Cameroon[1]

… Western societies should question the way they behave and articulate the social expression of their customs, if they want to help us. It is not enough to send money for condoms, but it is important to consider the quality and morality of attitudes and behaviour in society, for if the system of production were more moderate, we would consume something that was less daring, something that encouraged less excess than these images.[xlv]

6.1. Introduction

In recent years, Cameroon has overtaken Côte d'Ivoire as the country with the most severe HIV/AIDS epidemic in West Africa. The average HIV prevalence rate has increased rapidly from less than one percent in the late 1980s to 11% in 2000. HIV/AIDS gained a foothold at a time when the country was plunged into a serious economic crisis, which led to a marked drop in GDP per capita, increased poverty and reinforced inequalities. Not unlike other countries on the subcontinent, Cameroon embarked on structural adjustment programmes in an attempt to control the economic crisis. Since 2000, and more specifically in 2002 and 2003, the country has introduced a host of development planning frameworks aimed at promoting economic and social development. In light of the rapid spread of HIV and the severity of the epidemic, this seems to have been an opportune moment for Cameroon to integrate comprehensive HIV prevention and impact mitigation measures into development planning. However, this cursory review of development planning in Cameroon suggests that this opportunity has not been fully grasped.

6.2. Overview of development trends since 1980

In the past 20 years, significant progress has been made in relation to socio-economic development and health status in Cameroon. Yet, information on these trends is still limited, as few studies have been carried out in this area. What little information is available comes from sources such as annual reports published by national bodies (such as the Department of National Statistics and Accounting, DSCN), international organisations and NGOs. The two general population censuses of 1976 and 1987 and the Demographic and Health Surveys of 1991 and 1998 currently constitute the principal references in the area of population and development. This section draws on national and international sources in an effort to present a fairly comprehensive overview of development trends since 1980 (See Appendix 2 for the Country Profile of Cameroon and relevant references).

Demographic trends

Between 1980 and 2001, the population of Cameroon almost doubled, increasing from approximately 8.4 to 15.2 million people. Its average annual population growth of 2.7% during this period is not dissimilar to that of sub-Saharan Africa as a whole (i.e. 2.8%) (UNDP, 2003). The relative proportion of women has increased slightly, from 50% in 1980 to 51% in 2001. Cameroon has a youthful population. In 1998, 45% of the population was younger than 15 years, 50% was between 15-64 years and 5% was in the age group of 65 and older. At the time of the 1987 census, 56% of the population was under 20 years of age.

A significant proportion of the Cameroonian population lives in urban areas. In fact, Cameroon is one of the more urbanised countries in West Africa. Whereas in 1984 one in three Cameroonians were living in urban areas, this increased steadily to one in two by 2000/01. In absolute numbers, this growth rate correlates with a more than twofold increase in the urban population, from about 3.4 million in 1984 to approximately 7.5 million in 2000. Over the past two decades, urban growth has increased at a faster pace than population growth, although the rate of urban growth appears to be slowing down in recent years. In the first half of the 1990s, the rate of urbanisation was approximately 5.1% per annum. In the second half of the decade, this dropped to 4.7%, only to decline even further to 4% since 2000.

Apart from natural population growth, international migration and displacement also contribute to demographic growth in Cameroon. Most recent estimates suggest that the number of international migrants, many of whom originated from Chad and from Central Africa, residing in Cameroon was 250,000 between 1985 and 1990 (Segal, 1993). In addition, since the beginning of the 1990s increasing numbers of refugees have come to settle in Cameroon. In 1990, there were only some 4,100 refugees. Within one year, this number had multiplied ten-fold, reaching 42,000. Many refugees came from countries affected by conflict and humanitarian crisis, such as Chad, Rwanda, Congo and the Democratic Republic of Congo. In 1996, 46,000 refugees were registered throughout the country.

Economic performance and structure of the economy

Between 1980 and 2001, three distinct phases can be identified in terms of the performance of Cameroon's economy. In the pre-crisis period (1980-1986), the GDP growth rate, while declining, remained positive. It dropped from an average of 8% in 1980-1984 to 6.9% in the two subsequent years. During the second phase, which corresponds to a severe economic crisis affecting the country, stretching from 1987 to 1997, the GDP growth rate remained negative, averaging –4% per annum. The lowest economic performance was recorded in 1988, when the GDP growth rate was –7.1%. In 1998, the economy seemed to emerge from the crisis. Since then, Cameroon has experienced positive economic growth.

The structure of the economy has changed significantly during the period under review. In 1980, the services sector made the largest contribution to national GDP, amounting to 48%. The agriculture sector and industry contributed 29% and 23% respectively. The sectors most adversely affected by the economic crisis of the late 1980s were services and, to a lesser extent, industry. Towards the end of the 1990s, agriculture had become the prime contributor to the wealth of the country and was responsible for 41% of GDP, followed by services (39%) and industry (20%).

Cameroon's economic crisis was further aggravated by the country's foreign debt. Whereas in 1982 total debt amounted to 3.7% of GDP, by 1988 it had multiplied more than seven times to 27%, only to increase even further to 58% of GDP between 1991 and 1993. It appears to have declined slightly to 54% in 1996. The combination of spiralling external debt and structural adjustment has made it extremely difficult for the state to invest in social development, at a time when GDP per capita declined significantly and poverty deteriorated.

Poverty and inequality

Data on poverty in Cameroon is scarce. The first available data concerns 1996. Despite the lack of prior data, it is assumed that poverty increased in the beginning of the 1990s as a result of three factors: the economic crisis that started in 1987, the fact that there were two salary cuts of around 67% between 1987 and 1996, and the devaluation of the local currency (CFA franc) in January 1994.

In 1996 it was estimated that just over half the population (53%) was living below the national poverty line of 185.490 CFA franc (which corresponds to $1 a day). It was found that poverty affects households in rural areas far more than those in urban areas: six out of ten rural households were living in poverty, compared to four out of ten urban households. According to 2001 data, the incidence of poverty decreased substantially between 1996 and 2001 to 40%.[xlvi] The most significant reduction was recorded in urban areas, where the poverty rate almost halved to 22%. The concomitant decrease in rural areas to 50%, although less stark, was nonetheless significant. In the absence of data concerning the proportion of the population living on less than $2 a day, it remains difficult to properly assess this trend.

Whereas poverty data is not available for the period prior to 1996, it is possible to assess trends related to GDP per capita. Unsurprisingly, the negative performance of Cameroon's economy during the late 1980s and early 1990s resulted in a marked and sustained drop in the GDP per capita, which fell from $1010 in 1988 to $650 in 1997. This correlates with a drop in value of 36% and an average decline of 3.6% per annum. This clearly suggests a deterioration in the quality of life and standard of living of most Cameroonians during the economic recession.

Unemployment statistics, like poverty data, are hard to come by. Government data suggests that the unemployment rate (i.e. the proportion of persons of working age, who seek and do not find work over a given period) halved within a year, from 17% in 1995 to just over eight percent in 1996. As with the sudden drop in the incidence of poverty, it is difficult to determine the validity of this trend and what

factors could have contributed to it. Between 1996 and 2001, the unemployment rate has remained largely consistent at eight percent (MINEFI/DSCN 1997, 1999, 2001). In 1996, the official unemployment rate among men was higher than that among women, namely 10% and seven percent respectively. Although there is no data for the period prior to 1996, it is clear that the economic crisis has had a negative impact on formal employment, which has given rise to the growth of the informal sector. The informal sector accounts for a significant proportion of jobs in urban areas. For example, in 1993 the informal sector accounted for 57% of all jobs in all sectors in Yaoundé (Roubaud and Berthelier, 1993:10).

Finally, inequality indicators show that, despite the reported reduction in poverty between 1996 and 2001, income inequalities have in fact increased. For example, in 1996 the richest 20% of the population consumed seven times more than the poorest 20%; in 2001, this ratio had increased to eight (MINEFI/DSCN 1996, 2001). The noted shift in the Gini index, from 0.406 in 1996 to 0.408 in 2001, confirms this trend.

Human development

Access to safe drinking water and sanitation is critical for the health status of the population. Significant improvements have been recorded in enhancing access to drinking water since the early 1980s, when about a quarter of the Cameroonian population had access (26%). By 2000, twice as many Cameroonians had access, namely 52% of the population. Such averages hide stark geographical differences, particularly between rural and urban areas, with only 24% of rural households having access to safe drinking water (Belshaw and Livingstone, 2002).

A significantly higher proportion of the population has access to sanitation. Here, too, improvements have been recorded between 1984, when just below half the population had access to sanitation, and 2000, when three out of four Cameroonians had access to sanitation. Again, it is anticipated that marked differences exist between urban and rural service provision.

Access to basic health services seems relatively high, with an estimated seven out of ten Cameroonians having access in 1998. Yet, this figure hides the fact that the number of skilled health personnel, especially physicians, is low, despite recorded improvements since 1985. With an average of eight doctors per 100,000 people, Cameroon falls below the WHO norm of a minimum of 10 doctors per 100,000 people. Studies are currently underway to evaluate access to essential medicines. Because health policies related to access to ARV treatment are in the process of being put in place, it is as yet too early to make any assessment in this regard.

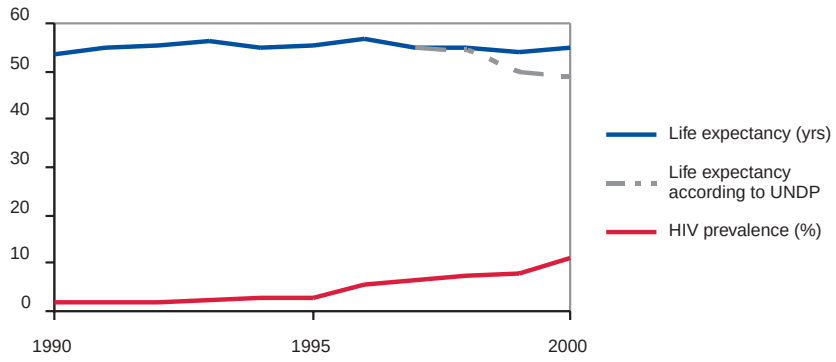
Knowledge acquisition improves the well being of individuals and education is unquestionably a critical factor in the fight against poverty. In Cameroon, much effort has been spent on reducing illiteracy and improving access to education. As a result, the adult literacy rate has risen from approximately one out of two adults in 1985 to approximately three out of four in 1998. The improvement over this period was noted in the case of both women and men and in 1998 adult literacy among women was on par with adult literacy among men in 1985, namely 61%. In 2000, female adult literacy had further increased to 68%, whereas among men it stood at 81%.

This improvement in adult literacy is partially the result of high primary school enrolment of both girls and boys. Unfortunately, there are no national or international (i.e. UNESCO) statistics on the net primary school enrolment ratio, but recent UNESCO figures suggest an improvement in gross enrolment figures from 88% in 1998/99 to 108% in 2000/01 following the introduction of free universal primary education in Cameroon.[xlvii] Yet, only a small proportion of boys and girls goes to secondary school. In 1995, one in four children of eligible ages was enrolled in secondary school. It is more likely for boys to continue their education, with about one in three boys going to secondary schools compared to almost one in four girls (23%).

The workload of primary school teachers remains high and seems to have become more severe over time. Whereas in 1980 the average class size was 48, in 1998 there were on average 53 pupils per teacher.

Finally, life expectancy at birth increased fairly rapidly and constantly during the 1980s and early 1990s. A Cameroonian born in 1981 was expected to live on average until the age of 50, whereas a compatriot born in 1993 was expected to live 6.3 years longer. Although the Country Profile (Appendix 2) suggests both downward and upward variations in life expectancy between 1994 and 2000, consistent data from the annual UNDP

Graph 6.1. Life expectancy and HIV prevalence rate in Cameroon



Human Development Reports indicate that since 1995 a declining trend has set in. In contrast to the anticipated life expectancy of 55 years in 2000 (in the absence of HIV/AIDS) as reflected in the Country Profile, UNDP estimates a life expectancy of 50 years and a further decline to 48 years in 2001 (See Graph 6.1). The gap between male and female life expectancy is not particularly great, namely 46.6 years and 49.4 years respectively. UNAIDS (2001) has anticipated a further nine-year reduction in life expectancy between 2000 and 2005 as a result of HIV/AIDS.

HIV/AIDS

According to data of the Ministry of Public Health (MINSANTE), HIV prevalence has risen rapidly since the start of the epidemic in 1986. HIV prevalence quadrupled from 0.5% in 1987 to 2% in 1992 and in the mid-1990s it exceeded 5%, only to increase even further to 11% in 2000. This trend denotes a significant increase in the number of people living with HIV/AIDS. For example, between 1997 and 1998, the reported number of AIDS cases more than doubled, from less than 1,000 to 2,045. Furthermore, it is estimated that the number of adults living with HIV/AIDS increased from 520,000 to 937,000 between 1999 and 2000 – in other words, an increase of 80%.

Disaggregated data, according to geographical area or sex, is still rare and what exists does not always allow for an assessment of trends over time. In 1990, it was estimated that the HIV prevalence rate in rural areas was 0.4%, compared to an average HIV prevalence rate of between 1.1% and 8.6% in urban areas. According to UNAIDS (2002), HIV prevalence among antenatal clinic attendees outside major urban areas has risen sharply from 1% in 1989 to anything between 6% and 13% in 2000. Whereas the notion 'outside major urban areas' does not correlate with rural areas, it does suggest that the epidemiological burden is shifting (or rather, spreading) from Yaoundé and Douala, which constitute the major urban areas in the UNAIDS classification. Here, the HIV prevalence rate among women attending antenatal clinics was 11% and 12% respectively in 2000.

As in most other countries affected by a severe HIV/AIDS epidemic in sub-Saharan Africa, there are more women than men living with HIV/AIDS. In 2000, it was estimated that for every two men living with HIV/AIDS there are three women living with HIV/AIDS. Put differently, six out of ten adults living with HIV/AIDS in Cameroon are women.

Statistics on AIDS deaths are also incomplete. In 1999, the number of cumulative AIDS deaths was estimated at 52,000. As a result of these deaths (most of which occurred among adults), there has been an upsurge in the number of orphans. Between 1990 and 1995, there was a 12-fold increase in the number of children whose mother or both parents died of AIDS, rising from approximately 3,000 to 36,000. By 2001, it was estimated that 210,000 children in Cameroon were AIDS orphans.

There is no data on HIV/AIDS in the public sector, either in general terms or in relation to specific sectors, like agriculture, education or health. The only study conducted to date found that HIV prevalence among military officers was 15% in 1996 (UNAIDS, 2002). This is a significant increase from 3.3% in 1990.

Whereas the Government initiated a national

programme on HIV/AIDS and established the National Committee for the Fight Against AIDS in 1990, it is only since 1997 that the national response to HIV/AIDS has gained momentum. In part, the delayed response can be attributed to the Government's perception that Cameroon was a low prevalence country. Since 1997, there has been a more concerted effort to curb the spread of HIV and provide treatment and care to people living with HIV/AIDS, which has included bringing down the cost of essential medicines. Part of this renewed impetus concerning HIV/AIDS programming was a focus on the decentralisation of the response.

Conclusion

During the 1980s, Cameroon seemed firmly set to make major advances across a range of social and economic development indicators. The acute economic crisis that set in towards the end of the decade clearly halted this progress. It was during this time that the first cases of HIV were recorded. Within this context of stagnated, if not reversed, development, HIV/AIDS managed to flourish. Currently, one in ten adults in Cameroon is infected with HIV. It is anticipated that before long the devastating impacts of the epidemic will transcend the household and community level to affect the economy and socio-political institutions in Cameroon. The following section reviews to what extent key representatives from Government and other sectors recognise the factors that facilitate the spread of HIV in Cameroon and the impacts of the epidemic. This serves as a prelude to section 6.4, which assesses whether the recently developed development planning frameworks take this reality into account.

6.3. The core determinants and key consequences of HIV infection in Cameroon

For the purpose of this study, 15 interviews were conducted with politicians and government officials, civil society organisations, organised business and international organisations. Given the busy schedules of high level politicians and administrators, it was not always easy to find time to accommodate the request for an interview. The list of organisations and persons interviewed is provided in Appendix 3. This section summarises the feedback from respondents in relation to the core determinants and key consequences of HIV infection in Cameroon.

Core determinants

The majority of respondents highlighted that HIV transmission in Cameroon was facilitated by one of three factors, or a combination thereof: ignorance (nine respondents), poverty (eight respondents) and cultural factors (five respondents). Ignorance was generally associated with the lack of education and at times with the poor dissemination of information. For quite a number of respondents who mentioned both ignorance and poverty, ignorance was considered the primary factor.

The perceived influence of cultural factors ranged from the value placed on procreation in African culture to a 'loss of culture', which is perhaps better summarised as a perceived 'loss of morality'. In particular, there was a strong perception that Cameroonian youth have embraced loose moral values and seek to imitate Western culture. In light of this, behavioural factors were considered important as well, in particular the failure to use condoms. In the words of one respondent: "AIDS is much more a problem related to behaviour than one related to poverty."[xlviii]

Others, however, argued that the emphasis on condom use to prevent HIV transmission served to justify the decline in moral standards:

> States that are subjected to ignorance and poverty, such as ours, are under an obligation to assume a certain number of control measures based on the fear of being punished for one's sins. For example, the condom has been presented as a solution, without any preconditions. The message '100% Youth, 100% Condom' means that people, irrespective of their age, even ten-year olds, have the right to have sexual relations as long as they wear a condom. And yet, one should be telling something different, such as to abstain and reserve the use of condoms for those who are already sexually active. In other words, adults. This easing of moral standards runs the risk of placing additional strain on our country. One should not imitate everything from the outside without adapting it to one's own context.[xlix]

Some respondents suggested that organisational factors, although perhaps not responsible for the spread of HIV, at least contributed to the failure to curb the epidemic. Reference was made to insufficient resource allocation (material, human and financial) at national and global level. Others pointed to the fact that the invisibility of the virus and its impacts at the onset of the epidemic led to a delayed government response. This view was

disputed by the UNAIDS representative, who argued:

> Until 1992, the programme for the Fight Against AIDS in Cameroon was one of the model programmes in Africa. In 1992, there was a change in the leadership and management of the structure. This change created instability and personnel were demotivated, because they were working only part-time on the programme.[l]

Cursory reference was also made to migration, the mixing of people and populations, inadequate health care conditions and even revenge as factors contributing to the spread of HIV in Cameroon. Yet, none of these factors was elaborated on.

A significant number of core determinants identified in Table 4.1 was not mentioned at all by respondents. For example, unemployment, income inequality, the lack of social cohesion, social conflict or inability to express political voice did not surface in the interviews. Only one respondent referred to lack of access to public services, by suggesting that inadequate health care conditions contributed to the spread of the epidemic.

Most notably absent in the discussion on core determinants enhancing vulnerability to HIV infection was gender inequality and the nature of gender relations in Cameroon. Only one respondent referred specifically to women when arguing that poverty constrains one's ability to make decisions. In fact, the few times reference was made to women in the interviews, there seemed to be a tendency to hold women responsible for the spread of HIV:

> Sometimes women accept propositions in the nature of '5000 francs with condom and 10,000 francs without condom' in order to have sexual relations with their partner. … When you are with a woman, you don't know how many men she has already been with.[li]

Contrary to the international view that during inter-generational sex the virus is most likely passed from older men to young women and girls, rather than vice versa, another respondent (representing the equivalent of a National AIDS Council) argued the following:

> When one separates the infection rate of men and women, one finds that it is higher among young women compared to men. It is higher among men in older age groups. This means that they are being infected by these young women.[lii]

If the views of these respondents can be considered representative of the Cameroonian Government and of society in general, it would seem that 15 years into the epidemic there is still relatively little consideration for the systemic development challenges that contribute to a context of vulnerability to HIV infection. The apparent disproportionate emphasis placed on knowledge, values and behaviour, although important elements of HIV prevention efforts, serves to constrain a more comprehensive response to the epidemic.

Key consequences

More than half of all respondents commented on the fact that HIV/AIDS is increasing adult mortality. The same number of respondents also observed that this will have negative implications for national production. Some made specific reference to the effect HIV/AIDS will have on the working population, leading to a reduction in human resources:

> The impact of the disease has not yet reached alarming proportions in the short term. But, if nothing is done, especially given the latent character of the disease before manifesting itself, it will be very serious in the medium and long term, especially in the world of workers: deaths, absenteeism of sick staff, drop in the labour force and hence drop in productivity, especially in the case of those difficult to replace from one day to the next because of the experience that they have acquired.[liii]

An increase in the number of orphans was also readily mentioned, with seven respondents highlighting this as a key consequence of the HIV/AIDS epidemic.

Five respondents pointed to the increase in the disease burden and associated health-related consequences, such as higher medical expenditure due to HIV/AIDS, the crowding out of other diseases and the need to provide treatment and care for people living with HIV/AIDS (including ARVs). The emphasis seemed to be mainly on macro level impacts, rather than on household level impacts and how households cope with the increased disease burden.

Both representatives from the Ministry of National Education (MINEDUC) and the Ministry of Higher

Education (MINESUP) commented specifically on the impacts of HIV/AIDS on the educational system.

> The impact on the educational environment is not yet real, but soon we will be witnessing a drop in educational levels. That is to say that factors such as the enrolment rate will be affected. For example, 100 children enrol in school, but how many complete their studies at the end of seven years? It will be a few years still before we have the figures to show this and it will be reflected in drop out rates …[liv]

Whereas this respondent did not refer to HIV/AIDS among teachers and support staff, his colleague indicated that in higher education there has been an increase in the number of people living with HIV/AIDS among lecturers, not just among students.

A relatively small number of respondents (four) mentioned that HIV/AIDS enhances poverty. Two respondents added that HIV/AIDS leads to 'family problems' or 'family disintegration', whereas stigma and shame was mentioned only once. Other impacts, like loss of income, enhanced income inequality or inability to pay for services or taxes (undermining local revenue generation and threatening financial stability) did not surface in the interviews. Apart from disregarding these household level impacts (which will eventually make themselves felt at larger scales), no attention was given to community level impacts either, such as entrenched gender inequality, the potential erosion of social support systems or the enhanced probability of social conflict and instability. It is possible that some of these impacts of the HIV/AIDS epidemic have not (yet) manifested themselves in Cameroon. Clearly, the most commonly identified consequences relate to adult mortality and its impact on the national economy.

Finally, one respondent suggested that one of the impacts of HIV/AIDS is, in fact, a diversion of development funds towards HIV/AIDS:

> … all the aid that we receive to combat AIDS could be used in other sectors for the development of the country and that is a great loss.[lv]

6.4. Development planning and HIV/AIDS in Cameroon

For two and a half decades since independence in 1960, Cameroon followed the tradition of adopting five-year planning cycles. This tradition was interrupted by the economic crisis that started in the late 1980s. In recent years, Cameroon has embarked on an extensive planning process and has adopted a vast range of development planning frameworks. This section will summarise the history of development planning in Cameroon and identify the primary development planning frameworks that are guiding the current development process in the country. This is followed by a discussion of the extent to which these frameworks take into account the core determinants and key consequences of HIV/AIDS. The final part of this section reviews how the various development planning frameworks have come about and reflects the observations of respondents concerning their alignment and implementation. Because most development planning frameworks were adopted within the year preceding this study, observations regarding their implementation are limited.

Development planning in Cameroon in historical context

Since independence, Cameroon embarked on five-year planning cycles. This process lasted until 1986, when the emergent economic crisis compelled the Government to abandon its development plans and adopt structural adjustment programmes. Between 1960 and 1986, five quinquennial economic and social development plans were elaborated.

Cameroon's first five-year socio-economic development plan after independence was drawn up at the end of 1960.[lvi] Its programme extended from 1961 to 1965. In terms of social development, its aims were to achieve more balanced nutrition, to extend and adapt education, and to ensure better utilisation of the potential of labour. The economic level plan focused on enhancing agricultural potential, developing economic trade and industrialisation.

The second plan covered the period 1 July 1966 to 30 June 1971. The projects envisaged related to the general conditions necessary for development (i.e. re-establishing public order and guaranteeing security for all, strengthening national cohesion and mobilising all the active forces in the country), enhancing production, rural development, opening the country up to the outside world, and strengthening economic independence. To achieve this, the following general areas of intervention were envisaged: 1) training people by making education more available; 2) developing the rural economy by diversifying production, exploiting new arable lands

and developing crafts; and, 3) developing industries, road infrastructures, settlements, urbanisation and administrative systems.

The third plan (1971-1976) focused on rural development through agriculture production, animal farming and forestry; the organisation of production by the State; industrialisation and trade; tourism; education and training (at primary, post-primary, secondary and higher school level); public health; social affairs; and, communication. It also covered the national planning framework, the modernisation of the administration and the budget.

The fourth development plan (1976-1981) was aimed at all socio-economic sectors and placed particular emphasis on the development of the provinces, whereas the fifth and last plan to be executed (1981-1986) made special reference to culture as an aspect of development. This plan considered the development of scientific and technical research, education and training, information science and statistics to be fundamental to the social and economic growth of the country.

The implementation of these various development plans enabled Cameroon to initiate development on the basis of GDP growth rates that were sufficiently high to counterbalance strong demographic growth. The economic recession that took root in the late 1980s throughout the early 1990s frustrated the development process and in some instances led to a reversal of the development gains achieved in the preceding two and a half decades. The first indications of an end to the crisis emerged towards the end of the decade, with the country's participation in the Heavily Indebted Poor Countries (HIPC) initiative and the mitigation of its debt burden. The time seemed right for the authorities to embark on reforms aimed at significantly reducing poverty through strong and lasting economic growth, improved efficiency with regard to expenditure, appropriately targeted poverty reduction policies and improved governance.[lvii]

Between 2000 and 2003, Cameroon has adopted the following key development planning frameworks:

- The Poverty Reduction Strategy Paper (PRSP);
- The Medium Term Expenditure Framework (MTEF);
- The Strategic Framework for the Fight Against AIDS;
- The Health Strategy;
- The Education Strategy;
- Rural Development Strategy (DSDSR).

It is worth noting that Cameroon does not have a national development plan at this stage. It is envisaged that the PRSP and the sectoral strategies will, in the long term, lead to the elaboration of a national development plan.

The PRSP further envisages that Cameroon will adopt an Urban Development Strategy to address the challenges related to urbanisation, such as the growth of informal settlements, the lack of sanitation, gated communities, unemployment, urban poverty, lack of security and an increase in crime. According to the PRSP, the strategy will be aimed at achieving the following objectives:

- To improve the living conditions of the urban population, the majority of which are living in tenuous conditions;
- To develop the economic role of urban areas through the extension, maintenance and repair of urban infrastructure;
- To develop a programme for promoting the social dimension in the urban environment.

The PRSP, 2003-2015

The PRSP, adopted in April 2003, is currently the principal development planning framework in Cameroon. It provides an overview of recent economic and social developments in the country and analyses the poverty situation and the dynamics of poverty in Cameroon. It further identifies seven priority objectives for achieving economic growth and poverty reduction in the short and medium term. These are:

- Promoting a stable macroeconomic context;
- Strengthening growth through the diversification of the economy;
- Stimulating the private sector as an engine for growth and as a partner in the provision of social services;
- Developing basic infrastructures and natural resources and protecting the environment;
- Accelerating regional integration within the context of the Economic and Monetary Community of Central Africa (EMCCA);
- Strengthening human resources and the social sector and incorporating disadvantaged groups into the economy;
- Improving the institutional framework, administrative management and governance.

The implementation period for the PRSP is from 2003 to 2015. At the end of this period, it is

envisaged in the PRSP that Cameroon should be close to reaching its Millennium Development Goals (MDGs), if it has not already achieved these goals.

The PRSP does not have a section devoted exclusively to HIV/AIDS. The only explicit reference to HIV/AIDS in the document occurs in the section on Health, where mention is made of the fight against STIs and HIV/AIDS, the reduction of the cost of ARVs and the relevance of the Strategic Framework for the Fight Against AIDS. Nonetheless, an assessment of the PRSP using the framework provided in Chapter 4 reveals that some of its objectives are, directly or indirectly, aimed at addressing the core determinants of a context of vulnerability to HIV infection. Furthermore, only two key consequences of HIV/AIDS identified in Table 4.1 appear to be covered by the PRSP.

Core determinants of HIV infection

Of the ten objectives identified in relation to addressing the core determinants of HIV infection in Table 4.1, six are explicitly articulated in the PRSP. These include objectives related to HIV/AIDS awareness raising, poverty reduction, access to income, gender equality, access to basic public services and urbanisation/migration/displacement in a specific context.

The PRSP supports the idea of awareness raising campaigns on HIV prevention, with a focus on condom use. To this effect, the PRSP makes reference to Government's intention to implement a sectoral communication plan to support the national Strategic Framework for the Fight Against AIDS. Thus, the document has an explicit focus on changing sexual behaviour to prevent the spread of HIV.

The PRSP explicitly recognises the need to reduce poverty by ensuring a minimum standard of living and food security (objective 1.2). It seeks to achieve this through the rapid creation of wealth to meet the basic needs of the population. The agriculture sector is seen as vital in enhancing food security for the Cameroonian population in general and in ensuring income for the rural population specifically. In relation to the forestry sector, the PRSP envisages that a share of forestry profits will be paid to village communities as a means to address poverty in these communities.

Within the framework of the PRSP, Cameroon envisages diversifying its economy in order to strengthen economic growth, promote job creation and integrate disadvantaged groups into the economy. With respect to the latter, the PRSP seeks to encourage the production of the goods and services urgently required by those who are poor. With respect to employment and access to income, the PRSP seeks to promote income generating activities for the poor, particularly those related to self-employment. The PRSP further mentions that a Declaration of National Policy on Employment will be forthcoming. However, no attention is given to the tension between agriculture reform and efforts to enhance economic competitiveness (especially in the manufacturing sector) - efforts generally associated with at best a stabilisation, at worst a contraction of the labour market and with greater labour disparities due to higher levels of specialisation – and the need for stable employment and decent wages. The emphasis on self-employment suggests that the Government recognises that the economy will not be able to provide enough jobs for all who need work.

The PRSP does, however, suggest that the social welfare system will be extended to support those who have remained on the margins of the system. These include workers in the informal sector, the rural population, those in liberal professions, merchants and other independent workers.

In accordance with the MDG to promote gender equality and empower women, the PRSP notes that the authorities should continue to strive for a better quality of life for women, respect for their rights, recognition of their effective contribution to the country's development process and their improved integration into economic activity. To achieve this, the PRSP refers to the Government's intention to develop a national strategy on the promotion of women before the end of 2003.[lviii] This strategy will focus on i) enhancing the social and legal status of women; ii) improving the quality of life of women; iii) greater equality and equity between the sexes in all sectors of national life; and, iv) strengthening existing institutions and mechanisms to address problems specific to women. To this end, the PRSP continues, at least three actions are to be carried out by the authorities at all levels. Firstly, gender disparity within the education system needs to be eliminated. Secondly, access to reproductive health services for women of child-bearing age and adolescents needs to be enhanced. Thirdly, technologies likely to make the work of women easier need to be promoted. Apart from this reference to a forthcoming strategy on the promotion of women, the PRSP remains silent on

gender inequality and the role of women in the economy, community development and household service provision.

In terms of access to services, access to drinking water remains a priority in the PRSP. The main objective is to reduce the huge gap in service provision between rural and urban areas. Referring to the "Rural Water II" programme, the PRSP is committed to promoting access to drinking water in all parts of the country by 2025 and, in particular, to ensure that 75% of the rural population has access. Reference is also made to enhancing access to sanitation and waste removal in urban areas. A more detailed discussion of urban development challenges as articulated in the PRSP follows below, in the context of migration and urbanisation.

With regard to access to health care, the PRSP highlights the steps taken by the authorities to improve access to basic medicines. The price of medication has therefore dropped by 40% and efforts are made to ensure that such medication is available in all health centres. Furthermore, in terms of education, the PRSP refers to the Government's objective to promote universal access to basic education and to focus on the provision of technical and professional training.

The last objective of Table 4.1 explicitly dealt with in the PRSP relates to urbanisation/migration and to rural and urban conditions respectively. The PRSP announces that the Government will develop integrated planning frameworks for rural and urban development respectively.[lix] With respect to rural development, mention has already been made of the PRSP's emphasis on agricultural production and on extending the provision of water in rural areas. According to the PRSP, the forthcoming integrated urban development strategy will have to address the precarious living conditions of the urban population, characterised by informal housing conditions and lack of basic services. It also has to focus on interventions to strengthen the urban economy, specifically through the extension, repair and maintenance of urban infrastructure. Finally, the strategy is expected to develop a programme to promote the social environment in urban areas. As the PRSP notes, the Government has already initiated a series of priority action plans to deal with the most urgent problems in urban areas, most notably the provision of public transport in Douala and Yaoundé, the provision of sanitation and waste management, state responsibility for the care of street children and those with mental problems, and awareness programmes for sex workers to make them aware of the risks associated with STIs and HIV/AIDS. It could be argued that the concomitant investment in rural and urban development may on the one hand lessen the push factors that lead people from rural areas to migrate to urban areas, whereas on the other hand it will ensure that the new habitat of migrants (and current urban residents) is liveable.

The PRSP does not specifically target displaced populations or refugees as disadvantaged groups, despite the fact that Cameroon has taken in many refugees from the sub-region for almost twenty years because of the instability in Central Africa. Cameroon constitutes the major economic centre of the Economic and Monetary Community of Central Africa (EMCCA) and its proximity to Nigeria, and hence to ECOWAS, strengthens its position in this regard. Within the context of the EMCCA, the Government intends to facilitate the free circulation and right of residence of its (EMCCA) people, so that they are able to contribute to growth in 'advantaged' areas and to ensure that the benefits derived from this kind of activity are also advantageous to their country of origin.

Four core determinants of vulnerability to HIV infection are not explicitly addressed in the PRSP. For one, whereas the PRSP recognises that significant income disparities exist in Cameroon, no specific action or strategy is proposed to deal with this. Furthermore, no reference is made to the potential lack of social cohesion or to the possibility of social instability and conflict as core determinants. Given that Cameroon is a relatively stable country, these factors may not be primary concerns for the country.

Finally, and rather surprisingly, the PRSP does not mention the importance of participatory processes or the need to involve poor communities and marginalised groups in the planning and implementation of development programmes. Instead, reference is made to the promotion of the rule of law and of the security of property and persons as being essential to the process of poverty reduction. As highlighted in the PRSP, the confidence of the people of Cameroon and of investors is dependent on the perception of there being an effective, lawful State in Cameroon, capable of applying the laws and regulations of society in an impartial manner. Thus, the PRSP emphasises the importance of enhancing the protection of civil and political rights of all and of

equal access to justice. To some extent, this could be interpreted as supporting political voice and equal access to political power, albeit rather indirectly.

Key consequences of HIV/AIDS
Few key consequences of HIV infection identified in Table 4.1 are explicitly recognised in the PRSP. In seeking to reduce adult and infant mortality as a result of HIV/AIDS, the PRSP emphasises the effectiveness of integrating both ARV treatment and medication for the treatment of opportunistic infections into the essential medicines plan. It further highlights the importance of popularising HIV/AIDS treatment and of preventing HIV transmission from mother to child.

In an apparent response to the request of the population that the Government provides for those affected by the HIV/AIDS epidemic, the PRSP also envisages that the authorities will take responsibility for AIDS orphans. What exactly such support would entail is not elaborated on.

None of the other key consequences of HIV/AIDS is dealt with in the PRSP. One could argue that the assumption of responsibility for AIDS orphans and the psychosocial assistance referred to in the PRSP could be seen as actions that contribute to a reduction in AIDS-related stigma and discrimination. Yet, no explicit attention is given to stigma and discrimination associated with HIV/AIDS, let alone how to address this in the workplace or society at large. The PRSP also does not highlight the importance of involving people living with HIV/AIDS and affected communities in decision making processes.

Despite its main thrust to reduce poverty in Cameroon, the fact that HIV/AIDS is likely to enhance poverty by pushing poor households towards greater destitution and creating new categories of disadvantaged groups is not elaborated on in the PRSP. Neither is attention given to the impact of the epidemic on people's ability to work and generate an income, nor to the burden of care disproportionately carried by women and other likely gender implications of the epidemic, such as a disproportionate number of girls dropping out of school. There is also no discussion of the fact that HIV/AIDS puts significant pressure on social support systems, which could ultimately erode social cohesion and may even lead to instability and social strife.

The PRSP is equally silent on the fact that HIV/AIDS is likely to create more and more complex demand for government support and services. Whereas the PRSP supports the objective of ensuring equitable access to services like health and education (which could be interpreted as encompassing the needs of those infected with and affected by HIV/AIDS), it does not recognise that the epidemic may jeopardise the very realisation of this objective.

Furthermore, despite the high HIV prevalence rate in the country and anecdotal evidence of an equally high prevalence rate in the public sector, the PRSP does not consider the impact of HIV/AIDS on the public sector to promote development and ensure consistent, quality service provision. In general terms, the PRSP is concerned with improving the capacity of the public sector by focusing on strengthening human and social sector resources, improving the institutional context, administrative management and governance. Yet, the eroding impact of HIV/AIDS on public sector capacity is not taken into account.

Given the fact that the PRSP does not seem to recognise that HIV/AIDS enhances poverty, it is not surprising that no consideration is given to the fact that the Government's ability to generate local revenue (through taxes and service fees) is under threat. At the macroeconomic level, economic growth projections have not taken account of HIV/AIDS and therefore seem highly optimistic, especially given the impact of HIV/AIDS on labour and national production.

In conclusion, as the principal development planning framework in Cameroon developed in recent times, one might have expected the PRSP to be more conscious of the factors facilitating the spread of HIV and of the key consequences of the epidemic. In particular, the bidirectional relationship between HIV/AIDS and poverty is not even touched upon. Instead, observations regarding HIV/AIDS are limited to a narrow conceptualisation of HIV/AIDS as primarily a behavioural and health problem, with an increase in the number of orphans as the only visible social impact being recognised. Unless relevant implementation programmes are able to rectify these gaps and omissions, it is feared that many of the laudable objectives of the PRSP may not be realised.

The MTEF, 2003-2015
The MTEF was adopted at the same time as the PRSP. In fact, it is included in the PRSP and its resource allocations are related to the objectives

articulated in the PRSP. It provides statistics on the growth profile and a framework for medium-term expenditure for the implementation of the various integrated and sectoral development planning frameworks. It also aligns the macro economic framework with the sectoral frameworks, especially those related to education and health, which were formulated prior to the MTEF. The MTEF projects that the share allocated to priority sectors will increase over time, between the 2003 and 2015 period. It is expected to increase from 3.4% to 4% in the case of education, from 1% to 2% in the case of health, and from 0.2% to 0.4% in the case of social development. However, it is worth noting that there is a financial mismatch between the resources allocated to these sectoral strategies within the MTEF and the actual resource requirements reflected in the strategies. This raises questions about the extent to which the objectives set out in sectoral strategies will be fully realised. Finally, the MTEF suggests mechanisms for its monitoring and evaluation.

Core determinants of HIV infection

The MTEF allocates resources to national priority programmes, including the national response to HIV/AIDS. Although no mention is made of MTEF support for HIV/AIDS awareness raising activities and the distribution of condoms specifically, the national programme on HIV/AIDS has a strong focus on these components. Through its funding for this programme, the MTEF could be seen to support individual behaviour change as a means to prevent the spread of HIV in Cameroon.

Between 2003 and 2015, the share allocated to the social, rural and employment sectors combined is expected to increase from 23% in 2003 to 32.4% in 2007 and 44.5% in 2015. This could be seen as an important contribution to enhancing employment opportunities and alternative forms of income. It is, however, unclear how much of this will be allocated to creating employment opportunities. Despite the PRSP's emphasis on self-employment, the MTEF does not make provision for access to credit facilities for those who are self employed or other mechanisms to support the informal sector. Even the intended aim to extend social welfare, as highlighted in the PRSP, is not provided for in the MTEF.

However, because agriculture development is seen as vital in ensuring food security for the Cameroonian population, growing MTEF support for the rural sector (which incorporates agriculture development) from 43 billion CFA franc to 62 billion CFA franc between 2003 and 2007 can be interpreted as an effort to promote food security, especially (but not exclusively) for the rural population. On the other hand, a significant proportion of agricultural products is meant for the global market rather than for domestic consumption, as the discussion of the DSDSR will reveal later.

A strong emphasis in the MTEF is on ensuring more equitable access to social services. For this reason, the MTEF makes provision for the financing of social infrastructures, particularly in relation to education, health and transport. For example, the MTEF envisages an increase in the allocation for the construction of class rooms and the recruitment of teachers from approximately 188 billion CFA franc in 2003 to 271 billion CFA franc in 2007. The number of teachers to be recruited is expected to increase from 1 879 in 2003 to 2 993 in 2006, after which it will decline to 2 357 by 2011. Between 2003 and 2007, the budget for strengthening health infrastructure and equipment will increase from 20.5 billion CFA franc to 24.2 billion CFA franc, and the budget for road construction and maintenance will increase from 272.8 billion CFA franc to 335 billion CFA franc. Provision is also made for increased financing for the recruitment of health specialists during this period.

The MTEF is also concerned with enhancing the effectiveness and management of social sectors. Thus, the allocation to support the decentralisation of the education system, improving the information system and promoting good governance in the education sector will increase from 1.8 billion CFA franc in 2003 to 2.2 billion CFA franc in 2007. Similarly, support for the management process in the health sector will increase from 620 million CFA franc in 2003 to 1.854 billion in 2007. These resources are intended to support the establishment of a tariff/follow-up evaluation system, to improve the sector's absorption capacity, to strengthen health planning and to support a health information system and an audit system.

The MTEF does not allocate resources to address other core determinants of a context of vulnerability to HIV infection, such as gender inequality or income inequality, lack of political voice, social instability or lack of social cohesion.

Key consequences of HIV/AIDS

The 2003 MTEF allocation to addressing STIs and HIV/AIDS is 15.5 billion CFA franc, after which it is

expected to increase to 21.25 billion CFA franc in 2007. Part of the annual budget allocation for HIV/AIDS in the MTEF is meant to finance the reduction in the cost of ARVs in Cameroon. Currently, the cost of ARVs in Cameroon is among the lowest in sub-Saharan Africa. This serves to contribute to the objective of reducing HIV/AIDS-related mortality.

Furthermore, because 19% of the total health budget is specifically allocated to HIV/AIDS and STIs, it could be argued that the MTEF is concerned with ensuring access to health services for people living with HIV/AIDS. To some extent, this could be seen as the MTEF's contribution to safeguard equitable access to public services, particularly for those affected by HIV/AIDS. Yet, the MTEF does not seem concerned with the possibility that HIV/AIDS is likely to lead to overcrowding in hospitals and could be crowding out other diseases. Although the MTEF's contribution to the health sector is anticipated to increase over time, as noted previously, this does not necessarily mean that it is sufficient to address the complex challenges to the health sector and health service provision posed by HIV/AIDS.

Otherwise, the MTEF does not reflect a concern with other key consequences of HIV/AIDS and no provision is made for resource allocation towards preventing or mitigating these impacts. Even though the PRSP mentions that the Government will assume responsibility for AIDS orphans, there is no budgetary provision for this task in the MTEF. There is also no recognition of the fact that the financial stability of the Government may be under threat as households get poorer and less able to pay rates, taxes or service charges as a result of HIV/AIDS. Nor is there any assessment of the anticipated impact of the epidemic on labour, national production and economic growth. Given the rapid spread of the epidemic and its current scale in Cameroon, these key consequences of HIV infection are likely to become manifest within the lifespan of this MTEF.

The Strategic Framework for the Fight Against AIDS, 2000-2010

The Strategic Framework for the Fight Against AIDS was the first strategic development framework to be drawn up since the Government adopted the national programme on HIV/AIDS in 1990. The framework was adopted in 2000 and covers the period 2000-2010. Its aims are to promote:

- The life of children (through the prevention of mother-to-child transmission), youth, adolescents, women and workers;
- The life of people living with HIV/AIDS;
- The safety of blood transfusions and injections; and,
- Greater solidarity towards people living with HIV/AIDS and orphans.

It also aims to sustain, in a viable manner, the social sectors of education and health by integrating specific strategies for each respective sector.

Core determinants of HIV infection

In response to behaviour patterns and life styles adopted by certain individuals, generally harmful to health and with a high risk of HIV infection in particular, the National Health Policy (part of which is incorporated in the Strategic Framework for the Fight Against AIDS) makes provision for strategies and actions aimed at changing individual behaviour. These include IEC strategies (adapted for different target groups) and awareness raising activities promoting breastfeeding within the first six months only. The Strategic Framework for the Fight Against AIDS also makes provision for the integration of Education for Life and Love (EVA) in educational programmes and the establishment or revitalisation of health and/or STI/AIDS clubs in primary, secondary and tertiary institutions. It also includes a focus on promoting community awareness through the use of mass media and the mobilisation of various sectors of the population. Furthermore, the framework aims to promote female condoms and the use of condoms (i.e. 100% condom use) among target groups, especially the military, the military police, customs officials, police officers, prison administration officers, students, sex workers and truck drivers. It further seeks to minimise the risk of HIV infection in young children (between 5-14 years).

The Strategic Framework for the Fight Against AIDS pays significant attention to the vulnerability of women to HIV infection and to the factors contributing to this reality. It recognises that the low level of education among women and their financial dependence on men keep women 'ignorant', contribute to a lack of awareness on HIV/AIDS and constrain their ability to stand up to various demands and pressures from men. Among its objectives are, therefore, to increase women's level of knowledge of HIV/AIDS, to reduce their dependence on men and to make the female condom available. To address the socio-economic status of women, the framework includes a

programme for improving women's access to micro-project finance and income generating activities.

Although support for social mobilisation and social cohesion (as a general development objective) is not an explicit aim of the Strategic Framework for the Fight Against AIDS, by involving community associations, churches, schools and civil society organisations in HIV prevention efforts, the framework could potentially contribute to enhanced social cohesion around a common goal: to curb the HIV/AIDS epidemic. No attention is given to social instability or conflict as a potential factor facilitating the spread of HIV.

The Framework does not elaborate on lack of access to basic public services as a factor contributing to an environment of vulnerability to HIV infection. Strong emphasis is put on improving school enrolment, which may not be surprising given the prominent focus on ignorance as a core factor facilitating the spread of HIV in Cameroon. But no attention is given to the significance of other services, like housing, health, water, and so on.

Rather surprisingly, perhaps, the Strategic Framework for the Fight Against AIDS fails to mention poverty, lack of (stable) employment and income, and income inequality as core determinants enhancing vulnerability to HIV infection. With respect to poverty, mention is only made of the fact that AIDS enhances poverty, not that poverty is a factor facilitating the spread of HIV. The Framework is equally silent on lack of political voice as a core determinant. In fact, it completely disregards the importance of involving marginalised groups (for example, women, rural poor, unemployed youth, and so on) in planning and decision making. No attention is given to migration, urbanisation and displacement and how these factors relate to HIV spread in Cameroon.

Key consequences of HIV/AIDS

The Strategic Framework for the Fight Against AIDS is obviously concerned with reducing HIV/AIDS-related morbidity and mortality. For this reason, it incorporates a focus on voluntary AIDS testing, especially making pregnant woman aware of the need to be tested, and making those who are HIV positive aware of the need to undergo treatment. Specific provision is made for the supply of ARVs to pregnant women (initially in 11 centres across the country) and for preventing the risk of mother to child transmission. The framework also allows for the treatment of opportunistic infections and ongoing treatment and care for people living with HIV/AIDS. This includes putting in place a system for the supply, distribution and subsidisation of ARVs. Implicit in this focus on treatment is a concern with patient adherence.

As mentioned earlier, the framework recognises that AIDS enhances poverty. It therefore views the fight against HIV/AIDS as a fight against poverty. One of its objectives is to reduce the economic consequences of HIV/AIDS. Hence, it aims to increase the number of people infected and affected by HIV/AIDS with access to income generating projects by 20%. To this end, provision has been made for identification and assessment of existing economic opportunities as a precondition for the creation of new opportunities. To some extent, although not an explicit objective in the document, access to income generating opportunities for people living with HIV/AIDS and affected households could help prevent an exacerbation of income inequality in Cameroon.

The framework also aims to take responsibility for the nutrition of 50% of people living with HIV/AIDS, although it does not spell out how this will be achieved. Attention is also given to the nutrition of AIDS orphans. Envisaged support for AIDS orphans further includes a focus on health and education, giving them priority access to bursaries and to ARV treatment, amongst others. The framework specifically aims to reintegrate children living under difficult circumstances, which includes the placement of AIDS orphans in families.

There is no recognition in the Strategic Framework for the Fight Against AIDS that the HIV/AIDS epidemic has different implications for women and men and girls and boys, due to their gender roles and responsibilities. Thus, there is no conscious attempt to alleviate the burden of care for people living with or affected by HIV/AIDS typically carried by women. There is also no discussion of the differential impact of HIV/AIDS on girls and boys, such as the greater likelihood that girls will drop out of school to look after siblings or sick parents.

The framework also does not seem concerned with the fact that the realisation of equitable access to basic public services is likely to be jeopardised by HIV/AIDS. There is a commitment to ensure access to medical and psychosocial care for people living with HIV/AIDS, which could be interpreted as a partial realisation of the fact that HIV/AIDS affects service demand. The framework hopes to achieve

this through the provision of home based care and the diversification of service providers. With respect to the latter, the framework emphasises the importance of involving NGOs, community associations and the private sector in treatment and care of people living with HIV/AIDS.

Yet, the concern with access to services does not extend beyond the immediate health needs of people living with HIV/AIDS to incorporate a prognosis of how the epidemic is likely to affect service demand and the nature of service provision. There is also no reflection on how HIV/AIDS is likely to erode public sector capacity and what measures should be put in place to address this.

Explicit attention is, however, given to the need for legislation that protects the rights of people living with HIV/AIDS, including legislation that protects their labour rights. In other words, it is recognised that HIV status cannot be a reason for failing to recruit a person or for losing one's job. Thus, the framework explicitly seeks to protect job security of employees infected with HIV. Legislation protecting the rights of people living with HIV/AIDS is also a critical instrument to prevent any form of discrimination on the basis of HIV status and to reduce HIV/AIDS-related stigma. A related activity outlined in the framework is training of associations of people living with HIV/AIDS on their rights and duties. No clarification is given as to what these duties would entail.

The framework also emphasises that people living with HIV/AIDS should be equal partners in the national response to HIV/AIDS. This means being involved in the conceptualisation, implementation and evaluation of relevant programmes and projects. Provision is also made for the establishment of a national network for people living with HIV/AIDS. These measures enhance the political voice of people living with HIV/AIDS, although no explicit attention is given to the political participation of social groups which have become marginalised as a result of HIV/AIDS, such as widows or the elderly.

In response to the eroding impact of HIV/AIDS on social cohesion and social support systems, the Strategic Framework for the Fight Against AIDS proposes that parent to child communication on HIV/AIDS and STIs be strengthened to support family cohesion. The shift towards home based care for people living with HIV/AIDS could also be seen as a measure to strengthen social support systems, especially if the stated intention to bolster the capacities of community structures that are expected to provide home based care is realised. Beyond these observations, however, there is no explicit discussion of the eroding impact of the epidemic on social support systems and social cohesion in the document.

Given that the Strategic Framework for the Fight Against AIDS serves as the guiding document for the national response to HIV/AIDS, one would expect it to be most comprehensive in acknowledging the core determinants and key consequences of HIV infection. It is therefore disappointing that the document fails to acknowledge a range of factors enhancing vulnerability to HIV infection, such as poverty and lack of work/income, particularly given the high levels of poverty in Cameroon. It is also disconcerting that no attention is given to the implications of the epidemic for service delivery, including the impact on the capacity of the public sector to deliver services and the extent to which the objective to achieve equitable access to services is likely to be jeopardised.

The Health Strategy, 2001-2010

Improving the health of the population represents both an economic and a social objective, which is central to development and poverty reduction. Noting three areas of insufficiency in the provision of health care – namely in human resources, infrastructure and equipment – the Government has outlined detailed strategies for the health sector, which will allow for the reform of the health system, make access to health services universal and achieve the objective of ensuring health for all.

The Health Strategy was adopted during the course of 2002 and covers the period 2001-2010. Its objectives set by the Government in the area of health, for the period of 2001-2010, fall under the following three categories:

- to reduce, by at least one third, the average morbidity rate and mortality among the most vulnerable population groups;
- to establish health centres providing Minimum Activity Packages (PMA) at one hour's walking distance and for 90% of the population;
- to effectively and efficiently manage the resources in 90% of health centres and public and private health services, at different levels of the health system.

To achieve these objectives, eight programmes have been formulated. These include programmes aimed at improving the accessibility and quality of health services, tackling the major diseases responsible for morbidity and mortality (i.e. malaria, tuberculosis, HIV/AIDS) and the promotion of the Extended Immunisation Programme for the prevention of diseases in children. Women and children, considered particularly vulnerable groups, are among the principal beneficiaries of these health programmes.

Given the particularly serious problem posed by the HIV/AIDS epidemic, the Health Strategy incorporates the main thrusts of the Strategic Framework for the Fight Against AIDS. Thus, it aims to prevent the spread of HIV and to minimise the consequences of HIV infection. It also aims to protect persons infected and affected by HIV/AIDS in all spheres through the provision of care and by preventing their marginalisation. Furthermore, given the fact that both the Health Strategy and the Strategic Framework for the Fight Against AIDS fall under the responsibility of the Minister of Health, it is to be expected that there will be a significant amount of overlap and synergy between the two documents.

Core determinants of HIV infection

In accordance with the Strategic Framework for the Fight Against AIDS, the Health Strategy emphasises the objective of changing individual behaviour through IEC programmes, developing communication and promoting the use of condoms. With respect to the latter, the Ministry of Public Health (MINSANTE) envisages making male and female condoms available at affordable prices and establishing a structure to manage and promote condom use. The Health Strategy sets targets of a 25% reduction in the HIV infection rate among those aged between 15 and 24 years and of a 50% reduction in mother to child transmission of HIV infection in 2003.

The main thrust of the Health Strategy is to improve access to health services and to improve the standard of health care. A number of strategies are suggested to achieve this goal, such as making essential medicines available and accessible (preferably in the form of generics) and establishing a pharmaceutical and rural laboratory system. The Strategy also seeks to promote the establishment of health villages and health centres and intends to make district health centres viable by expanding the health care provided. In recognition of the importance of human and financial resources for the accessibility and quality of health services, the Health Strategy elaborates on the mobilisation of resources and how staff competencies will be improved. With respect to the former, the focus is on introducing a system of cost-recovery through user charges, setting tariffs for all treatment protocols and implementing these tariffs to ensure the financial accessibility of health care for the population, and ensuring increased financing for the public health sector. To enhance staff competencies, the strategy proposes training of health care personnel in appropriate methods and establishing a mechanism for the provision of training at regular intervals.

Interestingly, the Health Strategy promotes the extension of social security to disadvantaged social groups, such as people from rural areas and people working in the informal sector. This inclusion is suggestive of an attempt to forge synergy between the Health Strategy and the Strategic Framework for the Fight Against AIDS, as it is unusual for the health sector to put programmes in place to realise this objective. In fact, the Health Strategy merely mentions this point and refers this objective to the relevant authority in Cameroon.

Equally unusual for a health strategy is the acknowledgement that gender gaps in education need to be addressed and that an improvement in the socio-economic position of women is necessary. Yet, when it comes to enhancing women's access to health services, the document limits itself to concerns about the high fertility rate and the high maternal mortality rate in Cameroon. Thus, the programmatic emphasis is on ensuring access to health care for mothers.

By encouraging communities to establish health centres in each district in an effort to share the disease burden, the Health Strategy could, unintentionally, strengthen social cohesion. The strategy also makes provision for involving religious organisations and members of religious communities in its implementation, which could potentially enhance social mobilisation. Whether these outcomes will be achieved will depend on what kind of support will be provided to communities and their associations in fulfilling these roles.

There is no explicit focus on health service provision in urban or rural areas specifically, nor does the Health Strategy elaborate on the health care needs of migrants or refugees in the country. There also

does not appear to be a strong emphasis on ensuring the participation of communities or particular social groups in health planning, except perhaps that the strategy makes provision for the establishment of platforms that facilitate dialogue between the various organisations involved in its implementation. However, within this context reference is only made to sector Ministries and private partners, not to communities or civil society organisations.

In general terms, a development planning framework related to the health sector is unlikely to engage with issues related to employment and income inequality. With respect to the Health Strategy, too, enhancing access to employment and reducing income inequalities are not articulated as objectives. There is, however, a concern with improving the remuneration of health care workers, which could contribute to a reduction in income inequality between those in the health sector and those in other sectors of the formal labour market. Also, the planned recruitment of new health care personnel is likely to provide an employment opportunity to those who are appropriately qualified.

Key consequences of HIV/AIDS

Because of the close synergy between the Strategic Framework for the Fight Against AIDS and the Health Strategy, both documents identify similar key consequences of HIV/AIDS and propose equivalent interventions to address these consequences. Thus, the Health Strategy elaborates on the reduction of HIV/AIDS-related mortality, support for AIDS orphans, safeguarding the food intake of people living with HIV/AIDS and the protection of their rights in similar ways as the Strategic Framework for the Fight Against AIDS.

Other key consequences of the epidemic are not mentioned at all in the Health Strategy. It does not even include a discussion on the enhanced disease burden due to HIV/AIDS and the pressures this puts on the public health sector, nor is mention made of the extent to which health workers may be infected with HIV and what this means for the capacity of the sector. Of course, in the absence of data on the proportion of health workers infected or affected by the epidemic, and at what level of the health system they are located, it would be difficult to project what consequences this may have for the sector as a whole. Yet, given the rapid growth of the epidemic particularly in the late 1990s, it is not unreasonable to expect the Health Strategy to engage explicitly with these two inter-related sets of consequences.

Linked to this is the silence on the need to protect the rights of those employed in the health sector, who may be living with HIV/AIDS or who may otherwise be affected by the epidemic. Likewise, although cost recovery is established as a guiding principle for health service provision, the fact that an increasing number of households and individuals will most likely be unable to afford health service charges is not touched upon. As a result, access to health care may be jeopardised for those who cannot afford it and at the same time the financial stability of the health sector may be at risk.

To conclude, the Health Strategy shows a significant amount of overlap with the Strategic Framework for the Fight Against AIDS, even up to the point where some points are raised that are not commonly associated with a health sector intervention. In the final analysis, however, the strategy does not seem to deal with a number of factors that are critical to the health sector, particularly in relation to addressing the key consequences of HIV/AIDS.

The Education Strategy, 2001-2011

The Education Strategy was adopted in 2001 and is directly related to the MDGs. The National Programme of Action for Education for All (PAN-EPT) was elaborated and adopted in 2002.

The Education Strategy sets out four key objectives:

1. To broaden access to education while correcting disparities, encouraging early childhood education and increasing access to primary, general secondary and technical secondary school education;
2. To improve the quality of education on offer by reducing school drop out, improving the quality of pedagogical training, adapting teaching programmes, improving the accessibility and availability of textbooks and good quality teaching materials, and by combating HIV/AIDS in the educational environment.
3. To develop an efficient partnership through the institution of participatory governance of educational institutions; involving the social and business community in the design of technical, technological and professional training programmes; developing and implementing a national policy on private education, and developing and promoting a partnership model between the State and role players in the field of private education.
4. To improve the management and governance of the educational system through improved

financial management and improved management of the Ministry of National Education's system of communication and through the promotion of good governance in the educational system.

Core determinants of HIV infection

An assessment of the Education Strategy in relation to Table 4.1 reveals that only a few core determinants of HIV infection are addressed in the document. One of the central objectives of the Education Strategy is to raise awareness about HIV/AIDS among pupils and students and to ensure they engage in safe sexual behaviour. Specific activities under this objective relate to an evaluation of knowledge, attitudes and behaviour concerning HIV/AIDS and sexual behaviour in the school environment, training of teachers and other actors on how to incorporate HIV/AIDS into the curriculum and, more generally, 'sensitisation'.

The overarching aim of the Education Strategy is to improve the coverage, accessibility and quality of education in Cameroon, especially at primary and secondary school level. A related concern is to reduce the high drop out rate, particularly in primary school. To achieve this aim, and in accordance with the Constitution of Cameroon and the Basic Education Act of 1998, the strategy makes provision for free, and compulsory, primary education. It also seeks to facilitate the accessibility and availability of text books and other educational material and to improve the quality of teaching. In an attempt to address regional disparities, priority education zones are identified which are targeted for increased school enrolment rates. These zones are mainly located in the three northern provinces (Adamaoua, Far North and North) and in certain disadvantaged neighbourhoods in the main cities. Study bursaries are made available to eligible children, specifically within the priority education zones, with a bias toward girls.

The Education Strategy is clearly concerned with addressing gender disparities at all levels of education. Thus, it seeks to increase not only enrolment rates among girls, but also their retention rates to avoid girls leaving school prematurely. The strategy does not specify how this will be achieved.

Other core determinants of vulnerability to HIV infection are not explicitly addressed in the document. It could be argued that the involvement of parent associations in the management of schools enhances social mobilisation and facilitates the expression of political voice for at least one interested party in the education of children, namely parents.

Also, as noted in the case of the Health Strategy, the planned expansion in the recruitment of new teachers at all educational levels throughout the period covered by the Education Strategy will promote access to employment for some young graduates. Obviously, the recruitment drive stems from the need to ensure the provision of equitable, quality education, rather than being the education sector's conscious contribution to overcoming unemployment (or under-employment) in the country.

Key consequences of HIV/AIDS

Under the objective of raising awareness about HIV/AIDS in the school environment, attention is given to the need to advocate for children's rights in a context of HIV/AIDS. More specifically, the Education Strategy aims to protect the right to education of learners living with HIV/AIDS and of AIDS orphans by stipulating that they should remain at school, where they ought to be provided with psychological and social support. Through this measure aimed at overcoming HIV/AIDS-related discrimination, the strategy safeguards equitable access to education for learners infected with and affected by HIV/AIDS.

This is, however, the extent to which the Education Strategy engages with the key consequences of HIV/AIDS. Despite its intention to overcome gender disparities in education, there is no recognition of the fact that this goal may not be achieved – and in fact, that gender disparities may even be aggravated – as a result of HIV/AIDS, with girls more likely to drop out of school to assist their families in times of need. One possible explanation is because the strategy identifies only two categories of learners affected by the epidemic: those living with HIV/AIDS and AIDS orphans. No reference is made of the impact of HIV/AIDS on children, and in particular on their educational prospects, who do not fall into either category.

Although the Education Strategy recognises that there is a high probability that learners living with HIV/AIDS and AIDS orphans will drop out of school whereby their access to education is in jeopardy, it does not engage with the impact of the epidemic among teachers and other educational staff. Thus, there is no consideration for the impact of HIV/AIDS

on the capacity of the education sector and on the provision and quality of education.[lx] It is true that provision is made to recruit more teachers over time to ensure better coverage of education across the country. Yet, these projections do not take into account the loss of teaching staff due to HIV/AIDS, nor are the financial implications of having to replace these teachers and other personnel worked out.

The strategy also does not seek to contribute to enhanced food security through a nutritional programme or school feeding scheme for AIDS orphans or other vulnerable children, nor is there an explicit focus on stigma-reducing activities within the educational environment. Finally, the Education Strategy does not engage with the prospective impact of the HIV/AIDS on the labour market and what role the education sector can play in replacing the skills and qualifications that may be negatively affected.

This cursory review suggests that the Education Strategy incorporates a number of obvious – and important – interventions aimed at addressing some core determinants and key consequences of HIV infection. Yet, it has also revealed that a significant number of factors are not dealt with in the strategy, despite their relevance for the education sector.

The Rural Development Strategy (DSDSR), 2002-2004

The Rural Sector Development Strategy Paper (DSDSR) provides a critical analysis of the contribution of the agricultural sector to the national economy. It acknowledges the importance of this sector and the role it will continue to play in the future. The DSDSR envisages that this role can only be achieved through practical programmes which aim, amongst others:

- To increase the productivity of agricultural production and stock (cattle and fish) farming;
- To encourage private initiatives, particularly those of women in programmes to combat poverty;
- To ensure continued and lasting long-term results, referred to as the "challenge of the environment".

It is worth noting that the DSDSR is principally an economic development framework. Other dimensions of rural development are supposedly captured in the PRSP. This economic thrust has implications for the reflection of core determinants and key consequences of HIV infection in the DSDSR.

Core determinants of HIV infection

The DSDSR makes no mention of HIV/AIDS or the importance of preventing the further spread of the epidemic in rural areas. Accordingly, no attention is given to changing sexual behaviour as a means to prevent HIV transmission.

As noted above, one of the aims of the DSDSR is to specifically encourage private initiatives of women. Recognising that women are a disadvantaged socio-economic group, the framework seeks to enhance their ability to generate income. In fact, gender inequality is the only core determinant of vulnerability to HIV infection explicitly dealt with in the DSDSR.

Other than that, the underlying assumption of the DSDSR seems to be that enhanced agricultural productivity will automatically reduce poverty and create employment opportunities in rural areas. It does not consider the distributional effects of potential economic growth in rural areas or the labour implications of particular types of agricultural reform strategies. The DSDSR advocates the use of new agriculture, stock-raising and farming technology to increase output. It also encourages private initiatives and profit distribution to farmers as an incentive to improve productivity. Unless accompanied by poverty reduction and labour enhancing measures, such interventions more often than not lead to a loss of jobs (especially in lower skilled positions), more poverty and enhanced income disparities. Also, whereas the DSDSR emphasises enhanced food production, this is not necessarily to the benefit of food security for the rural population or for the country as a whole. Rather, given the emphasis on trade, agricultural products would not necessarily be produced for the domestic market.

No mention is made in the DSDSR of the need to extend service provision and infrastructure development into rural areas. Given the service delivery gaps in rural areas (as noted in the overview of development trends in Cameroon), this omission seems rather surprising. However, the DSDSR is principally designed as an economic development framework, aimed at strengthening the rural economy and agricultural production. Any other aspect of rural development that does not fall inside this – admittedly narrow – interpretation of economic development is supposed to be addressed by the PRSP. The same applies to the development challenges related to migration and urbanisation, which are not dealt with in the DSDSR.

Table 6.1. Explicit objectives in Cameroon's development planning frameworks						
	PRSP	MTEF	AIDS Strategy	Health Strategy	Educ. Strategy	DSDSR
Core determinants of HIV infection						
1.1. Change in individual behaviour	++	+	++	++	++	-
1.2. Poverty reduction (minimum standard of living & food security)	++	+?	-	-	-	-
1.3. Access to decent employment or alternative forms of income	+	-	-	+?	-	-
1.4. Reduction of income inequalities	-	-	-	-	-	-
1.5. Reduction of gender inequalities & enhancing the status of women	+	-	++	+?	+	+
1.6. Equitable access to quality basic public services	++	++	-	++	++	-
1.7. Support for social mobilisation & social cohesion	-	-	+?	+?	-	-
1.8. Support for political voice & equal political power	-	-	-	-	-	-
1.9. Minimisation of social instability & conflict / violence	-	-	-	-	-	-
1.10. Appropriate support in the context of migration/displacement	+	-	-	-	-	-
Key consequences of HIV/AIDS						
2.1. Reduction of AIDS-related adult/infant mortality	+	+	++	++	-	-
2.2. Patient adherence	-	-	-	?	-	-
2.3. Poverty reduction	-	-	++	+?	-	-
2.4. Reduction of income inequalities	-	-	-	-	-	-
2.5. Reduction of gender inequalities & enhancing the status of women	-	-	-	-	-	-
2.6. Appropriate support for AIDS orphans	+	-	++	++	+	-
2.7. Equitable access to essential public services	-	+?	-	-	+	-
2.8. Effective/enhanced public sector capacity	-	-	-	-	-	-
2.9. Job security & job flexibility for infected and affected employees	-	-	+	-	-	-
2.10. Ensuring sufficient & qualified/skilled labour supply	-	-	-	-	-	-
2.11. Financial stability & sustainable revenue generation	-	-	-	-	-	-
2.12. Support for social support systems & social cohesion	-	-	+?	-	-	-
2.13. Support for political voice and equal political power, particularly for PLWHAs and affected households and individuals	-	-	+	-	-	-
2.14. Reduction of AIDS-related stigma and discrimination	-	-	+	+	+	-
2.15. Reduction of social instability & conflict	-	-	-	-	-	-
+ = to some extent or in part; ++ = to a greater extent; +? = possibly, but mostly indirectly						

For the same reason, there is no focus on involving rural communities or rural women in decision making and implementation of rural development plans. The DSDSR does encourage communities to establish 'economic interest groups' (GIE) or 'common interest groups' (GIC), which could be interpreted as a measure supporting social mobilisation. However, in accordance with the economic slant of the RSDPS, these groupings are clearly based on economic criteria, rather than cultural or other social criteria.

Key consequences of HIV/AIDS

Because the RSDPS does not take cognisance of HIV/AIDS, how it manifests itself in rural areas or what its implications are for rural development, none of the key consequences of HIV/AIDS identified in Table 4.1 come to the fore in the document. This is despite the anticipated impact of HIV/AIDS on labour and production, amongst others. Although the HIV prevalence rate in rural areas is considered to be lower than the urban prevalence rate in Cameroon, this does not mean that the rural economy (which is the preoccupation of the DSDSR) will not be adversely affected. Of course, other impacts of the epidemic in rural communities, such as those related to poverty, loss of work and income, gender relations and rural service provision also have to be factored in.

Table 6.1 summarises the preceding assessment of the extent to which Cameroon's primary development planning frameworks address the core determinants and key consequences of HIV/AIDS. It is clear that, with the exception of the DSDSR, all frameworks highlight the importance of raising awareness about HIV/AIDS and of changing sexual behaviour to prevent the further spread of the epidemic. Most frameworks also highlight the need to address gender disparities. Another common concern is related to the equitable provision of quality services. The least attention is given to

socio-political factors, such as the importance of participatory planning processes and the value attached to social cohesion and mobilisation. Lack of employment or secure income and income inequality are also not considered in the various development planning frameworks, except for the statement in the PRSP to promote self-employment. Although poverty reduction is supposedly the main objective of the PRSP, in practical terms it proposes very few concrete measures to achieve this. Like the DSDSR, the assumption seems to be that enhanced economic growth in itself will be sufficient to reduce poverty.

With respect to the key consequences of HIV infection, the three most commonly recognised factors are those related to mortality, AIDS orphans and, to a lesser extent, HIV/AIDS-related stigma and discrimination. Beyond these impacts, the development planning frameworks do not engage with the implications for public service provision, in terms of both supply and demand, but also in relation to financial resources. Even though the majority of respondents highlighted the impact of the epidemic on labour and national production, these factors are not taken into account in any of the frameworks. Again, the frameworks are largely silent on the socio-political implications of the epidemic. Most surprisingly is perhaps the general lack of attention given to poverty as a key consequence of the HIV/AIDS epidemic.

The planning process

The preceding discussion has alluded to some important dissimilarities between what respondents identified as core determinants and key consequences of HIV/AIDS and what is reflected in the development planning frameworks of Cameroon. To some extent, such discrepancies might be explained by the nature of planning processes in the country. Another plausible explanation is that the interviews took place at a time when levels of awareness of HIV/AIDS may have been higher than when the frameworks were developed.

Parliament

When asked about Parliament's involvement in the formulation of the principal development planning frameworks in Cameroon, the Member of Parliament interviewed suggested that Parliament has not played a primary role in the development of these frameworks. He described the role of Parliament as one of debating and ratifying draft bills and policy documents, rather than one of inputting into the design of these documents. In fact, he went as far as to say that unless there is a document for Parliament to peruse, it is unlikely that an issue will be discussed in Parliament. One would imagine that all the development planning frameworks have been tabled in Parliament for ratification, but this could not be gauged from the interview or from other respondents.

With respect to HIV/AIDS specifically, he further noted: "Although the seriousness of the epidemic would seem to call for an examination and debate in a plenary session of Parliament over a number of days, this has not happened." He added to this,

> In the context of HIV/AIDS, Parliament is informed about what is happening. Its members serve on committees for the Fight Against AIDS at local or regional level. A Member of Parliament is therefore a simple link in the knowledge about the phenomenon and the possibility of controlling it, but Parliament does not play a principal role.[lxi]

Sector Ministries

Given the fact that the Ministry of Economic Affairs, Planning and National Development (MINEPAT) has set up a committee with representatives of 16 sector Ministries and the technical partners in Cameroon within the context of the national development programme, one would anticipate a significant amount of multi-sectoral involvement in the formulation of principal development planning frameworks. During a number of interviews, reference was made to the involvement of different Ministries and departments in the formulation of certain development planning frameworks. In particular, the PRSP and the Strategic Framework for the Fight Against AIDS seem to have been underpinned by multi-sectoral involvement. With respect to the latter, it initially started as an initiative of the Ministry of Health, but gradually other sectors and civil society organisations have become involved. With respect to the sectoral strategies for health and education, reference was made to the fact that these have been drawn up with the coordination of MINEPAT.

Civil society organisations

The representative of the Cameroon National Association for Family Welfare (CAMNAFAW) indicated that his organisation had been involved in the formulation of the National Health Plan, the National Programme of Action for Education for All (PAN-EPT) and other policies in these sectors.

Because of its involvement in elaborating strategies for the health sector, which included HIV/AIDS-related strategies, the organisation also played a part in the Strategic Framework for the Fight Against AIDS. CAMNAFAW only became involved in the PRSP after it had been adopted as the principal development planning framework for Cameroon by making a submission to Parliament in December 2002. The organisation did not engage with macroeconomic planning or with the DSDSR, because these pertained to issues that were considered to be outside its area of competence.

Whereas government representatives argued that there had been significant civil society involvement in the planning process, particularly with regards to the PRSP, it was also noted that in practice such involvement may be limited because the role of some parties tend to be symbolic or "figurative" and, more than that, "in the end, it is always the civil servants who draw up the documents."[lxii]

The CNLS and organisations representing PLWHA
The National Committee for the Fight Against AIDS (CNLS) – which falls under the Ministry of Health – undoubtedly played a central role in formulating the Strategic Framework for the Fight Against AIDS in Cameroon. Beyond this, however, there was no indication that the CNLS was involved in the formulation of other development planning frameworks in the country. Unfortunately, the President of the Association of People living with HIV was relatively new in this position and was therefore unable to comment on the extent to which the organisation had been involved in the formulation of the Strategic Framework for the Fight Against AIDS, let alone of other development planning frameworks.

Development partners/donors
The interviews suggested that there has been significant involvement of the World Bank, UNAIDS, the French Development Cooperation, the German Development Cooperation (GTZ) and the European Union in the elaboration of Cameroon's principal development planning frameworks. Moreover, most of these frameworks are funded, in more or less significant ways, by these international agencies. The World Bank representative referred to his organisation's involvement in the PRSP, Strategic Framework for the Fight Against AIDS and the DSDSR as 'maximum participation'. UNAIDS's role in the formulation of the Strategic Framework for the Fight Against AIDS seems to have been substantial, not just by providing financial and technical support in the process leading up to its formulation, but also by elaborating the draft of the actual framework. UNAIDS continues to be involved in monitoring the implementation of the framework.

Private sector
An interview conducted with a representative from the Cameroon Employers' Federation (GICAM) highlighted the role of the private sector in the process of development planning in the country. As the representative argued, "There is not a single strategic framework for development that has been introduced without representation from GICAM".

Alignment and implementation of development planning frameworks
As the discussion of the various development planning frameworks has shown, a significant amount of alignment exists between the Strategic Framework for the Fight Against AIDS and the Health Strategy. This has been facilitated by the fact that both frameworks have been elaborated under the political leadership of the Minister of Health. It is clear from Table 6.1, though, that there is little evidence of alignment in HIV/AIDS programming between the Strategic Framework for the Fight Against AIDS and other frameworks.

Furthermore, due to its status as the principal development planning framework in Cameroon, the PRSP clearly seeks to fulfil an alignment function. The document identifies critical development challenges facing the country and refers to other planning frameworks (e.g. the urban and rural development strategies) and policy documents (e.g. the forthcoming policy on the promotion of women) for a more detailed elaboration of appropriate strategies.

In the course of the interviews, conflicting views on alignment of development planning frameworks emerged. For some, synchronisation was evident in the fact that the PRSP served as the principal planning framework that guided all other development planning frameworks. In the words of one respondent:

> Cameroon is a member of the United Nations and has had to adhere to all objectives set at international level, especially the Millennium Development Goals, and everything done at national level is directly related to these millennium goals through the PRSP, which today represents the economic and social policy framework for the country. All strategies

> of sector Ministries and of different sectors of activity (rural, social) work in synergy to achieve the objective embodied in that document or the PRSP.[lxiii]

Others pointed to the role of the Prime Minister in directing the work of government sectors, thereby suggesting that this resulted in a fair amount of institutional coordination. One respondent (a civil society representative) went as far as to suggest that "… civil society follows in the footsteps of Government"[lxiv], thereby suggesting that the whole of Cameroonian society aligns itself with government efforts aimed at the development of the country.

Yet, other respondents argued that there was very little coordination in efforts to promote development, whether it was aimed at poverty reduction or addressing HIV/AIDS, for example. Specific reference was made to the lack of coordination in the area of HIV/AIDS programming in particular, with some respondents suggesting that "everyone develops his or her own plan of action" and even that "there is total shambles around the question of AIDS in Cameroon". [lxv] It could be pointed out, though, that these observations seem less concerned with the alignment of planning frameworks at the macro level, but more with the lack of synergy and coordination of specific programmes and activities in the sphere of implementation.

Furthermore, although there is evidence of a certain amount of streamlining, especially with respect to the PRSP and MTEF on the one hand and the Strategic Framework for the Fight Against AIDS and the Health Strategy on the other hand, the fact that different development planning frameworks cover different time frames and follow different planning cycles is also likely to further complicate effective alignment.

With respect to implementation, it is worth noting that most of Cameroon's development planning framework had been adopted within the year preceding this assessment. As such, observations regarding the implementation of these frameworks were clearly limited. On a few occasions, reference was made to the process of decentralisation, identified by some as an example of 'good' implementation, whereas others regarded it as less successful and a challenge to the effective implementation of development planning frameworks.

One respondent commented specifically on the challenge in translating the good objectives reflected in Cameroon's development planning frameworks into practical and effective strategies and programmatic interventions. In other words, the relevant knowledge and insights to address development challenges seems to be there, but what remains is the 'how to' question.

With respect to the Strategic Framework for the Fight Against AIDS specifically, it was observed that the fact that everything in the framework was considered a priority served to hinder its effective implementation. It was also noted that there is a need for clear and reliable indicators that allow for an assessment of the implementation and impact of respective development planning frameworks. This, of course, links to another point noted during the interviews, namely the lack of basic data on which everyone agrees. As noted in Chapter 3, the lack of consistent and reliable data militates against the alignment of development planning frameworks.

Finally, the financing gap between the resources provided for in the MTEF and the resource requirements in other development planning frameworks, especially the sectoral frameworks, is indicative of poor alignment and will most certainly affect their effective implementation negatively.

Concluding comments

This section started by locating development planning in Cameroon in historical context. The six development planning frameworks discussed here have all been elaborated in recent years, since 2000, which indicates a renewed interest in development planning. It seems external partners have been very involved in this process, both in the design of these frameworks and by making resources available for their implementation. The formulation of the various development planning frameworks took place at a time when the HIV/AIDS epidemic in Cameroon took on unprecedented proportions. Thus, an opportunity existed to incorporate a comprehensive approach to HIV prevention and impact mitigation in these frameworks. However, this cursory assessment has revealed that this opportunity was not fully grasped. Even though the Strategic Framework for the Fight Against AIDS was the first to be developed, and therefore could have influenced the other planning frameworks in Cameroon, there is little evidence to suggest that this has actually occurred. There is also no indication that the CNLS was directly involved in the formulation of other development

planning frameworks, which could have facilitated better alignment on HIV/AIDS programming. It should be noted, though, that even the Strategic Framework for the Fight Against AIDS does not address all core determinants and key consequences of HIV infection.

6.5. Conclusion

The 1990s were challenging times for Cameroon. The economic recession that started in the late 1980s led to spiralling external debt, a steady decline in average GDP per capita, growing levels of poverty and informality and a general decline in the quality of life of Cameroonians. The first HIV/AIDS cases were observed when the country fell into economic crisis. Within a decade, HIV/AIDS had taken on epidemic proportions, with latest statistics suggesting that the HIV prevalence rate reached 11% in 2000.

Towards the end of the 1990s, Cameroon appeared to bounce back from the economic crisis. However, the benefits of positive economic growth are not shared equally among the population, as growing gaps between the rich and poor make evident. Perhaps there is a connection between the improved performance of the economy and the renewed concern with HIV/AIDS. In any event, by the end of the decade it becomes clear that HIV/AIDS has flourished and that a concerted effort is necessary to respond to the epidemic. This culminates in the Strategic Framework for the Fight Against AIDS in 2000.

Since then, development planning seems to have gained prominence again, as it had in the 15 years preceding the economic crisis. Within two to three years, Cameroon has adopted a range of development planning frameworks, in accordance with international thinking on development and on what are considered the most appropriate frameworks and instruments to facilitate development.

The timing of the development of these frameworks seemed most opportune to allow for HIV/AIDS to be incorporated. Yet, as this assessment has revealed, Cameroon's development planning frameworks at best cover a minimum package of prevention, treatment and care, and impact mitigation (limited to a concern with orphans). In particular, the emphasis is very strongly on HIV prevention through awareness raising and behaviour change. Little, if any, attention is given to the social, economic and political environment in which individuals think, relate and act. Thus, the significance of other core determinants of vulnerability to HIV infection, such as poverty and gender inequality, is not adequately recognised. Similarly, hardly any attention is given to the key consequences of HIV/AIDS, at micro and macro level. Although it is too soon to assess the implementation of the various development planning frameworks, it seems unlikely that all objectives and targets will be realised as a result of HIV/AIDS.

Although interview respondents generally highlighted poverty as a factor facilitating the spread of HIV, here too the main emphasis was on ignorance, loose moral values and inappropriate behaviour as the main reasons for becoming infected with HIV. Most remarkable was the lack of consideration for the status of women and the link between HIV infection and gender relations. Respondents did recognise a number of key consequences of HIV/AIDS that are not explicitly dealt with in the development planning frameworks. Those most commonly mentioned related to the loss of labour and the implications for national production. Given the country's recent emergence from an economic crisis, this concern with macro level impacts is perhaps not surprising. Still, what is remarkable is the silence on the link between HIV/AIDS and the loss of ability to work and generate an income, the added burden of care for women/girls and the pressure on social support systems to cope with the consequences of the epidemic.

In conclusion, it seems the key development planning frameworks in Cameroon at best cover what is considered the traditional mainstay of HIV/AIDS programming. Instead, a broader conceptualisation of HIV/AIDS is required, one that recognises the intricate interplay between HIV/AIDS and other development challenges. Given that these frameworks need to be translated into specific programmes and plans, there is a window of opportunity to rectify the noted gaps and omissions.