Republic of Cameroon

Country programme document 2013-2017

The draft country programme document for the Republic of Cameroon (E/ICEF/2012/P/L.35) was presented to the Executive Board for discussion and comments at its 2012 second regular session (11-14 September 2012).

The document was subsequently revised, and this final version was approved at the 2013 first regular session of the Executive Board on 8 February 2013.

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Basic data[†] *(2010, unless otherwise stated)*	
Child population (*millions, under 18 years*)	9.3
U5MR (*per 1,000 live births*)	136
Underweight (*%, moderate and severe, 2011*) (*%, urban/rural, poorest/wealthiest*)	15[a] 7/20, ../..
Maternal mortality rate (*per 100,000 live births, adjusted*)	690[b]
Primary school attendance (*% net, male/female, 2009*)	97/86
Survival rate up to the last year of primary education (*%, m/f, 2008*)	69
Use of improved water resources (*%*)	77
Use of improved sanitary services (*%*)	49
Adult HIV prevalence rate (*%, 15-49 years old, male/female, 2009*)	5.3
Child work (*%, 5-14 years of age, male/female, 2006*)	31
Birth registration (*%, children under 5, 2006*) (*%, male/female, urban/rural, poorest/wealthiest*)	70 71/69, 86/58, 51/91
Per capita GNI (*US$*)	1 160
One-year-olds immunized against DPT3 (*%*)	84
One-year-olds immunized against measles (*%*)	79

[†] Additional data on children and women are also available at www.childinfo.org.

[a] Underweight estimates are based on the WHO Child Growth Standards adopted in 2006.

[b] The reported estimate of 669 deaths per 100,000 live births (1998-2004) is provided in the 2004 Demographic and Health Survey (DHS).
The United Nations Interagency Group (WHO, UNICEF, UNFPA and the World Bank) produces internationally comparable sets of maternal mortality data, adjusted for the well-documented problems of under-reporting and misclassification of maternal deaths, and provides estimates for countries lacking such data. Internationally comparable datasets on maternal mortality for 1990, 1995, 2000, 2005 and 2010 are available at http://www.childinfo.org/maternal_mortality.html.

Summary of the situation of children and women

1. In 2007, monetary poverty in Cameroon affected 40 per cent of the population and 46 per cent of persons under 18. Between 2001 and 2007, the number of poor children increased from 3.6 to 4.1 million. There is a wide gap between urban and rural children regarding the incidence of poverty (16 and 60 per cent, respectively). The Adamawa, East, North and Far North regions of the country account for 60 per cent of poor children. Child poverty constitutes a stigma which prevents children from asserting themselves and impedes the protection and realization of their rights. Certain social practices (early marriage, early pregnancy, and rejection of health workers of the opposite sex) continue to have a negative impact on maternal and child health, with the concomitant effects of a low level of assisted childbirths (64 per cent in 2011), insufficient care for obstetric complications (16 per cent) and high maternal mortality rate, estimated in 2010 at 690 deaths per 1,000 live births.

2. Although still high, the infant and child mortality rate per 1,000 live births decreased from 146 in 2001 to 136 in 2006 and 122 in 2011. Achieving the target of 76 per 1,000 live births by 2015 in accordance with Millennium Development Goal (MDG) 4 seems unlikely.

3. According to the Demographic and Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS) of 2011, chronic malnutrition affects 33 per cent of children, and nearly half of those children (14 per cent) in a severe form. The stunting rate increases fast with age, amounting to 12 per cent for infants under 8 months and 17 per cent for 9 to 11-month-olds, then rising steadily to peak at 42 per cent for 18 to 23-month and 24 to 35-month-olds. The nutritional situation displays considerable urban-rural and gender disparities. The chronic malnutrition level is slightly higher among boys (35 per cent) than girls (30 per cent), while stunting affects 41 per cent of rural and 22 per cent of urban children. The nutritional status strongly affects infant and child mortality and is related to moderate or severe underweight affecting 14.6 per cent of the children in 2011. That situation is compounded by an increase in the rate of infantile morbidity due to diarrhoeal diseases from 19 per cent in 2006 to 21 per cent in 2011, and by the recurrence of cholera which, in three years, claimed more than 34,000 victims, caused 1,500 deaths and plunged the country into an emergency situation.

4. There has been modest progress with regard to immunization, as coverage for all antigens increased from 48 per cent in 2004 to 53 per cent in 2011, or by less than 1 per cent per year.

5. Maternal mortality continues to give grounds for concern. Maternal deaths are mainly due to remoteness from health services and to the low purchasing power of the population in general and women in particular. In the rural areas, 57 per cent of women aged 20-24 have stated that they had married while still under 18. In certain regions, women may not visit a medical facility on their own.

6. HIV/AIDS prevalence among persons aged 15-49, estimated at 5.3 per cent in 2004, was 4.3 per cent in 2011 (2.9 per cent of men and 5.6 per cent of women). Cameroon thus still belongs to the category of generalized epidemic countries. Of the approximately 560,300 persons living with HIV/AIDS, 55.8 per cent are women and 8.5 per cent children under 14. Prevalence among pregnant women is high (7.6 per cent). The number of orphans and vulnerable children (OVCs) increased from 183,500 in 2008 to 304,000 in 2010.

7. In 2010, the gross rate of access to pre-school education was 27.2 per cent and displayed wide geographic disparities. It was lowest among ethnic minorities and refugees and in the northern part of the country, namely the Far North, North and Adamawa regions, where it attained, respectively, 3.6, 6.3 and 10.6 per cent. The net primary school enrolment ratio was 88 per cent, namely 92 per cent among boys and 83 per cent among girls. The primary level completion rate is increasing and has reached 73 per cent.

8. The rate of working children was, in 2007, 32 per cent of those aged 5-14 and, in 2010, 39.7 per cent of those aged 10-17. The birth registration rate is expected to rise as a result of the recent extension of the time limit for such registration free of charge from 30 to 90 days. Of the 800 children detained in 2011, 80 per cent were held for minor offences. In its latest report, the Committee on the Rights of the Child regrets that the process of adoption of the draft Code on the protection of

children and the draft Code of the person and the family is slow, and that various adopted acts are inadequately implemented.

Key results and lessons learned from previous cooperation, 2008-2012

Key results achieved

9. The 2008-2012 programme supported the formulation of: (a) national plans for combating child exploitation and trafficking, reducing mother-to-child HIV/AIDS transmission, and scaling up mother-to-child transmission prevention; and (b) the strategic plan for OVC care, 2010-2012, and of the national policy for the integrated development of young children. The programme contributed to the development of other documents for action, including the health sector strategy. Various studies, surveys and evaluations produced factual input to the Educational Management Information System (EMIS); to two databases, accessible online, which concern social policies and the MDG monitoring indicators; and to strategic debates during the national forum on the vulnerability of children and social protection.

10. The DPT3 vaccine coverage rate has been stagnating, at 82 per cent in 2007, 84 per cent in 2010 (Joint Reporting Form) and 82 per cent in 2011. The number of children under 5 sleeping under an impregnated mosquito net is was only 13 per cent in 2006 (MICS 2006) and 21 per cent in 2011 (DHS MICS 2011), compared to the national target of 80 per cent. A national campaign for the distribution of long-lasting impregnated mosquito nets (LLINs) has been in progress since 2011. UNICEF provides mosquito nets and informs the population on their effective use. Community-Led Total Sanitation (CLTS) is implemented in 267 villages, of which 131 have been certified “No more outdoors defecation”. The adoption of CLTS by other development partners contributes to scaling up that process. The programme supported such prevention and response activities against cholera epidemic as water purification to make it drinkable, disinfection of contaminated areas and provision of relevant information to the population, in addition to the preparation, in 2011, of the water and sanitation component of the national contingency plan against cholera.

11. Since the start of the programme cycle, nutrition counselling coverage has increased from 6 to 40 health districts, with the focus on the northern areas. The capacities of providers of such services and of community relays were considerably enhanced as regards community care for acute malnutrition and basic nutritional support in relevant in-patient and day-patient treatment centres. Although the rate of anaemia among children and women is still high (60 and 40 per cent, respectively, in 2011), stepped-up nutritional action has contributed to reducing that rate. Since 2008, children under 5 have been receiving vitamin A and de-worming twice a year. Currently, refined vegetable oil is enriched with vitamin A and wheat flour is enriched with iron, zinc, folic acid and vitamin B12.

12. With regard to HIV/AIDS, the rate of women examined during pregnancy and accepting a screening test increased from 77 per cent in 2007 to 82 per cent in 2010; and the rate of seropositive pregnant women under preventive antiretroviral (ARV) treatment increased from 46.6 per cent in 2008 to 56.7 per cent in 2010. The number of health-care training activities covering the prevention of mother-to-child transmission (PMTCT) has practically doubled, increasing from 1,327 in 2007 to

2,067 in 2010. The number of infected children under ARV treatment increased from 2,450 in 2008 to 4,440 in 2011 but that figure accounts for only approximately 9.1 per cent of children in need of such treatment. Prevalence among persons aged 20-24 decreased from 5.4 per cent in 2004 to 2.2 per cent in 2011. In 2010, care was secured for approximately 25 per cent of the 304,210 OVCs.

13. The programme contributed to improving the net school enrolment ratio by promoting the enrolment of girls through scholarships and advocacy for greater community involvement. In view of the low rate of access to pre-school education (12.68 per cent in the priority education zones (ZEPs)) and the significant drop-out rate (given a 55.75 per cent completion rate in the ZEPs), various alternative ways of encouraging preparation for primary education and educational rehabilitation were tested under the programme. The first of those goals is pursued by helping children having lacked access to a preschool establishment to develop the capabilities necessary for adaptation to primary school. The second is pursued by helping children having dropped out to make up and join their class. Parental education is instrumental in furthering community involvement and the ownership, expansion and sustainability of initiatives, particularly those promoting school enrolment among vulnerable girls, refugees, children with disabilities, and ethnic minorities.

14. Advocacy and capacity-building brought about an environment offering better protection for children. In that connection, the civil status reform led to the delivery of 12,350 birth certificates, the reduction of the average duration of detention on remand of minors from 8 to 3 months in the Douala jurisdictions, and the creation of sections or cells for minors in 59 of the country's 75 prisons. Evaluations of action related to the children's parliament, juvenile justice and birth registration, and the study on alternatives to detention, helped to improve the legal framework through, in particular, the extension of time limits for birth registration, the enhancement of measures alternative to detention in the Criminal Code (currently under revision) and the creation of a rehabilitation centre for minors in conflict with the law. The National Plan for Combating Human Trafficking, the Code on the protection of children and the Code of the person and the family are under discussion.

Lessons learned

15. Cameroon is a lower-middle-income country, in which UNICEF implements, in addition to the regular programme, an emergency programme (against, inter alia, cholera, malnutrition, polio and measles) in approximately one half of the territory with insufficient resources. The State's participation in the response to recurring emergencies is limited, although the national budget for development is largely financed with internal resources. Despite the Government's efforts, governance problems impede the attainment of significant results regarding basic services accessibility and quality. The new programme must focus on mechanisms, capacities and funding for enhancing preparedness and response to the emergencies in question.

16. The failure of the information systems to compile disaggregated data prevents effective measurement of the effectiveness and fairness of the activities carried out, and therefore reduces the capability to identify and quantify priority actions in support of children and disadvantaged groups. The new programme must focus on strengthening the systems designed to monitor equity. In basic education, the

implementation of SIGE is already improving the situation and will contribute to the integration of programme components.

17. Since 2010, as part of effective decentralization, budgetary resources have been transferred to the communities in order to enhance the supply and quality of basic social services. Under the 2013-2017 programme, it is planned to build on that positive development through a strategy using community-based approaches to improve access to services and by strengthening local monitoring mechanisms in order to eliminate bottlenecks.

18. In order to enhance the equity of programme initiatives and to meet the needs of particularly disadvantaged children in the poorest regions (in the north and east of the country), the midterm review refocused programme action on four regions out of six with regard to basic education, and on 30 health districts out of 62 with regard to the supply of 4P[1] services. That focus will be consolidated in order to ensure better integration of the activities of programme components as a whole and to give priority to the Sahel region, where the social and economic indicators are at their lowest.

Country programme, 2013-2017

Summary budget table

	(Thousands of United States dollars)		
Programme component	*Regular resources*	*Other resources*	*Total*
Young child survival	7 093	22 438	29 531
Basic education	6 400	10 020	16 420
HIV and AIDS	6 410	12 700	19 100
Child protection	3 672	2 520	6 192
Social policy and planning	3 000	42	3 042
Intersectoral component	5 250	0	5 250
Total	**31 825**	**47 710**	**79 535**

Preparation process

19. The country programme has been developed through a participatory process involving the Government partners; and reflects the Growth and Employment Strategy Paper (GESP), 2010-2020, and the United Nations Development Assistance Framework (UNDAF), 2008-2012. The above process ensured the programme's alignment with the national priorities and the comparative advantages of the United Nations system, set forth in UNDAF, 2013-2017.

20. The relevant discussions were guided by, inter alia, an analysis of situation, the recommendations of the Committee on the Rights of the Child, the 2010 midterm review and other evaluations. Under the authority of the Ministry of Planning, the first version was presented to all key partners for consideration and amendments.

[1] The 4P programme consists in: prevention of mother-to-child HIV/AIDS transmission, paediatric care, OVC protection, and prevention of HIV/AIDS among young persons.

Results and strategies of the programme components

21. The programme aims at accelerating progress towards the attainment of the MDGs constituting GESP and UNDAF priorities, with emphasis on the survival, development and comprehensive protection of children, particularly those most vulnerable.

22. The programme will make it possible to achieve the following main results:

(a) Activities having a major impact on health, nutrition, water and sanitation selected, placed in context (at the strategic level) and then implemented (at the operational level) in order to help to reduce mortality and morbidity among children under 5, pregnant women and nursing mothers;

(b) Percentage of vulnerable pre-school children, girls in particular, who have access to quality basic education, increased in the ZEPs;

(c) Children, adolescents and their parents protected against HIV/AIDS and receiving comprehensive care on an equitable basis in the health districts in which the programme is implemented;

(d) The system for the protection of children against abuse, violence and exploitation strengthened, and access to citizenship and legal services enhanced;

(e) A social protection base and equity with regard to those most vulnerable, particularly children and women, provided for under national and sectoral policies.

23. These results will be achieved through a set of strategies, the most important of which are: ownership of the initiatives by the actors, and sustained local presence in the zones and pockets of vulnerability or inequity; building national capacities for addressing the children's interests more effectively in the framework of public and budgetary policies; strategic partnership with the institutions supporting decentralization and good governance through the involvement of civil society and the private sector, in order to improve the quality and accessibility of services by building technical capacities for supplying services to the most vulnerable; intersectoral integration and action which, over and above UNICEF programme components, will strengthen coordination mechanisms within UNDAF; results-based funding in cooperation with other partners, particularly the World Bank; and a community-based approach focused on the implementation of innovative strategies and targeted communication to encourage changes to social practices unfavourable to children.

24. All of the programme's strategic and managerial choices are guided by the five programming principles of the United Nations (gender, results-based management, human rights approach, capacity development and environmental sustainability). Prevention of and response to emergencies, particularly the food crisis and rampant cholera almost endemic in the north of the country, will be underscored.

25. Of the programme's five components, one (social policy and planning) is cross-cutting. The programme is country-wide and is focused on the most disadvantaged regions.

26. **Young child survival.** This component comprises the following three subcomponents: health; food; and water, sanitation and hygiene.

27. The health subcomponent aims at broadening coverage for activities with a significant impact on maternal and child health. At the strategic level, the programme will contribute to preparing and reviewing the relevant policy and strategy documents and promoting the most vulnerable persons' access to care (inter alia, free of charge). At the operational level, the poorest communities will be targeted by a set of activities including the expanded programme of immunization; community-based care for malaria, diarrhoea and acute respiratory infections; and the promotion of essential family practices. Care providers will benefit from capacity-building and enhanced follow-up and supervision.

28. The food subcomponent aims at scaling up the prevention of malnutrition and improving the nutritional status of children aged up to 59 months, pregnant women and nursing mothers. Activities designed to reduce chronic malnutrition and micronutrient deficiencies will be strengthened through the encouragement of exclusive breastfeeding, promotion of adequate nutrition practices for young children, and food fortification. Quality control of fortified foods will be improved and community-based care in acute malnutrition cases will be scaled up. At the strategic level, nutrition-related advocacy will be strengthened.

29. The water, sanitation and hygiene subcomponent will focus on activities related to emergencies, access to drinking water, basic sanitation for vulnerable population groups, and the implementation of strategic documents underscoring good practices regarding communication for development. Activities for the promotion of CLTS and hand-washing with soap will be further pursued, targeting mainly the areas where outdoor defecation is particularly widespread.

30. **Basic education.** This component will strengthen and expand the "network" approach conducive to pooling resources and experience and building the capacities of key actors in the current ZEPs and the other areas with a lagging school enrolment ratio. The main activities will focus on access to schools (including pre-school establishments), reduction of gender inequalities, and the quality and relevance of education. Sanitation in schools will be improved through the construction of latrines and water outlets and the promotion of hygiene. Support for such activities in favour of vulnerable children, including children of ethnic minorities and refugees will be sought by strengthening SIGE and parental education. Such education, particularly fathers' involvement, will be crucial to raising awareness in the communities and convincing them to accept an accelerated study programme for primary school entry and the educational rehabilitation of children who dropped out.

31. **HIV and AIDS.** This component aims at accelerating progress towards the elimination of mother-to-child HIV/AIDS transmission by 2017 through full development of PMTCT, paediatric care and the promotion of the 4P objectives as strategic pillars of the programme. Accordingly, in addition to PMTCT, primary prevention among adolescents and young persons and the reinforcement of OVC care policies will be scaled up with a view to synergy. The 4P objectives will be implemented through high-impact activities based on factual data and equity considerations.

32. **Child protection.** This component will contribute to strengthening the protection system in order to improve the most vulnerable persons' access to services and to prevent abuse, violence and exploitation. The component provides for the development of a national child-protection strategy and for support for appropriate civil status and juvenile justice reforms. A community-based approach focused on the promotion of changes to social practices detrimental to children's

rights will be implemented. The development of a national system of information on vulnerable children and families, the dissemination of juvenile justice standards and procedures involving forms of placement alternative to imprisonment, and relevant capacity-building will be conducive to a protective environment for children.

33. **Social policy and planning.** This component aims at strengthening advocacy of public policies and resource allocations taking children's rights into account. Emphasis will be placed on social protection with a view to reducing inequities. The country's internal resources suffice for the required investment, particularly in social safety nets. The programme, in cooperation with the World Bank, the International Labour Organization (ILO), the United Nations Development Programme (UNDP) and the World Food Programme (WFP), already supports the establishment of a national social protection base. The component will also support, at the national level, the development of a social protection strategy focused on the child and on gender issues and, at the local level, the inclusion of the needs of the most vulnerable population groups in community development projects.

34. Data collection and analysis will enhance the factual information available, political advocacy and strategic planning for the implementation of programme activities. Sustained microplanning will take place at the decentralized level. The development of monitoring and evaluation capacities are expected to improve the availability of disaggregated data on the situation of children and women, particularly those most vulnerable, and to support systems for monitoring results at the central and decentralized levels in order to identify, observe and eliminate bottlenecks which diminish the impact and equity of the activities carried out. Approximately 10 per cent of programme resources will be allocated to monitoring and evaluation support.

35. **Intersectoral component.** This component will handle the financing of operational costs (logistic, storage and operating expenses) and staff engaged in cross-cutting activities.

Relation with national priorities and the UNDAF

36. The national development priorities are defined in GESP, 2010-2020, and in the sectoral development strategies. Discussions between the Government and the United Nations system made it possible to specify by consensus three key areas of UNDAF results (strong, sustainable and inclusive growth; employment; and governance and strategic management of the State). UNICEF focuses on the following three of the five UNDAF outcomes:

(a) Outcome 2: Social protection base developed and national social protection system updated by 2017;

(b) Outcome 3: Access of the population, particularly the most vulnerable persons and refugees, to health services and quality education enhanced, made equitable and used by those beneficiaries by 2017;

(c) Outcome 5: Mission of national and local institutions carried out in a participatory and transparent manner and in compliance with gender equality, human rights and the rule of law.

37. These three outcomes have been formulated as programme component results in order to contribute to achieving UNDAF and GESP outcomes, namely access to

basic social services, community-based promotion of health, and social protection of the most vulnerable persons.

Relation with international priorities

38. The country programme is guided by the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. Programme objectives and strategies aim at ensuring that vulnerable children's needs are taken into consideration directly and indirectly and at accelerating progress towards the attainment of the MDGs.

39. Moreover, through its contribution to UNDAF outcomes 1, 2, 3 and 5, the programme reflects the priorities of the UNICEF medium-term strategic plan, 2006-2013. The implementation of the Harmonized Approach to Cash Transfers (HACT) will make it possible to reinforce respect for the principles of the Paris Declaration.

Major partnerships

40. The programme will pursue advocacy activities to ensure that UNICEF, WFP, ILO, WHO, UNDP and the World Bank jointly support the Government in implementing the national social protection base; and will mobilize UNFPA, the United States Agency for International Development (USAID) and the World Bank to provide joint financial and technical support for the funding of the fifth combined DHS/MICS survey, designed to produce indicators for measuring progress towards the attainment of the MDGs. Moreover, within the framework of the implementation of the joint operational plan concluded in 2011, UNICEF, WHO, UNFPA, the World Bank and the Joint United Nations Programme on HIV/AIDS (UNAIDS) will step up their partnership as part of the campaign for the accelerated reduction of maternal mortality.

41. At the local level, increased cooperation with the private sector is expected to encourage the effective involvement of businesses in the provision of services in support of children. UNICEF will form partnerships with the main actors of decentralization, particularly the Special Inter-communal Infrastructure and Intervention Fund, the National Programme for Participatory Development and the Association of United Councils and Cities of Cameroon in order to ensure the inclusion of programmes promoting the rights of children in the community development projects.

Programme monitoring, evaluation and management

42. Under the direction of the Ministry of the Economy, Planning and Regional Development the Government and UNICEF are jointly responsible for programme management, monitoring and evaluation. To that end, they will use the situation analyses drawn up periodically on the basis of reliable and disaggregated data; follow-up information on the implementation of activities on the ground; key indicators linked to the matrix of programme results; sector reviews; and evaluations carried out or supported by the programme as part of the comprehensive monitoring and evaluation plan, 2013-2017. A rolling biannual workplan will be developed for every programme component in cooperation with the Government and the other partners; and will serve as a reference framework for biannual and annual reviews.

43. A midterm review will be organized in 2015. In 2016 and 2017, a combined country-wide EDS/MICS survey based on a representative sample of households will provide a basis for an overall assessment of the programme.