

# Cameroon

Cameroon (population 16.06 million people) is a country in Western Africa bordering the Bight of Biafra that covers an area of 475,440 square kilometres. Its boundaries border Nigeria, Chad, Central African Republic, Congo, Gabon, and Equatorial Guinea. The capital of Cameroon is Yaoundé.

According to the United Nations human development index (HDI), Cameroon is ranked 141/177 countries worldwide (value 0.501)<sup>1</sup> and 13/45 African countries for which an index is available. This places Cameroon in the group of countries with medium human development.



## PALLIATIVE CARE SERVICE PROVISION

### Current services

Where opioids are generally unavailable, the definition of palliative care can be problematic. We have taken the view that where a service is in the process of development from (largely) physical care to a broader form of holistic care that approximates to the WHO definition, it should be included in the review.

In resource poor areas, the blending of supportive care with hospice/ palliative care is frequently linked to the development of previously established services, particularly home based care (HBC). Family Health International (FHI) defines home and community based care (HCBC) as “the provision of care and support that endeavours to meet the nursing and psychosocial needs of persons with chronic illnesses and their family members in their home environment”<sup>2</sup>.

While HCBC delivers patient care in the home environment, palliative care is an approach that attends to the needs of patients and families affected by a life threatening illness in a variety of settings including the home, hospice, hospital, clinic and community.

The health repercussions of the AIDS epidemic have been the impetus for introducing care to the chronically ill in Cameroon. Palliative care in the country is almost non-existent.

### *Cameroon Baptist Convention Health Board*

Several HIV/AIDS programmes, including Prevention of Mother to Child Transmission are in place at this rural hospital to provide support to those living with HIV/AIDS. While raising awareness of the epidemic has been prioritised along with coordinating with other support organisations, the need for the development of

palliative care in Cameroon was given a boost by the attendance of two delegates at the African Palliative Care Association conference in Arusha.

Some support for the chronically ill is provided by several other organisations in the country. George Mbeng describes the situation in his country:

We have many people in Cameroon who are carrying out support activities. Some of them will have not heard much about palliative care but they think that what they are doing is palliative care. I just think that going back to tell them the good news about palliative care, what it all involves, will only strengthen their views about support, care and support for people.<sup>3</sup>

### **Reimbursement and funding for services**

The Global Fund<sup>4</sup> has committed significant funding to HIV/AIDS programmes in Cameroon in Round 3 of an extensive strategy to combat the effects of the AIDS pandemic. The agreement was signed on 10 September 2004 for the Ministry of Public Health of the Government of the Republic of Cameroon to manage a project aimed at scaling up treatment and care of people living with HIV/AIDS. USD 14,641,407.00 has been approved to implement the project over 2 years. The goal is to improve accessibility and quality of overall case management for people living with HIV/AIDS and support for orphans and vulnerable children by December 2008.

Cameroon proposes to use Global Fund financial support to improve overall case management in order to complete the range of services available to people affected by AIDS, including 10 000 orphans and vulnerable children. The objectives of the project include making laboratory tests and antiretroviral therapies available to over 36 000 people living with AIDS. Although palliative care is not mentioned in the proposal, home based care, free treatment of opportunistic infections and adherence support are identified as priorities. Furthermore, economic, psychosocial and medical support will be covered by the Global Fund programme. Expected results include upgraded professional training of doctors, social workers, nurses and other health personnel. Community based agents will receive training on comprehensive home-based care.

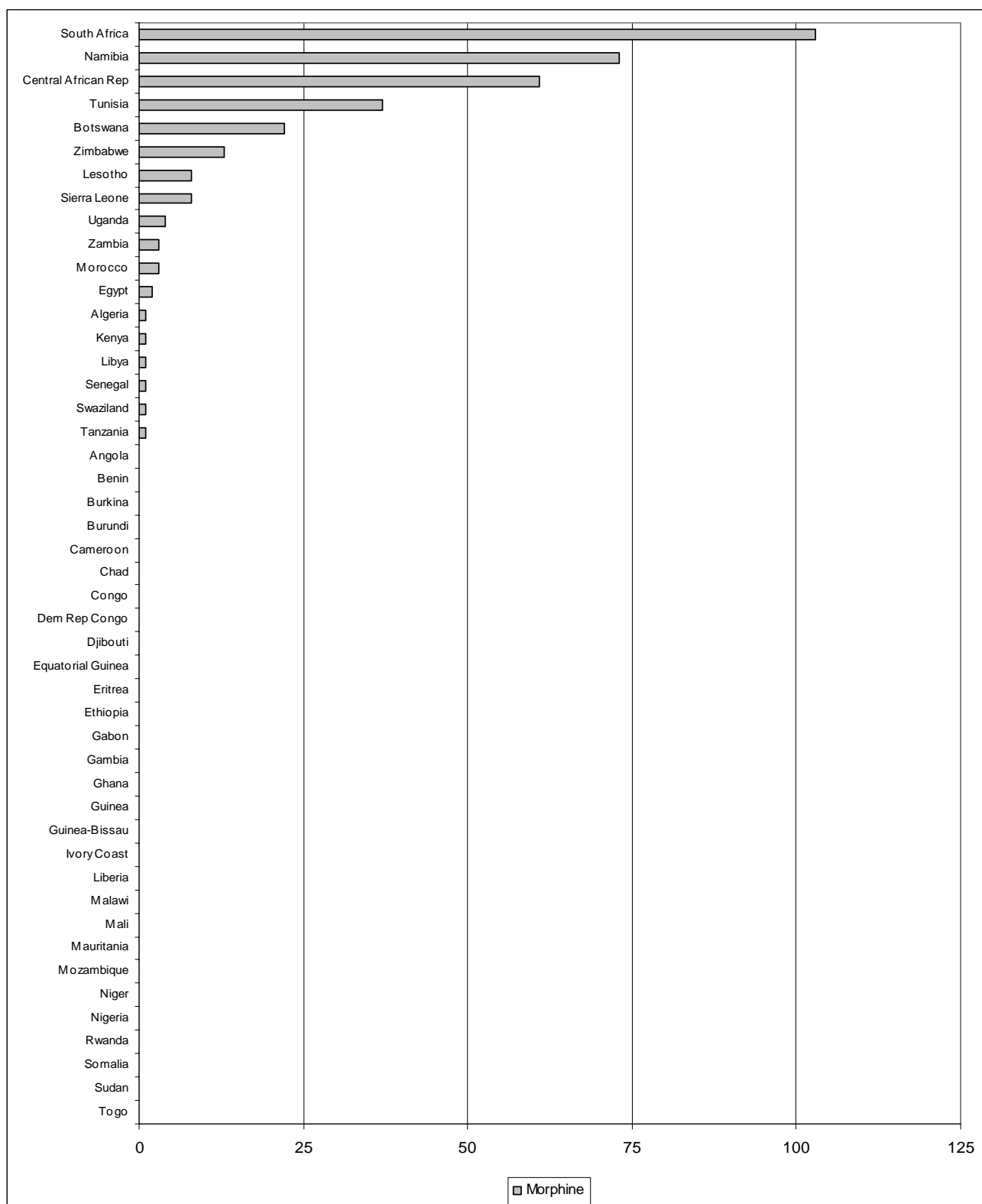
In Round 4 of a related project, the Global Fund approved USD 6,347,296.00 on 17 December 2004 for CARE International to mobilise civil society for the fight against AIDS.<sup>5</sup>

### **Opioid availability and consumption**

The International Narcotics Control Board<sup>6</sup> has no published figures for the consumption of narcotic drugs in Cameroon.

For the years 2000-2002, the average defined daily dose consumption of morphine for statistical purposes (S-DDD)<sup>7</sup> in Cameroon was 0. This compares with other African countries as follows: Swaziland 1; Egypt 2; Uganda 4; Zimbabwe 13; Namibia 73; South Africa 103. Twenty nine countries reported no morphine consumption during 2000-2002 (Table 1).

**Table 1 Average daily consumption of defined daily doses (for statistical purposes) of morphine per million inhabitants, 2000-2002: countries of Africa**



Source: International Narcotics Control Board *Narcotic Drugs: Estimated World Requirements for 2004. Statistics for 2002*. New York: United Nations, 2004.

## **National and professional organisations**

### **African Palliative Care Association (APCA)**

This international association was formed after a meeting of Hospice and Palliative Care trainers in Cape Town that led to the Cape Town Declaration. The first APCA steering committee meeting was held in Uganda from 19-20 February 2003. Steering committee members were drawn from: Kenya (Zipporah-Merdin Ali), South Africa (Kath Defilippi), Tanzania (Jacobson) Uganda (Anne Merriman) and Zimbabwe (Sambulo Mkwanzani).<sup>8</sup> In summary, APCA aims to:

- promote study, knowledge, training and research in palliative care
- foster networks and links at all levels of palliative care
- address ethical issues
- establish an international communication network
- sponsor publications
- disseminate achievements
- promote access to resources

Objectives include:

- promotion of standards
- advocating for palliative care at governmental level
- securing the availability of drugs
- encouraging the development of national associations within Africa
- promotion of training programmes
- devising standard guidelines
- advocacy

### **CARE International**<sup>9</sup>

CARE International in Cameroon will administer a Global Fund project aimed at mobilising civil society responses to the AIDS pandemic.

### **Palliative care coverage**

No data available.

### **Education and training**

*Cameroon Baptist Convention Health Board*

George Mbeng studied for the Diploma in Palliative Care at Hospice Africa, Uganda in 2004.

### **Palliative care workforce capacity**

No data available

## **HISTORY AND DEVELOPMENT OF PALLIATIVE CARE**

### **Narrative history of palliative care**

No data available

### **Hospice success stories**

No data available

### **Life/oral histories**

George Mbeng – *nurse, HIV/AIDS counsellor/trainer, Cameroon Baptist Convention Health Board*: interviewed by David Clark, 4 June 2004. Length of interview (West Africa group): 40 minutes.



George Mbeng refers to the current early development of services for those living with HIV/AIDS in Cameroon. His background as an oncology nurse equips him for his role as supervisor on the Prevention of Mother to Child Transmission programme that is one of several AIDS control programmes administered by the Ministry of Health. Much of the current focus of the government approach is aimed at supporting mothers to prevent transmission to their infants. Raising awareness of these issues and coordinating the work of related non- governmental organisations is pivotal to the AIDS programme. The next priority is to provide care for those living with HIV/AIDS, hence the decision to incorporate palliative care into the health system. George Mbeng is studying for the Palliative Care diploma at Hospice Africa Uganda and hopes to share his skills with colleagues in Cameroon. He feels that being a member of the African Palliative Care Association will strengthen the ability of his organisation to lobby his government to develop palliative care support for those living with cancer and AIDS. He identifies the need for further training and for funds to be sourced to support their work. He concludes by highlighting the importance of collaborating with other African countries. He describes current services in Cameroon as mainly support based with no established palliative care provision.

Jam Devine – *Physician, Cameroon Baptist Convention Health Board*: interviewed by David Clark, 4 June 2004. Length of interview: (West Africa group): 40 minutes.

Jam Devine briefly explains his hospital role as assessing patients who would benefit from antiretroviral therapies. He explains the value of attending the APCA conference as enabling him to develop strategies to implement palliative care in the Cameroon health system.

## **PUBLIC HEALTH CONTEXT**

### **Population**

Cameroon's population of around 16.06 million people is made up of the following ethnic groups: Cameroon Highlanders 31%, Equatorial Bantu 19%, Kirdi 11%, Fulani

10%, Northwestern Bantu 8%, Eastern Nigritic 7%, other African 13%, non-African less than 1%.

Religious groups include: indigenous beliefs 40%, Christian 40%, Muslim 20%.<sup>10</sup>

### **Epidemiology**

In Cameroon, the WHO World Health Report (2004) indicates an adult mortality<sup>11</sup> rate per 1000 population of 519 for males and 454 for females. Life expectancy for males is 47.2 for females 49.0. Healthy life expectancy is 41.1 for males; 41.8 for females.<sup>12</sup>

HIV/AIDS is a huge burden for sub-Saharan Africa. Throughout the region in 2003, an estimated 23-27 million people were thought to be living with the disease which also caused up to 2.5 million deaths. This represents a huge loss and impacts significantly on health systems and social and family structures.

Cameroon is a country in Western Africa that has been severely affected by the HIV/AIDS epidemic. Estimates suggest that in Cameroon, between 390,000 and 810,000 people were living with HIV/AIDS at the end of 2003. In the same year, up to 74,000 adults and children are thought to have died from the disease (Table 2).

**Table 2 Cameroon HIV and AIDS estimates, end 2003**

Adults (15-49) HIV prevalence rate.	6.9% (Range 4.8%-9.8%).
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 of the global AIDS epidemic*

### **UNAIDS reports:**

Coordination of AIDS control in Cameroon is the responsibility of the National AIDS Control Committee (CNLS) which is chaired by the Minister of Health. The Committee's Central Technical Group coordinates implementation of activities throughout the country, with the assistance of 10 provincial technical groups run by 10 provincial coordinators. CNLS is made up of 13 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 nongovernmental organizations, 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. CNLS holds two statutory meetings per year, convened by its chair.

The action of CNLS is supervised by its joint monitoring Committee. This is an audit and control body which also serves as an advisory body to CNLS. It is chaired by the Ministry of Territorial Administration and Decentralization and meets 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 organization, specifically in connection with the follow-up of activities funded by the Global Fund. The Country Coordinating Mechanism has 30 members and is chaired by the Chairman of 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.<sup>13</sup>

### **Health care system**

In 2001, the total per capita expenditure on health care was Intl \$42 (3.3% of GDP).<sup>14</sup> Among the countries of Africa, this figure falls within a spending range of Intl \$652 in South Africa (8.6% of GDP) and Intl \$12 in the Democratic Republic of Congo (3.5% of GDP). At 2.0% the smallest spending as a percentage of GDP is in Equatorial Guinea (Tables 3 and 4).

The WHO overall health system performance score places Cameroon 164/191 countries. This composite measure of overall health system attainment<sup>15</sup> is based on a country's goals relating to health, responsiveness, and fairness in financing. The measure varies widely across countries and is highly correlated with general levels of human development as captured in the human development index.

**Tables 3 and 4 Total health expenditure (Intl \$) per capita and as a percentage of GDP: countries of Africa, 2001**

<b>Table 3</b> Health expenditure (Intl \$) per capita: Africa		<b>Table 4</b> Health expenditure (Intl \$) as a percentage of GDP: Africa	
Country	Per capita	Country	%GPD
South Africa	652	South Africa	8.6
Tunisia	463	Kenya	7.8
Botswana	381	Malawi	7.8
Namibia	342	Namibia	7.0
Libya	239	Djibouti	7.0
Morocco	199	Botswana	6.6
Gabon	197	Tunisia	6.4
Algeria	169	Gambia	6.4
Swaziland	167	Zimbabwe	6.2
Egypt	153	Côte d'Ivoire	6.2
Zimbabwe	142	Mozambique	5.9
Côte d'Ivoire	127	Uganda	5.9
Liberia	127	Guinea-Bissau	5.9
Kenya	114	Zambia	5.7
Equatorial Guinea	106	Eritrea	5.7
Lesotho	101	Lesotho	5.5
Djibouti	90	Rwanda	5.5
Gambia	78	Morocco	5.1
Angola	70	Senegal	4.8
Senegal	63	Ghana	4.7
Guinea	61	Sudan	4.5
Ghana	60	Central African Republic	4.5
Central African Republic	58	Utd Rep of Tanzania	4.4
Uganda	57	Angola	4.4
Zambia	52	Benin	4.4
Mozambique	47	Mali	4.3
Mauritania	45	Sierra Leone	4.3
Togo	45	Liberia	4.3
Rwanda	44	Algeria	4.1
Cameroon	42	Egypt	3.9
Sudan	39	Niger	3.7
Malawi	39	Ethiopia	3.6
Benin	39	Mauritania	3.6
Guinea-Bissau	37	Burundi	3.6
Eritrea	36	Gabon	3.6
Nigeria	31	Guinea	3.5
Mali	30	Dem Rep of the Congo	3.5
Burkina Faso	27	Nigeria	3.4
Sierra Leone	26	Cameroon	3.3
Utd Rep of Tanzania	26	Swaziland	3.3
Congo	22	Burkina Faso	3.0
Niger	22	Libya	2.9
Burundi	19	Togo	2.8
Chad	17	Chad	2.6
Ethiopia	14	Somalia	2.6
Dem Rep of the Congo	12	Congo	2.1
Somalia		Equatorial Guinea	2.0

Source WHO World Health Report 2004

## Political economy

The earliest inhabitants probably were the Pygmies, who still inhabit the southern forests. Bantu speakers were among the first groups that invaded Cameroon from equatorial Africa, settling in the south and later in the west. The Muslim Fulani from the Niger basin arrived in the 11th and 19th centuries and settled in the north. Contact with Europeans began in the 1500s. During the next 3 centuries, Spanish, Dutch, and British traders visited the area, and there was costar slave trading. Christian missions appeared in the mid-1800s and still are active. In July 1884, Germany, the United Kingdom, and France each attempted to annex the area. In a treaty with local chiefs, the German Consul of Tunis, Tunisia, extended a protectorate over Cameroon. Germany strengthened its claim and expanded its territory by treaties with the United Kingdom and France, but British and French armies invaded the German colony in 1914. A 1919 declaration divided Cameroon between the United Kingdom and France, with the larger, eastern area under France. A 1922 League of Nations mandate sanctioned the division; in 1946, the United Nations converted the mandates to trusteeships. In December 1958, the French trusteeship was ended.<sup>16</sup> The post-colonial state in Cameroon began, under Ahidjo's leadership, as a federal union of UN trusteeships that were administered by Britain and France in 1961. In the drive to consolidate power, multi-party politics was supplanted by single-party politics in 1966, and in 1972 the federal republic was constitutionally replaced by a unitary state. Ahidjo voluntarily resigned the state presidency in 1982 and was replaced by Paul Biya, his Prime Minister since 1975.<sup>17</sup>

Cameroon has generally enjoyed stability since that time, which has permitted the development of agriculture, roads, and railways, as well as a petroleum industry. Because of its oil resources and favourable agricultural conditions, Cameroon has one of the best-endowed primary commodity economies in sub-Saharan Africa. Still, it faces many of the serious problems facing other underdeveloped countries, such as a top-heavy civil service and a generally unfavourable climate for business enterprise. Since 1990, the government has embarked on various IMF and World Bank programs designed to spur business investment, increase efficiency in agriculture, improve trade, and recapitalize the nation's banks. In June 2000, the government completed an IMF-sponsored, three-year structural adjustment program; however, the IMF is pressing for more reforms, including increased budget transparency, privatization, and poverty reduction programs. International oil and cocoa prices have considerable impact on the economy.<sup>18</sup> Although the Cameroonian economy remains in a relatively promising position, a higher rate of economic growth could very well be within its potential was it to utilise all its natural resources. The government must continue to implement IMF-led economic reform measures to realise quickly its goal of social and economic regeneration aimed at raising the living standards of its 14 million people. Despite occasional tensions, Cameroon still continues to enjoy a political and social stability lacking in many African countries. This has enabled the government to concentrate on developing social and economic infrastructures. In addition, Cameroon's abundant supply of oil and its favourable agricultural conditions have made it one of the best-endowed primary commodity economies in the region, offering one of the most solid foundations for economic development on the continent.<sup>19</sup>

GDP per capita is Intl \$1269. This falls within the range of \$8,272 (Libya) and \$346 (Democratic Republic of the Congo) in the countries of Africa (Table 5).

**Table 5 GDP per capita (Intl \$): countries of Africa, 2001**

Country	GDP per capita (Intl \$)
Libya	8272
South Africa	7538
Tunisia	7183
Botswana	5747
Gabon	5514
Equatorial Guinea	5239
Swaziland	5029
Namibia	4918
Algeria	4104
Egypt	3901
Morocco	3887
Liberia	2965
Zimbabwe	2271
Côte d'Ivoire	2045
Congo	1936
Lesotho	1844
Guinea	1752
Togo	1608
Angola	1578
Kenya	1452
Senegal	1323
Central African Republic	1289
Djibouti	1288
Ghana	1272
Cameroon	1269
Mauritania	1257
Gambia	1214
Sudan	1112
Uganda	964
Nigeria	915
Zambia	906
Benin	888
Burkina Faso	886
Mozambique	805
Rwanda	799
Mali	700
Chad	656
Guinea-Bissau	630
Eritrea	629
Sierra Leone	606
Niger	604
Utd Rep of Tanzania	599
Burundi	529
Malawi	501
Ethiopia	382
Dem Rep of the Congo	346
Somalia	

Source WHO

## ETHICAL ISSUES

### FURTHER READING

Amoaku E. Voluntary screening for HIV: 1997 World AIDS Day experience in a rural mission hospital in Cameroon. *Tropical Doctor* 1998;28(4): 248-249.

Harding R, Higginson IR. *Palliative Care in Sub-Saharan Africa: An Appraisal*. London: Diana, Princess of Wales Memorial Fund, 2004. See: [www.theworkcontinues.org/pressroom/6\\_3.publications.htm](http://www.theworkcontinues.org/pressroom/6_3.publications.htm)

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## REFERENCES

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<sup>1</sup> Report of the United Nations Development Programme 2004 (HDI 2002). Launched by the United Nations in 1990, the Human Development Index measures a country's achievements in three aspects of human development: longevity, knowledge, and a decent standard of living. It was created to re-emphasize that people and their lives should be the ultimate criteria for assessing the development of a country, not economic growth. Current values range from 0.956 (Norway, 1/177 countries) to 0.273 (Sierra Leone, 177/177 countries). Countries fall into one of three groups: countries 1-55=high development; 56-141=medium development; 142-177=low development. See: [http://hdr.undp.org/statistics/data/indic/indic\\_8\\_1\\_1.html](http://hdr.undp.org/statistics/data/indic/indic_8_1_1.html)

<sup>2</sup> Family Health International, Comprehensive Care and Support Framework

<sup>3</sup> IOELC interview: George Mbeng – 4 June 2004.

<sup>4</sup> See:

<http://www.theglobalfund.org/search/contact.aspx?countryID=CMR&contactType=PR&round=3&component=HIV/AIDS>

<sup>5</sup> CARE International in Cameroon:

<http://www.theglobalfund.org/search/contact.aspx?countryID=CMR&contactType=PR&round=4&component=HIV/AIDS>

<sup>6</sup> International Narcotics Control Board (2004) *Narcotic Drugs: estimated world requirements for 2004. Statistics for 2002*. New York: United Nations, 2004.

<sup>7</sup> 'The term *defined daily doses for statistical purposes* (S-DDD) replaces the term *defined daily doses* previously used by the Board. The S-DDDs are technical units of measurement for the purposes of statistical analysis and are not recommended prescription doses. Certain narcotic drugs may be used in certain countries for different treatments or in accordance with different medical practices, and therefore a different daily dose could be more appropriate.' International Narcotics Control Board. *Narcotic Drugs: estimated world requirements for 2004. Statistics for 2002*.

<sup>8</sup> Africa gets its own hospice and palliative care association! *HPCA* 2003;5(2): 4

<sup>9</sup> <http://www.careinternational.org.uk/>

<sup>10</sup> See: <http://www.cia.gov/cia/publications/factbook/geos/cm.html>

<sup>11</sup> This refers to adult mortality risk, which is defined as the probability of dying between 15 and 59 years.

<sup>12</sup> See: WHO statistics for Cameroon at: <http://www.who.int/countries/cmr/en/>

<sup>13</sup> <http://www.unaids.org/en/geographical+area/by+country/cameroon.asp>

<sup>14</sup> Total health expenditure per capita is the per capita amount of the sum of Public Health Expenditure (PHE) and Private Expenditure on Health (PvtHE). The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of

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currency conversion constructed to account for differences in price level between countries.

<http://www3.who.int/whosis/country/compare.cfm?country=s&indicator=strPcTotEOHinIntD2000&language=english>

<sup>15</sup> Tandon A, Murray CLJ, Lauer JA, Evans DB. Measuring overall health system performance for 191 Countries. GPE Discussion Paper Series: No 30; WHO.

<sup>16</sup> United States Government. *Background Notes on Countries of the World*. Washington DC: United States Department of State, Bureau of Public Affairs/Office of Public Communication, 2003.

<sup>17</sup> Dickson E. Through the prism of a local tragedy: political liberalisation, regionalism and elite struggles for power in Cameroon. *Africa* 1998;68(3).

<sup>18</sup> <http://www.cia.gov/cia/publications/factbook/geos/cm.html>

<sup>19</sup> World of Information Business Intelligence Report. Cameroon: Economy, Politics and Government. *Business Intelligence Report* 2001;1(1): 1-36.