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Decentralisation of Health Care Spending and HIV/AIDS in Cameroon

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Background Information

As Claude Ake pointed out in 1981, 'productive forces (comprising labour power, objects of labour and means of labour) express the overall capacities of a society. They tend to develop over time. When one talks of the development of productive forces, one may be thinking of the quantitative and qualitative improvements in labour power, for instance when people acquire more scientific education and technical skills. One could be thinking of the improvement of natural assets such as the irrigation of arid land to make it arable. One could also be thinking of the development of the technology with which man produces. The importance of the development of productive forces to society cannot be overemphasized. The state of the development of productive forces decisively influences social organizations, culture, the level of welfare and even consciousness'.

Labour power comprising the physical, psychological and intellectual capabilities of people constitutes the subject matter of productive forces. Good health is a major determinant of labour power and consequently, the health sector is generally one of the most sensitive of any in the economy and usually attracts a lot of attention from governments and institutions. Improved health contributes enormously to economic growth and development in four ways: it reduces production losses caused by worker illness; it permits the use of resources that can be totally or nearly inaccessible because of disease; it increases the enrolment of children in schools and makes them better able to learn; and it frees resources for alternative use that would otherwise have to be spent on treating diseases or illnesses. This implies that good health leads to productivity

gains and therefore improves the efficiency in the use of our scarce and depleting resources. Economic gains are relatively greater for poor people who are typically most handicapped by ill health and who stand to gain the most from the development of underutilised resources. Throughout Africa, the privatisation of health care has reduced access to necessary services. The introduction of market principles into health care delivery has transformed health care from a public service to a private commodity. The outcome has been the denial of access to the poor, who cannot afford to pay for private care.

The relation between economic change and health has been of interest to both social and medical scientists. Empirical studies have generally focussed on mortality or its opposite, survival, expressed as life expectancy at birth, probably because of the difficulties of collecting sound morbidity data, particularly in developing countries. Although a long-run general relation between economic and health conditions is evident in both cross-sectional and longitudinal analyses, the debate has centred on the relative importance to mortality reduction of income gains and of improvements in public health or medical technology. Most studies suggest that there is a very strong relationship between per capita income and life expectancy in the long-term (Wagstaff 2000). Historical records also show that mortality rates do respond to short-term economic fluctuations, particularly in poor and agricultural settings. The usage of health care facilities depends on the availability and accessibility of these facilities to users. The government, in most countries, plays a leading role in this regard. Existing literature also shows that the usage of health care facilities is sensitive not only to availability and accessibility alone but also to the quality of health care provided by each facility (Collier et al. 2002).

Over the past fifty years, life expectancy has improved more than during the entire previous span of human history, although the last twenty years have been ravaged by the HIV/AIDS pandemic. In 1950, life expectancy in developing countries was forty years; by 1990, it had increased to sixty-three years before dropping to below fifty-five by 2002 due to the HIV/AIDS pandemic. In 1950, twenty-eight of every one hundred children died before their fifth birthday; by 1990, this had fallen to ten (World Bank 1993). Despite these remarkable improvements, enormous health problems still remain. New fatal diseases like HIV/AIDS and to a lesser extent SARS, have surfaced; whereas old ones that were already under control like tuberculosis are reappearing. Absolute levels of mortality in developing countries remain unacceptably high. Child mortality rates are about ten times higher than those in developed countries. In addition, every year, seven million adults die of conditions that could be inexpensively prevented or cured. Surprisingly, remarkably few attempts have been made to estimate total national financing or expenditures from all sources and relate them to their various uses by all the health providers within the context of national health priorities. This study therefore is structured to answer the following questions that are essential

in evaluating the success of the decentralisation of health care spending in Cameroon:

- Who finances health care, how much and for what?
- Are expenditures consistent with health priorities (including the fight against HIV/AIDS)?
- How can resources be mobilised by the health providers and are the generated resources used more efficiently to reduce the spread of the HIV pandemic?

Objective of the Study

The main objective of this study is to examine the effectiveness of the decentralisation of health care spending in Cameroon. Specifically the study is structured to achieve the following minor objectives:

- Identify the respective sources of finances and the health care providers;
- Examine the changing trends in public and private health spending;
- Assess the trend and socio-economic impact of the HIV/AIDS pandemic;
- Make policy recommendation on the way forward.

Methodology

The main sources of data for this study are secondary. The data are extracted from reports of ministries involved in health related issues. Principally, the Ministry of Public Health provides the bulk of information, and to a lesser extent, the Ministries of Planning and Regional Development, Finance, Armed Forces, National Education, Higher Education and Social Affairs. Other relevant data, particularly on the external financing of health, are collected from the World Bank and World Health Organisation documents.

Basic analytical tools include descriptive statistics. These are complemented by the National Health Accounts Framework (NHA) technique. Peter Berman developed this technique in 1997. The choice of the above methodologies is aimed at ensuring simplicity in the analysis such that results should be more policy oriented.

Theoretical Considerations

When economic functions are shared among the various tiers of government with each tier handling its own activities, efficiency is enhanced. Efficiency, which is concerned with the need to finance or provide services in a way that maximises the well-being of the people, can be divided into two, namely, allocation and internal efficiency (World Bank 1997). Allocation efficiency, with respect to health care, for instance, involves the pursuit of health care programmes or services whose benefits are maximised. To be worthwhile; they must be expanded up to the point where marginal benefit equals marginal cost. Internal efficiency, on the other hand, deals with the avoidance of waste, which may be an aftermath of deficient administrative or managerial resources within the production process.

Both forms of efficiency manifest themselves in the health sector in various ways. Examples of allocation inefficiency include under-funding of health services, misallocation of resources among the primary, secondary and tertiary subsectors etc., while over-centralisation of financial decision making and underfunding of specific complementary inputs like drugs, fuel, working vehicles etc., are examples of internal inefficiency (World Bank 1987). Efficiency, whether allocation or internal, covertly or overtly relates to equity. Equity deals with access to health care services, especially for the poor in society. It looks at distribution rather than the processes through which distribution is achieved. More so, it does not necessarily emphasise an equal degree of health care for everyone, rather, its emphasis is on accessibility in physical and financial terms.

The efficiency and equity arguments tend to show why decentralisation is appropriate primarily for services provided directly to people in dispersed facilities, where there are user charges for drugs and curative care. This agrees with the argument that access to improved quality of health care through effective sharing of health care functions enhances, to some degree, the performance profile of labour, which, in turn, will increase productivity for the betterment of health care delivery.

Health Problems in Developing Countries

The characteristics and performance of the health sector vary tremendously among developing countries. However, in most cases the sector faces three main problems. It is argued here that each of these problems is due in part to the efforts of the government to cover the full cost of health care for everyone from general public revenues.

The first problem concerns the allocation of insufficient spending on cost-effective health activities. Current government spending alone, even if it were better allocated, would not be sufficient to fully finance for everyone a minimum package of cost-effective health activities, including both the truly 'public' health programmes noted above and the basic curative care and referral services on health. Not enough funding goes towards basic cost-effective health services. As a result, the growth of important health activities is slowed despite the great needs of fast expanding populations to pay at least some of the costs of health care.

The second problem concerns the internal inefficiency of public programmes. Non-salary recurrent expenditures for drugs, fuel, and maintenance are chronically under-funded, a situation that often dramatically reduces the effectiveness of health staff. Many physicians cannot accommodate their patient loads, while other trained staff are not productively employed. Lower level facilities are underused while central out-patient clinics and hospitals are overcrowded. Logistical problems are pervasive in the distribution of services, equipment and drugs. The quality of government health services is often poor; clients face unconcerned or harried personnel, shortages of drugs, and deteriorating buildings and equipment.

The third problem refers to the inequity in the distribution of benefits from health services. Investment in expensive modern technologies to serve the few

continues to grow while simple low cost interventions for the masses are underfunded. The better off in most countries have better access to non-governmental services, because they live in urban areas and know how to use the system. The rural poor benefit little from tax-funded subsidies to urban hospitals, yet often pay high prices for drugs and traditional care in the non-government care sector.

Decentralisation of the Health Sector in Cameroon

The decentralisation of the health sector in Cameroon has generated a lot of controversy, especially because of the concern for effective and rapid provision of health services nation-wide, given the threats of HIV/AIDS in the country.

The movement from colonial to independent state in the 1960s paved the way for Health Sector Reform in Cameroon. The colonial master, as was the case in other African countries, established health services in towns where the poor had little or no access. More so, the model of health care was purely colonial, intended to serve the needs of colonial administrators and expatriates, with separate or secondary provision made for Africans. It was characterised by the irrational distribution of health infrastructure, as hospitals were concentrated in the urban areas to the detriment of rural areas. It was also more curative than preventive oriented. Critical in the colonial period was the mobile medical team initiated by Dr Eugen Jamot to treat sleeping sickness and malaria with the aid of community members. Patients were treated on the spot and through preventive strategies. The post-independent period saw Cameroon in an experimental stage.

The DASP zone was introduced to replace the mobile team for the fight against endemic diseases with vertical programmes. Extension workers were trained and new institutions were created like the University Teaching Hospital (CHU). Although the DASP zone proved that communities were ready, to a certain degree, to finance health care and organise them to create village hospitals, it lacked inter-sectoral collaboration and was cost-ineffective, hence subject to revision.

For effective implementation of the decentralisation policy, the Cameroon health system adapted a pluralistic system because it was characterised by multiple sources of financing and health care providers. The main financing sources nowadays are the government, public enterprises, and foreign aid donors. Private enterprises, households, religious missions, NGOs, government health facilities, public enterprise health clinics, private clinics, pharmacies and drug retailers, and traditional doctors are the providers of health care. It is also a vertical system in the sense that financing sources deal directly with the providers without going through intermediaries or financing agents.

The Declaration of Health Sector Policy organised health services at three levels. The Cameroonian government clearly defined the roles and functions to be performed by each tier of government in its 1990 circular letter.

The constitution stipulates that the central government should support in a coordinated manner, three sub-systems of health care. The Ministry of Health

(MOH) prepared the schedule of responsibilities assigned to the different levels in such a way as to provide effective health services at all levels. These levels are:

a) Local health centres, usually staffed by certified nurses and providing preventive and basic curative care to the surrounding population;
b) Provincial and central level hospitals providing specialised medical services;
c) District and Departmental hospitals usually staffed by at least one physician and providing first referral health services.

Co-management of the health system, linked to both decentralisation and cost recovery measures, has been promoted since June 1990 when the minister of public health signed a 'lettre circulaire' authorising the creation of community health and management committees at the village, health centre and sub-divisional levels. Health Committees (called COSA) are being established for each catchment area and will have responsibilities for planning activities and expending resources made available to the community health facilities. A subcommittee of COSA (called COGE) will be responsible for managing the funds obtained through cost recovery. At the district level, COSADI are being established with similar responsibilities.

Financing the Health System

Cameroon's public health care system is financed by the national budget, revenues from the authorities to retain the proceeds from cost recovery at the local level, and external aid.

Government Financing

The government finances health care service delivery through the use of buildings and land ceded to the Ministry of Public Works; from civil servant medical and para-medical staff salaries paid by the Ministry of Finance; and from investment and operating support provided by the Ministry of Public Health.

Overall government spending on health has never substantially exceeded five percent of the national budget (compared with the ten percent recommended by WHO) but did attain approximately US$12 per capita (35.58 billion CFAF, or eight percent of the national budget) in 1985-86. The economic crisis forced deep budget cuts in 1986-87 and 1987-88. Since 1988-89 the budget has remained selectively stable both as a percentage of the national budget and in absolute terms, while obviously declining in real terms.

Community Financing

Since 1964 all health facilities have been authorised to charge fees for services, which, except for a percentage retained by consulting physicians as incentive payments, were retained by the treasury. Laws passed in 1990 and 1992 are designed to significantly increase financial resources available to meet operating expenses.

The drug financing law of 1990 authorises public health care facilities to establish community-managed drug revolving funds through which drug sale revenues can be retained locally. The Hospital Financing Law of 1992 authorised selected tertiary-level hospitals to retain fifty percent of fee-generated revenues.

The existing system of cost recovery in Cameroon (confessional health centres, bilaterally funded projects, and private non-profit health facilities) exhibits a wide variation in the kinds and amounts of managing revenues. The fundamental issues affecting the viability of cost recovery include the availability of essential drugs, an equitable pricing policy, and common approaches for dealing with chronic under-utilisation of health services.

External Financing

The principal sources of external support for Cameroon's health sector include the traditional multilateral donors (WHO, UNFPA, UNICEF, EU) etc.; a wide range of bilateral donors, several with many years of experience in the country (Germany, USA, Belgium, and France); and a significant non-profit sector comprising both international NGOs and local confessional groups. Germany (GTZ) is involved in the development of the decentralised health districts in the South West and North West Provinces. USAID financed maternal and childcare programmes in the Adamoua and South provinces. France for its part is providing assistance in hospital management in the North and Littoral provinces.

Discussion of Results

Sources of Funds to Providers of Health Care

A matrix of the sources of funds to providers in the Cameroon NHA for the 2000/2001 fiscal year is presented in Table 1. This Table illustrates the decentralised health care spending in the country. It portrays not only the allocation inefficiency but also the internal inefficiency in the utilisation of resources at the disposal of public health care providers. Sources of financing are presented at the top, and providers on the left, of the matrix. The country's total health expenditure for that year was estimated at CFA francs 2,225,103 million - equivalent to about US $347 million. Total GDP that year stood at CFA Francs 6,320 billion (US $8.262 million). National health expenditures represented 3.3 percent of GDP, equivalent to an annual per capita expenditure of CFA francs 13,332 (US $26.7). Total public spending on health (government plus state-owned enterprises plus foreign aid) was CFA francs 665,539 million, equivalent to US $6 per capita or 0.9 percent of GDP; while private spending (households, private enterprises, and religious missions/NGOs) totalled CFA francs 1,013,820 million, equivalent to US $20.6 per capita or 2.42 percent of GDP.

Table 1: Financial Sources to Providers Matrix (in millions of CFA francs)

Providers	Ministry of Economy & Finance	State Owned Enterprises	Foreign Aid	Private Owned Enterprises	House-holds	Private Non Profit	TOTAL
Ministry of Public Health	56.3,148		38.285			55.2,172	149.8,17
Other Ministry Facilities	4.1,292				27		31.1,292
State owned Enterprise Facilities		6.0,853			1,472.5		1,478.5853
Non Profit Facilities					90.1,542	5.58	95.7,342
Pharmacies & Drug Retailers		13.3,796		12.7,255	206.5,034		232.6,085
Private - Profit Clinics		3.3,511		7.6,353	9.1,388		20.1,252
Traditional Healers					27.1,033		27.1,033
TOTAL	60.4,440	22.816	38.285	20,360.8	2,022.4	60.797.2	2,225.103

Source: Data for this core matrix was obtained from numerous sources

The Providers of Health Care

In Table 1 we observed the allocation of health spending among the various categories of providers. The most important single use of expenditure in the Cameroon health system is for drugs, which came to CFA francs 232,608 million or 88.9 percent of total household health expenditure. This Table includes the actual cost of drugs in public and private health facilities, private pharmacies, drug retail stores, as well as sales by roadside vendors. It does not include profits on drugs in public and private health facilities. Unfortunately, no information is available permitting a breakdown by facility. The amount reflects the high cost of drugs in the country, due partly to the fact that virtually all drugs are imported, and partly to major inefficiencies in the drug procurement system. These are due to the long and cumbersome administrative procedures as well as the lack of transparency in the authorisation of drug imports.

In terms of the allocation of health spending between public and private facilities, CFA francs 1.478.585 million went to government facilities. Private not-for-profit and private for-profit providers received, respectively, 95.7,342 million

and 3.3511 million, while 27.103.3 million was estimated to have gone to traditional healers.

There has been a long-standing debate in Cameroon concerning the relative importance of the public and private sectors in the provision of health care. On the basis of the frequency distribution of patient consultations by category of health provider, information from the 1995 household budget-consumption survey suggests that 14.8 percent of these consultations were with traditional healers. As far as consultations in modern health centres are concerned 43.8 percent took place in public facilities and 56.2 percent in private facilities, even though services in the latter are 50 percent more expensive, and the former outnumber the latter by a ratio of 3:1.

These percentages are also confirmed in the North West province where excellent records of monthly consultations at health centres during the period 1989-1995 show that in 1995 there were 173,450 consultations in religious mission facilities and 129,569 at government facilities (Ghogomu et al. 1996). This is testimony to the superior quality of private sector health services. The household budget-consumption survey did not, however, provide any indication of the relative importance of public and private inpatient care (such as the total number of inpatient days for the two categories of facilities). But the records of monthly hospital consultations in the North West province show the domination of the government sector with 154,396 consultations in 1995 as opposed to 92,274 for the missions and 16,327 for the private for-profit sector. The evidence from the North West province during the past several years also suggests a steady decline in health care provision by the government sector: the share of the government sector in both health centre and hospital consultations fell from 72.9 percent in 1989 to 50.1 percent in 1995, while the share of mission and private sectors increased from 25.5 percent to 47 percent, and 1.6 percent to 2.9 percent respectively (Ntangsi 1996). The main reason cited for the declining role of the public sector was the economic crisis, which has drastically reduced resources for the maintenance of facilities and led to the demoralisation of health staff following the more than 60 percent cut in civil servant salaries in January 1991. Owing to a rapid deterioration of facilities the bed occupation ratio at the General Hospital in Yaoundé fell from 45 percent in 1985 to 23 percent in 2001, and since then this has been reported to be a generalised phenomenon throughout the country. These figures strongly demonstrate the ineffectiveness of the decentralised health care system in Cameroon. Also it explain the raison d'être for the increase of out-of-pocket expenditures by respective households.

High Transaction Costs in Government Spending

The low levels of government health spending and the advent of the economic crisis in 1985, combined with shrewd political expediency, ushered a new and harsh reality into the Cameroon budgetary system, which has had far-reaching

consequences for health care. Year after year, and in an apparent attempt to satisfy the demands of various political constituencies, government budgets approved by the National Assembly (Parliament) and allocated to ministries in the form of treasury vouchers (with the exception of salaries which are paid directly to staff by the Ministry of Economy and Finance) have largely failed to reflect the severe and steady decline in government revenues. The approved budget exceeded actual government revenues by 42 percent in the fiscal year 2000/2001. The total value of treasury vouchers issued in any one year for the purchase of goods and services has far exceeded government revenue, and a substantial number of vouchers have remained unpaid for several years. Treasury offices have been besieged by long queues of suppliers and other contractors waiting to be paid, but without any pre-established order of priority for payment. The end result has been that treasury officials at various levels of the bureaucracy have capitalised on the situation by extorting 'commissions' or bribes of up to 60 percent of the value of a voucher as a condition for payment.

Since the non-salary health expenditures by government involve substantial transaction costs, one must distinguish between expenditures for health and expenditures for health care. Expenditures for health are the resources that have actually been mobilised for the health sector. In the 2001 fiscal year they amounted to CFA francs 60.4434 billion of which 19.2 billion was in the form of salaries (for government health personnel). The expenditure balance of 41.24 billion in the form of treasury vouchers would have involved transaction costs evaluated at 20.62 billion (assumed to be approximately 50 percent of nominal value). This means that actual expenditures on health care were therefore only 20.62 billion. In NHA, transaction costs are counted as health expenditures even though they are not spent on health care; they are viewed as a penalty or a toll that must be paid in order to have access to the 20.62 billion. This is a demonstration of the internal inefficiency inherent in the health care system in Cameroon.

In a recent analysis of the Cameroon budgetary system undertaken for the European Union by AEDES, consultants Jean Benoit Burrion and Philippe Vinard made the following assessment:

> Whatever the level in the health pyramid, the testimony is unequivocal: the delegated credits [approved budgets to the regions] are utilized at no more than half their nominal value for the purpose for which they were intended. Some speak of 30% but it is difficult to evaluate. At any rate this is not rumor or widespread prejudice but a reality lived and experienced by everyone.

For about ten years the Treasury has experienced an acute shortage of liquidity. At first this shortage induces a 'waiting line' of suppliers for the settlement of their claims at the counters of the treasury. Delays of payment can be long (sometimes a couple of years). In the long-run an informal system of management of the waiting line installed itself based on the law of supply and demand. Given the limited resources of the treasury, these are sold to the most intransigent suppliers.

Progressively the informal system becomes a near institutionalised system in which everyone follows their interests. The system transforms itself into a network of complicity.

The system has two consequences. The first is some sort of natural selection of suppliers who are capable of negotiating their claims or who are financially solid. The second is the regulation of the market, which results in 'the law of 50 percent'. However, according to the authors, it is not that the authorities are ignorant of what is going on. At least one cabinet minister attempted unsuccessfully to fight the system. Indeed, as the authors have implied, far stronger action is needed at the highest political level to change the system. 'The system is known to everyone and the authorities at the central level are fully conscious about what is going on. Given the interests in play, it is very unlikely that an improvement of the liquidity situation or that a few exemplary "sanctions" will be sufficient to change the "system"'.

Equity Considerations

Given the low level of per capita incomes in sub-Saharan Africa, large segments of the population may not even have access to the basic package of health care. An important policy by its stewards should therefore be to improve equity of access through an appropriate distribution of health expenditures, either across geographical regions or across income groups. This is because stewards of the health system are entrusted to provide an optimal control and intervention package to reduce the prevalence of HIV/AIDS and to minimise the unfair financial burden.

The NHA sources regarding geographical regions and prevalence of AIDS matrix and the distribution of household per capita health expenditures by population deciles (which is a partial source to income group matrix) are presented in Tables 3 and 4. They are used to discuss equity as concerns of the spending in health care, given the challenges of HIV/AIDS.

The NHA geographical distribution analysis demonstrates that some regions are disproportionately penalised over the others in the allocation of public funds. Table 3 reveals more dramatic inequalities. Cameroon's political strategy, like in any sub-Saharan country where universal coverage has not been achieved, was to ensure that the limited public resources benefited the rural poor. A careful review, using national health accounts data revealed that, contrary to policy intentions in Cameroon, the allocation of resources for the rural poor disfavour the regions with greater epidemiological challenges such as HIV prevalence. The sources to regions matrix shows considerable inequalities in the distribution of health expenditures between urban and rural areas (and also to a lesser extent among rural areas).

Table 2: Sources to Geographical Regions and Prevalence of AIDS Matrix (in $ per capita)

Regions	Government	Public Enterprises	Foreign Aid	Private Enterprises	Households	Religious Missions	Total by region	HIV prevalence rate by region%
Yaounde	13.1	4.5	4.3	4.0	77.9	-	103.8	2.023
Douala	6.5	5.4	4.3	2.9	82.9	-	I02.0	27.9
Other towns	5.4	6.3	4.3	-	29.5	-	45.5	31
Rural Forest	5.4	6.4	4.3	-	32.4	-	48	34.1
Rural Plateau	4.5	-	4.3	-	33.8	-	42.6	32.054
Rural Savana	4.0	-	4.3	-	43.6		51.9	52.545
All Regions	6.8	2.4	4.3	2.2	43.6	68.1	127.6	34.1

Source: Computed by the author, 2004.

Following the presentation in the household surveys, Douala (the country's largest town), Yaoundé (the capital) and 'other towns' are treated as regions (they held some 40 percent of the country's population in 2000/2001) and there are also three rural regions: the forest area (covering the Centre, South and East provinces), the plateau area (covering the North West, West, South West, and Littoral provinces) and the savannah (covering the Far-North, North, and Adamaoua provinces).

As can be seen, per capita health expenditures were respectively $102.0 and $103.8 in Douala and Yaoundé compared with $42.6 and $51.9 in the rural plateau and rural savannah respectively. The high expenditures in Douala and Yaoundé are explained by the combination of high household expenditures (due to high incomes), high government spending, and a concentration of public-owned and private-owned enterprises. In other words government expenditures have helped to aggravate, rather than attenuate, existing regional inequalities in health spending by the other sources.

A cursory look at the distribution of health expenditures across income groups reveals more dramatic inequalities. Per capita household expenditure for health by the poorest ten percent of the population was only $11.4 while for the richest ten percent it was $191.2.

Table 3: Household Per Capita Health Expenditures by Decile of the Populations

Deciles of Population	Total Per Cap. Expenditure (C F A Francs)	Per Capita Health Exp. (CFA)	Per Capita Health Exp. (in dollars)	Total Population	Percentage of Total Population
1	87.2	8.3	11.4	1,894,784	12.47
2	132.7	12.7	17.3	2,097,108	13.8
3	161.5	15.5	21.1	2,048,879	13.48
4	200.7	19.2	26.2	1,815,854	11.95
5	236.2	22.6	30.9	1,661,053	10.93
6	291.5	27.9	38.1	1,379,780	9.08
7	373.1	358.1	48.8	1,362,861	8.97
8	489.6	470.0	64.1	1,107,016	7.28
9	679.5	652.3	89.0	921,984	6.07
10	145.9	140.1	191.2	907,868	5.97
Entire Pop	324.7	311.7	42.5	15,197,500	100

Computed by the author, 2004.

As noted earlier, the World Bank has evaluated the cost of a basic package of health care delivered to ninety percent of the population in a low-income country like Cameroon per capita to be approximately $50 (World Bank 2003). On the basis of our estimate the actualised cost in 2000/2001 was $42.2 per capita. This means that the sixth deciles of the population (with a per capita household expenditure of $38.1) all by themselves could not have been able to afford the totality of the basic health package. However, if it were assumed that the government expenditure of CFA francs 41.24 billion (after transaction costs) were to be distributed equally to the population (15 million in 2000/2001), this would have resulted in an extra per capita expenditure of $2.6. If foreign aid expenditures of $5.8 per capita were also added the extra expenditure would increase to $8.4. Expenditures for the sixth deciles would now be $46.5 (38.1 + 8.4) and the basic health package would become accessible. However, for the first five deciles of the population corresponding to a population of approximately five million (about forty percent of the total population) the health package would still not be accessible. At any rate, as we have seen, government expenditures are not distributed equitably, and therefore far more than five million would not have had full access to the health package. This is partly responsible for the high prevalence of HIV in the poorer segment of the society as demonstrated in Table 3 above. Also it is an indication of the allocation inefficiency, internal inefficiency and inequity in health care spending in Cameroon.

The Prevalence of HIV/AIDS

The low levels of government health spending coupled with gross mismanagement and misappropriation of funds in the health sector, usher in a new and harsh reality in fighting the spread of the HIV/AIDS in Cameroon. It is evident that the problems of budgetary allocation inefficiency, management inefficiency and inequitable distribution of revenue associated with decentralisation of the health system in Cameroon has resulted in poor maintenance of health care facilities, low incentives for health personnel, lack of essential infrastructure and in most cases insufficient hospital beds for patients. All these have culminated in an increase in the HIV/AIDS pandemic. According to the analyses of the Ministry of Public Health, the incidence of HIV/AIDS in the sexually active population of Cameroon was eleven percent in 2000, which is twenty-two times greater than its incidence in 1987 when it was only 0.5 percent. The World Health Report (2003) reported that the number of persons living with HIV was estimated at more than 937,000: one person out of nine in the sexually active population.

The prevalence rate in Yaoundé and Douala stood respectively at 10.33 percent and 9.0 percent, the rural forest and savannah stood at 16 and 11 percent respectively. It is worthwhile to note that the HIV prevalence rate in pregnant women in rural areas stood at 18 percent compared to 13.59 percent of pregnant women in urban areas.

Prevalence among ante-natal clinic attendees in twenty-eight sites was 10.8 percent; HIV prevalence in Yaoundé was 11.2 percent, and median HIV prevalence in Douala was 11.6 percent. In areas outside the major urban centres, the HIV prevalence among ante-natal attendees increased from less than one percent in 1989 to eight percent in 1996 and has continued to rise. In 2000, median HIV prevalence in 25 sites outside the major urban areas ranged from six percent to thirteen percent. HIV prevalence in 2000 among the 20-24 years old was 12.2 percent. HIV prevalence among sex workers tested in Yaoundé increased from 5.6 percent in 1990 to 45.3 percent in 1993.

In 1994, 21 percent of sex workers tested in both Yaoundé and Douala were HIV positive; in 1995 the rate was 17 percent. A couple of studies among truck drivers, conducted between 1993 and 1994, found that between 9 to 17 percent of those tested were HIV positive. In 1996, 15 percent of military personnel tested were HIV positive. HIV prevalence increased among male STI clinic patients tested from 5.6 percent in 1992 to 16 percent in 1996. Outside of the major urban areas, HIV prevalence among STI clinic patients tested in six sites had reached 8 percent in 1992. In 1994, 9 percent of patients tested in Banka, Central province were HIV positive (UNAIDS 2002).

Although HIV/AIDS-related issues affect everybody, they affect the vulnerable, the poor and women more. Details are contained in Table 4.

Table 4: Country HIV and AIDS Estimates, End 2003

Adult (15–49) HIV prevalence rate	6.9% (range: 4.8%–11.8%)
Adults (15–49) living with HIV	520,000 (range: 360,000–740,000)
Adults and children (0–49) living with HIV	560,000 (range: 390,000–810,000)
Women (15–49) living with HIV	290,000 (range: 200,000–420,000)
AIDS deaths (adults and children) in 2003	49,000 (range: 32,000–74,000)

Source: 2004 Report on the global AIDS epidemic

In response to this growing social and economic threat of the HIV/AIDS epidemic for the population, the Prime Minister launched a strategic plan in September 2000. This document, entitled 'A Strategic Document for the National Plan for the Fight against AIDS in Cameroon 2000–2005', better known by its French acronym 'Comité National pour la Lutte contre le SIDA (CNLS)', sets out the basis for collaboration between the state, national actors and bilateral and multilateral partners in countering the epidemic. The Minister of Public Health chairs this committee. The Committee's Central Technical Group coordinates the implementation of activities throughout the country, with the assistance of ten provincial technical groups run by ten provincial coordinators.

The CNLS is made up of thirteen representatives of the public sector, including the offices of the President of the Republic and the Prime Minister, representatives of the private sector (an employers' organization and a trade union), national and international NGOs, the representatives of the two networks of associations of people living with HIV, the representatives of donors, and in particular la Coopération Française, GTZ, the European Union, the members of the Theme Group, including the UNAIDS country coordinator and representatives of parliament. The CNLS holds two statutory meetings per year, convened by its chair.

Its joint monitoring Committee supervises the action of the CNLS. This is an audit and control body, which also serves as an advisory body to the CNLS. The Ministry of Territorial Administration and Decentralisation meets it four times a year. It approves the annual and quarterly plans of action and the annual activities report. The Theme Group takes part in its work.

The Country Coordinating Mechanism has just taken its place in this organisation, specifically in connection with the follow-up of activities funded by the Global Fund. The Country Coordinating Mechanism has thirty members and is chaired by the Chairman of the CNLS.

National initiatives such as agreements signed between the government and the private sector are subject to a further level of coordination, determined by their specifications and at the proposal of the private sector.

The main objectives of the plan are to preserve the health of children, women, and men at home, or at work, at leisure and in hospital. This is to be achieved through a series of measures: minimising the risk of contamination with HIV/AIDS among children aged five to fourteen by promoting a healthy lifestyle and the development of responsible sexual behaviour, developing information mechanisms aimed at bringing about changes in the behaviour of the sexually active population, reducing the risk of transmission of HIV from mother to child, minimising the risk of infection through blood transfusion, and developing a national mechanism for solidarity with persons living with HIV/AIDS.

The strategic plan adopted a decentralised sectoral approach aimed at reducing the spread of the virus and involving among others the educational, agricultural, transport and military sectors. A summit bringing together several African First Ladies, international experts and other delegations was held in Yaoundé in November 2002 with the theme 'African Synergy against HIV/AIDS and its Sufferings'. In order to ensure adequate financing for the implementation of the National Plan for the Struggle against AIDS, the government of Cameroon committed itself to setting up mechanisms to mobilise resources for the campaign from internal and external sources and to ensure rigorous and effective management of the resources.

UNAIDS Support to the National Response

Given the inherent limitations of the decentralisation of the health sector, in 2004 the government of Cameroon embraced the activities of the United Nations HIV/AIDS. The activities focused on the following points.

For the first time ever the country team organised a retreat to draw up the United Nations plan in support of the national response to HIV/AIDS (2004-2005). This retreat was divided into two phases: first of all, the heads of agencies defined priorities, after which the technicians translated the priorities into operational terms; the outcome was the plan referred to above.

The country team held three meetings with the Chairman of the National Committee to draw his attention to the following needs: the organisation of a forum among partners involved in the HIV/AIDS control effort, follow-up for major interventions (prevention of mother-to-child transmission, access to antiretroviral therapy, and the private sector), documentation of best practices, assessment of the impact of HIV and AIDS on the national economy and on the main sectors of activity (private sector, agriculture, and education), an increase in the national budget allocated to the other ministerial departments for AIDS control and the urgent need to introduce efficient management mechanisms for activities funded by the Global Fund. Also planned was the production and dissemination

of a liaison bulletin highlighting actions by the United Nations system in the field of HIV and AIDS. Technical and financial support for activities was linked to DHS (funding) through UNFPA and the World Bank. In addition, there was input for activities linked to the Global Campaign and to World AIDS Day by helping to draft the appeal made by the First Lady. Finally, implementation was planned together with the government and with synergies from Africans of the NO SIDA (AIDS) Caravan in all of Cameroon's provinces.

The Socio-economic Impact of HIV/AIDS

HIV/AIDS follows a different pattern in each locality. Geographical and ethnic factors, agro-ecological conditions, religion, gender, age and marital status play a role in the pattern and impact of HIV/AIDS and in people's perceptions of the disease. Urban and rural disparities in infection rates have also been observed. Initially, the prevalence was more in townships in Cameroon but is gradually engulfing rural areas at a more rapid rate. This has critical implications for the design of HIV/AIDS interventions.

HIV/AIDS is disproportionately affecting poor households, and particularly people in the most productive age groups. Women are more exposed to infection than males. There are far more AIDS widows than widowers. Young widows with dependent children tend to become entrenched in poverty as a result of socio-economic pressures related to HIV/AIDS. The HIV/AIDS stigma, for instance, which largely results from the prevailing stereotype that it is the women who are responsible for transmitting HIV, is undermining traditional coping mechanisms accessible to young widowed women and changing the socio-economic fabric of the extended family.

The socio-economic impact of HIV/AIDS is beginning to have an effect on the value system of the family in Cameroon as traditional norms and customs are breaking down under the pressures triggered by the HIV/AIDS epidemic. The result is that the social fabric of the extended family is showing signs of erosion and the close bonds that hold family members together are disappearing. To give but some examples:

The stigma attached to those infected with HIV/AIDS is as discussed above, in some cases, breaking up families and distancing widows from their children. Parents are forced to either send their children to work or to take them out of school. In both cases, youths are being deprived of family life education, which is instrumental in establishing a code of conduct between men and women and husbands and wives. Family life education is critical in the social development of young men and women, ensuring the transmission of family values, mores and norms, establishing a social and sexual code of conduct and setting limits in sexual conduct. Many parents attribute early sexual activity and multiple or casual partners to the disappearance of family life education.

In some areas in the country, families are being forced to adjust burial rites and ceremonies to cope with economic pressures resulting from HIV/AIDS. Firstly, the mourning time is being shortened to only two to three days. Secondly, less money is being spent. And thirdly, the drinking and socialisation taking place during burials is changing to discourage substance abuse and casual sex. Traditions such as ritual cleansing and wife inheritance are threatening the well being of the extended family as a result of HIV/AIDS but no acceptable alternative mechanisms have been developed.

Apart from affecting the value system of the family, HIV/AIDS has the potential to create severe economic impacts in Cameroon. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major remarkable economic effects are a reduction in the labour supply and increased costs.

On the labour supply side the loss of young adults in their most productive years affects the overall economic output. If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates.

On the costs side, the direct costs of AIDS include expenditures for medical care, drugs and funeral expenses. Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans. If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth.

The economic effects of AIDS are felt first by individuals and their families then ripple outwards to firms, businesses and the macro-economy. The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses. There is a loss of income of the patient (who is frequently the main breadwinner). Household expenditures for medical expenses increase substantially. Other members of the household, usually daughters and wives, miss school or work less in order to care for the sick person.

Death results in a permanent loss of income from less labour on the farm or from lower remittances; from funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labour, resulting in a severe loss of future earning potential.

Conclusion and Recommendations

Developing countries such as Cameroon that achieved a remarkable reduction in morbidity and mortality in twenty years are now confronted with the HIV/AIDS pandemic. An unfortunate collateral effect of the disease is the resurgence of certain almost eradicated infectious diseases like tuberculosis. This has increased the demand for the conventional services of hospitals and physicians. In Cameroon

where managerial resources are scarce, communication is difficult, transportation is slow, and many people are isolated, decentralisation of the government service system should be considered as one possible way to improve effectiveness in the fight against this deadly disease.

Decentralisation is appropriate primarily for HIV/AIDS intervention services, provided directly to people in rural households. These programmes are more effective if they are contracted out to local health providers. These health providers could easily create awareness of the existence of HIV/AIDS and knowledge on how the rural people can protect themselves. Myths, misconceptions, superstitions, stereotypes and stigmatisation are widely prevalent in poor, illiterate households. The less people know about the disease, the more negative they tend to be about HIV/AIDS-afflicted and affected families and the stronger the stigmatisation. What is particularly significant is that individuals tend to blame their partners for transmitting the HIV virus, not themselves for engaging in high-risk sexual behaviour.

Decentralisation of financial planning should include the general principle that revenue collected in the form of user charges should be retained as close as possible to the point at which they were collected. This improves the incentive for collection, increases accountability of local staff within limits that ensure that the choice of expenditures reflects local needs, and fosters the development of managerial talent at the community level.

To encourage community-run and private sources of health services that could enhance the fight against HIV/AIDS in the country, there is the need to reverse past tendencies toward unnecessary restrictions, hostility and neglect. Other positive steps in this direction include helping community-based non-governmental organisations. Government could start by increasing public funding for training and backup support, including technical supervision and assistance in procurement of the anti-retroviral drugs. The provision of technical and financial assistance to private voluntary organisations for training (especially such areas as management) and the coordination of activities are very desirable.

Other steps include making credit accessible (especially where markets are restricted) to private ventures that want to expand or upgrade services and facilities for major interventions.

One possibility is transferring the operation of government facilities to non-governmental health providers (through sales, lease or contract). Such a step is appropriate for preventive facilities where the benefits of care and support accrue directly to those served.

It is necessary to mobilise support for people with AIDS or people who are vulnerable to HIV/AIDS. Young widows/widowers whose families have been affected by AIDS could be involved in HIV/AIDS education and related activities and possibly given some incentives. They can also be assisted with information on how to live positively with AIDS within the community, and instructed how to make wills.

The promotion of condom use should include extensive sensitisation, covering issues such as how to raise the subject with their partners, when to use condoms, how to use them properly, how to dispose of them properly, underscoring the importance of consistent use, especially under the influence of alcohol.

Perhaps the most important role for the government in the fight against HIV/AIDS is to ensure an open and supportive environment for effective programmes. Governments need to make HIV/AIDs a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programmes can succeed and protect the country's future development prospects.

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