General, two technical advisors, Communications Services, a Central Administration, and External Services. Within the Central Administration and of particular interest is the Directorate of Community Health, where the subdirectorates of AIDS/STDs/TB as well as maternal/child health (MCH)/family planning (FP) are located.

The Community Health Directorate, formerly the Directorate of Preventive and Rural Medicine and the Directorate of Family and Mental Health, is responsible for the following general activities:

- ? Define, develop, and implement a national health strategy for community health and traditional medicine;
- ? Organize, supervise, and coordinate public community health services;
- ? Organize, supervise, and coordinate private community health services;
- ? Control endemic and all diseases important to public health;
- ? Conduct epidemiological studies throughout the country;
- ? Promote preventive activities in public and private health facilities;
- ? Integrate preventive medicine into development and socioeconomic programs;
- ? Promote hygiene and sanitation of the environment in collaboration with other concerned ministries;
- ? Promote health education; and
- ? Promote the organization and protection of maternal, child, and adolescent health.

The Community Health Directorate is divided into three subdirectorates, one of which is the Sub-Directorate of RPHC. This subdirectorate has three services: Epidemiology and Endemic-Epidemics Service, National AIDS/STDS/TB Program, and Community Health and Traditional Medicine Services.

### 2.6.1 Structure of the AIDS Program

From 1994-1997, the AIDS program was dormant. In an effort to revitalize the AIDS program in Cameroon, the program has a new name, location, and president. The National Aids Committee (NAC), formerly called the Programme Nationale de Lutte contre le SIDA (PNLS), now focuses attention on all sexually transmitted diseases and tuberculosis. Its new name, "Programme Nationale de Lutte contre le SIDA/Maladies Sexuellement Transmissibles et Tuberculoses," reflects this expansion. However, the acronym remains PNLS.

The NAC program began in 1988 under the Community Health Directorate (then the Directorate of Preventive and Rural Medicine). It was briefly moved to the Cabinet of the Minister of Health but has now returned to the Directorate of Community Health. The NAC, or PNLS, is now located under the Sub-Directorate of Primary Health Care, where it comprises the same three offices as the former service of AIDS/STDs/TB.

The Sub-Directorate of Primary Health Care has seven departments: research, clinical services for AIDS patients, laboratory and blood transfusion, IEC, administrative and finances, epidemiology, and counseling.

In addition, a memorandum of July 3, 1997, also nominates the Director of Community Health as the new president of the PNLS. He is responsible for coordinating the communities' activities and calling meetings of its two advisory boards. The two advisory board meetings are presided over by the Minister of Health. They are the National AIDS/STDs/TB Committee and the Multi-Sectoral AIDS Committee. Members of the committee include the following:

- (1) A representative from the following agencies: MINACOF, MINEDUC, MINFOC, MINJUS, MINDEF, MINTRAV, MINTRAVAUX PUBLICS ET TRANSPORTS, MINAT, MESIRES, and religious organizations;
- (2) Three representatives from the international donor community; and
- (3) The president of the NAC.

The Multi-Sectoral AIDS/STD/TB Committee is responsible for coordinating the interventions of different international donors to monitor the implementation of the NAC's actions plans. Members of this committee include the director or a representative of the Ministry of Economy and Finance, WHO, the United Nations Development Program, the United Nations Population Program Fund, UNICEF, l'OCEAC, the Centre Pasteur du Cameroon, international organizations conducting health activities, missionary hospitals, multi- and bilateral donor agencies, nongovernmental organizations, and the president of the NAC.

For the sake of clarity, the two implementation boards, formerly called "La Commission de Controle et de Suivi de la Lutte contre le SIDA" (CCLS) and "L'Unite de Lutte contre le SIDA" (CNLS) became the Service de Lutte contre le SIDA in April 1997. This service in turn became the National AIDS/STD/TB Committee outlined above.

The general objectives of the NAC are as follows:

- ? Reduce the transmission of HIV/AIDS, STDs, and tuberculosis,

- ? Reduce the individual impact of these illnesses on the economy and society, and
- ? Reduce transmission of HIV/AIDS from mother to child.

The placement of the AIDS program in the Directorate of Community Health is too recent to have shown any results. However, placing the NAC in the Community Health Directorate allows the director, who is considered a dynamic and efficient manager, to monitor AID-related activities. Whether the director will have sufficient time to allocate to AIDS remains to be seen. Since the departure of its efficient director in 1994, the AIDS program has been without a committed director.

All of these changes are in their infancy, but it is hoped that some dynamism will evolve in the Cameroon health sector and particularly in the HIV/AIDS/TB project. Support for this evolution is signaled by recent funding to the GOC. The July 1997 Letter of Intent signed between the GOC and the IMF calls for an increase in the health sector of the national budget.

## **2.7 MOPH HIV/AIDS Policy**

Shortly after AIDS first became known in 1985, Cameroon was rated as a country of weak to strong AIDS prevalence with a level of 0.5 percent and 21 cases of AIDS reported. The official statistics show that this prevalence passed 1 percent in 1990 and is now officially recorded as 5.5 percent nationally. The cumulative number of AIDS cases reported to WHO for 1995 was 8,141; for 1996, preliminary Cameroonian official statistics show 9,626.

The first HIV/AIDS national strategy was drafted by the NAC in 1987. In 1988, a Short Term Program served as an intermediate program until the Medium Term Program I (PMT1) for the period 1988 to 1992 was drafted by national and international partners. PMT1 was redefined in 1993, giving way to the Medium Term Program II (PMT2) for the period 1994 to 1996.

The first short-term plan was oriented toward multisectoral mobilization and collaboration, the decentralization and integration of activities. Wherever possible, a particular emphasis was placed on prevention and transmission by sexual contact.

PMT1 developed prevention, education, training, and research activities. This service generally concentrated on planning and administration, coordination and supervision of activities, and planning for the different sections. These sections included IEC, epidemiology, laboratories and blood transfusion, clinics, psychosocial management, tuberculosis, sexually transmitted diseases, and research.

Between 1990 and 1994, leadership of the PNLIS was fairly dynamic, but, when the management changed in 1994, the AIDS-related activities ceased with the exception of some limited IEC

activities. During this period, little leadership, few meetings of the CNLS, and no coordination of effort or resources took place, particularly at the central level.

Given the lack of activities during this period, the Medium Term Program II has been continued with new dates of 1997 to 1999. With the recent change in management, revitalization of effort has begun. This revitalization began with a meeting of the CNLS and mobilization of resources, which one hopes will result in the execution of the New Medium Term Plan.

The objectives of this Medium Term Plan II, 1997 to 1999, are as follows:

- ? Reduce the transmission of HIV through the blood supply,
- ? Reduce the sexual transmission of HIV, and (added this year)
- ? Reduce the transmission of HIV from mother to child.

To achieve these objectives, the committee has established the following activities:

1. Promote health through IEC and condom social marketing,
2. Train health providers in handling blood transfusion and counseling,
3. Develop laboratory services and safe blood banks, and
4. Conduct surveillance epidemiology of HIV infection.

#### 2.7.1 Psychosocial Rights of HIV-Infected Persons and Their Close Associates

In late 1995, the MOPH, in collaboration with WHO and GTZ, developed a guide for handling people with AIDS and their close associates. The guide entitled, "National Policy: On the Psychosocial Management of HIV-Infected Persons/AIDS Patients and their Close Associates or Counseling," is based on the principles from the Universal Declaration of Human Rights of the Paris Summit on HIV/AIDS organized by Heads of Governments in December 1994. The policy defines psychomanagement or counseling of HIV as "a dialogue centered on awareness as concerns the transfer of the responsibility of HIV prevention from medical personnel to others such as individuals, families, or indeed entire communities." The guiding principles of psychosocial management or counseling are as follows:

- (1) Every infected and noninfected person has a right to information and advice on HIV/AIDS;
- (2) Every professional and nonprofessional in possession of any worthy knowledge, aptitude, and practice in regards to psychosocial management has the obligation to

take care of infected people and their close associates;

- (3) All institutions, associates, NGOs, and international organizations should respect the national policy on management. Associations and NGOs should sign a partnership deed stating clearly their sphere of action;
- (4) Any person involved in psychosocial management has the obligation to impart correct and scientifically proven information;
- (5) Human dignity and confidentiality should be strictly respected;
- (6) Strict collaboration and coordination should be present at all levels; and
- (7) Any testing should be preceded and followed by counseling.

In theory, the policy outlines the role of each level of health facility in managing AIDS-infected people. In reality, it appears that none of the provincial or district hospitals are familiar with the policy and if so, few respect the rights of sharing knowledge with patients infected with this seemingly "hopeless" illness. The NAC should develop curriculum modules to conduct in-service training for health providers at each level of the health structure. In addition, former STD clinics have been converted to district hospitals in name, but in reality they continue to function as STD clinics without materials to provide full services to HIV patients.



### 3. EPIDEMIOLOGICAL ASPECTS OF HIV/AIDS IN CAMEROON

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The epidemiological surveillance in Cameroon was conducted by establishing a control system followed by studies of the following sentinel groups:

- ? Pregnant women who reflect the general, active sexual population;
- ? Patients suffering from STDs reflecting the high-risk population; and
- ? Patients suffering from tuberculosis.

There are six sentinel sites that test pregnant women. These are located at the protection maternelle et infantile (PMI) sections at the Centre Medicale Integre (CMI) in Central Yaounde, Bertoua, Garoua, Bamenda, Limbe, and Douala.

In practice, the sentinel surveillance operates fairly regularly, testing the seroprevalence of HIV and syphilis among pregnant women. Until 1995, a sample of 300 was recommended for each site; the recommended sample size has been raised to 400. The development of a high level of seroprevalence of HIV was confirmed in 1994 with an average of about 6 percent, reaching about 7 percent of pregnant women by the end of 1996.

The national prevalence levels estimated on the basis of the sentinel surveillance are underreported due to the following poor conditions:

- ? Frequent lapses in the delivery of reactivities to the sites charged with surveillance (noted by the significant variations in sample sizes) and the delay in providing serums;
- ? Lack of understanding of confirmation procedures by the personnel in the sites, and the inability to test the increased sample sizes, as seen in the annual report;
- ? Absence of systematic and organized information available to site personnel on the means of contracting HIV infection. This absence of adequate documented information reduces staff motivation and knowledge;
- ? Insufficient information on AIDS cases not covered by the sentinel surveillance sites; and
- ? Absence of computerized information and MIS.

The main constraint to proper reporting of HIV seroprevalence is the lack of sound statistical information in the system. This reporting affects not only AIDS/STD, but other aspects of health. When data are collected and sent back to the province and other levels, the process is extremely disorganized and summary information is not disseminated to any health professionals. The

sentinel surveillance staff often have no idea of the prevalence rate in their area for the preceding year. To improve this situation, GTZ and Cooperation Francaise are helping to establish a new system, the National Health Management Information System. This new system could benefit from the HMIS models developed by the MOPH and USAID in 1992-94.

The new system emphasizes management indicators and simplifies many of the morbidity and mortality indicators, especially those concerning AIDS/STD, where it is planned that the indicators should be reduced to a strict minimum. Many regional diversities exist, particularly at the institutional level and in the epidemiology of various illnesses. Certain regions, particularly those in the West, have a fairly good system for collecting information, satisfactory internal organization, and regular transmission of data collection. However, the data collected locally changes when it is treated and analyzed at the central level. This change in the data indicates a real organizational problem at the central level in compiling and analyzing the data.

Following are the sample sizes and results of the sentinel surveillance from central- and regional-level reports. As noted, these results are limited in terms of their accuracy.

### 3.1 Seroprevalence among Pregnant Women

**Table 2**

**Seroprevalence among Pregnant Women by Country**

	Yaounde		Douala		Bamenda		Bertoua		Garoua		Limbé	
	%	Sample	%	Sample	%	Sample	%	Sample	%	Sample	%	Sample
1988												
1989	0.7											
1990	1.3		1.1	300	1.1	300					1.1	300
1991	1.6	1,205*			2.3	300			2.5	300	4.7	300
1992	2.0	307	2.4	290	4.2	199	7.9	140	2.0	200	2.0	151
1993	1.3	301	4.7	275	7.8	165			3.0	301	4.1	142
1994	3.0	300	5.7	300	9.0	203	10.5	311	3.1	300		103
1995	2.7	300			9.0	251	6.0	298	3.4	298	7.8	102
1996	5.0		4.5	398	8.8	419	6.3	254	3.3	399	11.2	394

\* At three sites

Bertoua, the province in the East near the CAR frontier, had a high prevalence rate in 1992. Unfortunately, no prior information for Bertoua is available to allow a comparison. Bamenda in the Northwest has a consistently high prevalence rate; the rate for Limbe in the Southwest is growing rapidly. These rates could reflect better record keeping in these two provinces.

Despite variations by province, Cameroon's prevalence rates have increased, reaching about 6.5 percent.

Generally, the recommended sample sizes were achieved in Yaounde and Garoua. Elsewhere, sentinel survey numbers vary considerably, because of the previously mentioned constraints.

### 3.1.1 Seroprevalence of Syphilis among Pregnant Women

**Table 3**

**Seroprevalence of Syphilis among Pregnant Women**

Sentinel	Seroprevalence Rate (%) by Year				
	1992	1993	1994	1995	1996
Yaounde	17		14	23.3	
Douala	26		20.1		n.a.
Bamenda	15.6		13.5	n.a.	3.1
Bertoua	n.a.		15.3	3	
Garoua	10.5		13	6	3.5
Limbe	38.4*		21.4	4.9	5.3

\* RPR only

NB The tests used are RPR and PHA in 1994, TPHA in 1995, and RPR and TPHA in 1996

In most parts of Cameroon there has been a very high prevalence of syphilis cases for a considerable time. Many physicians recognize this very real problem of syphilitic seropositivity.

With the current state of knowledge and the tests available, it is not possible to distinguish between PIAN and syphilis.

### 3.1.2 Epidemiology of Other Sexually Transmitted Diseases

Other than syphilis, which is included in the sentinel surveillance, little data exists on other STDs. Some studies put STDs in fifth place as reasons for adult health consultations in Cameroon. The results are very variable from one health facility to another. There are not enough studies of rigorous methodology available to give good epidemiological reporting. A review of disparate studies gives the following results:

**Table 4**

**Prevalence of Chlamydia**

Group	Location	Date	Rate (%)
Pregnant women	Douala	1992	43.5
Patients visiting STD clinics	Yaounde	1993	24.2
Prostitutes		1991	41

**Table 5**

**Prevalence of Gonorrhoea**

Group	Location	Date	Rate (%)
Pregnant women	Yaounde	1980	13.5 and 10.1
Patients visiting STD clinics	Yaounde	1993	23

From the Nonoxynol 9 project in 1995, the incidence of STDs in a group of 1,700 single women showed gonorrhoea at 8.8 percent, chlamydia at 7.5 percent, and syphilis at 16.3 percent.

To confirm or dispute the correlation between the prevalence levels in the general population and those of pregnant women, we now examine the prevalence levels from other sources.

### 3.2 Blood Donors

A study conducted between 1987 and 1990 among 8,384 blood donors in four towns? Yaounde, Douala, Kumba, and Bamenda? showed that the HIV prevalence was 1 percent. HIV seroprevalence was also studied between 1990 and 1994 among blood donors in three towns? Douala, Ebolowa, and Yaounde? with the following results:

**Table 6****Evolution of HIV Seroprevalence Among Blood Donors**

Year	Sample Size	Prevalence (%)
1990	5,558	4.3
1991	5,549	3.5
1992	6,074	4.6
1993	7,389	7.1
1994	8,880	10.8

These data show a growing prevalence 4.3 percent to 10.8 percent among blood donors. In the same study, the data is broken down by gender.

**Table 7****Prevalence Among Blood Donors by Sex**

Year	Female (%)	Males (%)
1990	2.7	4.6
1991	3.1	3.5
1992	4.6	4.6
1993	5.9	7.4
1994	8.1	11.5

An increase in prevalence is shown for both sexes: females reach 8.1 percent and males 11.5 percent in 1994. In addition, the most recent data from Bamenda and Bertoua show blood donor prevalence to be 8 percent and 10.3 percent in 1995 to 1996.

Information provided by the General Hospital in Douala for 1995 showed varying prevalence levels among different donors groups? 5.8 percent among students, 8 percent among the armed forces, and 10 percent among the families of donors.

These studies of prevalence among blood donors show a probable 3 percent higher prevalence level among blood donors than among pregnant women as shown in the sentinel studies. These findings clearly cast some doubt on the officially assumed general population prevalence level.

### **3.3 High-Risk Groups**

#### **3.3.1 Studies among Armed Forces**

The armed forces and police showed a seroprevalence of 3.3 percent in 1990, 6.8 percent in 1993, and 17 percent in 1996.

### 3.3.2 Studies among Prostitutes

**Table 8**

**Seroprevalence among Prostitutes**

Date	Location		
	Yaounde	Douala	Bamenda
1987	6.9	7.3	
1988	7.1	6.7	
1989		10.9	
1990	9.2		8.0
1991			9.1
1992	26.6	45.3	
1993	23	35	
1994	21.1		

There is a very high level of seroprevalence among prostitutes, especially in Douala and Yaounde.

### 3.3.3 Studies among Tuberculosis Patients

**Table 9**

**HIV Prevalence (%) among Tuberculosis Patients**

Date	Prevalence Rate
1989	2.4
1990	4.1
1991	9.9
1992	
1993	
1994	22.4

Prevalence among truck drivers was 17 percent in 1993.

In summary, the high-risk groups show the following prevalence levels: 17 percent among the military, 25 to 45 percent among commercial sex workers (CSW), and 17 percent among truck drivers.

### 3.4 Regional Information

During the case study, the team visited various Cameroonian provinces and collected data directly from the local health posts and hospitals. Although not comprehensive, these data are shown in the following table.

**Table 10****HIV Prevalence Rate (%) by Province**

Date	North West		South West		Littoral		North (Garoua)		Extreme North	
	(%) Blood Donor	Clinical Suspect								
1994			6.0	42			5.0			
1995	5.2	43	7.0	37			4.1			
1996	8.0	48			5.5	39	5.1			31
1997										77

These data show prevalence levels among blood donors to be between 5 and 8 percent and over 40 percent clinical suspects.

## 3.4.1 North, Extreme North, and Adamaoua Provinces

**Table 11****Evolution of Seropositivity and AIDS Cases at the Pasteur Centre, Garoua**

Date	Number of Seropositives Per Region			Total Seropositives	Total AIDS Cases* in Country
	Extreme North	North	Adamaoua		
1988	4	17	0	21	21
1989	10	34	1	45	36
1990	27	70	30	127	76
1991	36	120	92	248	158
1992	75	199	163	437	276
1993	121	335	324	780	517
1994	128	447	424	999	671
1995	356	645	506	1,507	1,007
1996	567	942	506	2,115	1,323

\* Illnesses notified.

These seropositivity and AIDS cases come exclusively from Pasteur Centre, which is sent samples by certain health facilities, and private and public religious groups. Tests carried out in public hospitals, HIV spot and multispot, are not sent to the Pasteur Centre for confirmation because of cost.

The number of seropositives is very close to the number of AIDS cases (100 percent +ve versus 60 percent AIDS). Although the data could be said to be selective and somewhat biased, it is nevertheless unusual that the seropositivity is similar to the number of AIDS cases discovered. This similarity would indicate that a patient must be extremely ill before a sample is sent for analysis. In other words, seropositivity is not usually discovered early. With patients in the public hospitals where samples are not sent to the Pasteur Centre for confirmation, the patient almost certainly has AIDS symptoms before a test is carried out. This theory was supported by data for hospitalized patients given by the hospital in Maroua.

### **3.5 Official Reporting of AIDS Cases in Cameroon, 1985 to 1996**

As seen in Table 12, officially published statistics indicate the number of reported AIDS cases in Cameroon has grown steadily (and slowly compared to other countries in West and Central Africa). These statistics also indicate that the number of AIDS cases actually decreased in 1996, which is almost impossible and illogical.

**Table 12****AIDS Cases in Cameroon**

Year	Number of Cases	Cumulative Total
1985-1986	21	21
1987	20	41
1988	33	74
1989	60	134
1990	183	317
1991	604	921
1992	1,308	2,229
1993	1,385	3,614
1994	1,761	5,375
1995	2,766	8,141
1996	1,485	9,626

Table 13 shows that the cumulative number of AIDS cases up to 1995 is divided overall male to female at approximately a 1 to 1 ratio. Although no data by sex is available for each year, this ratio has probably changed over time with an increasing number of female AIDS cases identified.

Data in Table 13 show an increase in the transmission of AIDS from mother to child. It also shows a higher proportion of AIDS cases in the female age group 15 to 24 years, compared to males in the same age group. There are, however, greater proportions of males with AIDS in age groups 25 to 59 years. Thus, females are contracting AIDS at an earlier age than males, as in other countries where AIDS is prevalent, suggesting that women become infected earlier than men and that they in turn infect a much larger number of older men. The epidemic is progressing extremely rapidly and will continue to grow exponentially unless massive interventions are carried out quickly.

**Table 13****Number of AIDS Cases by Age and Sex, Cumulative to 1995**

Age	Males		Females		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
0 to 4	108	2.4	118	3.1	226	2.8
5 to 14	46	1.0	88	2.3	134	1.6
15 to 24	410	9.3	1,089	29.3	14,991	8.4
25 to 34	2,128	48.0	1,514	40.8	3,642	44.7
35 to 44	1,263	28.5	697	18.8	1,960	24.1
45 to 59	422	9.5	177	4.8	599	7.4
60 to 80	53	1.2	28	.1	81	1.0
Total	4,430	100.0	3,711	100.0	8,141	100
		54.4		45.6		

Source: Ministry of Health

Data in Table 14 show that, in 1995, there were greater proportions of female cases than male cases in the Central, Littoral, East, West, and Southwest provinces. Overall, about twenty-one cases of AIDS were reported per million population, but numbers vary considerably between the provinces. This variance, however, may be more a function of reporting than of incidence. Northwest public and private health facilities are considered the most organized in the country; therefore, people with AIDS may travel there from other provinces, as well as from Nigeria, and the reporting of data is better.

**Table 14****Number of Reported AIDS Cases by Province and Sex, 1995**

Province	Males	Females	Total	AIDS Cases Per Million
Adamaoua	32	27	59	0.9
Centre	186	204	390	18.8
East	80	86	166	25.5
Extreme North	97	81	178	7.6
Littoral	155	175	330	19.4
North	71	41	112	10.7
Northwest	422	306	728	46.8
West	138	192	330	19.6
Southwest	138	208	346	32.8
South	72	55	127	27.0
TOTAL	1,391	1,375	2,766	21.0

**3.6 Comparison between Official Statistics and Those Collected in the Provinces**

Table 15 compares the actual number of AIDS cases reported at the regional level with the officially reported statistics. These cases are diagnosed when a patient presents two major and one minor sign of the disease and is able to pay for the examination. Patients are recruited by external consultations or when they have been hospitalized.

Because of the deficiencies in reporting, AIDS cases are considerably underreported at the central level. Unfortunately, these are the statistics that are officially published nationally. The actual number of AIDS cases is two and one-half to three times the number of cases that are actually reported.

**Table 15**

**Regional versus Official Reporting of AIDS Cases**

Date	Province	Official Statistics	Reported AIDS Cases	Official Regional Reporting (%)
1995	Three northern provinces	340	1007	35
	Northwest	728	826	88
	Southwest	346	755	46
<b>Total</b>		<b>1,423</b>	<b>2,588</b>	<b>55</b>
1996	Three northern provinces	302	1,323	23
	Northwest	554	1,160	48
	Littoral	-	808	0
<b>Total</b>		<b>856</b>	<b>3,991</b>	<b>21</b>

### 3.7 Summary of Mortality Related to AIDS

No national-level statistics exist for mortality related to AIDS. Although there is a national policy relating to counseling and psychosocial care for patients, this policy does not operate in practice. Few organizations are prepared to provide this care and, for the most part, AIDS patients disappear and never return after they have received their diagnosis. As one doctor in the northwest said, "We are seeing an increasing number of deaths in the villages which are accredited to witchcraft or chronic poisoning."

Tables 16 and 17 reflect data from the provincial and district hospitals visited by the team where doctors asserted that in the last two years, AIDS has become the second or even the primary cause of death. In the N'Kongsamba Health District in the Littoral Province, at 8.1 percent, AIDS was the major cause of death in 1996.

**Table 16**

**Causes of Death in N'Kongsamba, 1996**

Illness/Condition	Cases	Deaths	Mortality Rate (%)
Occlusion intestinal + hernis	168	9	5
Pregnancy complications	215	9	2.4
Accidents	362	9	2.4
AIDS	37	3	8.1
Malaria	9,355	18	0.3

In Maroua, there were the following number of AIDS cases and resulting deaths:

**Table 17**

**AIDS Cases and AIDS-Related Deaths in Maroua**

AIDS Cases and Deaths	Year					
	1992	1993	1994	1995	1996	1997*

AIDS cases	6	10	8	12	18	16
Deaths	0	2	3	4	4	3

\* Six months

It was also reported that at the provincial hospital in Bamenda, AIDS is the second major cause of death after malaria.

### 3.8 Summary

The number of AIDS cases is increasing rapidly. This rapid increase is very strongly associated with the high prevalence of syphilis. The number of female cases is increasing, particularly in the younger age groups.

The close proximity in the number of seropositives identified and the number of seropositive people who have full-blown AIDS indicates that detection is not at a well-developed stage. Patients do not come to hospitals until they are seriously ill, and only then is their seropositivity identified. Thus, HIV prevalence is probably considerably higher than the officially declared 5.5 percent.

Similarly, the number of AIDS cases reported by the provinces is well below that officially reported by the GOC. This underreporting may be due to organizational deficiencies, but may also be due to the politics of the situation.

Therefore, in reality Cameroon has a much larger HIV/AIDS problem than is officially recognized.

## 4. POPULATION SERVICES INTERNATIONAL

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### 4.1 History

1989

DKT International initiated social marketing in Cameroon in 1989 with the launch of Prudence condoms, a Sultan product from Zaire. A local pharmaceutical distributor, HOSPICAM, was appointed as agent and repackaged the product in packets of four, priced at 50 FCFA at the retail level and marketed under the Prudence brand name. HOSPICAM distributed other products mainly in the two main cities of Douala and Yaounde. Prudence sales developed modestly in these two places, with some distribution elsewhere through the wholesale trade.

1990

Sales continued through 1990 and, following the relative success of the launch, plans were developed to hand the project over to PSI and to seek funding from USAID for additional product lines. These additional products included an oral rehydration salt, oral contraceptives, and a proprietary kit for STDs. The contract with HOSPICAM was renewed.

1991

In 1991, development activities continued with further funding for research and development for the three proposed products. HOSPICAM's contract was again renewed, but only for the condom business. During the year, HOSPICAM encountered some financial difficulties and although it remained with the same proprietor, was renamed GROUPE SANTE. Because of the development of new products, PSI staff was increased to include a full-time researcher and a marketing manager.

1992

During 1992, some consumer problems were perceived with the Sultan condoms, so baseline research was undertaken to enable a relaunch of the brand in the following year under the name Prudence Plus. It was also discovered that although GROUPE SANTE was registered with the GOC, it was only registered with the Ministry of Commerce, not with the MOPH. In effect, this meant that GROUPE SANTE was not licensed to distribute officially to other pharmaceutical wholesalers. For this reason, the pharmacy trade refused to stock the Prudence brand condom. Furthermore, pharmacists felt that because Prudence was sold on the open market, it was not a suitable product for them. Thus, during the year a second, new brand of condom, Promesse, was developed for sale through the pharmacy trade. This condom was sold directly by PSI, priced at 100 FCFA for a packet of three condoms.

The number of sales staff, as well as the number of salesmen attached to the distributor, was increased to handle distribution increases outside of the major urban areas.

With funding from various sources, PSI researched the three proposed products: the oral contraceptive (OC) Novelle, the oral rehydration salt (ORS) Biosel, and the STD kit M-Stop. In addition, PSI conducted baseline studies into Cameroonians' attitudes toward Prudence and investigated knowledge and incidence of STDs. PSI conducted product introductions with large commercial organizations and carried out a major innovative consumer on-pack promotion using a "scratch and win" approach. This promotion attracted considerable interest and captured the imagination of the public, thus helping sales and distribution in the general marketplace.

1993

In 1993, PSI opened a second office in Yaounde to maintain easier and closer contact with other organizations, such as donor groups, NGOs, and particularly government bodies. A Protocol d'Accord was signed with the MOPH, which formalized PSI's presence in Cameroon. The goal of this document was to develop with the MOPH the condom social marketing program in Cameroon. One of the detailed objectives was for PSI to work with the National AIDS Program; in return, the MOPH would facilitate the airing of IEC messages, help with relationships with other GOC ministries, and waive customs duties on imported goods and materials necessary to the project.

Changes were made to the agreement with GROUPE SANTE, restricting them to being the distributive agent for the Littoral Province only. This action freed up PSI to develop more effective distribution to the other provinces.

At this time, a new USAID-funded AIDS Control and Prevention project began. Through this vehicle, research was carried out on the high-risk groups of students, prostitutes, and the armed forces.

1994

This was a difficult year for PSI. A costing exercise was carried out to compare the costs GROUPE SANTE proposed for packaging, selling, and distributing the product with the cost for PSI to do these activities. PSI's costs were lower and GROUPE SANTE was informed that their contract would not be renewed. In response, in July GROUPE SANTE seized all of PSI's stocks of packaging materials and finished product and, through legal appeal, froze PSI's bank account. Although GROUPE SANTE's objective was to block PSI's business, PSI quickly took measures to import new stock and packaging materials and transferred large volumes of condoms from its operation in Zaire. Despite these difficulties, sufficient stock of product was present in the trade, and consumer sales were not seriously disrupted. However, the pipeline of product in the wholesale trade was severely diminished and undoubtedly some sales were lost. In addition, the legal process to try and overturn the seizure of product was extremely time consuming for PSI management and some activities had to be curtailed. Furthermore, the rapid closure of the USAID mission and the cessation of bilateral support for the program meant PSI personnel had to be laid off.

Nevertheless, in 1994 PSI conducted a second, planned on-pack promotion, which was again immensely successful with the consumers. This promotion, "10 good reasons to use a condom," combined an educational approach with the opportunity to win prizes. Despite the interruptions to business caused by GROUPE SANTE, condom sales continued to increase throughout the year. In addition, during 1994 PSI launched Novelle and Biosel into the pharmacy trade following an extension of the Protocol d'Accord with the MOPH.

1995

In March of 1995, a successful appeal was granted against Groupe Sante and the seized stocks were released. However, the former distributor immediately took further action and resealed the stock and, more importantly, succeeded in being granted an injunction against PSI, preventing them from importing any further stock. Also, PSI was prevented from using any of their bank accounts or from opening any new bank accounts. This situation continued for a year until, in 1996, the case was finally resolved following intervention by the MOPH on PSI's behalf. Fortunately, PSI had sufficient stock of product to continue trading and again, consumer sales were not dramatically affected. PSI's Cameroonian commercial director was promoted to interim resident advisor when the previous expatriate PSI director was transferred to another country.

1996

In 1996, a new Protocol d'Accord was signed with the MOPH. This formalized the creation of Program Marketing Social of Cameroon (PMSC) as an NGO, with assistance from PSI/Washington. Also, the Cameroonian resident advisor was confirmed as Country Representative. The strong links now developed with the GOC resulted in an important feature of the new protocol: the MOPH would assist in any action that caused a disturbance or interruption in the social marketing (SM) program. This feature prevented a recurrence of the troubles with GROUPE SANTE. Also, the MOPH committed to facilitate the speedy clearance through customs of pharmaceutical products, which has always been a lengthy procedure in Cameroon because of bureaucratic deficiencies and occasional corruption.

Following the closure of the USAID mission in 1994 and the ending of the AIDSCAP project, PSI had to spend much time searching for funding. Although USAID provided a large stock of condoms during 1996 and some funding from SFPS (Sante Familiale pour la Prevention de SIDA, REDSO/West's Regional Family Health and AIDS Project), and revenue derived from sales of product was adequate given the constraints of a nonprofit SM program, PSI still needed to seek funding for marketing and new development activities.

1997

In February of 1997, the retail price of Prudence Plus was increased to 100 FCFA. The recommended retail price had been held at 50 FCFA since the product's launch in 1989, but for many years the street price had been 100 FCFA. Unfortunately, news of this price increase was released to the trade rather prematurely, and wholesalers purchased and stockpiled condoms. These actions caused some isolated disruption to distribution of stock and have severely affected the consistency of sales into the trade from PSI. The situation is now beginning to ease and, with the new price structure, both retailers and wholesalers will benefit from increased price margins. The price to the consumer seems to be holding at 100 FCFA; thus, consumer sales continue to grow.

Despite their proven success in 1992 and 1994, consumer promotions are expensive to run as is the cost of media in Cameroon. During 1997, PMSC has conducted a multimedia promotional campaign, carried out sensitization activities with truck drivers and large commercial organizations, and is in the process of setting up a community-based distribution (CBD) program with the Peace Corps in the Extreme North. Attempts are being made to air the series "Sida dans le cité" the successful film produced by PSI's Cote d'Ivoire operation. The problem is the cost of air time in Cameroon. Negotiations are taking place to try and obtain some reduction in costs from TV station representatives, who are being somewhat uncompromising, insisting that the film is promoting a brand and therefore should pay commercial rates.

Novelle, the oral contraceptive, has been repackaged and relaunched as Novelle Duo, now with two cycles of pills. The repackaging and relaunch was necessary because the supply of the original brand of donated contraceptive was discontinued and a new brand was needed to

maintain consumer confidence in the packeted cycle. Biosel sales have virtually ceased because of lack of stock, but the other brands continue to grow. However, PSI is trying to obtain up to \$300,000 for a national ORS project. Similarly, PSI is seeking funds for a pilot project integrating SM and service quality in the public sector health centers and for a mobile video unit to help promote PSI products in rural areas.

Overall, the PSI/CAM project has performed very well given its financial insecurities and constraints. While PSI handled its legal problems so that business could continue, inevitably the rapid growth of condom sales was affected.

## 4.2 Social Marketing Project Funding

**Table 18**

### Funding Per Year (US\$)

Donor	1990	1991	1992	1993	1994	1995	1996	1997
FHI	84,500	331,725						
AIDSCAP (SM)				200,000	200,000	200,000		
USAID/REDSO (SM)							334,350	263,465
GTZ (IEC AIDS)			16,400				10,000	
WHO (IEC/Theater)				52,388				
Cooperation Francaise (IEC)					6,000			
USAID (Edea Research)							138,000	
JAPANESE (Condoms)							75,000	
CNCC (Transport)							2,782	
ONPC (Transport)							2,390	
SAGA (Various)							13,990	
Tulane (Research)								11,000
Urban Communities								5,700
UNALOR (IEC)								4,400
<b>Subtotal Condom</b>	<b>84,500</b>	<b>331,725</b>	<b>16,400</b>	<b>252,388</b>	<b>206,000</b>	<b>200,000</b>	<b>576,512</b>	<b>284,565</b>
USAID (ORS)			500,000					
BASICS (ORS)								95,000
<b>Subtotal ORS</b>			<b>500,000</b>					<b>95,000</b>
Foundations (SM OCs)					90,000			
SEATS (OCs)			363,347					
<b>Subtotal OCs</b>			<b>363,347</b>		<b>90,000</b>			
<b>TOTAL</b>	<b>84,500</b>	<b>331,725</b>	<b>879,747</b>	<b>252,388</b>	<b>296,000</b>	<b>200,000</b>	<b>576,512</b>	<b>379,565</b>

Total funding for the PSI/CAM project over its nine years of existence has been about US\$ 3 million. Much of this funding has been provided by USAID directly or via the AIDS Technical Support project's communication component (AIDSCOM) and AIDSCAP. However, a majority of this funding to PSI/CAM was designated for product development activities rather than for the social marketing HIV/AIDS component, and USAID's funding to PSI was confirmed on a year-by-year basis only. In addition, some of the original funding of the DKT project came from private sources in 1989 and 1990 and from PSI/Washington for staffing during 1994 and 1995.

Approximately US\$ 595,000 was designated for the ORS Biosel project and US\$ 453,000 for the OC project. Thus, only \$2 million has been donated for the condom SM project for either Prudence or Promesse. Also, there have been 17 donor sources, 10 of which are not associated with USAID. The absence of any one major donor to commit long-term funds to the SM project has necessitated much time being spent by PSI in seeking donors to be able to continue its work. Furthermore, there is a lack of guaranteed continued commitment of funds, particularly by USAID sources. This has created uncertainty for PSI management.

Mainly as a result of USAID's withdrawal from Cameroon in 1994 and the resulting loss of funding, PSI had to lay off staff. This staff reduction has undoubtedly inhibited PSI's ability to expand its active promotion and sales activities in the provinces. Also, in the absence of guaranteed funding, PSI has been unable to use mass-media SM activities that are necessary because of the GOC's lack of public activity.

Despite PSI's prudent management of limited cash resources and an estimated \$400,000 revenue from product sales, PSI's Cameroon SM program has been inhibited in its participation in the fight against AIDS by lack of funding. Over the nine years of the project, only \$220,000 has been spent on advertising and promotion of products. This amount is particularly significant given the actual growth of the AIDS epidemic in the country and the lack of funding from the GOC.

### **4.3 Sales**

As indicated in Figure 5, condom sales have grown to an estimated 10.5 million for 1997. Sales increased sharply in 1992 and 1994 when the two consumer promotions were run on Prudence. Notably, sales were not substantially affected during the stock seizure by GROUPE SANTE. About 250,000 units per year of Promesse, the second condom brand, were sold only through the pharmacy trade. Prudence Plus is the major brand sold.

**FIGURE 5**

**Condom Sales**

Because of the high volume of business conducted through wholesalers in Douala and Yaounde and who also supply other regions, about 50 percent of condom sales are in the Littoral and Central Provinces. About 30 percent of the sales in these major towns are delivered for resale in other parts of the country. In addition, some traders who come to these towns for other goods, also buy condoms instead of buying them in their own province. In the early stages of the project, GROUPE SANTE sold condoms only in these provinces, with some smaller sales in the West and Northwest. Now, PSI sells condoms directly in all provinces. Of course, each province has a different population size and, because of the purchase of product from Douala and Yaounde for eventual consumption in outlying provinces, it is not possible to provide accurate data on the provincial condom consumption per capita. Nevertheless, it would appear that the Littoral, Central, and Western Provinces use about one condom per capita per year, compared to the three northern provinces that use only about 0.2 condoms per capita per year.

By the end of 1997, the project will have given away approximately 1.7 million sample condoms out of the estimated cumulative sales of 50 million condoms. Giving sample condoms to the public is an important activity, especially in the early stages of a SM project, and continuing this activity through other NGO programs is a useful adjunct to media marketing.

In addition to its other sales, PSI has exported Prudence condoms to neighboring countries? mainly to Chad and Gabon. Now that PSI/Chad is operational and since the price of Prudence Plus condoms increased in Cameroon in 1997, some condoms have been imported from Chad to Cameroonian distributors in the Extreme North. Because of the continuing lower prices in Chad? presently 50 FCFA retail? these Chadian products are undercutting the Cameroonian product in some marketplaces. This selling of the Chadian product has caused some disturbance among the local PSI/CAM distributors, but it reflects the increasing market for Prudence condoms. If there was no demand for condoms, condoms would not be imported.

Sales of the OC Nouvelle have reached 43,000 cycles since launch. This is commented on in greater detail in Chapter 7.

Of the 500,000 sachets of Biosel donated by USAID, 21,000 were sold in 1994, 65,000 were sold in 1995, and 400,000 were used extensively by the MOPH in 1995 in regions affected by cholera. Since 1995, Biosel has not sold successfully because of an absence of funding and product (until recently), and like many other countries, because of the lack of real promotion of a commercial ORS product.

MSTOP, the STD kit, was only a test project. About 1,500 units were sold each year from 1993 to 1995. Funds for this were limited and the pharmacy lobby resisted the sale of an over-the-counter STD treatment kit.

#### 4.4 Distribution

Only four sales representatives cover the entire country for condom sales, and one person covers the pharmacy trade products, Nouvelle and Promesse. Because of long distances and poor roads between the outlying provinces, sales representatives visit only every two or three months. Therefore, the wholesalers, semi-wholesalers, and retailers in the trade systems are relied upon to maintain the supply of products to the provinces. Through the 26 regional wholesalers, with usually two or three in each major town, Cameroon has distributed condoms through approximately 10,000 retail distribution points.

In the absence of major funding to create consumer pull-through, there is a danger that the growing condom sales may plateau shortly. Therefore, PSI is conducting an experiment in the North with a detailer on commission only, who tries to encourage demand with product promotion to the trade and attempts to keep the trade stocked via transfer ordering from the wholesalers. Given the relatively low absolute margin and volume of sales compared to other products stocked by a sales outlet, creating demand is necessary for an individual semi-wholesaler or retailer. Otherwise, the trade "forgets" to reorder stock. Of course, consumers can continue to buy condoms, there is always a nearby source. However, the visibility and dynamism of the product may be lost.

Given the lack of sales resources, if and when the MVU is forthcoming, depots and offices may be opened up in the more inaccessible Northern and Northwest Provinces, with the potential addition of extra staff.

Availability of condoms varies somewhat by province, but in-store stock is generally good and on-street visibility is evident, especially in areas around bars and hotels. Particularly in the North, the product is more discreetly available, mainly because of religious and social sensitivities. Condoms are available in most market areas thus demonstrating the acceptance of the product by the public. In some pharmacies, there are packets of out-of-stock Promesse and Nouvelle, but this is mainly due to the poor ordering systems of the pharmacist through the wholesaler, rather than to PSI's sales ability. The presence of out-of-stock product in pharmacies is a common problem in Francophone markets where the margin for SM products is generally lower than in commercial competition, and pharmacists are slow to actively recommend and promote SM products over other products.

Stores seldom have display materials other than some older stickers, calendars, and occasionally a poster. Posters are seen more in health centers and public health offices. With the distribution of condoms being heavily weighted to street vendors and market stalls, the absence of display material is natural. However, in bars and other closed points-of-sale, product displays could be better.



## 5. BEHAVIOR CHANGE

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In Cameroon, remarkably little good national-level information exists to indicate the changes in knowledge and behavior among the general population. The last Demographic and Health Survey (DHS) was conducted in 1991. A second, survey is planned for 1998 but is currently delayed. AIDSCAP/PSI reports have yielded some sound data, but these data are restricted to high-risk groups, namely students, prostitutes, and the armed services. In addition, some research data can be extracted from PSI project reports.

### 5.1 Demographic and Health Survey

This survey mainly deals with contraceptive use for family planning purposes and is reported on in Chapter 7.

### 5.2 High-Risk Groups

As part of the AIDSCAP program, research was undertaken with three high-risk groups: prostitutes and their clients, students, and the armed services. Quantitative studies were conducted in 1993 and again in 1996 to measure behavior change in the target groups that followed programmed activity under both AIDSCAP and PSI, along with other NGO programs such as those of the Cooperative for Assistance and Relief Everywhere (CARE) in the East province and Save the Children in the Far North province. The NAC was also active in the high-risk group program. GTZ and WHO were active in sentinel surveillance, development of national STD guidelines, and peer education. Also, where relevant, complementary data was extracted from research conducted by PSI in 1992 and 1993 and from a knowledge, attitudes, and practices study (KAP) conducted in the Nylon District of Douala by the MOPH. In some instances, the formal AIDSCAP research did not always provide comparative data from the base study.

#### 5.2.1 Knowledge of AIDS

Table 19 shows the results of AIDSCAP's 1993 and 1996 studies and its Nylon KAP study. In all of the studies, most people in the high-risk groups had heard of AIDS. At 80 percent to 88 percent, the most commonly known method of avoiding AIDS was use of a condom. High-risk groups also cited fidelity and avoiding the use of nonsterile syringes as methods of avoiding AIDS. Overall, the students were better informed and knowledge of at least two methods of preventing contraction of AIDS has grown significantly in most groups. The general population, reflected by the Nylon study, were not as well informed, apart from knowledge of condom use. Nevertheless, even after years of AIDS campaigns, most groups still gave one or more false responses: most commonly, being bitten by mosquitoes or sharing food from the same plate with

an AIDS carrier.

**Table 19**

**Percentage Noting a Method of Preventing AIDS by Group, 1993 and 1996**

	Prostitutes		Clients		Male Students		Female Students		Armed Forces	Nylon
	1993	1996	1993	1996	1993	1996	1993	1996	1996	1996
Use condom		82		80		85		86	85	88
Fidelity		72		76		84		86	87	63
Abstinence		43		44		62		50	n/a	34
Syringes		80		83		95		95	88	34
Know 2+ methods	40	86	50	86	79	95	84	96	90	38
False response	27			27		15		17	23	28

**5.2.2 Condom Use**

As shown in Table 20, condom use has increased consistently in all high-risk groups, particularly among prostitutes and their clients, and among female students. Condom use by male students has hardly changed and consistent use has yet to be achieved. Use by armed service personnel is at slightly lower levels than those of the other groups.

**Table 20****People Who Have Ever Used a Condom (%)**

Year	Prostitutes	Clients	Students (M)	Students (F)	Armed Forces	Rural
1988	28					
1990	56	56	77	23		
1991	89				44	6
1993	68	68	85	65	66	
1996	88	81	86	85	74	

As shown in Tables 20 and 21, the use of condoms during the last occasion of sexual contact has grown for clients of prostitutes and female students. Condom use in other groups has not changed much and use among prostitutes and armed forces personnel is at noticeably lower levels. Thus, the message seems to have been recognized by high-risk groups, but other groups are still not using condoms. Sometimes, prostitutes are in situations where they cannot insist on condom use and the armed forces continue in their risky behavior.

**Table 21****Condom Used Last Time with Non-regular Partner (%)**

Year	Prostitutes	Clients	Students (M)	Students (F)	Armed Forces (Occ)	Armed Forces (Prost)
1993	69	75	75	63	66	70
1996	69	97	70	77	74	72

As shown in Table 22, condoms are not frequently used with a regular partner, usually because of "trust" in the partner or because of reticence in asking a partner to use a condom for social reasons. On the other hand, particularly among male students and the armed forces, condom use with prostitutes is quite high. Nevertheless, some clients of prostitutes continue to take risks and students in general do not consistently use a condom with occasional partners.

**Table 22****Condom Use by Type of Partner (%)**

Type of Partner	Prostitutes		Clients		Students (M)		Students (F)		Armed Forces
	Always	Never	Always	Never	Always	Never	Always	Never	Last time
Regular	13	56	12	63	26	37	22	38	17
Occasional	75	19	n/a	n/a	59	7	6	11	45
Prostitute	n/a	n/a	63	32	77	9	n/a	n/a	72

Over the period of the AIDSCAP activity, claimed consistent use of condoms has increased from 52 percent to 75 percent among prostitutes, and consistent use has become more frequent but not consistent among students. Behavior has not changed substantially among prostitute clients or the military over the three-year period.

### 5.2.3 Number of Partners

Because of the nature of their work, prostitutes have multiple partners, an average of 5.8 partners in the last three months. Perhaps not surprisingly, their clients are also promiscuous, having a similarly high number of sexual partners. Many members of each group have more than three partners. The members of the armed forces also have a high number of sexual partners; students are much more circumspect.

**Table 23**

**Number of Partners in the Last Three Months (%)**

Number of Partners in Three Months	Prostitutes	Clients	Students (m)		Students (f)		Armed Forces	
	1996	1996	1993	1996	1993	1996	1993	1996
0	1	1	17	26	23	29	4	7
1	9	13	30	36	64	54	25	28
2	12	14	27	19	14	14	24	27
3+	78	72	25	17	-	3	47	37
Average	5.8	5.8	2.0	1.6	0.9	0.9	3.2	2.7

In the three years of the program, the reported average number of partners for prostitutes has fallen from over 12 to just under 6, although it is unclear whether this is because less professional women are turning to occasional prostitution, the economy has worsened, or there has been a real change in behavior. The average number of partners for the prostitutes' clients has increased from five to six partners; in other groups, the average number has decreased slightly. Although armed forces personnel appear to have reduced the number of occasional partners, the number of personnel using prostitutes has increased.

#### 5.2.4 Sexually Transmitted Diseases

As shown in Table 24, among prostitutes and their clients the percentage of people who have ever had an STD has decreased over the last four years. Similarly, the people who have had an STD episode in the last three months has decreased. For students, the percentage of male students having an STD has decreased, whereas the percentage of female students has increased. These changes are mainly due to the peer education on STD and to better recognition and reporting of the affliction among women students. In 1997 the incidence was underreported.

**Table 24****Incidence of Sexually Transmitted Diseases (%) in High-Risk Groups**

Incidence of STDs	Prostitutes			Clients			Students (M)		Students (F)		Armed Forces
	1992	1993	1996	1992	1993	1996	1993	1996	1993	1996	1996
Ever had STD	53	37	33	77	69	62	42	29	10	30	72
Had STD in three months	13	10	7	34	12	9		4		5	12

Compared to the other groups and particularly to prostitutes, the very high incidence of STDs among armed forces personnel and the clients of prostitutes continues. It is believed that prostitutes at least take some action to protect themselves by using condoms regularly, but the other two groups, which are predominantly male, maintain their risky behavior although they know of the risks they are taking.

Among high-risk groups, the access to treatment for STDs is good and has apparently improved over time. From 1992 to 1996, use of treatment among prostitutes went from 34 percent to 86 percent, and for clients from 65 percent to 84 percent. These groups mainly use doctors and hospital clinics. There is now better access to these treatment centers than previously, when self-treatment was more likely. The armed services have always had better access to facilities and the only change here is between the doctor or infirmary to the hospital or clinic.

As indicated in Table 25, 30 to 40 percent of prostitutes, their clients, and all students do not report their STDs to anyone. Although there has been little change in the percentage of people with an STD who do not notify anyone, the percentage of students and armed forces personnel who notify all their partners, rather than being selective, has increased. This increase may be associated with the slight reduction in number of partners in some groups, which enables individuals to more easily identify the partner or partners involved.

**Table 25****Notification of STDs to Partners (%) in High-Risk Groups**

Notification of Partner	Prostitutes		Clients		Students (M)		Students (F)		Armed Forces	
	1994	1996	1994	1996	1993	1996	1993	1996	1994	1996
Notified all partners	44	39	43	42	34	53	39	78	49	60
Not notify anybody	33	34	39	39	n/a	33	n/a	17	24	22



## 6. CAMEROON COMPARED TO OTHER COUNTRIES

### 6.1 Condom Sales

Table 26 shows the number of condoms sold into the trade by SM programs in various West and Central African markets since 1989. In all cases, the programs are run by PSI.

**Table 26**

#### Numbers of Condoms Sold by Social Marketing Programs (Thousands)

Market	Year								
	1989	1990	1991	1992	1993	1994	1995	1996	1997*
Nigeria		1,132	1,876	7,051	23,614	45,243	55,654	34,185	30,000
Cote d'Ivoire			1,828	6,420	5,974	8,929	10,806	12,400	15,400
Cameroon	736	1,990	3,194	5,111	5,756	7,205	7,337	9,254	10,500
Burkina Faso			2,789	2,266	3,237	5,171	6,583	7,570	10,000
CAR					1,381	1,892	2,392	2,000	1,500
Chad								779	3,200

\* = Estimated

Apart from Nigeria and the CAR, both of which peaked in 1995 but have since declined, other Central and West African markets have continued to develop and sell more condoms each year. PSI's three main markets of Cote d'Ivoire, Burkina Faso, and Cameroon have sold an average of 20 percent more condoms per year in each of the last 2 years, although each of the markets has a totally different type of marketing program. Chad has only just started its program and, as previously mentioned, some of the sales attributed to that market have been sold into Cameroon.

## 6.2 Condoms per Capita

**Table 27**

**Condoms Per Capita Sold by Social Marketing Programs**

Market	Year								
	1989	1990	1991	1992	1993	1994	1995	1996	1997*
Cote d'Ivoire			0.15	0.50	0.44	0.62	0.72	0.84	0.98
Burkina Faso			0.30	0.48	0.33	0.51	0.68	0.71	0.91
Cameroon	0.07	0.17	0.27	0.42	0.45	0.55	0.54	0.68	0.75
CAR					0.46	0.61	0.75	0.61	0.44
Chad								0.12	0.48
Nigeria		0.01	0.02	0.09	0.28	0.51	0.61	0.33	0.30

\* = Estimated

Because of the different size populations in the program countries, condoms sold per capita is a better measure of the success of the programs than absolute number of condoms sold. For Cote d'Ivoire, the number of condoms sold continues to increase and this year may break the one condom per capita barrier. Sales for Burkina Faso are not far behind at an estimated 0.91 condoms per capita for the current year. Apart from the programs in Bangladesh and Botswana, no other PSI programs have broken the one condom per capita barrier.

In the Cameroonian program, the number of condom sales has grown steadily, but this program has not had the continuous financial support of the other two programs in Cote d'Ivoire and Burkina Faso, nor has it had the advantage of high media exposure from the SM program itself or from the public sector. As previously mentioned, the HIV/AIDS public sector program in Cameroon has been weak; therefore, the PSI/CAM program can be regarded as having been relatively successful under the circumstances. The other two markets do show, however, what can be achieved with both financial and public support.



## 7. FAMILY PLANNING

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## **7.1 Family Planning Background**

In the 1980's family planning services were available primarily in Yaounde and Douala and modern contraceptives were prescribed only to multiparity women who were at risk of maternal mortality. Cameroon was a rigid pronatalist state with an official policy prohibiting the sale of contraceptives through the anticonceptional publicity law (Law 29/69 of May 20, 1969). Attempts to assist the government in drafting a national population policy were met with strong opposition by government officials and the population, especially men. Without supportive policies, women were fearful of seeking family planning services, and public and private health providers were reluctant to provide them.

During the 1978 National Fertility Survey, contraceptive prevalence rates for modern methods was at 2 percent and by the 1991 Demographic Health Survey, the rate had increased only to 4 percent. The proportion of married women knowing of a modern contraceptive method increased from 29 percent to 63 percent between the two surveys. The DHS found that 12 percent of women were using traditional family planning methods. Moreover, the DHS found that 22 percent of nonusers had a need for modern methods and 16 percent of users lacked regular sources of provisions in both rural and urban zones. The process of meeting this unmet need began in 1990 with the opening of 25 high-risk clinics at the maternity units at provincial hospitals and at maternal child care units in Yaounde and Douala.

By 1994, when USAID/Cameroon closed, modern contraceptive prevalence had increased from 4 percent in 1991 to an estimated 16 percent. This increase in use of modern contraception was attributed to the expansion of services to rural and urban health facilities in all 10 provinces. At that time, there were 305 health facilities providing family planning services. Of this amount, 200 were PHC public health facilities, 51 were public none primary health care; and the remaining 48 facilities were within the confessional sector. Couple years of protection increased from 30,000 in 1990 to 90,000 in 1993. Today, because of the lack of supervision and coordination at the central level, the number of sites is unknown. In addition, contraceptive rates and the number of couple years of protection (CYP) are not known.

## **7.2 Family Planning Policies**

Because of the effects of the economic crises, a National Population Policy was drafted in 1990 and was finally adopted in 1992. It is a broad-based document that addresses trends in fertility, mortality, migration, the status of women, youth, and educational opportunities. The policy authorizes the development of specific policies and program activities to reduce high infant and maternal mortality rates. Maternal child health/family planning policies were drafted by public and private sector health providers in 1990, received their final review from the MCH/FP technical committee in 1991, and were approved by the Minister of Health in August 1992. This was the first accomplishment of the Directorate of Family and Mental Health, which was created in 1989 to develop national policies, expand service delivery, and draft educational materials to dispel myths concerning modern contraception. By 1992, "Maternal and Child Health Care and Family Planning Policies and Standards," a practical guide booklet in English and French was published and widely disseminated to RPHC district team members responsible for maternal child health, as well as to non-RPHC sites, which were mainly urban-based PMIs and maternity sections at provincial hospitals. Health providers continue to refer to this document as their protection against husbands and family members who oppose the practice of family planning. This document requires revision to reflect changes in the national health system.

In the policy document, family planning is defined as an integral part of MCH that aims to improve the health and well-being of mothers and children to reduce maternal and infant mortality and morbidity. The MCH policy includes six primary service components ranging from preconception, prenatal, pregnancy, postpartum, juvenile, and adolescent care. The three FP service components are contraception, infertility prevention and STD/AIDS, and IEC/FP Family Life Education.

Specific MCH and FP policies define the reason for the delivery of services, the beneficiaries of these services, the service providers, levels of services provided, and the frequency and conditions of each service. The standards define the type of services provided, the minimum level of performance for each are service level within the context of the RPHC, and the qualitative and quantitative elements required for level of service provision.

In addition to the policy document, a separate Family Planning Service Protocol was disseminated at the same time. The protocol standardizes methods and procedures for delivering and supervising family planning activities. The protocol document provides health providers with step-by-step guidelines on how to conduct IEC/FP services, including discussions on contraception, STDs and AIDS, infertility, and referral systems. A Maternal Health Service Protocol has not been drafted. For this reason, prenatal exams are not standardized across the country. In some clinics, STDs/AIDS testing occurs systematically, in others it does not. At the District Hospital of Nylon in Douala, 45 percent of prenatal patients test positive with syphilis. At most other sites, STD/AIDS tests are not systematic unless clinical signs are evident.

### **7.3 Cameroon versus Other Population Service International Markets**

Since the launch of OC products in PSI's program in Cameroon, 43,000 cycles have been sold, the equivalent of about 4,000 CYPs. By comparison, in Cote d'Ivoire, where OCs were launched in 1996, some 2,500 CYPs have been sold, although many of these will have been sold into the trade. In Guinea where there is coordination with the public sector, some 5,000 CYPs have been sold. Thus, although PSI/CAM has sold an OC product for longer than the other two markets, the sales generated have not met expectations.

This has been due to stock blockages, but also to the restriction of OC sales through the pharmacy trade. As noted, it is possible to obtain OCs from pharmacies without a prescription, but the pharmacist dispenses the brand prescribed on the physician's prescription, sells whatever brand the woman was first prescribed, or, because of the desire for a greater profit margin, sells one of the commercial brands rather than the SM brand.

The major restriction to Novelle's success was the lack of involvement of the MOPH at the planning and agreement stage to support a socially marketed OC. This lack of involvement led to lack of positive promotion by the pharmacists with their vested interests, and lack of publicity to the general female population who were used to obtaining supplies at the health centers.



## 8. OTHER PRODUCTS

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## **8.1 Sexually Transmitted Disease Kit**

This was an innovative pilot study, originally designed by PSI for their Zaire market. A kit was developed, which included antibiotics, condoms, and a partner notification leaflet, all contained in a presentation sachet. Initial research showed a worthwhile consumer interest for the project to continue beyond the conceptual stage.

Considerable assistance was given by two pharmaceutical companies who provided printing and packaging, and a brochure, which unfortunately for the mainly illiterate local population, was printed in French. The NAC approved the concept but the MOPH did not accept the proposition of syndromic management at that time. Subsequently, this became a major drawback. With no firm policy on STDs in Cameroon, there were inevitably complications with the activity, which ultimately led to its cessation.

Trials were conducted in an STD clinic in Douala and one in Yaounde. Distribution was subsequently expanded to a pharmacy in Douala and one in Yaounde, along with distribution to the military and universities. However, public sale was never authorized by the MOPH because of the pharmaceutical lobby and the government view that antibiotics issued, even under a SM project, were classed as drugs, and therefore prohibited. The reaction by certain MOPH personnel was such that they cited arguments that the STD kit, as presented, resembled a "gift" and as such should be discouraged; they also complained that the kit was "designed in Washington," so there was little local ownership of the activity.

Subsequent research showed that the product was almost universally accepted by consumers, 98 percent were satisfied with the kit. However, the activity failed due to lack of involvement of the appropriate MOPH decision makers from the outset. PSI believes that the medical culture of the time thought that, on medical matters, it knew more than a commercial SM company. Better involvement of the MOPH would have led to the medical authorities adopting the activity as their own and giving it the appropriate support.

## **8.2 Oral Rehydration Salts**

As in the case of the STD kit, poor communication with the MOPH when the Biosel product was launched hampered its development. Initially when Biosel was launched, the MOPH viewed ORS as a pharmaceutical prescription product and did not approve its open sale in the marketplace. Although it was well recognized that ORS was a useful treatment for rehydration and could, indeed, be distributed by the MOPH in times of emergency, sanction for its sale on the open market by PSI was not given. This inevitably inhibited the product's SM potential.

Small sales were made through pharmacy outlets, which did not push the product, and a large amount of originally donated stock was made available to the MOPH during a cholera crisis. By 1995, Biosel was out of stock. UNICEF promised to donate 300,000 units but, at the time of this case study, the units had not been delivered.

Under the auspices of the USAID Family Health and AIDS Regional Project an ORASEL activity has been developed. This activity aims to develop a regional brand of ORS and is targeted at Ivory Coast, Burkina Faso, and Togo. In addition, it was proposed that Cameroon take part in this activity but, at the time of the case study, no agreement had yet been reached for Cameroon's participation. It was suggested that Cameroon might take part in this project with a launch in March/April 1998, provided that some of the original objections to Biosel had been overcome and that, in the light of the recently developed accord with the MOPH, ORS was more readily accepted as a health product rather than a pharmaceutical one.

## **9. OTHER ORGANIZATIONS**

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Various organizations other than PSI have been working in Cameroon in the HIV/AIDS and FP areas. At present, these organizations are very much regionalized; specific organizations work in a particular province. In recent years, many small NGOs that work in different areas of development have come into existence. To work in Cameroon, an NGO must be approved and registered with the GOC. Others who have tried to register with the GOC have not yet received approval mainly due to bureaucratic delays. To avoid mismanagement of funds, donors are now less likely to provide funding unless GOC approval has been given to the NGO.

### **9.1 The Ministry of Public Health and Its Relationship with Nongovernmental Organizations**

On December 19, 1990, the National Assembly passed Law No. 90/053 giving Cameroonians the right to associate freely or to form political parties and nongovernmental organizations. Later, with several NGOs registering at Prefectures across the country, the Prime Minister, in an August 7, 1993 letter requested that each ministry define how it would collaborate with NGOs working in its sector. In response, the MOPH organized a WHO-funded, two-day seminar in September of that year to define its methods of collaboration with NGOs. In circular letter No. 136 of April 2, 1997, the MOPH finally released the necessary registration procedures. The MOPH reserves the right to accept or reject applications submitted from NGOs. However, NGOs also have the right to an answer regarding their status. Several NGOs listed in the following section have submitted their applications and have not received a response from the MOPH. It is acknowledged that some groups may lack experience in implementing health care development projects. The MOPH should establish criteria for classifying NGOs, such as whether the NGO has an office or whether personnel have experience in working with the MOPH as well as with the international donor community.

### **9.2 Nongovernmental Organizations**

#### **9.2.1 The Society of Women and AIDs in Africa**

The Society of Women and AIDs in Africa (L'Association des Femmes d'Afrique Face au SIDA [SWAA]) is a Pan-African NGO founded in 1990, with chapters in 20 African countries. Its objective is to educate women and girls on the causes and effects of AIDS within an African context. SWAA/Cameroon launched its activities in 1991 in Douala, which has become the national headquarters. SWAA has representatives in the following provinces: East, Northwest, South, and Central.

In 1992, SWAA received donor support to renovate a section of the Littoral Provincial Hospital of Laquintinie. The SWAA developed a "Pavillion AIDES," which was initially staffed with a volunteer and has since expanded to five permanent employees including one person with AIDS. Other staff include a nurse, two counselors, and a secretary. A team of private volunteer doctors receives people with AIDS who have been referred from SWAA clinics.

SWAA is one of the few NGOs providing visible, reliable IEC and services to reduce the spread of AIDS in Cameroon. Its activities include conducting IEC sessions at the pavilion, training grassroots women leaders to present and conduct STD/AIDS sessions, providing medical services to persons with AIDS, and counseling the families of persons with AIDS.

IEC activities held at the pavilion's documentation center are designed to remove the mystery of AIDS and provide concrete evidence of the existence of AIDS in the world and in Cameroon. These IEC activities include videos of people infected with AIDS, slide shows of clinical signs of infection, question and answer periods, and role playing. Preventive measures, such as the use of condoms, are stressed in the sessions. In addition, SWAA assists in numerous talk show debates.

Women associations, "tontines," and IEC sessions focus attention on STD consultations and sexual hygiene. Significant emphasis is placed on the dangers of traditional practices that spread AIDS, such as using razor blades more than once, piercing ears with nonsterilized needles, and patronizing mobile barbers and manicurists. Early marriages, widowhood practices, and traditional sexual practices are also discussed. Women's group leaders attend a three-day training session on how to present and discuss STD/AIDS. At the end of their training, they receive a photo album of persons infected with STD/AIDS, a model penis, condoms, and IEC materials such as flyers and stickers (from PSI). Last year, the women led 20 sessions under the supervision of a SWAA member and contacted 1,400 people (526 men and 874 women).

In addition to the documentation center, the pavilion includes a room for private consultations, a pharmacy where donated medicines are distributed, a secretariat, and a room with one bed for daily care of AIDS patients.

SWAA receives regular requests from high school and university students to conduct discussions in sex education, information about their bodies, and family planning methods. SWAA has found that young people are particularly interested in understanding the real causes and effects of AIDS. SWAA conducted 37 IEC sessions in 1996, the majority of which were for young people. These sessions reached 2,060 persons. Young people are also trained to conduct IEC sessions to share in their villages during the academic vacation.

Additionally, SWAA attends international conferences and participates in annual festivals for "Fete de la Jeunesse," "Fete de la Femme," Cameroonian AIDS Day, and the International AIDS Day.

SWAA receives donations from its members and financial support from the following sources: the International Women's Health Coalition, which provides IEC training for tontines and the documentation center; the French Cooperation, which provides medicines for seropositive patients; and the Women's Club, which tracks AIDS patients.

In comparing number of pavilion visitors to the number of visitors versus the number of actual registered AIDS patients, Table 28 confirms that the general population, the group not generally targeted by donors, desires accurate information on AIDS from reliable sources. Rumors and misinformation about AIDS transmission is widespread among the general population and some health providers.

**Table 28**

**Visitors and HIV/AIDS Persons Registered at SWAA**

Year	Visitors	Registered AIDS Patients
1993	340	43
1994	405	32
1995	596	66
1996	1,500	120
Jan to mid-July 1997	1,505	109

SWAA is considered to be an active, efficient NGO that provides concrete services to reduce the spread of AIDS in Cameroon. A significant percentage of its members are doctors and nurses working in the health field.

### 9.2.2 The Association of Single Brothers and Sisters

The Association of Single Brothers and Sisters (Association des Soeurs et Freres Uniques [AFSU]) is a small support group for HIV-infected persons. This group provides moral support and counseling to persons with HIV and their families. Under the guidance of SWAA, some members of AFSU agree to conduct radio and television interviews to dispel myths related to the transmission of AIDS and life with AIDS. Members of AFSU struggle to integrate themselves into a society that discriminates against them. For this reason, the majority of the members remain anonymous.

### 9.2.3 African Women and Progress

The African Women and Progress organization (Africaines Femmes et Progres [FEP]) was established in 1991 in Maroua as a nonprofit and apolitical group with the objective of improving the living conditions of the underprivileged population. This organization targets women in semirural and rural areas and young people, and advises women of their right to speak up. In the area of health, FEP has developed simple IEC booklets that are given to students to share in their villages. The health messages are on AIDS/STD/FP, hygiene, and water sanitation. FEP has 58 groups in three different rural areas around Maroua.

### 9.2.4 Cameroon National Association for Family Welfare

The Cameroon National Association for Family Welfare ("Cameroon Association pour la Bien-etre Familiale" [CAMNAFAW]) was created in 1987 and opened offices in 1990 as a chapter of International Planned Parenthood Federation. This organization operates active reproductive health clinics in Yaounde and Bamenda, where it provides family planning services including infertility treatment. Since 1992, CAMNAFAW has focused on health education for youth by developing youth leaders. Youth centers exist in Yaounde, Douala, and Bamenda where weekly IEC sessions address young people on topics, such as family planning, responsible parenthood, and AIDS/STD. CAMNAFAW has established a reputation for being approachable and friendly and for providing individual attention to young people.

### 9.2.5 Cameroon Health Project

The Cameroon Health Project (CHP) is an NGO created in 1996 by former Cameroonian employees of FHI/AIDSCAP to carry on AIDS/STD activities. CHP staff have expertise in managing HIV/AIDS control and prevention programs, and technical skills in the areas of training, research in behavior change communication, NGO capacity building, monitoring, and supervision. CHP continues to conduct IEC sessions among military personnel and to coordinate terminating and upcoming projects for Family Health International in Cameroon. CHP recently terminated a Letter of Agreement (LOA) with AIDSCAP to monitor AIDSCAP-funded projects

in Cameroon. The LOA ended in July and now the NGO anticipates obtaining financial support from international donors to continue IEC activities among high-risk groups, such as military personnel, prostitutes, university students, and young people not attending school. Opportunities are being sought with the MOPH, UNAIDS, WHO, GTZ, and others. CHP's employees act as consultants to other NGOs, such as CARE, monitoring their AIDS prevention program among long-distance truck drivers. This dynamic group of experienced project managers is committed to reducing the spread of HIV infections in Cameroon.

#### 9.2.6 Cooperative for Assistance and Relief Everywhere

CARE, an internationally known, U.S.-based private voluntary organization (PVO) with offices around the world, has been conducting HIV/AIDS prevention and research projects in Africa and Asia since 1989. CARE/Cameroon implements projects in the Extreme North and East Provinces. In the Extreme North, CARE has an office in Mokolo, where it operates AIDS/STD education projects. In the East Province, CARE receives funds from AIDSCAP (USAID-funded) and CARE/London to carry out rural development and HIV/AIDS prevention. CARE has been implementing projects in Cameroon's Eastern Province since 1978. CARE's rural development activities focus on well construction and maintenance.

CARE recently terminated an AIDSCAP-funded, three-year peer health education project to influence youth in the Eastern Province to adopt low-risk behavior. For those youth in schools, approximately 40 teachers from 37 secondary and technical schools were trained as trainers and supervisors of 240 in-school peer health educators. For out-of-school youth, 40 community animatrices from the departments of agriculture, social affairs, youth, and sports were trained as trainers and supervisors of 400 out-of-school peer health educators. The educators conducted IEC sessions in neighborhoods where youth were found. They provided IEC materials on STD/HIV transmission and explained the importance of visits to health centers. In collaboration with the MOPH and PSI, educators stressed prevention through use of condoms. In the East Province, CARE has focused on truck drivers and child prostitutes. Because of limited funding, CARE anticipates closing its East Province office by the end of 1997.

#### 9.2.7 Women, Health, and Development

Women, Health, and Development (Femme, Sante, et le Developpement [FESADE]) an NGO established in 1993, continues activities that started under the Canadian Development project, "Femme et Sante." The project was implemented from 1990 to 1995 by the Institut Pan-Africain pour le Developpement (IPAD) in Douala. At the end of the project, the Canadian agency transferred the equipment and furniture to FESADE's Yaounde office. With an experienced three-person staff, the NGO carries out training, IEC for parents and girls, and research. These activities are based on findings from operations research studies conducted during the

development project. Its objectives are to improve the health of women so that they can participate in the development of Cameroon. The NGO's specific health objectives are (1) to increase the contraceptive prevalence from 4 to 9 percent within five years in the zones where it is working, (2) to increase use of condoms by 25 percent within five years, and (3) to reduce STD/AIDS and undesirable pregnancies. FESADE is receiving support from USAID's Family Health and AIDS Regional Project to meet these objectives.

FESADE studies found that Cameroonian parents lack approaches to discussing sex education with their children, especially adolescent girls. In an effort to provide approaches and reduce teenage pregnancy, FESADE has developed user-friendly booklets for parents. Teenage girls are recruited to serve as youth leaders and create clubs at their schools. FESADE's major accomplishment is the drafting and publishing of a sex education curriculum for teachers. The 14 modules of the curriculum were recently approved by the Minister of Education and will be integrated into the secondary teachers' curriculum.

FESADE is an energetic organization that prefers using traditional communication structures such as tontines. It has a bank of 400 tontines located in the Central, West, and Littoral Provinces.

#### 9.2.8 Institute for Research and the Study of Human Behavior

The Institute for Research and the Study of Human Behavior ("L'Institut des Recherche et des Etudes de Comportement Humaine" [IRESCO]) is an NGO created in 1993 by a multidisciplinary research team, including former PSI employees. Its principal objective is to conduct social science and human behavior research. This young group of scholars collaborate with government and private sector organizations to plan, monitor, and evaluate development projects; identify socioeconomic indicators for marketing of products; develop and distribute IEC materials; and conduct training sessions, opinion polls, and operations research. IRESCO has successfully collaborated with several major national and international organizations. It is currently implementing the pilot phase of a health education project for adolescents in N'Kongsamba in the Littoral Province. Its AIDS/STD/FP project is funded by Tulane University through USAID's Regional Family Health and AIDS Prevention Project. The group is being considered to conduct the fieldwork for the upcoming Cameroon Demographic and Health Survey.

#### 9.2.9 "Caution AIDS"

As the oldest advocate of HIV/AIDS awareness in Cameroon, "Caution AIDS" (SIDALERT) was created to sensitize the general population on the importance of changing their sexual behavior. With offices in Yaounde and Douala, this organization distributes AIDS/STD education handouts

and was the first to provide services to HIV-infected people. The offices also counsel family members to accept AIDS orphans. It is testing strategies to provide seed capital for people with AIDS to start small businesses.

#### 9.2.10 Commercial Sex Workers

Commercial Sex Workers (CSW) were organized as a group by AIDSTECH and AIDSCAP. This organization is not registered as an NGO. The project was operational from 1989 to 1996.

Between 1989 and 1991, 80 CSW peer educators were trained in Yaounde and Douala to conduct IEC sessions on STD/AIDS transmission and infection and to promote safe sex through use of condoms. CSW swiftly became a dynamic force in providing accurate information to prostitutes by holding informative IEC sessions at antivenereal clinics, organizing STD/AIDS awareness campaigns, and producing lively, spellbinding productions through its theatrical troupe. Between the complementary activities of PSI's condom social marketing and CSW's IEC activities, the demand for condoms increased. Although it is believed that social change in sexual behavior is slow in most societies, the impact of CSW's IEC activities is evident. CSW sold 1.1 million of PSI's condoms.

Between 1992 and 1994, the activities of 164 CSW peer educators expanded to include the towns of Ebolowa, Kribi, Bertoua, Garoua, and Maroua. Condom sales continued to rise to 2.2 million. With the proceeds earned from the sale of PSI's condoms, some of the CSW members earned enough seed money to open small businesses. One of the CSW leaders earned enough to open "Prudence Bar" (named after PSI's condoms) in Yaounde. Although AIDSCAP activities have terminated, the bar continues to display IEC posters with AIDS/STD messages. Another CSW has a thriving dressmaking kiosk in a popular market. Others prepare food to sell daily. This type of occupational change shows the impact of knowledge in changing lifestyles.

For their clients, signs in behavior change are also reported. According to the CSWs, men now bring their own condoms when they visit them. Another impact of sensitizing men is that they are practicing less risky sex with the CSWs. The cost of sexual relations has decreased from 5,000 to 1,000 FCFA with a condom and from 10,000 FCFA to 5,000 FCFA without a condom. However, it is still possible to buy the services of a prostitute for 200 to 500 FCFA. Now, most of the experienced CSWs refuse to engage in unprotected sex, especially at the reduced rates. With this decline, most of the CSWs now invest their time in other income-generating activities.

Another important behavior change is that some men prefer to seek "safe" sex with women who are not classified as CSWs, but are women they "know." These women are described as married women whose husbands are unemployed, unemployed secretaries or office workers who have received salary cuts, university students, and single women with children from unwanted pregnancies. As the economic condition in Cameroon has declined, more women have become "closet CSWs" just to pay household expenses.

Experienced CSWs argue that these unofficial CSWs are unaware of the necessity of protecting themselves and their clients from STD/AIDS. Under AIDSCAP, the unofficial group of CSWs was so large that they ordered several hundred cartons of condoms, and to encourage the use of condoms, PSI gave the group 2 free cartons for every 50 ordered. The free condoms were given to new CSWs to initiate them in the importance of protecting themselves and their clients. Without the experienced CSWs to guide them or any mass media to remind the general population and particularly unofficial CSWs of their risky behavior, Cameroon is in danger of losing the gains it has made with CSWs under the AIDSCAP program.

Between 1995 and 1996, the CSWs in Yaounde and Douala participated in a study to assess whether vaginal contraceptive film with nonoxynol-9 could protect women against HIV/STD infections. The conclusions were that the film does not present any danger to women and is as safe as a contraceptive, but it does not provide any additional protection against HIV/STD. During the study, CSWs received regular examinations to control HIV/STD. They were required to monitor when clients used or did not use condoms. Professional CSWs believe that because they are more conscious of the need to use condoms, the GOC should institute a program to encourage regular check-ups at reduced rates.

Because the AIDSCAP and FHI projects have ended, the CSW in Yaounde is now a small group of only 10 people who are committed to disseminating accurate IEC sessions at health facilities. They explained that they have the time to conduct IEC messages, but often lack funds for transportation. Transportation was provided by the AIDSCAP project to get to the health facilities to carry out the IEC sessions. Of the 10 remaining CSWs, only about 5 still sell condoms today, usually selling between two and five dispensers of Prudence per day, or 96 to 240 condoms.

### **9.3 Religious Health Facilities**

Religious health facilities play a crucial role in providing health care services in Cameroon's semi-urban and rural zones. They include Federation des Eglises et Missions Evangeliques du Cameroun (FEMEC), Catholic Mission Health Services, and Ad Lucem.

#### **9.3.1 Federation des Eglises et Missions Evangeliques du Cameroun**

FEMEC, an organization of all the Protestant churches in Cameroon, operates a total of 137 member health facilities throughout the country, including 25 hospitals ranging in size from 40 to 250 beds. Satellite clinics, classified into developed and elementary categories, are the equivalent of health centers. Developed clinics have at least four health providers with one bed, and elementary clinics have two health providers. The elementary clinics are often located in zones

where government health facilities do not exist or government sites are understaffed and underequipped. FEMEC referral hospitals have experienced expatriate medical specialists from Europe and America. For this reason, Bansa Baptist Hospital attracts people with HIV from Cameroon and neighboring countries. FEMEC's drug distribution and supervision system is well organized. An experienced national administrator of health services is based in Douala and is responsible for collaborating with the MOPH and donor agencies. Although FEMEC operates independently of the MOPH, it collaborates with the government by submitting monthly reports on its health care activities.

Four of FEMEC's member hospitals will serve as reference hospitals in the RPHC strategy: Hopital de District at Elongal in Littoral Province, Hopital de District at Ngaoundere in Adamaoua Province, Hopital de District at Mamegin in Southwest Province, and a Hopital de District in the Far North Province. This year, FEMEC opened a new hospital in the Haute Sanaga in the Far North Province.

In early 1991, under the auspices of Family Health Initiatives II, a regional population project, USAID/Yaounde provided support to FEMEC to integrate family planning services into its health facilities. In October 1991, a symposium was held to sensitize influential church leaders to the concepts of modern family planning. Soon after, meetings were held with the secretary-general, representatives from member churches, and health providers to form a committee to prepare a proposal for integrating family planning activities into its health facilities.

From 1992 to 1994, the FEMEC benefited from input from the National Family Health Project, USAID's bilateral family planning project, in that FEMEC progressively increased its family planning sites from 0 to 43. This positive result was obtained by taking advantage of the input provided by the project including support for five-week comprehensive training sessions for doctors and nurses. At the end of these training sessions, trainees returned to their sites with medical standards and protocols, a stock of IEC materials, and an IUD insertion kit. Soon afterward, a stock of contraceptives arrived at the site permitting the trainees to use their newly acquired skills.

In February of 1994 in preparation for the June 1994 closing of USAID's Cameroon Mission, contraceptive supplies, IEC materials, spare parts for the Ford pick-up truck, and funds to support the private sector were discontinued. By early 1995, FP service sites began to experience stock outs of contraceptive supplies and were unable to procure spare parts for the truck. The quality of and access to family planning services decreased in all 43 family planning services sites assisted by the National Family Health Project. Although the truck is five years old and it has taken two years for FEMEC to procure parts, today it is in excellent running condition and looks new. Vehicle management systems established under the USAID project are still being executed.

In 1995, GTZ provided FEMEC with a small stock of contraceptives. Under the REDSO/WCA project, SFPS, FEMEC is receiving support for 17 of 43 family planning sites. These sites will

benefit from project-supported contraceptives. To avoid future stock outs and to provide drugs to nonproject-supported sites, FEMEC should seek to integrate family planning contraceptive supplies into their regular drug supply system. Contraceptives could be purchased from PSI at an affordable price.

FEMEC has always recognized the link between responsible child spacing, sexually transmitted diseases, and infertility. However, FEMEC did not perform routine screening for STDs until it introduced family planning activities into its facilities and resources were available through USAID-supported projects. Some rural health centers have the capability to perform laboratory tests to diagnose STDs. Four FEMEC hospitals have the laboratory equipment and trained personnel necessary to conduct HIV testing. These hospitals are Bansa Baptist Hospital in the Northwest Province; Hopital Protestant de Ngaoundere in Adamaoua Province; Djoungolo Hospital in Yaounde, Centre Province; and Bonanjo in Douala, Littoral Province. These hospitals could play a larger role in the control of AIDS/STD by serving as reference hospitals for tracing and treatment of sexual contacts, providing health education to patients and church members, counseling seropositive patients, and providing clinical treatment of AID/STD patients. An increase in collaboration with PSI for non-project-supported sites could increase the sale and distribution of condoms and OCs in rural areas.

### 9.3.2 Catholic Missionary Health Services

The Catholic Missionary Health Services operates 182 health facilities? 8 hospitals and 174 health centers? in Cameroon. Similar to FEMEC, their sites are located in semi-urban and rural areas. Catholic facilities are participating in the RPHC strategy.

The Catholic Mission's health facilities adhere to the Sacred Congregation for Catholic Education, which teaches that "sex is permitted only within a marriage." Married couples are urged to remain faithful to each other and to use a natural FP method, which has achieved considerable success in Cameroon especially among women who attempt to have male babies. Unmarried people are told to practice total abstinence until they are married. The Catholic Mission has been a strong opponent of modern FP practices in the Northwest Province and has created some problems for PSI. These problems have been resolved and, although the Catholic Mission adheres to its principles, it is no longer obstructing the sale and promotion of condoms in public places.

According to discussions with health staff at the Centre Jean XXIII at Mvolye in Yaounde, there are two tendencies regarding the use of condoms; conservatives do not allow condom use in any circumstances, but when one married partner is HIV infected, there is a liberal permission to use condoms.

### 9.3.3 Ad Lucem

Ad Lucem is an offshoot of the Catholic Mission that accepted use of modern methods of contraception. There are some twenty health facilities; ten are currently involved in USAID's regional project. Ad Lucem is also an essential drug distributor.

## 9.4 Private Sector Agencies

Private for-profit clinics are multiplying as civil servant doctors and nurses seek to supplement their reduced salaries. These clinics cater to the elite in the cities since their services are more expensive and the quality of care is better. Health providers are opening clinics in neighborhoods to meet an unmet demand for urban-based public facilities. The World Bank plans to implement the RPHC into government health facilities. So far, the names have been changed, but integrated services have not yet started. Hence, creative entrepreneurs are opening laboratories and curative care and family planning clinics in Yaounde, Douala, Baffousam, and Bamenda. PSI is already collaborating with many of the private for-profit clinics that are more established, but the newer ones are less likely to have any IEC materials or to sell affordable contraceptives. PSI could seek to collaborate with them to display posters and promote prescriptions for Novelle.

Parastatal companies offer healthcare services to employees and their families. Although the GOC is pursuing a plan to privatize many of the companies, the largest companies, such as the Cameroon Development Corporation (CDC) and Brasserie du Cameroon, are likely to remain public. After the state, CDC is the second largest employer in Cameroon. Its headquarters is located in Tiko, near Limbe, in the Southwest Province. CDC produces bananas, tea, rubber, and palm with 40,000 hectares under cultivation in four provinces. CDC employs about 16,000 workers and provides healthcare for families (over 80,000 people). The health system consists of 67 aid posts, 19 clinics, and 3 referral hospitals. The USAID-funded regional project (SFPS) plans to integrate family planning service delivery into a limited number of CDC health facilities. Organizationally, CDC is ready and able to integrate STD/FP into its entire system. PSI could provide condoms and oral contraceptives to CDC sites not selected by the regional project. It should be mentioned that CDC has benefited from several years of IEC materials under the United Nations Population Fund's (UNFPA) "Family Life Education for Workers" project. This project does not provide contraceptive service delivery, only IEC sensitization.

Caisse Nationale de Prevoyance Sociale and the train stations' employee clinics are other facilities into which PSI could integrate STD/HIV services. PSI should also consider integrating FP activities in health facilities at lumber mills in the East Province.



## 10. DONORS

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USAID/Cameroon laid the foundation for HIV/AIDS projects in Cameroon. Starting in 1987, USAID provided grants to support the First and Second Medium Term Plans. Under AIDSTECH and AIDSCAP, USAID launched projects with CSWs, students, the military, and implemented programs to strengthen condom social marketing, sentinel surveillance, and computer modeling of the AIDS epidemic. Quality assurance for HIV testing and strengthening of AIDS prevention counseling services were scheduled to take place, but AIDSCAP's early termination prevented this from occurring. Today, counseling is a weak element in the AIDS prevention program in Cameroon. However, field visits indicate that where health providers have been assigned to their provinces of origin and where their skills have been updated, they are committed to providing quality health care.

USAID's abrupt departure has had a profound effect on the MCH/FP national program. Many of the gains in strategy development and methods of integration into RPHC have been lost. One of the most severe impacts of the program is in the provision and distribution of contraceptives on a national plan. USAID was the only donor providing contraceptives to both the RPHC sites and the important non-RPHC sites.

Donor coordination has always been a concern in Cameroon. Therefore, during 1990 to 1994 USAID, WHO, and GTZ played lead roles in holding monthly coordination meetings. In addition, periodic meetings with donors and NGOs were presided over by the MOPH. These meetings reduced the chance of two or more agencies implementing the same activities, often in the same health facility. In the absence of such donor coordination, the possibility for duplication of resources and human effort is great. WHO and the World Bank are attempting to coordinate activities in the public sector, but their attempts are mainly limited to establishing who is going to pay for a certain activity in some part of the country, rather than to being proactive in ensuring a coordinated program on the ground. It is important that the MOPH collaborate with donors to present plans and seek appropriate funding by site and activity. In addition, donors are now reducing support to Cameroon because of fraudulent elections and the lack of an anti-corruption policy. Switzerland and the United States have pulled their development assistance, and donors from Great Britain, Canada, and Germany have reduced their support.

### 10.1 Belgian Government Cooperation

The Belgian Cooperation is implementing the RPHC strategy in the Extreme North. It has been working in PHC in this province prior to the RPHC.

## **10.2 Canadian Government Cooperation**

The Canadian government supports an STD/AIDS prevention project being implemented by CARE/Cameroon in the East Province and in Douala. The project sensitizes long-distance truck drivers and CSWs about the use of condoms. Also, it supports local manufacturing of an HIV test by the Faculty of Medicine (CAMTRIX). Lastly, it funds a program to train IEC professionals on HIV.

## **10.3 Sante Famiale pour la Prevention de SIDA**

Following the closure of the USAID Mission to Cameroon in 1994, a Regional Project was started in Abidjan, Cote d'Ivoire. Representation for this project was requested in Cameroon and SFPS was established in Yaounde to coordinate the USAID/REDSO West African Family Health and AIDS Project.

It is believed that originally PSI could have taken over responsibility for this function, as PSI was one of the major partners in the Regional Project. However, the idea of United States interventions following the rapid closure of the USAID Mission prevented this from occurring. Instead, the appointment of the SFPS director was a joint Regional Project/Cameroonian one and the director's duties were limited to the management of logistics, storage, equipment, and finance. SFPS has been involved in developing training modules in health service delivery for health centers and some activity with an outreach project on child survival, but little proactive work involving the Regional Project has been done. It was felt that the other participants in the Regional Project from Abidjan passed on activities to SFPS rather than involving the organization as an active participant. Thus, despite the efforts of the well-intentioned SFPS director, his presence in Cameroon has not achieved all that it might have.

## **10.4 European Union**

The European Union (EU) assists in developing RPHC in the Central, West, and East Provinces. In addition, the EU proposes to assist the government in developing a national drug distribution system that will procure drugs and supplies for government health districts. Although contraceptives are listed on the essential drug list, it is not clear whether they will be procured by the EU or whether a vertical distribution system will be established.

## **10.5 Fonds d'Action et de Cooperation**

The French Cooperation supports three health activities in Cameroon: RPHC, HIV/AIDS, and TB. Working in the North and Extreme North Provinces, it is assisting the MOPH in developing

health districts. Family planning activities have been limited in the North Province, but UNFPA is integrating FP into health districts in the Extreme North.

GOC signed a three-year agreement with FAC for the project, "Appui a le lutte contre le SIDA au Cameroun." The project is providing 880 million FCFA for the following three areas:

- (1) Preventing AIDS in the North Province. A well-stocked AIDS documentation center has been established at the MOPH Delegation at Garoua. Several IEC activities have been conducted in the health districts in the North Province. Under this project, the HIV Rapid test is performed at health centers and district hospitals in the North Province.
- (2) Establishing the first AIDS unit at the Central Hospital in Yaounde, a national referral center that receives patients from around the country. The unit will provide psychosocial management of people with HIV, as well as providing medicine. The unit will also monitor blood supply at the Central Hospital.
- (3) Providing medication for TB, leprosy, and other endemic diseases as in the past.

## **10.6 German Government Cooperation**

The German Government Cooperation (GTZ) is implementing the RPHC in parts of the Northwest, Southwest, and Littoral Provinces. Since 1987, GTZ has been helping the government to strengthen institutional management capacity, to develop a drug resupply system based on a cost-recovery system, and to integrate program interventions. In 1996, GTZ introduced the National Management Information System (developed initially with USAID funds) at the health center of the health district. Unfortunately, at the provincial and central levels, data entry and generating reports of these important decision-making statistics are weak. In the Northwest Province, the system appears to function.

GTZ is integrating family planning activities into health districts. In 1995, it trained 130 health providers. PSI provided condoms to GTZ's provinces as free samples. Other contraceptives are integrated into the essential drug supply.

With respect to STD/AIDS, GTZ has provided support to the NAC at the central level. Within the provinces where it is implementing the RPHC, GTZ is integrating STD/AIDS activities. In 1996, GTZ conducted a study of 23 NGOs working in the health field in the Littoral Province. Eighteen of the NGOs are working in STD/AIDS; 13 are actively providing counseling to people who test HIV positive and those with full-blown AIDS. In collaboration with SWAA/Douala, GTZ provided funding for service delivery to people infected with STDs/AIDS. It has also helped the MOPH to sensitize the general population on STD/AIDS during World AIDS Day.

GTZ collaborates well with PSI. It has helped PSI conduct a two-week study to identify PSI distributors selling condoms in the local markets in Douala. GTZ provided fuel and per diem for PSI's staff.

## **10.7 UNICEF**

UNICEF is helping the GOC to implement community participation in the RPHC strategy in the Extreme North, Central, and West Provinces. It continues to provide support for the national immunization program and is collaborating with the ORS program. Other UNICEF activities involve improving the lives of women and children.

## **10.8 United Nations Development Program**

The United Nations Development Program (UNDP) acts as a coordinating and funding agency for UN-specialized agencies. In this role, it collaborated with WHO to relaunch the NAC by organizing the recent donor commitment meeting. As mentioned below, UNDP is providing a grant to WHO to implement an AIDS project.

## **10.9 United Nations Population Fund**

The UNFPA's projects support the national population policy, "Family Life Education for Workers," a project developing IEC at factory sites, and integrating family planning into the RPHC strategy in five provinces. Between 1988 and 1990, UNFPA, the World Bank, and USAID had been asked by the GOC to support the same activity? developing a national population policy. Donors, working in collaboration with the implementing agency (Ministry of Plan [MOP]), agreed to carry out individual, yet complementary activities that led to a national policy and dissemination seminars at the provincial level. The National Population Policy was adopted in 1992. UNFPA continues to support population monitoring activities.

"Renforcement de Programme National de SMI/PF a Travers les SSP," is UNFPA's project to integrate FP in the Central, South, East, North, and Extreme North Provinces. The project plans to integrate FP into 60 rural integrated health centers, 20 district hospitals, and 8 urban centers, formerly PMIs. UNFPA has supported family planning services at the Maison de la Femme for several years.

## **10.10 World Bank**

The World Bank is supporting the RPHC through its "Projet Sante, Fecondite et Nutrition." This project provides \$43 million for six years starting in 1996. Eighteen district hospitals, 155 health centers, and several new buildings will be constructed in the project provinces, including East, South, Center, West, Littoral, and Extreme North. The World Bank's other project activities include conducting a national fertility survey, which has not been done since 1978; providing nutrition counseling for women and children; and providing support for the national population policy.

## **10.11 World Health Organization**

With the lack of constant and strong MOPH central-level leadership, WHO appears to act as the lead donor coordinating agency. Its principal activities are support to the PNLS, RPHC, and child immunization. In August 1997, WHO signed an agreement with UNDP to implement a \$500,000 project to reduce the spread of AIDS in Yaounde and Douala areas only. This three-year project will provide psychosocial management for people with HIV and their families, manage the AIDS program in Cameroon, and ensure a safe blood supply. WHO anticipates providing funds to PSI to implement the IEC component of this project. WHO received \$80,000 from the joint United Nations Program on AIDS Geneva program to support AIDS activities in 1996. WHO also procures a small quantity of condoms for the NAC.

WHO is attempting to start supporting the institutional capacity-building component of the RPHC activities in the South Province, formerly supported by USAID. This component trains district-level personnel and is promoting community participation. Its limited funds do not permit full support for program interventions of the RPHC strategy. It is also implementing the immunization component for children under five. Lastly, it funds research in reproductive health at the University Teaching Hospital, CUSS.



## **11. IMPACT OF SOCIAL MARKETING**

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### **11.1 General**

In general, social marketing programs aim to promote the purchase and use of products in the social arena, usually supported by all of the marketing tools employed in the commercial sector. In some developing countries, the use of mass media for product promotion of any type is often limited. In these and other countries, cultural and social mores are sometimes restrictive to behavior change. Very often, national government programs are limited by risk of political exposure, or lack of funding or real marketing and communication skills. Similarly, small face-to-face communication activities by NGOs tend to be localized or, because of funding restrictions, targeted to a limited objective audience. In these circumstances, the very presence of an active and visible social marketing program will usually attract enormous attention from members of the general population and can also assist in effecting change. Thus, well-funded social marketing programs, independent of national or localized restrictions, can make a massive impact and, where there is synergy with other programs, help the activities of other organizations.

Although the mandate for a social marketing program is usually clearly defined by the donor with the knowledge of the host government, the implementing organization (IA) operates in a much freer private sector mode than many other sponsored activities. The very nature of the programs brings the IA into effective contact with the normal commercial sector, providing a ready distribution link to target consumers.

Nonetheless, social marketing programs are not without difficulties. Generally, they deal with changing social behavior that has been extant for generations and, unless carefully handled or in cases where they operate in a vacuum without support from government or other agencies, these programs can run into difficulties with cultural and religious bodies. These bodies may then take actions that hinder or sometimes halt the social marketing program entirely.

### **11.2 The Impact of Population Services International in Cameroon**

It is commonly accepted by GOC, major donors, and NGOs that the PSI program has made an important contribution to the fight against AIDS in Cameroon. PSI has not only made a contribution itself but, by creating overt awareness of condoms, and achieving visibility of product and promotional activities, PSI has enabled other organizations to proceed more easily with activities within their own spheres.

Prior to the launch of the PSI program, the availability of condoms was somewhat limited. Condom distribution tended to be in clinics and centers where the potential user was required to go and seek condoms. Commercially marketed condoms were available in pharmacies, but were highly priced and in restricted distribution. Media communications on AIDS was limited, and

existing communication tended to inform and educate, rather than to encourage a demand that impelled consumers to use condoms.

PSI's activities have raised the profile of AIDS and in particular condoms, along with the messages of abstinence and fidelity. However, in the absence of sensible mass media budgets, PSI has been unable to sustain the necessary messages to complement those of the GOC to the general public. Although activities targeted at high-risk groups have changed their behavior to some extent, efforts to communicate the need for a change in sexual behavior or the need to use condoms have failed to reach the general public.

During this project, PSI has sold over 30 million condoms into the trade, and consumers are purchasing about 10 million condoms per year. At current rates, PSI/CAM has achieved a noteworthy condom per capita sales rate, the third best in the West Central Africa region. "Prudence" is almost a generic condom in Cameroon and is distributed nationwide in most towns and major villages. PSI's limited media and promotional work has increased the level of knowledge of HIV/AIDS, despite the notable absence of strategic direction by the GOC. Because PSI has had funding restrictions, its SM program is one of the most efficient programs run by PSI. PSI/CAM has not had the benefit of mass-media activities that they themselves have produced, nor have they had much support in this area from other agencies. By contrast, their two major consumer promotional activities have had an enormous impact on the visibility and acceptance of condoms.

PSI has worked satisfactorily with other organizations, particularly NGOs, and has participated in efforts to encourage the GOC to address the increasing problem of HIV/AIDS. Unfortunately, for a variety of reasons, these efforts have been less than successful. PSI has been intimately involved with the AIDSCAP project that targeted high-risk groups. The programs worked well together until the withdrawal of USAID. Indeed, in the early stages, it was PSI who provided much of the research activity through its own staff.

The open nature of most Cameroonians has meant that PSI's program has been able to proceed without many problems, other than an isolated conflict with the Catholic Church in the Northwest province and some reticence in accepting public visibility for condoms in the Far North. The problem with the Catholic Church has been overcome satisfactorily and progress is being made in the Far North. PSI's general style of SM was probably particularly appropriate to the early Cameroonian situation, and in more recent times, efforts made with the MOPH have improved the situation.

However, some problems remain. It is generally felt that the NGOs are weak, that activity is too fragmented in the provinces, and the absence of an active multisectoral approach by the GOC has slowed down the progress that could have been made by PSI.

Because the PSI program has been forced to rely on a limited sales force to sell condoms and has

had to rely on the trade to ensure distribution, the program growth may slow down. Internally, PSI needs to devote time and effort to ensure good links between retailers and wholesalers. Retailers need to be made aware of the easy access to their local source of supply and wholesalers to increase their own visibility as stockers of Prudence. Otherwise, the program is more or less dependant on consumer demand, which will not increase rapidly enough unless mass-media communication programs are reintroduced.

Mass-media activities targeted toward the general public need to be revitalized and general public messages updated so that the public realizes that their behavior is risky. Because of their prevalence, STDs need to be addressed in their own right; the denial of AIDS needs to be overcome; and support services, particularly in the blood transfusion area, need to be revised and a new strategy developed. It is unlikely that PSI can take on this responsibility singlehandedly even though it is the only NGO outside of the GOC that has national coverage. It is feasible, however, that PSI, in collaboration with the GOC, could become much more active in public sector health facilities and, where funding permits, develop the HIV/AIDS/STD program in these areas.

It would be unwise to rely solely on the condom SM program to overcome the increase in HIV prevalence in Cameroon on its own. This is indicated by simulation modeling programs and is supported by current observation. PSI's condom sales have grown, but condom use by a sufficient critical mass of the general public has yet been reached; nor will use increase in the foreseeable future to reverse the AIDS epidemic.

PSI's other activities, namely OCs, ORS, and STD kits, have been less successful. PSI's distribution of OCs is hampered by the need to get doctors to prescribe Novelle in the first instance. Further efforts need to be made to increase the sale of OCs in the open market. Until these problems are solved, the potential for a socially marketed OC will be limited due to the reticence of pharmacists to promote the product. Although Novelle is available and affordable to many women, the restrictions on its promotion are somewhat inhibiting.

The ORS program has been hampered by the same limitations and the general lack of supportive activities by other agencies, as well as the conflict with the initial distributor and subsequent unavailability of stock. The lack of funding and provision of stock that followed USAID's withdrawal has also affected the success of this program.

The STD kit was basically a pilot project with some merit; the need for activity in addressing the Cameroonian STD problem is obvious. However, this activity also ceased due to lack of funding and availability of stock, and because of the medical lobby. Solutions to these problems with the medical lobby need to be found if the project is to be resurrected.

### **11.3 PSI's Linkages with other Family Planning and Health Program**

Concerning the gaps and strengths of linkages established with family planning and other health programs, the team found that PSI is viewed among other stakeholders, including the MOPH, as the prime mover in the provision and distribution of quality AIDS prevention and contraceptive products in Cameroon. In collaboration with representatives of the donor community, PSI often serves as a liaison to assist local NGOs or the MOPH in successfully implementing AIDS and FP IEC campaigns in urban and rural zones. An example of this type of collaboration is when GTZ provided the per diem and cost of fuel for the MOPH's Littoral Provincial Coordinator of MST/AIDS to conduct two weeks of IEC in rural areas. PSI agreed to provide a vehicle and driver for this activity. Another example is when FESADE requested that PSI train its staff to conduct condom demonstrations on wooden penises that they in turn used to train over 400 women tontines. Furthermore, PSI has given thousands of sample condoms to local NGOs. Because of these activities, PSI has earned the reputation of being a friendly and cooperative organization. PSI understands that maintaining harmonious relationships with the MOPH, donors, and local NGOs provides essential complementary activities that support social marketing. PSI plays a key role in the organization of the annual "Journee Mondiale de SIDA."

Another area of strength is PSI's ability to identify private physicians who consult working women. These women are unable to visit government health facilities which are open only during the week and in the day. With PSI's launch of Novelle, working women now have access to affordable contraceptives. Sales of Novelle have amounted to some 43,000 cycles since the product's launch in 1994. The product was more affected by the stock seizure than was Prudence Plus, but sales in 1996 topped 25,000 cycles. Since the product is only distributed through pharmacies, this is no small achievement. However, for PSI the problem is still to get the prescribing physicians to prescribe Novelle as opposed to other, more expensive commercial brands that still comprise the majority of pharmacy sales. Although it is strictly illegal (but frequently occurs) a pharmacist will sell OCs without a prescription. This is usually on repeat use with a known customer who will commonly demand the same brand as first used. Thus, the problem remains to promote Novelle being prescribed the first time a woman consults her physician for OCs.

The team learned that PSI is integrating pills and condoms to about 15 public health facilities. Although PSI is to be applauded for this effort, the primary gap that PSI can fill is identifying health facilities in each province that are not part of the RPHC. This would involve collaborating with provincial delegates and CAPP directors to supply subsidized contraceptives to non-RPHC sites. Many of these sites received contraceptives under the former vertical contraceptive logistic system, which was operational under the former Directorate of Family and Mental Health with assistance from USAID. Since the reorganization of the MOPH resulted in the termination of this directorate and the closing of the vertical system, these sites have been left confused and lack direction on how to replenish stock. Under SFPS, the REDSO regional project, some of these sites will be included. It is clear that neither the regional project nor the donors have sufficient funds to meet the needs of all the health facilities in Cameroon. PSI could complete these gaps.

Private sector and religious health facilities are not able to procure contraceptives at an affordable cost, nor do they have the internal capabilities to train staff on STD/AIDS preventions. Therefore, PSI should try to sell contraceptives to private clinics, parastatals, and private for-profit companies. It could also fill the void by organizing periodic training sessions to private sector health providers for a fee. To do this, PSI may need to hire an outside health professional.

It is regarded as essential that the SM program continues, but other interventions need to be put in place to work with the SM condom marketing program. PSI has achieved excellent results in a relatively short time but, as yet, the general public does not recognize the risks in their own behavior. Funds should now be directed toward continuing coordinated work to encourage behavior change, in particular, by examining target groups and the messages needed to promote behavior change.



**APPENDIX A**  
**Statement of Work**

## APPENDIX B

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## APPENDIX C

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## APPENDIX D

### Early Primary Health Care in Cameroon

Following the 1978 Alma-Ata Primary Health Care (PHC) conference of 1978, the GOC tried several methods to ensure health care for its population. In the mid-1980s, the National Primary Health Care Program consisted of community health posts staffed by community health workers. These posts served as vaccination campaign rallying points and village-level first aid points. A review of the community health posts found that they functioned poorly, because community health workers did not have the training, skills, or resources to effectively provide preventive or curative services. In addition, there were no effective links or supervision between RPHC posts and MOPH health facilities, and the attrition rate of community health workers was high since, as volunteers receiving salaries in kind, they hoped to become permanent employees of the MOPH.

In MOPH hospitals and rural health facilities, services were hampered by the lack of essential drugs, laboratory equipment and reagents, and other expendable supplies. In addition, the focus was on curative services. Furthermore, there were no preventive programs, such as childhood immunization, oral rehydration therapy, nutrition and growth monitoring, family planning and sexually transmissible diseases including AIDS. Supervision was rare and when it did occur, lacked guidelines and protocols.

In 1986, the MOPH carried out an assessment of this situation and concluded that the overriding problem of the national health system was that it was too highly centralized. Indications of this centralization were identified as follows:

- ? Activities were planned from the top down,
- ? Directorates developed budgets on perceived rural needs,
- ? Collected revenues were sent to the national treasury and funds were not retained locally, and
- ? Drugs were sent to health facilities based on estimated needs determined at the central level.

It was believed that decentralization of health activities would improve the function of the system and the health of the population.

In that same year, the MOPH sought bilateral assistance from the German Cooperation to launch a pilot project to address decentralization of the health program in the Littoral, Northwest, and Southwest Provinces. The key elements of the pilot strategy were as follows:

- ? Develop a sustainable drug distribution system,
- ? Encourage community participation, and
- ? Train personnel to manage health centers.

Within two years, this project accomplished much; however, there were still issues that the government desired in its national health care strategy.

In 1988, USAID-funded child survival initiatives were launched under Project SESA (Sante des Enfants d'Adamaoua et Sud) by supporting diarrheal control and vaccination activities in Adamaoua and South Provinces. Unfortunately, bottlenecks in implementation arose in this project due to a highly centralized decision-making process, vertical interventions, and lack of national budget for rural health. To address these problems, in 1989 the MOPH conducted a national assessment of all existing PHC programs and revised its strategy. The new strategy was released in the same year in a document entitled, "Reorientation of Primary Health Care in Cameroon." This strategy follows closely both UNICEF's Bamako Initiative and WHO's strategy of delivering PHC through provincial, district, and subdistrict-level health structures. Successful elements of the resupply of drugs program launched in the Northwest Province were expanded to include the funding of recurrent costs associated with the delivery of PHC services.

To test the new strategy, USAID was asked to develop health care planning strategies, a health management information system, cost recovery, and community participation components in Adamaoua and South Provinces. The successful drug procurement and distribution system model were taken from the Northwest Province and expanded to include the funding of recurrent costs associated with the delivery of PHC services.

The MOPH had the good fortune to have the same minister for six years. He was committed to the design and timely implementation of the RPHC strategy. Since his departure, the RPHC appears to have regressed (such as in FP and ORT) and program interventions established have been dismantled.

### **A. Cameroon Government Health Policy**

The Reorientation to Primary Health Care (RPHC) is the current Cameroon health policy, which was developed in 1989 and formally adopted in 1992. In the light of a worsening economy, which forced a decline in the national health budget, and the weakness of the previous health system, it was important that the MOPH implemented this program with some urgency. The policy is gradually creating a decentralized and integrated national health system based on providing a minimum package of PHC services through health districts. The policy empowers local communities by including them in the cofinancing and comanagement of health facility

services.

Health facilities in Cameroon's ten provinces have been organized into health districts, linking hospitals to health centers. The three fundamental elements of a health district are as follows:

1. A health committee composed of the community and health center staff.
2. Several health centers covering a specific, delineated area with a population of approximately 5,000 to 10,000 people in rural areas.

(When the facility is based in urban zones, it is called a subdivisional medical centre plus the name of the area, e.g., "Centre Medicale d'Arrondissement de Congo II".) Former PMIs, venereal disease centers, or other urban health facilities have become integrated facilities.

3. A district hospital that is the referral point for health facilities in the area. This level provides technical support to draft annual action plans, monitors implementation of the plans, and supervises health facilities within the district. The district hospital does not serve a specific population as do the health centers or CMA's.

The health district, based at the district hospital, has a district team that is responsible for monitoring and supervising health centers that are comanaged and cofinanced by community health committees within the health zone. The management of the health district is carried out by a committee that draws its membership from community representatives of each of the health areas and the health district office.

Provincial hospitals act as referral points and provide technical support for the health districts. They assure the coordination, training, supervision, supplies, and monitoring and evaluation of health districts. The province takes on a specific role in operational research and technical support, such as the maintenance and repair of equipment and vehicles in the districts.

#### A.1 Financial Support

Financial support for the RPHC strategy comes from the sale of drug supplies and the cost-recovery systems. A 1990 Cameroonian law permits MOPH facilities "to recover the costs related to the sale of generic medicines." In the absence of a national procurement system, provincial drug procurement and distribution warehouses or depots, called CAPPs or "Provincial Pharmaceutical Supply Centres," have been established in all 10 provinces. At present, each provincial depot procures its own drugs from private drug distributors or orders them from overseas. There is, however, a proposed European Union intervention to develop a national procurement system.

CAPPs were first established in the Northwest province by GTZ and were replicated by USAID-funded RPHC projects in the Adamaoua and South Provinces. By 1994, when the USAID Mission was closed, CAPPs had been established in Adamaoua and South Provinces. As an indication of the success of this pilot, in Meiganga District Hospital in Adamaoua, 72 percent of health center recurrent costs were covered by fee revenues in cofinanced health centres and 69 percent of the health districts recurrent costs are covered by recurrent fees.

Unfortunately, these successes and other gains in establishing the RPHC in USAID-supported provinces have been lost due to the abrupt closure of the USAID mission. There was a follow-up plan carried out by UNICEF, which provided initial stocks for reorientating health centers, but in the absence of regular training activities and supervision, this plan has not continued in a structured manner.

On the positive side, CAPPs are now functioning in all 10 provinces. Health centers staff come to the provincial capital to procure drugs with funds generated from community participation. These funds come from the purchase of essential drugs, payment for consultations and other medical services, and contributions from development committees of the health center's area.

The management subcommittee of the area health committee uses these sources of income to finance the following activities at the center:

- ? The salary of a locally recruited administrative agent to manage the pharmacy and other cost-recovery activities;
- ? The replenishment of the pharmacy;
- ? The reordering of different forms used by the MOPH;
- ? The reordering of laboratory reagents and expendable supplies;
- ? The costs related to mobile activities (outreach, supervision of PHC posts, etc.); and
- ? Other health-related costs as determined by the health committee.

## A.2 Donor Contributions

With a declining health budget, the MOPH is virtually dependent on assistance from donors to implement the RPHC strategy in Cameroon's 10 provinces. The MOPH's priority for donor assistance in the non-community areas are training MOPH staff to improve planning and management capabilities, renovating health facilities by painting and making minor repairs, and purchasing and procuring an initial stock of essential drugs.

Donors currently assisting the GOC to implement the RPHC in selected provinces are the Belgians in the Far North Province; Agence de la Cooperation Francaise (FAC) in the North Province; GTZ is supporting Northwest, Southwest, and Littoral Provinces; and World Bank in the Central, West, and East Provinces.

The levels of effort and the degree of success of the RPHC varies from one province to another and sometimes within the same province. At the provincial level and in districts where the level of commitment of personnel is high, the strategy has not only taken off, but is in full operation. However, in areas where personnel have not been trained and the strategy is in theory only, little has been achieved.

There are currently several functioning health districts created in the country. Each health center in the district has a pharmacy and cost-recovery mechanism to permit funding of important recurrent costs of the RPHC program. The MOPH's contributions to the system are infrastructures, health provider's salaries, and training to health committees.

Population access to essential medicines and curative care has increased from 0 percent in 1990 to 60 percent in 1996. The RPHC program in Cameroon is functioning in a financially sound and coordinated manner in most provinces. At the provinces visited by the team, the provincial drug procurement systems (CAPPs) are procuring and selling over 1.5 million FCFA in essential drugs monthly. Drug distribution methods vary from one province to another. In the Northwest, provincial teams' drugs are distributed quarterly. In the Far North and East Provinces, the "commis" (community-elected salesperson at the health center) comes to the provincial-level CAPP to purchase the drugs. District annual action plans are developed and appear to be carried out as planned. At the health districts, supervision appears to occur, but not at the rhythm suggested in the national health policy manual, which is quarterly from the provincial level and twice a year from the central level. However, under the RPHC supervision occurs more frequently than it occurred prior to the RPHC policy when centers went years without supervision. The accent is on strengthening management systems and not on program interventions. Hence, vaccination coverage has fallen. Family planning activities, integrated into the RPHC district health system, have not been supervised since 1995. This is partly due to a lack of central-level guidance and provincial-level emphasis. Although the drugs are available, making once underutilized health structures active, it appears that the system continues to provide curative care and is not addressing preventive needs.

In Cameroon as in other countries in the region, there are different views on how to implement an integrated approach to primary health care. Critics of Cameroon's strategy claim that it is an academic exercise that is unrelated to the realities of rural communities. Those committed to the RPHC strategy, usually provincial delegates with recent degrees in public health, are enthusiastic and are collaborating with donors to implement the strategy in their provinces. They point out that for the first time, delegates have the rights to make and implement decisions without

authorization from the central level. The weaknesses and strengths in implementing the system in the different provinces are often due to the local population and the commitment of personnel to making the system work.

## **B. Staff Development and Personnel Management**

Despite the progress made in developing a drug supply system, staff development and activities that train and motivate employees to expand their responsibilities within their units are weak. There are approximately 19,000 staff, of which 4 percent are physicians and 31 percent are recruited from the national nursing schools. The nursing schools continue to train personnel, but the MOPH has not recruited new staff since 1992. Graduating nurses are recruited by missionary health programs or private industry, or they join the "brain drain" and seek employment in neighboring countries. Health personnel, like other civil servants, have had two salary cuts, and given the devaluation of the currency within the past three years, their monthly salaries have been reduced by 70 percent. A physician who earned 300,000 FCFA is now earning 90,000 FCFA. As a result, personnel absences are extremely high, productivity is low, and the organization is getting weaker. This environment fosters mismanagement and lack of commitment, and slows the stability of the PHC programs. On the one hand, Cameroon medical personnel are joining the brain drain to other African countries and elsewhere in the world. On the other hand, health providers in the provincial capitals and integrated health structures who originate from the assigned sound are often committed to providing quality health care. Those not from the area and not willing to integrate themselves spend their time seeking reassignment to Yaounde or Douala. Personnel across the country are described as "demotivated." The renovation of facilities, in-service training through the RPHC programs, and most importantly the availability of drugs have improved their performance.

Another setback for the MOPH has been the frequent change in ministers. The MOPH has had three different ministers between 1994 and 1997. Prior to that time, the minister of six years took particular interest in developing and implementing the RPHC program and the National AIDS Program. Since his departure, the constant change and a seemingly poor selection of ministers, has installed a sense of uncertainty among personnel, especially at the central level. From mid-1994 to early 1997, the same person headed the MOPH. To his credit, the minister who headed the MOPH from mid-1994 to early 1997 publicized the rapid expansion of AIDS in Cameroon by leading marches and signing the policy on psychosocial management of people with AIDS. Yet, he failed to supervise the PNLS activities, plan for the transmission of the departing PNLS president, and nominate a "prime mover" to revitalize the PNLS. After this minister's departure, another person was assigned to the post who stayed for only a couple of months. In April 1997, a former high school principal accepted the challenge of heading the MOPH, and it looks as if he will stay. He is gaining the respect of the donor community and it appears that he wants to carry on activities in RPHC and AIDS that the six-year-term minister had started. One of the new minister's first tasks has been to revitalize the National AIDS Program by terminating the inactive director, presiding over the meetings of the two advisory boards: National

AIDS/STD/TB Committee meeting in April and the Multi-Sectoral AIDS/STD/TB in July. The twin engines of this administration are to reduce HIV/AIDS/MST/TB and to increase the vaccination coverage rates.

As mentioned, the PNLs has suffered from the lack of strong leadership. The new minister issued a memorandum nominating the Director of community health as the new PNLs director. This decision was welcomed by the donor community.

As in other African countries, Cameroon health providers are slow to accept assignments in rural health centers where the living conditions are less favorable. For this reason, transfers are often made without the consent of the employees. To this end, employees spend their time seeking relocation to provincial capitals or to Yaounde or Douala. The Centre Province has the highest portion of physicians per population compared to the Far North Province. The Centre has 15 physicians per 100,000 inhabitants compared to 2 physicians per 100,000 inhabitants in the Far North Province. Nurses are 70 per 100,000 compared to 17 for the same population in the Far North. For this reason, the MOPH should discuss transfer plans directly with employees and carefully select and train personnel who will use new skills. Although training motivates personnel to perform, it is not beneficial when personnel from other units receive per diem and training and do not use new skills.

### **C. Organizational Structure of the MOPH**

The latest MOPH organizational structure is outlined in Ministerial Decree Number 95/040 of March 7, 1995. This decree maximizes limited resources and regroups related services under one directorate. The MOPH is now composed of a private secretariat to the minister, an inspector general, two technical advisors, a Communications Services, a Central Administration, and External Services.

The Central Administration now consists of five rather than six directorates: Human Resources; Financial and Infrastructure Resources; Hospital Services; Pharmacy and Drugs; and Community Health. All directorate heads report directly to the secretary general who heads the Central Administration. The inspector general and the two technical advisors receive instructions directly from the minister. The Communications Services, a new service, head also reports directly to the minister. This service is responsible for coordinating activities related to developing, standardizing, and disseminating all health information, education, and communication messages.

Of particular interest to this report is the Directorate of Community Health where the subdirectorates of AIDS/STDS/TB as well as MCH/FP are located. The Community Health Directorate, formerly the Directorate of Preventive and Rural Medicine and the Directorate of Family and Mental Health, is responsible for the following general activities:

- ? Define, develop, and implement a national health strategy for community health and traditional medicine;
- ? Organize, supervise, and coordinate public community health services;
- ? Organize, supervise, and coordinate private community health services;
- ? Control endemic and all diseases important to public health;
- ? Conduct epidemiological studies throughout the country;
- ? Promote preventive activities in public and private health facilities;
- ? Integrate preventive medicine into development and socio-economic programs;
- ? Promote hygiene and sanitation of the environment in collaboration with other concerned ministries;
- ? Promote health education; and
- ? Promote the organization and protection of maternal child-adolescent health.

Three subdirectorates are responsible for developing the specific activities of the Directorate of Community Health. They are the Sub-Directions of Public Hygiene and Sanitation; Primary Health Care, and Family Health. The Sub-Direction of Public Hygiene and Sanitation has two services: Local Hygiene and the Office of Water and Sanitation Services. This direction controls the quality of urban and rural water as well as maintains a clean environment in collaboration with concerned parties.

Three services exist under the Sub-Direction of RPHC: the Epidemiology and Endemic-Epidemics Service, the National AIDS/STDS/TB Program, and the Community Health and Traditional Medicine Services. The Epidemiology and Endemic-Epidemic Services has three offices to control endemic diseases: the Leprosy Office; the Malaria, Anti-Vector, Trypanosomiasis, and Onchocerciasis Office; and the Endemic-Epidemic Office.

In an effort to revitalize the AIDS program in Cameroon, the program was given a new name, location, and president. These recent changes are explained in a May 1997 report of the National AIDS Committee Meeting and in a memorandum signed by the minister and dated July 3, 1997. The National AIDS Committee formerly called, "Programme Nationale de Lutte contre de SIDA" (PNLS), now focuses attention on all sexually transmitted diseases and tuberculosis. Hence, its new name reflects this expansion by being called "Programme Nationale de Lutte contre de

SIDA/Maladies Sexuellement Transmissive et Tuberculoses." However, the acronym remains PNLs.

The same report locates the PNLs temporarily at the cabinet of the minister where its activities could be closely monitored. Since its 1988 creation, the program was based under the Directorate of Preventive and Rural Medicine. However, the July 3 memorandum terminated the PNLs's short life at the cabinet and returned it to its original home, which is now the Directorate of Community Health. Thus, the PNLs is now located under the Sub-Directorate of the Primary Health Care, where it consists of the same three offices as the former Service of AIDS/STDs/TB. Its offices are the AIDS Office, the STD Office, and the Tuberculosis Office. There are seven departments: research, clinical services for AIDS patients, laboratory and blood transfusion, IEC, administrative and finances, epidemiology, and counseling.

The July 3 memorandum also nominates the director of Community Health as the new president of the PNLs. He is responsible for coordinating its activities and calling meetings of its two advisory boards. The advisory board actors and their responsibilities are outlined in Ministerial Decision No. 0360, Decree No. 88/772 of May 1988, which also created the National AIDS Committee.

The two advisory board meetings are presided over by the minister of health. They are the National AIDS/STDs/TB Committee and the Multi-Sectoral AIDS Committee. The committee is responsible for establishing general objectives and strategies to control the spread of AIDS/STDs/TB in Cameroon. This committee should meet at least twice a year. Members of the committee include a representative from MINASCOF, MINEDUC, MINFOC, MIN JES, MINDEF, MINTRAV, MINTRAVAUX PUBLICS ET TRANSPORTS, MINAT, MESIRES; a representative from religious organizations; three representatives from the international donor community; and the president of the PNLs.

The Multi-Sectoral AIDS/STD/TB Committee is responsible for coordinating the interventions of different international donors to monitor the implementation of the PNLs's actions plans. Members of this committee include the director or a representative of the Ministry of Economy and Finance, the World Health Organization, the United Nations Development Program, the United Nations Population Program Fund, UNICEF, l'OCEAC, and Centre Pasteur du Cameroon, international organizations conducting health activities, missionary hospitals, multi- and bilateral donor agencies, nongovernmental organizations, and the president of the PNLs.

For the sake of clarity, the two implementation boards, formerly called "la Commission de Controle et de Suivi de la Lutte contre de SIDA" (CCLS) and "l'Unite de Lutte contre le SIDA" (CNLS) become the Service de Lutte contre de SIDA in April 1997. This service in turn became the Program Nationale de SIDA/MST/TB.

The general objectives of the PNLs are as follows:

- ? Reduce the transmission of HIV/AIDS, sexually transmitted diseases, and tuberculosis;
- ? Reduce the individual impact of these illness on the economy and society; and
- ? Reduce transmission of HIV/AIDS from mother to child.

Family Health consists of Maternal Health Services and the Office of Child Survival Programs. Maternal Health Services is divided into the Maternal Health Office and the Nutrition Office, which is responsible for the following activities:

- ? Promote the health of mothers;
- ? Organize, supervise, and protect the health of mothers;
- ? Develop programs to control genetic diseases; and
- ? Provide surveillance and nutrition education for mothers.

The Office of Child Survival Programs is also divided into two offices: the Office of Primary Preventions and the Office of Secondary Preventions. Responsibilities include the following:

- ? Promote the health of infants and juveniles,
- ? Organize and supervise the protection of infants and juveniles,
- ? Develop primary preventive programs such as vaccination and breastfeeding, and
- ? Develop secondary preventive programs such as diarrheal diseases and acute respirators.

The External Services of the MOPH comprise the administrative and health facilities located in the provinces. These include Provincial Delegations of Public Health, Divisional Services of Public Health, and Sub-divisional Services of Public Health.

Provincial Delegations of Public Health are headed by provincial health delegates (PHD), who are 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 health activities and programs. Reporting directly to the PHDs are the head of the Office of the Health Statistics and Information; the head of the Office of Health Education and Nutrition; and the head of the Mail Services. Other provincial representatives also reporting directly to the PHDs are as follows: the provincial chief medical officer, who is the director of the provincial hospital, nursing school,

and mental health services; the community health services officer, who coordinates the Offices of Hygiene and Sanitation, Primary Health Care Services, Maternal Child-Adolescent Health Services, Infant Care Services, and Epidemiological and Operational Team; the pharmacy and drug officer, who is responsible for the Offices of Procurement, Inspection and Pharmaceutical Information, and the Drug Transportation Services from Douala; and lastly, the administration and financial services head, who coordinates the Offices of Personnel and Training, Equipment and Maintenance, and Budget.

#### **D. Analysis of Organogram**

The MOPH's organizational structure defines the relationship among organizational units, the chain of command, and the roles and responsibilities of the different directorates, services, and offices. The organizational structure is amendable to change as seen when the PNLs was attached to the cabinet of the minister and later moved to the Directorate of Community Health. The decision-making process conforms to those embodied in the structure. The RPHC program? the health policy is reinforced with support from all units of the structure? has moved from being a theoretical exercise to a practical one with committed provincial delegations and health district teams drafting their own annual action plans.

Past organograms focused on key interventions by developing a separate entity for the intervention. This organogram follows the same pattern by creating the Communications Services, placing the National AIDS Program in the Community Health Directorate, and developing an organizational chart of a health district. Communication messages of all PHC interventions will be developed, tested, and disseminated by this service. This should standardize national messages and reduce the variation in messages by different partners. It appears that the lesson of developing standard family planning messages and disseminating them to all partners? donors, NGOs, and private sector? will serve as model for other health intervention messages.

The Directorate of Family and Mental Health, where maternal child health and family planning activities were organized, and the Directorate of Preventive and Rural Medicine were expunged and their activities were combined into the new Directorate of Community Health. The Sub-directorate of Family Health is now a few offices and has been without a director for several months.

The placement of the AIDS program in the Directorate of Community Health is too recent to produce any results. By placing the PNLs in the Community Health Directorate, the director, who is considered a dynamic and efficient manager, can monitor the activities. On the other hand, whether the director will have sufficient time to allocate to AIDS remains to be seen. Since the departure of its efficient director in 1994, the AIDS program has been without a committed director. Early this year, the program was reactivated by a technical advisor in the ministry. The

advisor, working closely with the United National AIDS Program coordinator hopes to revitalize the AIDS Program. The National AIDS Committee held its first meeting on April 29, 1997.

The Letter of Intent signed between the GOC and the IMF in July 1997 calls for an increase in the health sector of the national budget.