

PD-ABC-365

PRIMARY HEALTH CARE SUB-SECTOR
REFORM PROGRAM
(631-0087)

A Program Assistance Initial Proposal (PAIP) for a FY 1991
Non-Project Assistance Initiative

February 1991

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ACTION MEMORANDUM FOR THE DIRECTOR, USAID/CAMEROON

DATE: February 13, 1991
FROM: *Richard*
Richard Greene, EHRD/HNP
THRU: James Washington, Chief EHRD *JW*
SUBJECT: Primary Health Care Sub-Sector Reform Program.

Ref: Greene/Johnson Memo dated 2/13/91

Problems: Your approval is required in order to submit the attached program assistance identification proposal (PAIP) for the Primary Health Care (PHC) Sub-Sector Reform Program to AID/W for approval.

Discussion: The purpose of the PHC Sub-Sector Reform Program is to provide the required legal and procedural basis for the nationwide implementation of the Ministry of Public Health's reoriented PHC strategy. The proposed policy reform agenda will legalize cost recovery activities at all levels of the health system and provide procedures for integrating family planning services and modern contraceptives into the PHC service delivery program. This activity will complement and reinforce USAID's ongoing Health and Population portfolio which provides technical, logistic, and financial support for the reoriented PHC strategy.

The proposed policy reform agenda in this PAIP was developed in close collaboration with MOPH personnel as well as with other donors.

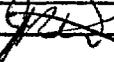
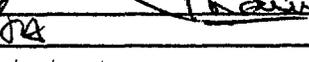
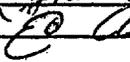
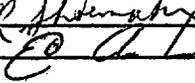
The Mission conducted a comprehensive review of this PAIP on January 28, 1991. The finalized document incorporates the modifications proposed in this review as outlined in the referenced memo.

Recommendation: That you approve the attached PHC Sub-Sector Reform Program PAIP for submission to AID/W.

Approved: 
Disapproved: _____
Date: 2/21/91

Attachment: PHC Sub-Sector Reform Program PAIP.

Clearances:

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EHRD:JWashington	<u></u>	Date	<u>2/20/91</u>
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PRM:LTaylor	<u></u>	Date	<u>2/19/91</u>
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DDIR:EAmundson	<u></u>	Date	<u>2/19/91</u>

Drafter: RGreene:hat: RM 2/12/91#0408B

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ACRONYMS

AID	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
CAA	Caisse Antonone D'Amortissement
EAPRI	Office of Economic Analysis and Policy Reform Implementation
EEC	European Economic Community
FSSRP	Fertilizer Sub-Sector Reform Program
GDP	Gross Domestic Product
GRC	Government of the Republic of Cameroon
GTZ	German Cooperation
HPNO	Health Population Nutrition Officer
MCH	Maternal Child Health
MCH/CS	Maternal Child Health/Child Survival
MOPH	Ministry of Public Health
ORT	Oral Rehydration Therapy
NPA	Non-Project Assistance
PAIP	Program Assistance Identification Proposal
PGA	Program Grant Agreement
PHC	Primary Health Care
PHD	Provincial Health Delegate
PIL	Project Implementation Letter
PRAMS	Program for the Reform of the Agricultural Marketing Sector
PREPS	Program for the Reform of Export Marketing Sector
SDA	Social Dimensions of Adjustment
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development/Cameroon
WHO	World Health Organization

EXECUTIVE SUMMARY

Problem: In the late 1980's Cameroon's ongoing economic recession exacerbated existing problems in the health sector and resulted in an almost complete cessation of support for rural health services. In response, the Ministry of Public Health ((MOPH) in 1989 devised a new primary health care (PHC) program based on decentralized planning, community co-financing and community co-management of health services, and full integration of interventions. The MOPH has mobilized donor support to begin implementing the new PHC program in all ten provinces. As implementation of this new program has begun, the MOPH has identified policy constraints to the sustainability of the program and to the effective integration of child spacing into the service delivery strategy.

Purpose: To provide the required legal and procedural basis for the nationwide implementation of a national PHC program based on decentralized planning, community co-financing and co-management of health care, and the provision of family planning services as part of a fully integrated service delivery system.

Expected Achievements: This NPA activity will assist the MOPH to legalize and expand cost recovery activities at every level of the health care system. In addition, this program will assist the MOPH to adopt family planning service delivery standards and to integrate contraceptives into the essential drug system to assure that quality child spacing information and services are available throughout the health care system. Specific policy reforms will include:

- adoption of legal texts authorizing the collection of fees for services at all levels of the health system, and authorizing health facilities to retain revenues they collect.
- adoption of an essential drugs and medical products list which includes modern contraceptives.
- development and adoption of service delivery policies and medical standards for family planning services.

This reform program is non-controversial and is fully supported by policy makers within the MOPH. This program will focus the entire Government's attention on the constraints to effectively implementing the national PHC program and, thus, assure that critical reforms are adopted in a timely fashion. In addition, the local currency equivalent of \$5 million generated from this program will provide critical funding for:

- the purchase of locally available essential drugs to provide start-up stocks for community managed drug stores.
- support for the PHC line item in the MOPH budget in order to renovate and equip health centers in areas which lack access to primary health care services. This will permit the MOPH to launch the community co-financing and co-management of health care in these areas.

The major funding constraints for expanding the PHC program nationwide are the provision of start-up supplies of essential drugs and the renovation and equipping of health centers in underserved areas. With the local currency provided under this NPA program the MOPH will be able to initiate community co-financed and co-managed health centers in an additional 100 to 200 health areas representing improved access to PHC services for an estimated 1,500,000 persons.

I. INTRODUCTION

A. Macro-economic Environment:

The Republic of Cameroon experienced relatively rapid economic growth throughout the 1970's and into the mid 1980's. Growth was led by export earnings from agricultural products, principally coffee and cocoa. During this period, gross domestic product (GDP) increased at an average annual rate of 5.2 percent from 320 billion CFA francs in 1970/71 to 1,800 billion CFA francs in 1980/81. The substantial expansion of oil production beginning in 1978 further accelerated growth of the GDP to 9 percent annually from 1980/81 to 1985/86, with per capita income reaching the equivalent of \$800.

Since 1986, the Government of Republic of Cameroon (GRC) has endured an economic recession which has resulted in an estimated 21 percent decline in GDP. The drop in the world price of oil in 1986 and the subsequent steep reduction in the world prices of cocoa and coffee beginning in 1987 and continuing up to the present have cut export earnings by almost one-third overall. This drastic reduction in export earnings has plunged the GRC into an economic recession and financial crisis which the country is still struggling to overcome.

Cameroonian Approach to Adjustment:

Beginning in early 1988, the GRC began discussions with both the IMF and the World Bank regarding the stabilization and structural adjustment of its economy. With the support of a Stand-By Arrangement approved in September 1988 and a Structural Adjustment Loan approved in July 1989, the GRC began to undertake actions aimed at: curtailing the growth of public expenditures; strengthening and broadening revenue collection; reforming the civil service; liberalizing the trade regime; liquidating, privatizing, and restructuring the parastatal sector; and restructuring the commercial banking sector.

USAID Support for Adjustment:

During the period of sustained economic crisis, USAID/Cameroon has focused its program in support of the on-going structural adjustment program (SAP) that is being pursued jointly by the GRC and the major donors. The Mission's approach emphasizes addressing the dysfunctional institutional arrangements that underlie the existing economic problems. It is the Mission's view that the set of formal and informal rules, regulations and incentives that have been developed since independence to support a state-led model of development must be replaced with a new set of institutional arrangements that will support private sector activity and investment. The present USAID program in support of structural adjustment includes: the Policy Reform in the Export Marketing Sector Program which supports the development and implementation of a privately managed Free Trade Zone Regime; the Program of Reform in the Agricultural Marketing Sector which aims to remove the marketing impediments and pricing constraints in the arabica coffee subsector; and the Fertilizer Subsector Reform Program which aims to eliminate the subsidy on fertilizer and to facilitate the private sector marketing of fertilizer.

The Social Dimensions of Adjustment :

The current economic crisis which the GRC is experiencing has led during the last three years to a significant reduction in per capita income and the private consumption of goods and services. In addition, in its effort to significantly reduce the public budget deficit, the Government has curtailed grants to the social sector including such fundamental domains as health and education. The economic downturn and the resulting structural adjustment program has also had an overall negative impact on employment. In response to the negative effects of the crisis on the population, the GRC, in collaboration with multilateral and bilateral donors, developed the Cameroon Social Dimensions of Adjustment (SDA) Program. The principal objectives of this program include:

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

The SDA Program has been an effective mechanism to mobilize donor funding in the areas of health, population, education, employment, and women in development. Major donors in the health sector include the European Economic Community, (EEC), France, the German Technical Cooperation (GTZ), the Japanese Government, the United Nations Fund For Population Activities (UNFPA), USAID, the Belgians, UNICEF, Swiss Government and the World Health Organization (WHO). The health assistance programs of USAID, GTZ, the Belgians, and UNICEF are focused on supporting primary health care. The EEC has developed plans to restructure the pharmaceutical sector. The French Cooperation has concentrated its resources in tertiary and curative care. The World Bank is presently planning to fund a Program Preparation Fund Project which will finance studies in the health sector as a preliminary step to an eventual health sector loan. WHO, UNDP, USAID, GTZ, and EEC are the major donors of Cameroon's Medium-Term AIDS Program. Finally, USAID and UNFPA are the chief donors involved in supporting the delivery of family planning information and services.

B. Health Sector Environment

Cameroon's ongoing economic recession has affected all aspects of society, particularly the public health sector. The Ministry of Public Health (MOPH) budget has registered a sharp decline since 1986. In 1988, in the midst of the crisis, the MOPH's funding for rural health care was cut by 50% causing an almost complete cessation of support and supervisory activities. Utilization of MOPH health facilities, already low, worsened as the population lost confidence in the national health system.

In addition, the supply of medications to rural facilities, already inadequate, virtually ceased. These financial problems, which have continued, have been exacerbated by poorly motivated health personnel who lack community support. As a result, primary health care (PHC) services and rural health facilities have ceased to function in a coordinated, effective fashion. The weak public health system is manifested by low coverage rates for preventive services. Vaccination coverage for measles is estimated at less than 20%. Oral rehydration therapy (ORT) usage rate is estimated at 24%. Despite 100-150 private pharmacies in the country selling contraceptives, contraceptive prevalence is estimated at 2% and child spacing services are available in less than 20 public clinics. The infant mortality rate which had declined to approximately 90 per 1000 during the early part of the 1980's is now believed to be increasing again. The major constraints to the health system are summarized below:

- Despite numerous health structures in the country there is a lack of availability of essential drugs, laboratory equipment, and reagents. Health facilities are severely underutilized and exhibit significant managerial problems related to personnel management, logistics management, and clinical practice.

- Preventive programs such as childhood vaccinations, oral rehydration therapy, nutrition monitoring and promotion, child spacing, pre-natal and post-natal care are essentially absent from many health centers.

- Despite numerous medical, paramedical, and administrative personnel, the professional health cadre is lacking in motivation due to inappropriate incentives, the limited means available to treat patients, and poor relations with the community. In addition, personnel are maldistributed in favor of the urban areas and lack clear job descriptions. The problems of the civil service personnel system (lack of accountability, insufficient career development, supervision, and in-service training) have resulted in poor morale among all cadres of health professionals.

- The medical referral system does not function properly. Due to lack of confidence in primary health centers, patients bypass these structures and utilize secondary and tertiary facilities as large dispensaries.

- The national drug procurement and distribution body has ceased to function effectively resulting in no central mechanism to purchase essential generic drugs in bulk for the population. The existing primary health care projects depend for essential drugs on a few local private suppliers who at times experience stockouts of key pharmaceuticals.

- The MOPH's resource allocation process suffers from a high percentage of budgetary resources being devoted to personnel costs, a lack of clear programmatic priorities for the remaining funds available for operations and for health investment, and an inefficient and inequitable system for the distribution of credits to the provinces. Furthermore, existing pilot cost recovery efforts are hampered by regulations which do not permit the retention of income by health facilities except on a waiver basis.

II. BACKGROUND INFORMATION ON THE HEALTH SECTOR

A. Health and Population Profile:

Cameroon is a coastal country bordering West and Central Africa. Its surface area is estimated at nearly 184,000 square miles. Cameroon's population is estimated at approximately 12 million in 1990, up from 7.6 million inhabitants as reported by the 1976 general census. This yields a growth rate of approximately 3% per annum. The average population density of Cameroon is estimated at 65 inhabitants per square mile, with a rate of urbanization of approximately 40%. The structure of the population indicates that nearly 55% of Cameroonians are under 20 years of age, with the economically active population representing less than 40% of the total. The principal health problems in Cameroon are diarrhea/dysentery, measles, malaria, complications of pregnancy and child birth, and other infectious diseases including schistosomiasis, onchocerciasis, and tuberculosis. The national prevalence of HIV infection in the adult population is estimated at one percent but is growing.

B. Structure of the Health Service Delivery System

1. Ministry of Public Health

The Ministry of Public Health (MOPH) is composed of six central directorates: Hospital Services; Preventive and Rural Medicine; Family and Mental Health; Pharmacy; Planning, Studies, Statistics; and Administrative Affairs. All directorates report to the Secretary General. Representing the Minister of Public Health on the provincial level is the Provincial Health Delegate (PHD). The PHD is the chief medical officer in charge of overseeing all provincial level public health services -- delivery of curative care, administration, health planning, and preventive medicine activities and programs. Reporting directly to the PHD are the Provincial Chief of Preventive Medicine and Public Hygiene, overseeing preventive medicine activities, and the Provincial Chief Medical Officer, who is the director of the provincial hospital.

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

At the provincial, divisional, and sub-divisional levels there are Primary Health Care Coordinators who supervise the village health posts staffed by community health workers.

2. Tertiary and Secondary Care

Tertiary care is carried out in four large referral hospitals located in Yaounde and Douala. Full service hospitals offering specialty care are located in the provincial capitals. General hospitals which do not offer specialty services are located in divisional and subdivisional capitals.

3. Primary Health Care

Primary health care is delivered through a network of health centers and village health posts. Health centers are defined as either elementary (defined to serve approximately 5,000 people) or developed (serving 10,000 people, including some maternity and inpatient beds). In practice there is little distinction between the two types of facilities. The best estimate of the number of functioning public health centers in the country is between 600-800. For village health posts, communities contribute resources and build health units out of local material. Community health workers (CHWs) are selected by the village and trained at the sub-divisional hospital. The community is responsible for the remuneration of CHWs. The government considers the health posts to be outside of the public sector.

4. Other Facilities

There are approximately 55 maternal child health centers in the country, many of which are attached to provincial hospitals. In addition there are approximately 23 women's centers in the country managed by the Ministry of Social and Women's Affairs which conduct income generation, counseling, and health programs targeted at women. Finally, Cameroon has approximately 100 pro-pharmacies, MOPH recognized community-owned drug stores in areas where there are no commercial outlets.

5. Private Health Sector

There are between 25 and 35 Protestant Hospitals operating in the country and hundreds of small satellite clinics which are supported by these hospitals. In addition, there are 30 to 50 private and parastatal businesses which manage their own health facilities for their employees. There are also an undetermined but large number of private for-profit clinics and several hospitals in the cities and towns of the country. Finally, there are approximately 170 private pharmacies operating in Cameroon.

C. Economic Analysis of the Health Sector

Cameroon is considered to be a lower middle income country based upon a per capita income of \$800 (1987 estimate). Unfortunately, Cameroon's health indicators (infant mortality estimated to be greater than 100 per thousand with much higher rates in some regions of the country) are more indicative of lower income countries. This poor performance in the health sector has prevailed despite relatively high public expenditure levels for health (\$12.60 per capita in 1988/89).

Although GRC budgetary allocations for health grew during the 1970s and early 1980s they did not grow as fast as overall government spending. As a result the percentage of the national budget devoted to health has fallen from approximately 6.0 percent in 1968/1969 to a current level of only 4.10% for the 1990/1991 budget. This is well below the WHO's recommendation that lower income countries devote 10% of their national budgets to the health sector. While the GRC budget allocations for health as a percent of the overall GRC budget has fallen steadily over the years, the current economic crisis has necessitated a drop in overall government spending. As a result, the GRC recurrent health budget has dropped from 27.8 billion FCFA in 1986/1987 to its present level of 22.75 billion FCFA. Table 1 summarizes recent trends in the GRC recurrent health budget.

The GRC investment budget for health totaled a mere 2.6 billion FCFA during the period between 1981 and 1985. Investment spending increased markedly in 1986 to a total of 23 billion FCFA and remained at similar for several years (21.5 billion FCFA in 1987/1988 and 17.6 billion FCFA in 1988/1989). Most of this investment spending was consumed by hospital construction. In 1987/1988 only 14% of investment was spent for the construction of primary health centers. Hospital construction grew to 92% of health investment spending in 1988/1989. Indications are that investment spending for health has fallen drastically in the 1989/1990 and 1990/1991 budgets and represents no more than 1% of total GRC investment spending.

Within the GRC recurrent health budget, personnel costs currently consume over 80 percent of the total. This leaves little for drugs and other operating costs. In 1989/1990, 2.1 billion FCFA (193 FCFA per person) was allocated for drugs within the total recurrent health budget. However, in that year, GRC expenditures for drugs amounted to only 400 million FCFA (19% of budget) or a mere 37 FCFA per person. With high fixed personnel costs there appears little hope for improvement in this situation.

There exists a significant private sector for health care delivery in Cameroon as well. This is composed of both private for profit practitioners and pharmacies, and non-profit facilities operated by religious and private voluntary organizations. There is no information available regarding total expenditures within the private sector (although one source estimates that non-profit sector spending represented approximately \$15 million in 1986). However, it is estimated that in 1989 a total of 28 billion FCFA was spent on drugs through the private for profit sector and another 1.8 billion by the non-profit sector (the 400 million spent on drugs by the MOPH represent, therefore, a mere 1.3% of spending on drugs in the country).

Despite the former MOPH policy of free health care (including drugs) for all it is clear that households have traditionally spent significant amounts on health care. A 1983 study estimated that spending on health care was approximately 15,000 FCFA per person per year nationwide. This figure represents a national average based upon estimates of 21,120 FCFA per person per year for urban populations and 4,587 per person per year for populations living in rural areas with limited access to health care. Other studies of demand for health care and current household expenditures for care are underway in conjunction with the USAID Maternal Child Health/Child Survival Project.

Under its new policy to introduce cost recovery in the health system, the MOPH has allowed hospitals to begin to collect fees for services. In addition, recent legislation has been approved allowing health facilities to charge patients for drugs. The MOPH, with USAID assistance, is planning in 1991 a study of the fees charged and the revenues generated at one hospital in Douala. Operations research on the ability of health centers to recover recurrent costs beyond drug sales is currently being conducted in collaboration with donor (including USAID) assisted projects in several provinces. Such research will provide the MOPH with further information to modify the health finance policy in the future.

TABLE I:
Recurrent Health Budget; Cameroon 1983-1991

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

III. DESCRIPTION OF PHC SUB-SECTOR: THE MOPH'S RESPONSE TO CONTRAINTS IN THE OVERALL HEALTH SYSTEM

The MOPH has confronted the identified problems of the national health care system by attempting to improve the most basic level of health services, primary health care (PHC). In 1989 the MOPH conducted a national assessment of the existing PHC program and developed a revised PHC strategy. This strategy which is described below stresses community involvement in PHC, community co-management of health facilities, community co-financing of health services, and full integration of interventions. USAID was the first donor to provide full support for this new strategy under the Maternal Child Health/Child Survival (MCH/CS) Project. Other health donors including the German Cooperation, UNICEF, French Cooperation, the EEC, and the Swiss Cooperation have also embraced the MOPH's new PHC strategy in their rural health care programs. The MOPH has now identified donors to fund the revised PHC strategy in major areas in all ten provinces. USAID's entire health population portfolio is now oriented to this new approach.

A. Description of the MOPH's New PHC Strategy:

In May 1989, the MOPH released its new PHC strategy 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 primary health care in three phases. The plan conforms to the administrative division of the country into provinces, divisions, and sub-divisions.

According to the new strategy, the national health system will be reorganized in such a way that local communities will take greater responsibility for their health care. Each political sub-division in the country will be organized as a health district which will receive technical and administrative support from the divisional and provincial levels. Within the health district, health areas will be established in zones surrounding functional health areas. Health centers will be co-managed by the community health committee of the health area. Each health center will have a drug store and other cost recovery mechanisms which will permit the funding of certain recurrent costs of the PHC program. The community health committee will manage the funds generated from the cost recovery mechanisms. Health services will be delivered in a fully integrated fashion with emphasis on continuity of care for each episode of illness. A full description of the PHC system is outlined below.

1. Community/Village Level

The existing village health posts, community health workers, and village health committees will be maintained.

2. Health Center Level (Health Area) (pop. 3-15,000 persons)

A community health committee will be elected to represent the concerns of all the villages in the health center's catchment area. The health committee will select a subcommittee responsible for managing the health center and pharmacy. This management subcommittee will consist of community representatives and health center personnel, and will be overseen by the chief medical officer of the sub-division.

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

Each health center will establish a pharmacy stocked with essential drugs. These community managed pharmacies are intended to sell drugs at low prices but still make a profit sufficient to cover many of the variable recurrent costs of the health center. Other cost recovery mechanisms will be developed.

Health center staff will provide outreach, supervision, and full services to PHC posts within the area. Vertical child survival programs will be delivered by health center staff and will be fully integrated into the PHC program.

3. Sub-Divisional Level

a. Each sub-division will be divided into its health centers and their catchment areas (health areas). The sub-division (health district) will be the functional management unit of the new health system. A health district team (including public health and PHC specialists) will be responsible for coordinating all PHC activities throughout the sub-division.

b. The sub-divisional hospital will serve as the referral hospital for the health centers in the sub-division.

c. A sub-divisional health committee will be created consisting of representatives from the different area health committees.

d. The sub-divisional health committee will form a management subcommittee responsible for overseeing the sub-divisional hospital and the divisional drug depot, if one is located there.

4. Divisional Level

The divisional health team will provide technical and administrative supervision of the sub-divisions.

5. Provincial Level

- a. The provincial health team will provide technical and administrative supervision to the divisions.
- b. The provincial hospital will serve as the referral hospital for the sub-divisional hospitals.
- c. A provincial health committee will be created consisting of representatives from the sub-divisional health committees.
- d. Each provincial health committee will form a management subcommittee responsible for overseeing the provincial hospital and the provincial drug depot.

6. Financing the System

The state, with contributions from international donors, will provide salaries, pre-service training of health personnel, construction and rehabilitation of health centers, transport for health centers, and the initial supply of drugs to be sold in the pharmacies. The community will participate in financing its health care by:

- purchase of essential drugs;
- payment for selected medical services;
- contributions from development committees of the catchment area.

The management subcommittee of the area health committee will utilize the above sources of income to finance:

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

(Note: Due of the lack of a viable national drug procurement entity, the MOPH envisions that communities will procure essential drugs from private drug suppliers.)

7. Supervision

Supervision will be both technical and administrative. The sub-divisional team will conduct supervision to support the health center staff, management committees, and health committees in their different management roles. Technical supervision will focus on maintaining the correct delivery of health services by medical personnel. A supervision hierarchy will ensure that all workers receive regular supervisory visits which will be supported by a program of in-service training.

B. Experience to Date with the Revised PHC Approach and Perceived Constraints:

The MOPH's reoriented PHC strategy is intended to address many of the key constraints of the health sector including:

- the lack of essential drugs and reagents (by establishing revolving fund drug stores);
- poor motivation of health personnel (by involving the community in the planning, management, and financing of health care);
- lack of supervision and outreach activities (by community financing of PHC operating costs);
- lack of a medical referral system by establishing clear referral guidelines and training health workers in the principle of continuity of care.

The reoriented PHC strategy is being implemented in pilot zones in Adamaoua, South, Extreme North, North-West, and West Provinces with plans underway to begin implementation in major areas of the remaining provinces over the next five years. Experiences to date are positive but indicate that there are important policy related constraints to the effective implementation of this program nationwide. These policy related constraints to the new PHC strategy include:

- the current health finance law does not permit the collection of fees for services at sub-divisional hospitals and at health clinics.
- the current health finance law does not permit all health facilities to retain income generated from cost recovery activities. (Health facilities in pilot zones implement cost recovery activities on a waiver basis).
- the MOPH's prevailing profit sharing system does not include paramedical personnel, and serves as a disincentive for public health physicians to conduct supervision, management, and outreach activities.
- there is currently no legal basis for the election and operation of community health committees. (In pilot PHC zones, community health committees obtain special authorization from the chief divisional administrative officer in order to operate).

- the existing essential drugs and medical equipment list needs to be amended to include modern contraceptives and needs to be formally approved.
- there currently exists no legal basis for the regulation, importation, and sale of anti-diarrheal drugs and infant feeding formulas.
- a family planning service delivery policy and family planning medical standards need to be developed and disseminated to every public and private health center in the country.
- the national drug procurement and procurement body has ceased to function effectively resulting in no effective mechanism by which to purchase essential drugs in bulk for the population. The existing PHC projects depend for essential drugs on a few local private drug suppliers who at times experience stockouts of key pharmaceuticals.
- the access of the population to contraceptives from private pharmacies is limited by artificially high prices.
- the national diagnostic and treatment schedules developed for the PHC program needs to adapted to individual epidemiologic regions.

IV. PROGRAM GOAL AND POLICY REFORMS

Policy Reform Strategy:

Many of the constraints affecting the health sector are structural, multi-sectoral, and linked to the ongoing economic recession in the country. In view of this, USAID proposes that this NPA Program:

- be focussed on reforms which are feasible given the prevailing reform and political environment in the country and given the limited financial resources of this grant.
- reinforce the impact of the existing USAID health and population portfolio and complement the efforts of other health donors.
- support the overall policy thrust of the Mission in the areas of community participation, cost recovery, decentralization of planning and services, and the expansion of voluntary family planning services.

The strategy of this reform program is to assist the MOPH to provide a legal foundation for the implementation of the national reoriented PHC program and the integration of family planning services into this program. As such, this NPA activity is directly linked to implementation of the Mission's two major bilateral projects; the MCH/CS Project which assists the MOPH to implement the reoriented PHC program in Adamaoua and South Provinces, and the Family Health Support Project which assists the MOPH to integrate child spacing and related maternal health interventions in the reoriented PHC program in five provinces. This NPA activity will provide the reoriented PHC program with a firm legal foundation for community-managed cost recovery activities; provide national standards for family planning and maternal health; and make modern contraceptives readily accessible to the population by including them in the national essential drugs program.

A. Overall Goal and Purpose:

Program Goal: The overall goal of the Primary Health Care Subsector Reform Program is to assist the GRC to improve the health status of the population (particularly women and children). This improvement will come about, in part, through an improved health delivery system that effectively implements a sustainable primary health care program which includes the delivery of family planning services.

Program Purpose: The program purpose is to provide the required legal and procedural basis for the nationwide implementation of a national primary health care program based on decentralized planning, community co-financing of health care, community co-management of health services, and the delivery of family planning information and services within a fully integrated system. This program purpose will be achieved through the implementation of key policy reforms agenda designed to provide legal and procedural policies in support of the national primary health care program.

B. Policy Reform Agenda:

The policy objectives of the program will be achieved through specific policy reforms defined by the grant agreement and considered as conditions precedent to the disbursement of grant funds to the GRC. The specific policy reforms and the corresponding conditions precedent will be developed during the PAAD process after a thorough analysis of the policy needs in each of the major areas as well as the impact of possible reforms on the subsector. At this stage, USAID and the MOPH have identified a series of policy reforms which would provide a legal foundation for cost recovery activities and facilitate the integration of family planning services into the PHC system. While these reforms are non-controversial and are fully supported by policy makers in the MOPH, this NPA program is necessary to assure the timely and formal adoption of these critical reforms by the GRC.

1. COMMUNITY PARTICIPATION IN THE FINANCING OF HEALTH SERVICES:

Policy Reforms:

- draft and adopt legal texts authorizing the collection of fees for services at all levels of the health system; and authorizing health facilities to retain the revenues which they generate through cost recovery mechanisms.

Current budgetary constraints dictate that the community participate directly in the financing of health care delivery. A recently signed law allows health facilities to sell drugs in order to recover costs. However, it may not be possible for drug sales alone to generate sufficient revenue to assure the delivery of important primary health care services on a sustainable basis. Although the collection of fees for services is allowed at national and provincial hospital facilities, it is not currently permitted at sub-divisional hospitals and health centers except on a waiver basis. Pilot regions are currently implementing cost recovery mechanisms based on fees for services and drug sales in such a fashion. Legal texts need to be written and adopted that will allow the MOPH to install a fee for service system at all levels of the health care system. It will be necessary for the MOPH to draft the appropriate texts and assure their adoption. These texts would serve as a complement to the recently passed legislation that now authorizes the sale of drugs at health facilities.

These legal texts should also authorize health facilities to retain the revenues generated through fees for services. These revenues would then be managed by the community in order to improve the quality of preventive and curative health services available to the population. Current finance laws in Cameroon require that facilities turn over all funds generated from fees for services to the Treasury. In principal, the Treasury is obligated to return a certain percentage of these funds to the facility. Negotiations need to be undertaken with the Ministry of Finance in order to reform these laws to allow health facilities to

retain the revenues generated from fees for services. The effect of this reform on the PHC system will be to provide an increased incentive for health facilities to collect fees on a systematic basis and to assure correct and complete accounting for revenues. These are key elements to the successful implementation of cost recovery mechanisms.

Adoption of Reforms: The MOPH currently has the capacity to draft the texts described above. The MOPH is prepared and capable to conduct negotiations with the Ministry of Finance to assure the adoption of the texts. Short-term technical guidance which may facilitate the process will be provided by the USAID MCH/CS Project. The MOPH is currently planning to conduct a study to analyze several pilot fee for service projects in which large national hospitals which legally collect fees are permitted to retain the preponderance (greater than 80%) of the revenues collected. This study will clearly document that these large hospital facilities are able to support improved health services while at the same time increase the revenues they normally return to the Treasury. This increase in payments to the Treasury is due to increased patient utilization and better collection and accounting practices. Preliminary discussions with the MOPH indicate that the Ministry of Finance would be willing to greatly reduce the percentage of revenues which they now collect from large hospitals providing that it does not significantly reduce income to the Treasury. In addition, the MOPH believes that, with negotiation, the Ministry of Finance would be willing to permit small hospitals and health centers to begin to collect and to retain 100% of their expected fees since this would not diminish existing revenues to the Treasury.

MOPH Application Texts Related to Health Financing Reforms: Once the GRC adopts the health financing reforms described above, the MOPH will need to draft and adopt an application text which reforms the current profit sharing policy for health workers. This text will be required because a small amount of the funds generated through cost recovery measures will be reserved for profit sharing with health service providers.

The current system of profit sharing allows for a percentage of the fees generated at national and provincial hospital facilities to be returned to the medical personnel who performed the medical consultations. With the extension of a fee for service system to all levels of the health delivery system, it is anticipated that this profit sharing system will be extended as well. The current system provides no incentives to medical (and paramedical) personnel to engage in activities that do not directly generate revenue such as supervisory visits, management tasks, and outreach activities. A system to pool the revenues allocated to the profit sharing system is needed so that all personnel regardless of their tasks benefit appropriately from the system and in order to eliminate the current disincentive for medical personnel to perform critical supervisory, management, and outreach tasks.

Adoption of Application Text: The drafting of appropriate application texts by the Minister of Public Health is within the capabilities of Ministry personnel and would require no outside technical assistance or funding. A consensus needs to be developed among medical personnel that

the new system is equitable and should be implemented uniformly. The policy change adopted may delegate to health committees the responsibility and authority to establish profit sharing mechanisms for their communities.

2. INTEGRATION OF FAMILY PLANNING SERVICES INTO PRIMARY HEALTH CARE:

Potential Reforms:

- develop and adopt appropriate service delivery policies and medical standards for family planning services consistent with MOPH primary health care policy;

The development of a family planning service delivery policy, including medical standards, is an essential first step in the national initiative to integrate child spacing services into the primary health care program. A national service delivery policy will define the roles of individual health workers in the delivery and support of these services. The policy will also provide authorization and reference points for service delivery. The medical standards will establish quality of care criteria for training and supervision of services. Method protocols must be developed (or adapted from existing models) for precise guidance in the delivery of each available family planning service. The service policy and medical standards developed and adopted as a whole will provide a coherent national framework for the safe and effective delivery of clinical services and related community based services.

- officially adopt list of essential drugs and medical products that includes modern contraceptives.

The MOPH currently lacks an officially recognized list of essential drugs for use at health facilities. A draft list has been prepared by the MOPH but awaits official adoption. The draft list does not include modern contraceptives. Availability of essential drugs is a key element in the MOPH's primary health care policy and its plans for cost recovery. The availability of contraceptives is crucial to the integration of family planning services into the overall delivery of primary health care. The MOPH needs to add contraceptives to the draft list and officially adopt that list for use in all public health facilities.

Adoption of Reforms: The technical assistance required to develop family planning service delivery policies and medical standards will be provided by the USAID Family Health Support Project. It is anticipated that the MOPH will sponsor a national seminar to finalize and obtain a consensus for these policies and standards. This seminar would also be funded under the Family Health Support Project. The official adoption of a revised essential drug and medical product list which includes contraceptives would require no outside technical assistance or financing.

C. Program Components:

The proposed grant will generate an equivalent of \$5 million in CFA francs to be made available to the MOPH to be used for activities as mutually agreed upon by the GRC and USAID during the course of the grant.

It is anticipated that these activities will support the implementation of the reoriented primary health care program in the country as outlined in the categories below:

- the purchase of locally available essential drugs to provide start-up stocks for community managed drug stores.
- support for the primary health care line item in the MOPH budget in order to renovate and equip health centers in areas which lack access to primary health care services. This will permit the MOPH to launch community co-financed and community co-managed health care in these areas.

The major funding constraints for expanding the PHC program nationwide are the provision of start-up supplies of essential drugs and the renovation and equipping of health centers in underserved areas. With the local currency provided under this NPA program the MOPH will be able to initiate community co-financed and co-managed health centers in an additional 100 to 200 health areas representing improved access to PHC services for an estimated 1,500,000 persons. These funds will be utilized in provinces in which the reoriented PHC program has already developed effective supervision and drug logistic systems.

Policy Reform Measure	Development an Implementation Plan in a Form and Substance acceptable to AID	Use of Local Currency	Perform the Action in a Form and in Substance Acceptable to AID	Use of Local Currency
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Financing of Health Services

1. Adopt legal texts authorizing the collection of fees for services at all levels of the health system; and authorizing health centers to retain the revenues generated from cost recovery mechanisms.	Condition precedent to first disbursement (\$1,000,000).	Purchase of essential drugs to provide start-up stocks at community-managed pharmacies.	Condition precedent to second disbursement (\$2,000,000).	Support of PHC line item in MOPH budget to fund renovation and equipping of health centers.
2. Adopt MOPH application text modifying the current profit sharing mechanisms for health personnel in order to make profit sharing more equitable and provide increased incentives for public health medical personnel to undertake supervising, outreach, and management activities.	Condition precedent to first disbursement.	Purchase of essential drugs to provide start-up stocks at community-managed pharmacies.	Condition precedent to second disbursement.	Support of PHC line item in MOPH budget to fund renovation and equipping of health centers.

Integration of Family Planning Services into the PHC Program

1. Develop and adopt appropriate service delivery policies and medical standards for family planning services consistent with the MOPH primary health care policy.	Condition precedent to first disbursement.	Purchase of essential drugs to provide start-up stocks at community managed pharmacies.	Condition precedent to third disbursement (\$2,000,000).	Support of PHC line item in MOPH budget to fund renovation and equipping of health centers.
2. Officially adopt list of essential drugs and medical products that includes modern contraceptives.	Condition precedent to first disbursement.	Purchase of essential drugs to provide start-up stocks at community-managed pharmacies.	Condition precedent to third disbursement.	Support of PHC line item in MOPH budget to fund renovation and equipping of health centers.

D. Rationale for Program Focus and Justification for Non Project Assistance

The GRC has long experience engaging in policy dialogue with USAID/Cameroon and other donors. The policy dialogue climate in Cameroon has recently been rendered favourable as a result of landmark democratic openings (such as a new law of association) and a series of new laws which eliminate some of the broad policy constraints which existed in the economic and social sectors.

Furthermore, the non-project mode of assistance is not new to the GRC. The Mission and the GRC have negotiated the following NPA programs: the Fertilizer Subsector Reform Program, the Policy Reform in the Export Marketing Sector Program (PREPS), and Program for the Reform of the Agricultural Marketing Sector (PRAMS). The Government believes its large base of trained professionals are capable of implementing policy-based sectorial programs.

The proposed program will assist the MOPH to develop and adopt appropriate policy reforms in order to facilitate the nationwide expansion of a community co-financed and community co-managed primary health care program which includes family planning services. The proposed changes are within the technical capabilities of the MOPH (including donor supplied technical assistance). The development of the policy reform agenda contained in this program will serve to focus government attention on the importance of the PHC subsector. The proposed reforms are critical to the implementation of the national PHC program. This NPA Program will assure that these reforms are formally adopted in a timely fashion. In addition, the program will serve to leverage the impact of USAID's health and population project portfolio as well as the health and population projects of other donors. Finally, the provision of grant monies will provide the MOPH with much needed critical financial resources for the expansion of the reoriented PHC program nationwide.

E. Important Policy Issues Not Addressed in this Program:

1. Development of a National Population Policy

In 1990, the Ministry of Plan completed a draft national population policy which includes the following elements: a demographic and social analysis of Cameroon; justifications for reducing the country's population growth, fertility, urbanization, and infant mortality rates; a rationale for the integration of family planning services in the national maternal and child health program; statements concerning the rights of women and children; and the importance of strengthening the country's demographic capability. In the latter part of 1990, USAID and UNFPA collaborated in the funding of a series of provincial seminars to obtain feedback on the draft policy. A national seminar to make final revisions in the draft policy is scheduled for early 1991.

To date, the provincial seminars demonstrated that there exist considerable controversy regarding the perceived anti-natalist thrust of the draft policy as well as the ability of the central government to fund the increased infrastructure required to support a much larger Cameroonian population. Much of the resistance to the draft policy in the provinces is directly attributable to the political, ethnic, and regional antagonisms prevailing in Cameroon as well as the people's general distrust of the central government.

If the concerns raised in the provincial seminars can be successfully addressed in the national seminar, the Ministry of Plan expects that a national population policy will be presented to the President for signature by mid 1991. If the issues raised in these seminars cannot be resolved, then the adoption of a formal population policy for the country will not be possible in the near future.

In either case, USAID does not feel that conditionality on the adoption of a national population policy would be effective in furthering this process. Instead, the donors will continue to provide the technical assistance and funding required for the Ministry of Plan to continue the national dialogue on the issues and to draft appropriate texts which will lead to a national consensus. Regardless of the outcome of this process, the MOPH and the Ministry of Plan have made policy statements and undertaken actions which unequivocally support the delivery of family planning services as an integral part of the national PHC program. Integrated family planning and maternal child health programs are proceeding at this time with the firm support of the GRC.

2. Adoption of Legal Texts Concerning the Establishment, Composition, and Responsibilities of Community Health Committees

Legal texts need to be adopted to formally authorize the creation of health committees at all administrative levels. The health and health management committees which have been created in PHC pilot zones and whose members are elected by their communities need to have a legal basis for their activities. To date the functioning health committees and health management committees are authorized by provincial authorities.

USAID and the GRC feel that the development and revision of these texts will necessarily be an evolving process over the next decade. Ongoing experience will be required to definitively establish the composition and responsibilities of these committees. The MOPH is closely monitoring the effectiveness of the health committees and the health management committees which are presently functioning and have developed working texts which are acceptable to provincial and national authorities. Under the MCH/CS Project, USAID will provide technical assistance and other support as required to support the evolution of these texts. USAID does not feel that inclusion of these texts in the NPA Program will facilitate the reform process.

F. Linkage of this Program with USAID's Health and Population Portfolio:

USAID has focused its health and population portfolio on supporting the nationwide expansion of the MOPH's reoriented PHC program which is based on decentralized planning, community co-financing and co-management of health care, and the full integration of services. Since 1989, the USAID Maternal Child Health/Child Survival (MCH/CS) Project has supported the implementation of the reoriented PHC program in Adamaoua and South Provinces. In support of the program, the MCH/CS Project has developed a comprehensive training program consisting of modules on community mobilization, the establishment of community health and community management committees, the delivery of integrated and rationalized health care, managing a drug logistics system, integrated supervision, and other PHC topics. The project supports long and short-term technical assistance (TA), in-country training, commodity support, operations research, and participant training. By 1993, the MCH/CS Project will have introduced community co-financed and community co-managed health services into approximately 96 health areas in the two target provinces.

USAID is also funding the PVO consortium of Save the Children and CARE to implement the reoriented PHC program in four divisions of the Extreme North Province.

In late 1990, USAID collaborated with the MOPH in the design of the Family Health Support Project. The purpose of this project, which will be authorized in 1991, is to integrate quality child spacing and related maternal health services into the reoriented PHC program. Major achievements will include:

- Child spacing medical standards and referral guidelines developed and tested.
- National trainers identified and trained and an in-service curriculum developed in child spacing and related maternal health topics.
- Approximately 400 public and private sector health providers trained in child spacing information and services and related maternal health topics.
- An integrated information, education, and communication (IEC) program developed and implemented that will lead to increased demand for MCH and child spacing services and positively affect health status.
- Child spacing and related maternal health activities integrated into the PHC supervision, refresher training, and health management information programs.

- Child spacing services integrated in a phased fashion into approximately 100 community co-managed and co-financed public health health facilities and into approximately 80 private sector clinics.

V. PROGRAM IMPACT:

A. Impact of the Program:

The proposed program will contribute to the stated objectives of the SDA program to: protect disfavoured and vulnerable segments of the population who are directly affected by the economic crisis; encourage participation of poor groups of the population in the process of economic recovery; and provide assistance to political reform of the social sector. The specific impact of this program can be summarized as follows:

1. Short-term Impact:

- Local communities will be involved in the management of local health services and will contribute to the funding of the recurrent costs of the PHC program.
- Essential drugs will be available at all levels of the health system at affordable prices.
- The population will benefit from a strengthened PHC program which includes family planning services.

2. Medium-term Impact:

- The health/population sector will have additional resources due to the contribution of the population through cost recovery activities.
- Professional health workers will be more effective in their jobs because of the availability of essential drugs and the local financing of supervision, outreach, and other PHC operating costs.
- Health professionals will interact more effectively with the population because of the management role played by community health committees.

3. Long-term Impact:

- The cost of curative health care will be reduced as a result of more accessible, less expensive, and more effectively utilized essential drugs.
- Infant, child, and maternal mortality rates will be reduced because of a more effective PHC program.

B. Beneficiaries of the Program:

The expected beneficiaries of the proposed program include:

- Approximately 4.5 million women of reproductive age and children under 5 in the country who will have access to effective and sustainable PHC services. These persons will be the primary beneficiaries of the program.
- Other persons who will have access to improved health facilities which are community co-managed and co-financed and stocked with essential drugs.
- Health professionals who will work in improved health facilities with essential drugs and who will have access to local financing for supervision, outreach, and other PHC operating costs.

C. Potential Negative Effects of the Program:

The legalization of cost recovery at all levels of the health system risks the possibility that the GRC or the MOPH will reduce budgetary support to PHC: This possible negative effect has been thoroughly discussed with high level MOPH officials who have confirmed that the goal of the reoriented PHC program is not to reduce the Government's contribution to PHC but to enhance the overall resources available to the system. A covenant formalizing the GRC's commitment in this area will be included in the Program Agreement. GRC budgets for health will be closely monitored over the next five years to assure that resources are not diverted from PHC.

The cost recovery system could lead to over-prescription of essential drugs: This possible negative effect has been rendered unlikely due to the development of general diagnostic and treatment schedules for health providers which rationalize the prescription of pharmaceuticals. In any case, the USAID MCH/CS Project as well as other donor projects are closely monitoring prescription practices in implementation zones.

The cost recovery system could deny indigents access to PHC services: The ability of people to pay for health care has been carefully studied in PHC implementation zones. People already pay considerable amounts for health care from traditional providers or for drugs sold in markets or pharmacies in large towns. In any case, the MOPH is encouraging community health committees to adopt local policies to deal with persons who cannot afford to pay for health care.

VI. PRELIMINARY ANALYSES

A. Relationship to GRC Policies and Priorities:

The GRC has demonstrated a strong commitment to improving primary health care in the rural areas through its new policy and strategies. In 1989, the MOPH, in response to drastic funding cuts for rural health care, medications, and health support services designed a revised national PHC strategy. This strategy emphasizes decentralized health planning, community management of health facilities, and community co-financing (with the MOPH) of health services. By stressing decentralization, community participation, and cost recovery, the revised PHC strategy directly supports the objectives of the GRC/IBRD Structural Adjustment Program.

In 1990, in response to the 3 percent population growth rate in the country, the GRC completed a draft national population policy. This policy, which is expected to be authorized in 1991, provides a clear framework for defining the population component of the SDA program. The draft policy calls for the development of integrated child spacing information and services in both the public and private sectors in order to reduce the prevailing high infant, child, and maternal mortality rates, improve the health status of women and children, and decrease the prevailing high demographic growth rates in the country.

While developing its national population strategy, Cameroon has taken important steps to launch a national child spacing program. In 1989, the MOPH created the Directorate of Family and Maternal Health (DFMH) with MCH and child spacing portfolio and coordination responsibilities. The medical and nursing schools have developed pre-service reproductive health and child spacing training programs with practicums. The MOPH targeted child spacing as an emphasis area in its 1991 Work Plan.

The GRC has made important policy advances towards the development of a PHC program based on community participation and cost recovery, and towards a national policy supporting the availability of child spacing information and services as part of an integrated MCH program. However, further action needs to be taken. The proposed AID program complements and reinforces these policies by further encouraging the elimination of constraints that deter full implementation nationwide of the reoriented PHC program.

B. Relationship to USAID Strategy and the Development Fund for Africa

USAID/Cameroon's 1990-1994 CDSS, 1990-2 Action Plan, and 1990 Assessment of Program Impact Report aims to assist Cameroon in achieving sustainable, market-oriented, and broad-based economic growth. To achieve this goal, USAID has identified two strategic objectives: increasing the role and efficiency of private markets; and increasing the efficiency with which public services in agricultural research, higher education, and health care are provided. The proposed health sector reform program directly supports the Mission's health strategy by encouraging the integration of child spacing services into the national PHC program while improving the efficiency of the health sector, encouraging private sector development and cost-recovery programs.

Under the Development Fund for Africa's Action Plan, Target 1 and 3 orient support toward improved equity and efficiency in health and family planning programs. For the health sector, the Bureau is committed to strengthening and broadening its health and child spacing activities to include health financing, particularly cost-recovery, as part of an overall sustainability strategy. The proposed program with its emphasis on reinforcing GRC policies that govern the delivery of PHC, child spacing, and health cost recovery directly supports the thrust of the Development Fund for Africa. The program also supports the expanding role of private health providers in delivering child spacing services, and thus meet the Mission's strategic objective to promote private markets.

In developing the proposed program, USAID has focused on those policies and programs which complement the activities of other donors and which have been major constraints to efficient delivery of quality primary health care and child spacing programs. The program complements the objectives of proposed and ongoing USAID health projects including the Maternal Child Health/Child Survival Project and The Family Health Support Project.

C. Dollar Disbursement Mechanism

Three options are available to Mission for fast disbursement of program funds in support of policy reform: an ESF Cash Transfer, a Commodity Import Program (CIP) or a Sector Cash Grant. The ESF is not applicable if the source of financing is the DFA. Based on discussions between AID/W and USAID/Cameroon, it has been agreed that the sector cash grant is the optimal financing mode due to the need for quick disbursement of funds to stem some of the effects of the SAP and to support the World Bank SDA. The Sector Cash Grant mode supports policy and institutional reforms with a focus on long-term development objectives. Dollars disbursed under the program will be deposited in a Separate Dollar Account in a United States bank identified by the GRC. This account shall be established solely for such funds. These funds shall not be commingled. All interest earned on the bank account shall be used only for agreed upon purposes. Dollar utilization and tracking will follow guidelines provided by 1990 State 194322 "Financial Management on Dollar Separate Account for ESF Cash Transfer and ESF, DA, and DFA funded Non-Project Sector Assistance Cash Disbursements".

The dollar disbursement is planned in 3 tranches over the two year life of program. The initial disbursement will be at the time of obligation and will provide start-up local currency for PHC reform activities. The remaining two disbursements will be based on the GRC meeting specific conditions to be agreed upon between GRC and USAID. The local currency equivalent of the dollar disbursements shall be deposited in a Special Account and uses of these counterpart funds will be mutually agreed upon by AID and the GRC.

The GRC will expend funds from the dollar disbursements for the following purposes, in order of preference:

1. Importation of goods from the United States;
2. Importation of goods from other countries included in AID Geographic Code 899, and in conformity with the policies of the GRC;
3. Payment of debts owed by the GRC to the United States (other than payment of principal or interest on loans or credits which originally financed military requirements), provided payment of such debts is consistent with the agreed rescheduling arrangements where applicable;
4. Payment of a debt owed by the GRC to a multi-lateral bank; or
5. Such other uses as the parties may agree in writing.

AID and the GRC will agree upon the general uses of the dollars which shall be identified in the PAAD, and subsequently in the Program Grant Agreement (PGA). Upon satisfaction of the appropriate conditions precedent, AID will make NPA cash disbursements.

The Program Agreement will require the GRC to deposit each tranche of the sector dollar grant into a non-commingled, interest-bearing account at a Commercial Bank in the United States of America. The bank will be selected by the GRC. All interest earned on the bank account shall be used only for the purposes identified above.

At the time of the request for the cash transfer from AID/Washington, the Mission will identify the separate, non-commingled account established by the GRC at a United States bank to which the funds will be disbursed. Based on the Mission's experience with the Fertilizer Sub-Sector Reform Program (FSSRP), it is expected that the transfer will be completed in two days, and therefore, under current guidelines, additional accounting measures during the transfer process will not be required. However, in the event that this expectation is not realized, USAID will require separate accounts for the entire transfer process.

The Caisse Autonome d'Amortissement (CAA) will be responsible for managing the dollar separate account. Based on the performance of the CAA in managing the separate dollar account for the FSSRP (17.0 million cash grant), the Mission has determined that the CAA has the capability to provide the necessary financial management. CAA will provide USAID will quarterly reports on the separate bank account for the Primary Health Care Sub-Sector Reform Program (PHCSSRP) dollar account. The format for these reports will be outlined in a PIL, and will provide information on deposits to, withdrawals from, and disposition of dollars from the separate account. The PIL will also identify any documentation necessary to verify the accuracy of the reports and which documentation should accompany the reports that are submitted to the Mission. In addition, the Mission will make arrangements to receive statements on the separate account directly from the bank where the account has been established. The Mission will verify the reports at least once per year by inspection of GRC records pertaining to the separate account. An annual review of the account will be conducted by the Mission. Given past experience with the CAA, the Mission does not feel that a full audit is warranted on an annual basis. However, the Mission will reserve the right to conduct non-federal audits of the account.

D. Local Currency Programming and Tracking:

1. Uses of Local Currency:

The PAAD and Program Grant Agreement will require the GRC to deposit in a Special Account the local currency equivalent of the amount of each sector dollar grant received from the Primary Health Care Sub-sector Reform Program within 45 days upon receipt of each such dollar grant. The amount of local currency shall be calculated at the highest

exchange rate in Cameroon for any person for any purpose in Cameroon on the date of the sector grant disbursement by AID.

The PAAD and Program Grant Agreement will specify that upon receipt of each dollar grant, the GRC will deposit into a separate, non-commingled, interest-bearing account the equivalent local currency amount. AID and the GRC will agree in writing on the bank where the account will be established.

The PAAD and Grant Agreement will discuss the approved uses for the local currency. Illustrative uses for the local currency are provided section IV of this PAIP. Detailed criteria for the use of local currency will be negotiated with the GRC during PAAD development.

E. GRC Implementing Institutions

The main implementing agency for the GRC will be the Ministry of Public Health. However, the proposed program requires that the Ministry of Finance and the Ministry of Plan play important roles in implementation planning, meeting of conditions precedent, and disbursement of the tranches. Their role will diminish as actual implementation and programming of local currency progress. They will also participate with the MOPH in the designation of the allocations of the dollar generated CFAF funds against activities included in the Cameroonian budgets of 1991, 1992 and 1993. At least two directorates in the Ministry of Public Health will be key actors in the implementation of the policy and institutional changes. Mission staff has already conducted in-depth discussions with Ministry officials on possible activities for which CFAF funds might be earmarked. The chief implementing body will be the Directorate of Preventive Medicine and Rural Health which is responsible for the planning and implementation of the national PHC program. The other key implementing body will be the Directorate of Family and Mental Health which oversees all maternal child health and family planning activities in the country.

The Mission has worked very closely with GRC officials in developing this PAIP. Discussions have been frank and productive. Mission believes that there are no serious institutional impediments to effective implementation of the sector assistance. However, a more detailed institutional analysis will be carried out at the PAAD development stage to fully assess the compatibility of projected institutional arrangements with project objectives. GRC capabilities. The analysis will focus on the broader institutional framework within which policy and institutional reforms are to take place, the potential roles for each of the MOPH directorates, the Ministry of Finance, the Ministry of Plan, the local/provincial governments, and the local communities. This analysis will also emphasize a projection of the people level impact the sector grant might have on reinforcing institutional capacities for policy reforms in the health sector.

F. USAID Management Capacity

USAID/Cameroon Health Nutrition and Population Division will be the main implementing office for the proposed project supported by the USAID Office of Economic Analysis and Policy Reform Implementation (EAPRI).

The extensive experience the Mission has in implementing NPA activities and for promoting policy reforms will be drawn upon in implementing this program. The Mission has the PRAMS, PREPS and Fertilizer Sub-Sector Reform Program (FSSRP) as NPA examples to draw on. The Mission is familiar with the procedures for releasing, monitoring and accounting for dollar disbursements. The procedures that have worked well for these NPA projects have been documented and serve as guides for implementation of NPA activities. Contacts have been established with GRC policy makers which will facilitate policy dialogue.

The proposed health sector reform program like reform programs elsewhere will prove to be staff intensive, requiring senior staff-level input into policy dialogue. Health planning and economic technical assistance will be provided through the ongoing USAID MCH/CS Project. In order to facilitate the management of this program, the Mission will constitute a program committee which will be chaired by the HPN Officer. Other members of the committee will include representatives from EAPRI, the Program and Project Development Offices, the Controller, and the Deputy Director. The committee will provide guidance on AID requirements and resources related to the implementation of the program. The HPNO and USAID/Cameroon senior management will lead discussions with high level GRC officials to facilitate policy implementation, reforms and dialogue.

G. Monitoring

The monitoring objectives of this health sector program are to verify GRC compliance with the program's conditionality; to identify and resolve constraints to program implementation; to verify attainment of program objectives; and to assess the people level impact both positive and negative of the program. Monitoring will take place on the input, output, and purpose levels. Reliable baseline data will be required to monitor activities. The complementary MCH/CS Project provides resources to assemble such data. Detailed plans for monitoring and evaluation will be developed during PAAD design process.

H. Financial Plan

Financial arrangements for this health sector reform program consists of two basic elements: foreign exchange in the form of dollars and local currency generated from the foreign exchange.

1. Dollar Funds: \$5 million in foreign exchange will be provided to the GRC in three tranches over a two year period to be deposited in a U.S. Bank. Dollars will be tracked.
2. Local Currency Budget: The GRC will be required to provide the CFAF equivalent of \$5 million to be used for mutually agreed upon program purposes. Current estimates are that the local currency would also be disbursed over the two year program period. Possible uses in the health sector are outlined in section IV of this PAIP.

I. PAAD Design Strategy:

Four principles should guide the PAAD design process:

- 1) maximum participation of the MOPH and other implementing agencies.
- 2) coordination with other donors involved in the sector such as the UNICEF, the German Cooperation, UNFPA, and WHO.
- 3) detailed analyses of the institutional arrangements of the proposed policy reforms; the institutions which will develop and implement the policy reforms; the positive and negative impact on the target population; and the concept and implications of health cost financing in Cameroon.
- 4) linkages to the USAID MCH/CS and Family Health Support Projects.

J. PAAD Design Team

The team should include a project development officer; a health economist with experience in designing NPA projects involving national budgetary, health planning, and cost recovery programs; a health and population officer with experience in policy development and implementation; and an experienced health planner. This team should be supplemented by local consultants in sociology to analyse program beneficiaries and impact; an institutional analyst to review the institutional capability of the implementing agencies; and a financial analyst to review mode of financing, disbursement and recurrent costs.

The MOPH should assign a team of health officials with responsibility for health budgetary, health financing and cost recovery, population, and PHC to participate as part of the overall PAAD team. The PAAD team will also hold discussions with other key donors in the sector UNICEF, the German Cooperation, WHO, and UNFPA. Efforts will be made to negotiate program policies that complement rather than compete with other donor plans. PAAD design team composition, level of effort, source, and costs are shown below.

<u>Team Members</u>	<u>Weeks</u>	<u>Probable Source</u>	<u>Costs</u>
Project Development Officer	4-5	REDSO/WCA	OE
Health Officer	4	Mission	OE
Population Officer	4	REDSO/WCA	OE
Health Economist	4	Contractor	28,000 PDS
Health Planner	2	Contractor	14,000 PDS
Social Analyst	2	Contractor (local)	5,000 PDS
Institutional Analyst	4	Contractor	28,000 PDS
Regional Legal Advisor	1	REDSO/WCA	OE
		TOTAL PDS	<u>\$75,000</u>

Timing: USAID/Cameroon expects AID/W ECPR approval by mid February 1991; social, institutional and health budget expenditure and cost financing analyses done by end April 1991; and design of program to completed by the end of May 1991 for USAID/Cameroon field authorization by fourth quarter of FY 1991.

Annex

Initial Environmental Examination or Categorical Exclusion

Country: Cameroon

Program Title: Primary Health Care Subsector Reform Program

Funding: DFA: \$5 million

IEE Prepared by: Janet Schulman, PDO, REDSO/WCA

Environmental Action Recommended

Positive Determination -----
 Negative Determination -----
 Categorical Exclusion -----
 Deferral _____

Categorical Exclusion

This activity meets the criteria for Categorical Exclusion in accordance with 22 CFR 216.2 (c) (2) (viii) and is excluded from further review because it is an activity involving health services and includes no components which adversely affect the environment.

Approved 
 Disapproved _____
 Date 2/21/91

Concurrence

Bureau Environmental Officer
John J. Gandet, AFR/TR/ANR

Clearance:GC/AFR_____