ABSTRACT

Mechanisms for the Co-ordination of health sector donor assistance in Cameroon: a case study

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As global resources continue to shrink, donors are increasingly taking an interest in the maximisation of the impact of available resources invested in the health sector of developing countries especially of Africa South of the Sahara[1]. Sector-wide co-ordination of donor assistance to optimise resource mobilisation and use has been identified as one means of achieving this goal.

There is an apparent dearth of literature on viable mechanisms of the co-ordination of donor assistance. This case study seeks as a first step, to enhance an understanding of aspects of the co-ordination of donor assistance by analyses of the mechanisms for co-ordination aid in Cameroon. It is a case study of the types as well as the scope of informal and formal mechanisms of co-ordination of health sector aid in Cameroon. The study identifies and highlights the potentials and constraints of the main mechanisms that have been created. The organisation and functioning, operating methods, and the strengths and weaknesses as well as the level of efficiency of the Consultative and Steering Committee of the HIPC Funds is exposed in the process. The paper also identifies the strengths of the latter committee to include the civil society and the donor community but questions its compatibility with the principle of non-interference in the internal affairs of sovereign states.

Key words: Co-ordination of donor assistance mechanisms, Cameroon HIPC Consultative Management and Steering Committee, sector-wide approaches to health development (SWAps)

[1] According to UNAIDS, this sub-continent has 10% of the World's population and more than half of the World's population of people with AIDS.

MECHANISMS FOR THE CO-ORDINATION OF HEALTH SECTOR DONOR ASSISTANCE IN CAMEROON : A CASE STUDY

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Introduction:

Cameroon receives health sector assistance from multilateral and bilateral partners as well as from non governmental organisations.[2] During the period covered by the present study (1991-2003), the budget of Cameroon that was allocated to the health sector has varied but has at no time exceeded the ceiling of 6% of the said national budget; (which figure represents the minimum recommended by WHO for national health sector financing).[3]

Geographically, the European Union provides budgetary assistance to Cameroon's health sector under the 9th European Development Fund (EDF) initiative. This assistance targets primary health care activities in the Centre, South and West Provinces. Coverage by UNICEF and UNFPA is national but thematic. UNFPA assists in reproductive health activities in the Far North, the West, East, and the Centre and South provinces. UNICEF covers maternal and child health (MCH) as well as the enlarged vaccination programme in all provinces of Cameroon. Germany supports primary health care activities in the Littoral, the South West and the North West Provinces. The French co-operation supports primary health care activities in the North Province while providing thematic assistance (like to vaccination activities etc.) through its urban health Project in a number of health districts in Yaoundé. The Far North and the East until recently were beneficiaries of the assistance respectively of Belgium and Italy. Non Highly Indebted Poor Country (HIPC) initiative bilateral or multilateral aid is not included in the national health sector budget.

Funding levels of the various donors vary. These levels have experienced a decline in recent years[4] with the exception of the assistance of France. [5] Funding levels or instruments as such do not however constitute the subject of this study.

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[2] Currently, UNFPA, WHO, UNDP, UNICEF and the European Union are the major multilateral donors to Cameroon's health sector. Germany, France, China, Japan and the United States of America are its leading bilateral partners. *CARE International, Plan International, International Planned Parenthood Federation* and *Hellen Keller* count among the most important international NGOs that support Cameroon's health sector alongside two prominent local NGOs; *Cameroon National Family Welfare Association* (CAMNAFAW) and *l'Association Camerounaise de Marketing Social* (ACMS).

[3] For example, during the period under study, there were decreases in Cameroon's national budgetary allocations to the health sector, leaving total allocations that varied from 5.6 % in 1989 to 3, 06 % during the 1997/1998 budgetary years. Conversely for example, aid constituted 30 % of the national budget allocated to health in 1990, 27% respectively in 1991 and 1992, 50 % in 1994 and 18 % in 1995 according to UNDP country development co-operation reports

[4] UNDP '*Rapport sur la Coopération pour le Développement*', (1998)

[5] French bilateral debt relief will effectively result in a considerable increase in its health sector assistance to Cameroon should the latter attain the completion point of the HIPC initiative. Under its 'C2D Project,' the French government intends to provide decentralised integrated inter-

It follows from the foregoing that the rationale for the co-ordination of health sector donor assistance rests *inter alia* on the number and the diversity in the objectives pursued by the donors, the volume and levels of funding they together and respectively provide, the proliferation in the number of donor supported projects and the fragmentation of government systems that this engenders, institutional weaknesses of beneficiary countries, promoting participatory governance, the search for optimal resource mobilisation and according to *Buse et Walt (1997),* the increasing use of foreign aid to influence health sector reform. The objective of this case study is to analyse mechanisms or ways of working between donors and the government of Cameroon for the co-ordination of the assistance provided by this large and diverse group of health sector donors and to draw lessons there-from.

Methodology
In the absence of a standard methodology for the collection and analysis of data on mechanisms for the co-ordination of donor assistance, data relating to the present study was collected through participation in donor meetings held between 1991 and 2003, a review of literature and legislation on the subject, interviews with representatives of donors to the health sector of Cameroon in 1997/1998, 2000/2003 and internet search.

Conceptual Framework:
This study builds on the premise that development aid will continue to decline. Effective recipient-driven institutional arrangements that serve to better co-ordinate development aid with a view to maximising output are therefore a necessity. An analysis of current mechanisms for the co-ordination of health sector aid in Cameroon constitutes a useful starting point towards the search for suitable mechanisms for optimising health sector resource mobilisation and management through better and functional tools for managing donor-government dialogue. For this purpose, it is useful to briefly define 'co-ordination,' 'mechanisms,' and the sector-wide approach (SWAp).

Though co-ordination is generically defined as 'a common action or movement, an attempt to harmonise or act together in a concerted way', "co-ordination mechanisms[6]" for the purpose of this paper is loosely used to mean any

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sectorial assistance to the Cameroon amounting to CFA 72 (some EUR 1.075) billion for priority projects).

[6] Theory distinguishes between *upstream* and *downstream* mechanisms of co-ordination. Upstream mechanisms or co-ordination frameworks address co-ordination at the macro and meso, inter-sectoral or sectoral levels. This level involves government and donors directly. In this mechanism feature National Health Development Plans (NHDP) like Senegal's 1997-2002, Côte d'Ivoire's 1996-2005 and Cameroon's 2001-2005. Cameroon's NHDP records the unique quality of having been elaborated entirely at the initiative of the government with inter-ministerial and grassroots level participation in the identification of priorities and subsequent endorsement by the donor community. Furthermore, in the said plan the national health objectives are identified, costed and prioritised with a timetable for execution. This fairly comprehensive Cameroonian NHDP has now been replaced by the health sector strategy paper. *Downstream* mechanisms for co-ordination of assistance include fora and instruments at micro-level such as district or community levels. The actors at these levels are technicians who meet to exchange experiences and to discuss problems of implementation of given assistance.

instrument , way, method or approach that aids orientation (e.g. plan), or any forum where aid agencies meet with the partner or other donors, negotiate, obtain information on priority health sector domains requiring aid, or expose, discuss and find solutions to practical problems of implementing the same.

According to Cassels (1997), EC Briefing N° 25 (2000); Tom Merrick, WB Institute (2000?); Graham Hobbs (2001), and Schacter, (2001), SWAps is a way of working between donors and governments, a way of doing business through a long term partnership and statement of the intended direction of change. The SWAps aims at increasing coordination with donors and government supporting one health sector programme, making systemic improvements, as well as increasing government ownership and support rather than deplete government systems.

In Cameroon in practice, whatever the mechanism, the various instruments for the co-ordination of health sector aid seem to be lodged in two main frameworks; one formal and the other informal. Formal mechanisms include those fora (whether inside or outside the Ministry in charge of health) that are endowed with authority to co-ordinate assistance to the health sector in conformity with the principle of economic co-operation which is to the effect that government "has central responsibility for aid co-ordination" (DAC/OECD, 1992). The formal framework consequently includes those instruments of the state within and outside the Ministry in charge of health that have been formally conferred with authority to co-ordinate aid[7].

The informal framework emanates from inadequacies of the formal. Thus the informal framework refers to fora that (albeit employing formal procedures of an institution) lack institutional legal status as well as formal and decision making powers. The informal framework is commonly used by health sector donors and health sector operators as instruments for dialogue, leverage and information sharing.

1. INFORMAL MECHANISMS FOR COORDINATION IN CAMEROON

Two main informal co-ordination mechanisms have been identified: the International health sector NGO Group led by US Peace Corps and the informal meeting of the community of health sector donors (now split into the UN family or the EU country groups).

1.1. The International health sector NGO medium of co-ordination of assistance

This mechanism was born out of disenchantment of international NGOs with the effectiveness of the larger informal meeting of the community of health sector

[7] The formal framework would, for example, be best placed to address macro and meso level co-ordination of aid to meet the health, population and nutrition (HPN) priorities of the recipient country by mechanisms that ensure social justice and equity, by guiding the geographical location of donors accordingly; or again, by co-ordinating aid via donor/subject matter/geographical zone of operation.

donors. This group argues that the larger informal meeting of donors is too top heavy as it combines both questions of political choice (suitable for discussion between governments at strategic level) and technical/operational level matters. Moreover, it does not adequately address operational level concerns of development cooperation actors.
The focal point of this co-ordination forum is the US Peace Corps Volunteers. Current members include CARE International, Sight First, PSI, UNICEF and Plan International. Monthly meetings of international health sector NGOs are convened and held on the premises of US Peace Corps Mission. The subjects often discussed are practical and operational level issues of who is where, doing what, for how long, with what collaboration and what success or difficulty from which others can learn.

1.2. The informal meeting of the community of health sector donors

This forum was initiated in the late eighties by the GTZ health projects in Cameroon. Its formal membership includes all health sector donors and major partners like CARE International, FEMEC, Plan International, Catholic Health Services, but excludes the Ministry of Health.

1.2.1. Procedures.
The meetings of this forum used to be monthly until year 2000 that saw the emergence of the UN family and the EU country health sector groups. The host of the meeting often chaired the session. The host of the next meeting, its venue, time and date is known before each session rises. The said meetings are convened in writing. Minutes are taken of proceedings and later circulated among participants. Depending on the agenda, a technical director of the Minsanté may be invited to attend.

1.2.2. Subjects of discussion
These subjects are mostly strategic or policy related; considering that these are issues that affect all donors. For example, in the meeting of January 14, 1997 where twenty health sector partners and donor representatives were present, discussion focused on:

- drug supply problems especially the non-completion of the then pharmacy policy document, stock-outs in drugs in public health units;
- obstacles to the development of PHC. The absence of a PNDS, political will for effective decentralisation and co-ordination were sorely regretted,
- absence of community and NGO participation in health policy implementation.

1.2.3. Constraints and potentials of the informal mechanisms.
This instrument (as a group or split into UN family or EU family) has scored several successes including remarkable unity shown in favour of the creation of the *Centrale nationale d'Approvisionnement en Médicaments Essentiels* (CENAME), joint financing of consultancies for that purpose, endorsement of the health sector strategy paper etc. It would appear that this was the most dynamic and predictable mechanism for the co-ordination of donor assistance and dialogue with the Minsanté until the creation in 2000 of the EU and UN groups.

Today, donors from EU member countries continue to meet on health sector issues. These EU member meetings have culminated in the taking of a common position in correspondence with the Cameroonian partner, the pooling of technical assistance, the undertaking of jointly financed studies for example in the drug procurement sector.

From the perspective of sector wide approaches (SWAps), this now depleted (EU group and UN group) mechanism is a useful tool for influencing health policy from without. It constitutes a near arms-length way of working between donors and Government. It is therefore evident, from the SWAps perspective, that this mechanism of coordination of aid hardly increases government's ownership of its coordination systems.

2. FORMAL MECHANISMS OF COORDINATION

The 1995 UNDP country development co-operation report stated that there is no single formal mechanism for the systematic exchange of information between donors and the government in Cameroon. In other words, (with the exception today of the co-ordination of HIPC funds), there is no single forum or institution at national level that is endowed with sole authority to co-ordinate donor assistance. This statement is still valid in year 2004 because several Ministerial departments; Ministry Finance and the Budget (Minfib), Ministry of External Relations (MINREX), Ministry of Economic Affairs, Planning and regional Development (MINEPAT) and technical Ministries (like the Health Ministry) as well as municipal councils are endowed with formal powers to co-ordinate aid. Palliatives to this void however seem to exist today in the "Comité de Co-ordination de l'Aide au Développement" CCAD and the Consultative Committee for the Steering and Management of HIPC funds (CCS/PPTE).

2.1. The Comité de Co-ordination de l'Aide au Développement (CCAD).

The CCAD is a consultative organ created in September 1995 and mandated to serve as a forum for dialogue between donors and government. Government's objective for creating the CCAD is to harmonise and optimise the use of development aid from all external sources.

2.1.1. Duties of CCAD

The duties of the CCAD include among others, the promotion of information exchange on programs and projects at all levels of their elaboration and implementation so as to maximise the impact of the relevant resource allocation, better co-ordination of co-operation efforts in the execution of multi-sectoral development projects, the discussion of the implementation of sectoral and regional strategies of socio/economic development programs (so as to identify objectives and priorities), as well as short and long term means to be mobilised.

2.1.2. Membership of CCAD

The Chairperson of the CCAD is the Prime Minister (who may delegate the Minister in charge of Finance to act). Otherwise, members of the CCAD are all

government Ministers.[8] The Chair person is empowered to involve any person or organisation in the proceedings of the CCAD.

2.1.3. Organisation, structures, meetings and procedures of CCAD

The CCAD meets once every six months or as and when required at the invitation of the Chairperson. The CCAD may call a sectoral, regional or theme group meeting of part of its members. In addition, CCAD may constitute itself into the following sub-committees: rural, water resources, mines, power and industry, social, civil service, and public works. The Prime Minister defines the membership and chairperson of each sub-committee. The latter meetings are quarterly and convened by its chairperson. Recommendations of sub-committees of the CCAD are made to the Chairperson of CCAD. Recommendations of CCAD are made to the government.

The CCAD has a Technical Secretariat which is headed by the Director in charge of Economic and Technical Co-operation at the Minepat. The duties of the Technical Secretariat *inter alia* are to prepare the annotated agenda of CCAD meetings and of its sub-committees and to provide technical and logistic support to secretaries of sectoral sub-committee meetings of CCAD;

2.1.4. Constraints and potentials of the mechanism

CCAD is nine years old. Its level of representation albeit centralised, (mainly in members of government), leaves it with awesome potential. Its duties are far-reaching. CCAD is a consultative and not a decision-making body or say the nucleus of a basket funding body[9]. This leaves other considerations (e.g. political) to determine the implementation of CCAD recommendations. Again, CCAD meetings have not held and there is no information on its activities to date. The reason for this is said to reside in the location of this rather technical cooperation tool at the very high office of the Prime Minister (rather than with a technical Ministry). An assessment of the efficacy of the mechanism of working between donors and the government is therefore well-nigh impossible.

2.2. Institutionalised co-ordination of aid by the Ministry of in charge of health (Minsanté)

Institutionalised co-ordination of donor assistance within the Minsanté is defined by Decree N° 95/040 of March 7, 1995 (as modified in 2002)[10] organising the said Ministry. Here, the Permanent Secretary in the Minsanté is empowered with all functions of co-ordination including those of health sector aid. For the latter purpose, a *Comité Technique de Suivi des projets et programmes* Santé was

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[8] Minister in charge of finance (MINFIB), Minister in charge of Economic Affairs (MINEPAT), Minister in charge of External Relations (MINREX), Minister in charge of the Public service (MINFOPRA), Minister in charge of the Environment (MINEF), Minister of Agriculture (MINAGRI), Minister in charge of Animal Breeding and Husbandry (MINEPIA), Minister in charge of Industrial Development (MINDIC), Minister in charge of Mines and Energy (MINMEE), Minister in charge of Education (MINEDUC), Minister in charge of Health (MINSANTE), Minister in charge of Labour (MINTEPS), Minister in charge of Women's Affairs (MINCOF), Minister in charge of Social Affairs (MINSOC) Minister in charge of Public Works, (MINTP).

[9] For an excellent discussion of this instrument see Hobbs, Graham, The Health sector-wide Approach and Health sector Basket Fund, Economic and social Research Foundation, Final report, February 2001.

[10] Cameroun : Décret N° 2002/209 du 19août 2002 portant organisation du Ministère de la Santé Publique

created in the early 90s. This is a health sector donor assistance co-ordination forum of exchange and dialogue with the Minsanté. Records do not seem to show that this structure has met ever since it was created.

Against the above background, there was an evolution in favour of theme group co-ordination of donor assistance beginning with the creation in May 1995, of the theme group "*Sous-Comité de co-ordination des intervenants dans le domaine de la Santé Maternelle et Infantile/Planing familiale*". The mission of this Committee is to harmonise national MCH /FP programs, define objectives and strategies and identify necessary resources for the implementation of MCH/FP issues in Cameroon. Members of this committee include UNFPA, UNICEF, GTZ, FEMEC, Fondation Ad Lucem (NGO), the Directorate in charge of Pharmacy and WHO. The committee's meetings are chaired by the Permanent Secretary in the Minsanté. The committee was designed to meet on a monthly basis. It held its first meeting in May 1996, scheduled the next for June 25, 1996. The latter meeting aborted and thereafter no records seem to exist of meetings of the theme group.

Other current health sector aid co-ordination initiatives seem to favour mechanisms that are project or donor specific[11]. These project-specific aid co-ordination structures are mandated consultative organs. They are charged with the duty to examine plans of operation, co-ordination and follow-up of project implementation, provision of advice necessary for the good of the project. Its meetings are quarterly and are convened by the Chairperson - the Minister of Health or his representative.

Membership of these co-ordination mechanisms is standard. They bring together technical directorates and Services of the Minsanté (that are in charge of community health, human resources, Financial resources, Pharmacy, Medical services, Co-operation, and provincial delegates) with the Head (usually expatriate) of the Project at the centre of co-ordination assistance to the exclusion of the rest.

Constraints and Potentials

Theme or project-specific mechanisms for the co-ordination of aid suffer from the limitation of cost inefficiency. This shortcoming is often due (for want of an overall body that assures effective sector-wide co-ordination), to a tolerance of overlaps into other themes of the sector. For example, agenda at meetings of theme groups is limited to those issues that affect the project or the theme, leaving co-ordination of all sectoral or all that go beyond the theme or project untouched. In view of the objective of this study which is to draw lessons from current mechanisms and co-ordination experiences that may be useful for the optimisation of sector-wide government-donor interaction, the foregoing weaknesses of theme/project specific co-ordination mechanisms limit its usefulness to SWAps.

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[11] Thus for example, there are the Minsanté/EU Project Co-ordination Unit "*Appui aux services de santé MSP-UE*" (that was created in November 1996, by Decision N° 00113/D/MSP/CAB of the Minsanté) and the ; '*Comité de Coordination des Projets Germano-Camerounais*' created in November 2001 by Decision N° 0074/D/MSP/CAB of the Minsanté

2.3. Institutionalised co-ordination of aid by the Ministry in charge of finance and the Ministry in charge of the economy (Minepat)

This institutionalisation of the sector-wide co-ordination of aid is incarnated in two structures; the Steering Committee of Economic Programmes (CTS) and the CCS/PPTE.

2.3.1. Technical Committee for the Steering of Economic Programmes (CTS)

This structure was created by the Cameroonian government at the end of 1999 and has since been charged (among other tasks) with the elaboration of the Poverty Reduction Strategy (PRS). PRS processes today constitute the basis of World Bank and IMF concessional lending and for the conversion of debt to aid (EC Briefing N° 25, 2000).

In year 2000, CTS using the participatory approach[12], elaborated an interim PRSP that secured admission of Cameroon into the Highly Indebted Poor Country (HIPC) initiative of the Brethon Woods institutions. The now finalised PRS outlines macro-economic objectives of poverty reduction, sectoral objectives (including health), identifies pillars of economic growth, and costs the implementation of the strategy.

The national budgets since year 2002 have been geared towards poverty reduction based on the PRS. In addition, development projects (including those of the health sector) identified for financing from HIPC funds by CCS/PPTE target priorities set in the PRS.

2.3.2. CCS/PPTE

In order to ensure transparency and efficiency in the management of HIPC funds, the government of Cameroon, at the behest of the IMF and the World Bank, created the CCS/PPTE in June 2001. This committee is made of nineteen members of which seven are Ministers[13] three bilateral partners (Germany, France, Canada), two multilateral partners (UNDP and EU), seven representatives of the civil society. It meets every quarter. The IMF, ADB and the World Bank Resident missions participate in these meetings as observers.

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[12] See for general idea: "Participatory approaches to research on poverty" March 2004 @ www.jrf.org.uk

[13] (MINFIB MINEPAT, MINEDUC, MINSANTE, MINTP, MINVILLE, MINAGRI),

Operation and Functioning of the CCS/PPTE

National investment budget allocations anticipate funds from the HIPC Fund per sector. Loan servicing by the Cameroon treasury is credited to the HIPC account of the Bank of Central African States (BEAC) rather than to the creditor country. The CCS/PPTE Committee oversees the operation of the said resources by reviewing and approving requests and the release of funds from the BEAC account. The decision of the CCS/PPTE committee to fund a project is based on the availability of loan service funds deposited at BEAC.
On request, these funds are transferred from the national BEAC account to the national treasury HIPC account. Here, the funds are managed as part of government money and therefore follow government financial rules and procedures
Out of a currently available balance at the national branch of BEAC of some CFA 161 billion FCFA, the meetings (as at June 2004) of the CCS/PPTE have examined, adopted and effectively disbursed resources for the financing of poverty alleviation development projects worth upwards of CFA 50 billion (some Euro 76 million). Records at the Permanent Secretariat for the management of HIPC funds reveal for example that 6.7 billion FCFA was allocated to health sector projects in 2001, 17.6 billion FCFA in 2003 and 18.2 billion FCFA in 2004. Under the mechanism of disbursement, HIPC Funds that are allocated but remain undisbursed at the end of that financial year are reabsorbed by the treasury for reallocation. Administrative and other constraints have to date limited the general level of disbursement of these funds to 20.4% in real terms.

2.3.3. Constraints and potentials of MINEPAT co-ordination mechanisms.

Among the limitations of CCS/PPTE are the facts that it was created to last the availability of HIPC funds and has no post-funding impact monitoring and evaluation capacity. This leaves the question of accountability (whether to the debt forgiving country, the Cameroonian government or the beneficiary citizens) uncatered to. In addition, the bureaucratic red-tape and delay that surrounds disbursements by the national treasury has led some members of the Steering Committee to express concern over using government systems in joint funding arrangements. There would however seem to be no clear vision on how to override this weakness; thus leaving the constraint intact.

On the positive side however, institutionalised co-ordination of assistance by MINFIB and MINEPAT structures through CTS and CCS/PPTE presents a predictable platform for interaction between donors and the government. Through this platform, overall sector strategies and sector budgets developed under the leadership of the government of Cameroon provide orientation for significant donor interventions. As indicated above with specific regard to the health sector, the results demonstrate some quest for equity in territorial coverage through the nationwide provision of basic health care. For example over the last three years, HIPC funds have targeted the financing of three components of the AIDS prevention emergency plan, the nationwide extension of the programme for the fights against malaria and tuberculoses as well as the enlarged vaccination

programme all over the national territory. The membership of CCS/PPTE is fairly light, cross-cutting and representative of stakeholders in development.

3. CONCLUSION

The multiplicity of types of informal and formal mechanisms of coordination of health sector aid in Cameroon has been noted. Of these, the informal aid coordination mechanism in Cameroon has immense leverage as pressure groups for influencing health policy. Even if discussions of the groups are often sector-wide, it is submitted that the mechanism hardly increases government's ownership of its coordination systems because government is not part of its membership. It has also been noted that few of the formal coordination structures put in place within the Minsanté are functional. Moreover, the bilateral, project-oriented or theme group coordination structures of the Minsanté are not sector-wide.

CCAD as a macro-level tool for the coordination of donor assistance seems to have been the forerunner of SWAp in Cameroon. It however lacks the teeth of basing reflection and intervention on clear sector-wide strategies like the PRS and HSS of today.[14] Technocrats at the MINEPAT suggest that CCAD may also be underperforming today because, lodged at the Prime Minister's Office, it requires recourse to technical ministries with expertise in technical cooperation matters rather than routinely holding dialogue with donors as part of its business. Another reason advanced by technocrats of the MINEPAT for the apparent weakness of CCAD is the absence in its ranks of any member of the donor community and the civil society as is the case with the CCS/PPTE.

The hitherto geographical 'balkanisation' of certain provinces as sole spheres of influence of specific donors has been observed. With the advent of HIPC and CCS/PPTE the objectives of a sector-wide health plan are currently being implemented nationwide.

It is evident from the foregoing analysis that prior to Cameroon's admission into the HIPC initiative, there were no clear procedures for geographically orienting health sector aid, for avoiding duplication, waste and overlaps, for assuring equity in the distribution of health sector donor assistance, for tapping the comparative advantage of others etc at macro or meso-economic levels. At micro level too, there would seem to be no formal fora for experience-sharing and the enhancement of meso and operational level matters by various donors.

The existing instruments for aid co-ordination seem to be concerned with macro-level co-ordination. The PRS process through the Health Sector strategy paper has served as an invaluable tool for the orientation sector-wide aid. So, a principal result of this case study on instruments for the co-ordination of donor assistance in Cameroon is that, of the current recipient-driven mechanisms, only the HIPC Resources Steering and Management Consultative Committee

[14] or national health development plans (NHDP) like Senegal's (1997-2002, Côte d'Ivoire's (1996-2005).

(CCS/PPTE) is functional. As earlier stated, this Steering Committee assesses sectoral development strategies, duration and cost of projects that constitute development priorities for the entire nation for HIPC funding. Basing therefore on the HSSP, the CCS/PPTE Steering Committee constitutes a formidable sector wide method of working between donors and the government.

The combination of the HSSP and the HIPC funds Steering and Management Committee also provides one functional model of roles for the partner and donors in upstream co-ordination of development aid. For example, government elaborates the PRS and the Steering Committee assesses the same for funding. Again, the PRS and HSSP constitute data-bases of information regarding health sector priorities that are useful to both the donor and the partner. At the level of the Steering Committee, those health sector priorities that are being addressed are known.

In relation to the other mechanisms that have been reviewed, it is clear that the Cameroonian health system is still weak in the creation and management of functional structures for interaction between government and donors or the coordination of assistance of donors to the health sector. Whether with its imperfections, the presence in the CCS/PPTE of the civil society and the donor community constitutes an asset that enhances its functioning has not been analysed. Irrespective of the findings of any such analysis, the presence of these blocks of stakeholders in development in the CCS/PPTE Committee raises the wider question of how far governance or institutional weaknesses of a beneficiary state to foreign aid justify waivers to the principle of the non-interference in the internal affairs of a sovereign nation[15]. One point is however clear: the identification, prioritisation and costing of national health problems in the HSSP and the financing of the resolution of these problems by the CCS/PPTE constitutes one huge way by which Cameroon's health policy reform has been influenced by this mechanism of sector-wide aid coordination.

Consequently, it seems safe to state that as a mechanism for the coordination of donor assistance, the CCS/PPTE unlike the others, works. Furthermore, its strength lies in its being backed by and basing on a sector-wide strategy like Cameroon's HSSP. Nevertheless, the CCS/PPTE will do with evaluation and monitoring capacity for accountability purposes. It will also be a tremendous improvement to see that all donor support forms part of a coherent health programme and is recorded (as HIPC funds now are) in the national budget. Judging from the composition of CCAD and comparing with the origins and apparent potential of the CCS/PPTE however, the attainment of this objective depends on the political will to co-ordinate assistance on a permanent basis. On the premise that there exists the said political will, the time to start is now.

[15] For an excellent discussion of this see: Gellner, Ernest, 1994, Conditions of Liberty: Civil Society and its Rivals (London:Hamish Hamilton),; Jackson, Robert H, 1991. Quasi-States: Sovereignty, International Relations and the third world (Cambridge: Cambridge University Press).

LIST OF ABREVIATIONS AND ACRONYMS

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ADB	African Development Bank
BHA	Better Health in Africa
BEAC	Banque des Etats de l'Afrique Centrale.
Camnafaw	Cameroon National Association for family Welfare
CENAME	Centrale National d'Approvisionnement en Médicaments Essentiels
C2D	Coopération au Développement pour le Desendettement.
CCC/PPTE	Comité Consultative et de Suivi/ Pays Pauvre Très Endetté
CS	Child Survival,
EU	European Union.
EDF	European Fund for Development
FP	Family Planning
FEMEC	Fédération des Eglises et Missions Evangéliques du Cameroun
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIPC	Highly Indebted Poor Country
IEC	Information - Education - Communication
IFC	International Finance Corporation
IMF	International Monetary Fund
Minsanté	Ministère de la Santé Publique
Minfib	Ministère des Finances et du Budget
NGO	Non Gouvernemental Organisation
OECD	Organization for Economic Cooperation and Development
EVP	Enlarged Vaccination Programme
PHC	Primary Health Care
MCH	Maternal and Child Health
PMSC	Programme de Marketing Social au Cameroun
ACMS	Association Camerounaise de Marketing Social
PSI	Population Services International
RH	Reproductive Health
SFPS	Santé Familiale et Prévention du SIDA
UN	United Nations
UNAIDS	United Nations Aids Consolidated Agency
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WDR	World Development Report
WHO	World Health Organisation

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