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Analysis of Non-communicable Diseases Prevention Policies in Cameroon



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Table of Contents

| | |
|--|------------|
| List of Figures | vi |
| List of Tables | vi |
| Abbreviations | vii |
| Executive summary and key messages | x |
| 1.0 Introduction | 2 |
| 1.1. Overview Of Nature Of Study | 2 |
| 1.2. Aim of study, objectives, significance, scope, key research questions and chapter outline | 2 |
| 1.3. The global burden of NCDs | 2 |
| 1.4. NCDs in Cameroon | 3 |
| 2.0 Guiding framework | 8 |
| 3.0 Methods | 11 |
| 3.1. Document review | 13 |
| 3.2. In-depth interviews | 14 |
| 3.3. Observations | 15 |
| 3.2. Policy context | 13 |
| 3.4. Data quality assurance | 15 |
| 3.5. Data management | 16 |
| 3.6. Data analysis | 17 |
| 3.7. Data storage and transmission | 17 |
| 3.8. Ethical considerations | 17 |
| 4.0 Findings | 19 |
| 4.1. Data sources | 20 |
| 4.2. NCD Policy landscape in Cameroon | 21 |
| 4.2.1. Global context | 22 |
| 4.2.2. Local context | 23 |
| 4.2.3. Summary | 28 |
| 4.3. Tobacco control policies in Cameroon | 29 |
| 4.3.1. Policy content and history | 29 |



| | |
|---|-----------|
| 4.3.2. Policy process | 32 |
| 4.3.3. Actors and multi-sectoral involvement | 33 |
| 4.3.3.1. Actors in tobacco control policy formulation and implementation | 33 |
| 4.3.3.2. Multi-sectoral involvement | 33 |
| 4.3.4. Implementation, monitoring and evaluation | 36 |
| 4.3.5. Facilitators and barriers to tobacco control policy formulation and implementation | 43 |
| 4.3.6. Summary | 46 |
| 4.4. Alcohol-control policies in Cameroon | 46 |
| 4.4.1. Policy content and history | 46 |
| 4.4.2. Policy development of the Finance Act 2015 | 48 |
| 4.4.2.1. Policy process | 48 |
| 4.4.2.2. Actors and multi-sectoral involvement | 50 |
| 4.4.2.2.1. Actors in alcohol control policy formulation and implementation | 50 |
| 4.4.2.2.2. Multi-sectoral involvement | 50 |
| 4.4.2.2.3. Facilitators and barriers in the use of MSA in formulation | 51 |
| 4.4.2.3. Facilitators & barriers to alcohol control policy formulation & implementation | 51 |
| 4.4.3. Implementation and monitoring/evaluation | 52 |
| 4.4.4. Summary | 54 |
| 4.5. Other NCD prevention policies in Cameroon | 54 |
| 4.5.1. Policies for the prevention of physical inactivity in Cameroon | 54 |
| 4.5.1.1. Policy content and history | 54 |
| 4.5.2. Policies for promotion of healthy diets in Cameroon | 55 |
| 4.5.2.1. Policy content and history | 55 |
| 4.5.3. Summary | 57 |
| 5.0 Discussions | 58 |
| 5.1. Gaps in NCD policy formulation and implementation | 59 |
| 5.2. Gaps in MSA for formulation and implementation of NCD prevention policies | 61 |
| 5.3. Facilitators and barriers to NCD policy development | 62 |



| | | |
|-------------|---|-----------|
| 6.0 | Limitations | 65 |
| 7.0 | Conclusions | 62 |
| 8.0 | Recommendations | 69 |
| 9.0 | Reference list | 71 |
| 10.0 | Appendices | 79 |
| | 10.1. Final interview guides | 80 |
| | 10.2. Final observation guide | 85 |
| | 10.3. Ethics review certificate | 86 |
| | 10.4. List of key informants for each policy analysed | 87 |
| | 10.5. Ministries in Cameroon | 89 |

List of Figures

| | |
|--|----|
| Figure 1: Map of Cameroon (3) | 3 |
| Figure 2: Proportional mortality in Cameroon (% of total deaths, all ages taken together) (5) | 4 |
| Figure 3: Percentages of people aware and managed for hypertension in Cameroon (7) | 5 |
| Figure 4: Prevalence of type 2 diabetes in Cameroon, 1994-2003 (7) | 5 |
| Figure 5: Percentages of people aware and managed for diabetes (7) | 6 |
| Figure 6: Guiding framework used in policy analysis by Walt and Gilson | 10 |
| Figure 7: Selected regions for the analysis of policy implementation | 13 |
| Figure 8: Structure of the government of Cameroon | 24 |
| Figure 9: Forms of advertising of tobacco products in five selected regions of Cameroon | 37 |
| Figure 10: Tobacco product packages with health warnings | 38 |
| Figure 11: Tobacco product packages with no health warnings | 39 |
| Figure 12: Implementation of the smoking-free area policy in some schools | 40 |
| Figure 13: Drinking spots found around some schools visited in Yaoundé and Douala | 53 |
| Figure 14: Poster on public awareness on the reduction of salt intake in Yaoundé | 57 |

List of Tables

| | |
|---|----|
| Table 1: WHO “best buys” | 11 |
| Table 2: Number and type of documents reviewed for the Cameroon NCD prevention policy analysis | 20 |
| Table 3: Policies for which interviews were done with key informants | 20 |
| Table 4: Number and type of respondents for in-depth interviews by sector | 21 |
| Table 5: Global and regional policies and instruments used in developing the Cameroon | 23 |
| Table 6: Economic context of tobacco production and use in Cameroon | 26 |
| Table 7: Tobacco Prevention and Control Policies in Cameroon | 30 |
| Table 8: Engagement of actors from multiple sectors in the formulation of tobacco control | 34 |
| Table 9: Implementation of the smoking-free area policy in secondary schools | 40 |
| Table 10: Harmful use of alcohol prevention and control policies in Cameroon | 47 |
| Table 11: Engagement of actors from multiple sectors in the formulation and implementation Finance Act 2015 | 51 |
| Table 12: Implementation of the policy prohibiting of sales, distribution and consumption of alcoholic beverages and banning opening of drinking spots, within or in the outskirts of school | 53 |

Abbreviations

| | |
|-----------------|---|
| ANPPA | Analysis of NCDs prevention policies in Africa |
| APHRC | African Population and Health Research Centre |
| BAT | British American Tobacco |
| C3T | Cameroonian Coalition Against Tobacco |
| CAMBoD | Cameroon Burden of Diabetes |
| CAS | Cameroon Academy of Sciences |
| CEMAC | Central African Economic and Monetary Community |
| CFA | Coopération Financière en Afrique |
| FAO | Food and Agricultural Organization |
| FCTC | Framework Convention for Tobacco Control |
| FENASSCO | Fédération Nationale du Sport Scolaire |
| GATS | Global Adult Tobacco Survey |
| GDP | Gross domestic product |
| GICAM | Groupement Inter-patronal du Cameroon |
| GYTS | Global Youth Tobacco Survey |
| HIPC | Heavily indebted poor country |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome |
| HoPiT | Health of Population in Transition-Research group |
| IARC | International Agency for Research on Cancer |
| IDF | International Diabetes Federation |
| IDRC | International Development Research Centre |
| LMIC | Low and middle-income country |
| LUTOMA | [Association de Lutte contre les Toxicomanies et les Maladies Mentales] |



| | |
|--------------------|--|
| MSA | Multi-sectoral approach |
| NCDs | Non-communicable diseases |
| NGO | Non-governmental organisation |
| NIMSPC-CNCD | National Integrated and Multi-sector Strategic Plan for the Control of Chronic Non-communicable Diseases |
| PARTEC | [Projet d'Appui à la Relance de la Tabaculture à l'Est Cameroon] |
| SARS | Severe Acute Respiratory Syndrome |
| SCT | [Société Cameronnaise des Tabacs] |
| SITABAC | [Société Industrielle des Tabacs du Cameroon] |
| SSA | Sub-Saharan Africa |
| WHO | World Health Organization |

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Executive summary and key messages

Background

Non-communicable diseases (NCDs) currently constitute a serious threat to health worldwide, with the situation expected to worsen if concerted actions are not urgently taken. The World Health Organisation (WHO) identified population-based interventions addressing four NCD risk factors – tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity; also known as “best buys” – and proposes the use of multi-sectoral approaches (MSA) to engage the public, private, and non-profit sectors to implement these best buys. In November 2014, the African Population and Health Research Centre (APHRC), with funding from the International Development Research Centre (IDRC), led Cameroon and five other African countries in a study to analyse how countries are addressing NCD prevention in order to best facilitate MSA for NCD prevention in Africa.

Aims

The aims of this study were:

1. describe the development of policies in multiple sectors designed to address NCDs or best buys, and
2. through key stakeholder interviews and field observations of policy implementation in Cameroon, describe the status of implementation of current policy and perspectives on how to best implement MSA for NCD prevention in Cameroon.

Methods

We used a case study design to integrate data from three sources. First we reviewed all national policy documents related to the prevention and control of NCD risk factors in Cameroon before conducting 43 in-depth interviews with policymakers and implementers on the context, formulation and implementation process of NCD prevention policies. Finally, we conducted field observations on the level of implementation of some of these policies.

Key results

The burden of NCDs

In Cameroon, NCDs are responsible for 31% of mortality. NCDs pose a major public health challenge in Cameroon, with a significant prevalence of hypertension (21.6%) and diabetes mellitus (6.5%). Decision-makers remain more focused on policies for the control of infectious diseases compared with policies for the prevention of NCDs.

NCD prevention best buys policies /policy content

Cameroon has a National Integrated Strategic Plan for the prevention and control of chronic NCDs, although it was never implemented. Nevertheless, many individual policies were formulated to address NCD risk factors. Among these policies, 12 policies were found to address best buys for tobacco use, six policies for the harmful use of alcohol, one policy for physical inactivity but no policy for unhealthy diet. Tobacco best buy policies addressed the creation of smoke-free



zones, warnings on tobacco products, a ban on tobacco advertising, and tax increases. Alcohol policies addressed restriction on alcohol access, tax increases, and alcohol advertising. The physical activity policy addressed awareness through mass media.

The formulation and implementation process

The creation of these policies in Cameroon was driven primarily by both national data on the increasing burden of NCDs and their risk factors, and international WHO actions, such as the WHO Framework Convention on Tobacco Control in 2004 and the Adoption of the Resolution of the UN General Assembly on the Prevention and Control of NCDs in 2010. The interaction of different actors in the policy formulation and implementation is limited because of the uni-sectoral character of most interventions. The formulation process for some policies, such as smoke-free areas and tobacco tax policies, was simple and straightforward, while that for other policies, such as alcohol tax and tobacco health warnings, was rather complex, involving many actors and transactions between the government and business operators. The level of implementation appeared inconsistent throughout all the policies created. On one hand, we had policies with high levels of implementation (tobacco taxation and health warnings on tobacco packages) and on the other, policies with low levels of implementation (policy banning tobacco advertising), varying from one region to another (policy prohibiting alcohol consumption and trade inside and around schools, and policy setting smoke-free sign at the main entrance and inside schools).

The use of MSA

The main actors involved in the reviewed policies were representatives of the public administration, but we found the use of MSA during the policy development process was limited. In general, these policies are formulated inside a ministry and most often involve only one sector during policy-making. Nevertheless, there were some collaborations with different public sectors (formulation of the NIMSPC-CNCD and policy on health warning in tobacco packages) and between public and private sectors (policy increasing taxes on tobacco and alcohol products), even though these collaborations were limited in their implementation. This situation is favoured by a fragmentation observed in NCD prevention and control policies and also in the functioning of the different sectors or institutions.

Gaps in NCD policy formulation and implementation

The development and implementation of NCD prevention policies in Cameroon and the use of MSA have the following gaps:

- **No national NCD prevention position and policy statement.** Although Cameroon ratified the WHO Framework Convention on Tobacco Control, effectively agreeing with the WHO's recommendations for countries to manage both demand reduction strategies and supply issues, Cameroon's ratification did not serve to unify MSA toward tobacco policies. Despite the fact that some public administrations (Ministry of Finance, Ministry of Public Health and all the ministries of education) took measures to control smoking in their institutions, silence remains from most of the other key administrative units. Therefore, policy responses tend to be piecemeal rather than comprehensive and integrated.



- **Political dissonance.** Despite signing the Framework Convention for Tobacco Control (FCTC), Cameroon continues to allocate funds to support tobacco farming.
- **No comprehensive and integrated NCD risk factor and disease prevention policies.** Despite the existence of the National Integrated Strategic Plan for the prevention and control of chronic NCDs in Cameroon, the plan has not fully elucidated an integrative and comprehensive strategic plan that incorporates all of the WHO's best buy interventions. Interviewees commonly described NCD prevention as fragmented and inefficient.
- **The non-existence of a national platform for the prevention and control of NCDs.** Existing platforms are often dedicated to the resolution of a single risk factor (i.e. smoking) and do not often integrate all relevant stakeholders, thereby missing significant opportunities to increase policy impact.
- **Non-compliance with policy writing standards.** Adopted policies typically include aims/objectives and measures to be adopted (changes or new behaviour); however, the information on institutional arrangements of implementation, milestones, timelines, funding, and monitoring/evaluation plans is often missing, incomplete or imprecise.
- **Under-prioritisation of NCDs and low resources allocation.** Despite the consistent damage caused by NCDs, and WHO's recommendations on NCD prevention, most resources are allocated in communicable disease management, directed towards disease control. This leads to poor implementation of existing policies and a lack of monitoring and evaluation parameters. Implementation of existing policies is then poorly coordinated and the monitoring and evaluation tools are non-existent.

Lessons learnt and recommendations

Significant facilitators/achievements

Significant facilitators/achievements include:

- Existence of two important directorates in the Ministry of Public Health: the directorate of health promotion and directorate of disease control (with the Non-Communicable Disease sub-directorate);
- Cameroon is a UN member state and so ratifies most of the international conventions like the Framework Convention on Tobacco Control; and
- The political will of some ministries to move forward in the control of NCDs.

Significant barriers/challenges

Barriers to the NCD policy development process include:

- Awareness and expertise. The lack of expertise and knowledge of some key stakeholders despite the increasing awareness of NCD prevention and control are barriers to the formulation and implementation of the recommended interventions. These gaps resulted in challenges translating evidence into policy.



- **Competing priorities (communicable diseases vs NCDs).** In Cameroon, as in many other low and middle-income countries (LMIC), communicable diseases (malaria, AIDS and tuberculosis) cause the death of thousands of people annually. For several years, most health resources were directed towards control of these diseases, neglecting NCDs despite their increasing morbidity and mortality.
- **Absence of a real national political will.** Although the Cameroon government has demonstrated political will to establish a NCD department in the Ministry of Public Health and ratified certain international treaties such as the FCTC, inconsistencies in the anti-tobacco law, funding of tobacco farming, non-implementation of regulations on alcohol, physical activity and diet are still observed.
- **Poor allocation of resources for NCDs.** Lack of technical and financial resources is a substantial barrier to the full implementation of some policies.

Recommendations

Based on these findings, the following is recommended to improve NCD prevention and the use of MSA in the overall process:

- **Policy and governance to develop a holistic approach.** It is recommended that the government updates its National Integrated Strategic Plan for the Prevention and Control of Chronic Non-communicable Diseases in Cameroon to (a) incorporate all WHO best buys and recommendations; (b) engage experts to translate evidence to practice across multi-sectoral actions; (c) establish clear roles for key actors and institutions involved in the control of the burden of NCDs; and (d) incorporate specific funding, milestones, timelines, and monitoring/evaluation plans.
- **Resources.** The government should increase domestic budgetary allocations for the prevention and control of NCDs and explore viable financing options through voluntary innovative financing mechanisms, including taxation on tobacco and alcohol.
- **Partnerships and use of MSA.** Establish a national multi-sectoral platform for the prevention and control of NCDs.
- **Broad training for health promotion.** Although curative health workers receive training in health promotion, it would be beneficial to provide training to a wider spectrum of workers associated with health care, including staff in health promotion, health policy, and health administration.



1.0

1.0 | Introduction



Introduction



1.1. Overview Of Nature Of Study

Non-Communicable Diseases (NCDs) are a major public health problem, responsible for nearly 36 million deaths worldwide in 2008. The World Health Organization (WHO) predicts this number will rise to 52 million by 2030 if urgent action is not taken to manage their risk factors. In November 2014, Cameroon and five other countries in Africa (Kenya, Togo, Nigeria, South Africa and Malawi) were selected to undertake a study on the theme: “Analysis of NCDs prevention policies in Africa (ANPPA)”, initiated by the African Population and Health Research Centre (APHRC) and funded by the International Development Research Centre (IDRC).

1.2. Aim of study, objectives, significance, scope, key research questions and chapter outline

Aim of the study

The long-term goal of the ANPPA project is to promote multi-sectoral approaches (MSA) to policy-making for NCD prevention by providing evidence on the effectiveness of these approaches in the implementation of best buys in sub-Saharan Africa (SSA). The short-term goal was to generate evidence from Cameroon while building research capacity for MSA.

Research questions

- Which NCD prevention policies are adopted in Cameroon?
- What are the content and the process gaps of these policies?
- What is the state of implementation of the adopted policies?
- To what extent were multi-sectoral actions applied in Cameroon during formulation and implementation of these policies and their consequent interventions?
- What are the implementation barriers/challenges to policies with regards to up-to-date guidelines?
- Which approaches and interventions can be recommended to improve policy implementation?

Primary objectives

- To gather information on NCD best buys policies and interventions adopted in Cameroon.
- To analyse NCD best buys policies and their formulation and implementation processes.
- To analyse the level of implementation of the adopted NCD best buys interventions.
- To describe the level and depth of multi-sectoral action in the formulation and implementation of these policies.
- To identify the barriers to the effective implementation of the NCD best buys interventions.
- To recommend strategies for enhancing the awareness, formulation and implementation of NCD best buys interventions.

1.3. The global burden of NCDs

NCDs, also known as ‘chronic diseases’, are diseases that cannot be spread from person to person. Instead, they are chronic and generally of slow progression.



The morbidity and mortality related to NCDs are linked to four main diseases: cardiovascular diseases, including heart attacks and stroke; cancers; chronic respiratory diseases, such as chronic obstructive pulmonary disease and asthma; and diabetes (1). These NCDs are the world's leading causes of death and kill more people each year than all other causes combined (1).

In 2012, NCDs were the world's leading causes of death, responsible for 38 million (68%) out of the 56 million deaths worldwide. More than 40% of them (16 million) were premature deaths of individuals aged less than 70 years. Almost three-quarters of all NCD deaths (28 million), and the majority of premature deaths (82%), occurred in low and middle-income countries. Cardiovascular diseases were responsible for the largest proportion of deaths caused by NCDs under the age of 70 (37%), followed by cancers (27%) and chronic respiratory diseases (8%). Diabetes was responsible for 4%, and other NCDs were responsible for 24% of NCD deaths under the age of 70 years (1).

1.4. NCDs in Cameroon

Study Context

Cameroon is a central African country located in the Gulf of Guinea between the 2nd and 13th degrees of north latitude and the 9th and 16th degrees east longitude. It is triangular in shape with a surface area of 475,440 km²; stretching nearly 1,200 miles from north to south and 800 km at its base from west to east. It is bound to the west by Nigeria, to the north east by Chad, to the east by the Central African Republic and south by Congo, Gabon and Equatorial Guinea. In the south-west, the country opens to the Atlantic Ocean (Figure 1). The natural environment is very diverse with multiple ecosystems (2).

Figure 1: Map of Cameroon (3)





Socio-demographic context (2)

Cameroon, with more than 200 ethnic groups and almost as many national languages, is a low and middle-income country (LMIC), whose population (19.9 million in 2011 and 21.9 million in 2015, with an average density of 38 people per km²) is predominantly young, since 64.2% of the population is aged under 24 years and 4% over 65. The population growth rate is 2.6% per year.

NCD epidemiology and prevention policies in Cameroon

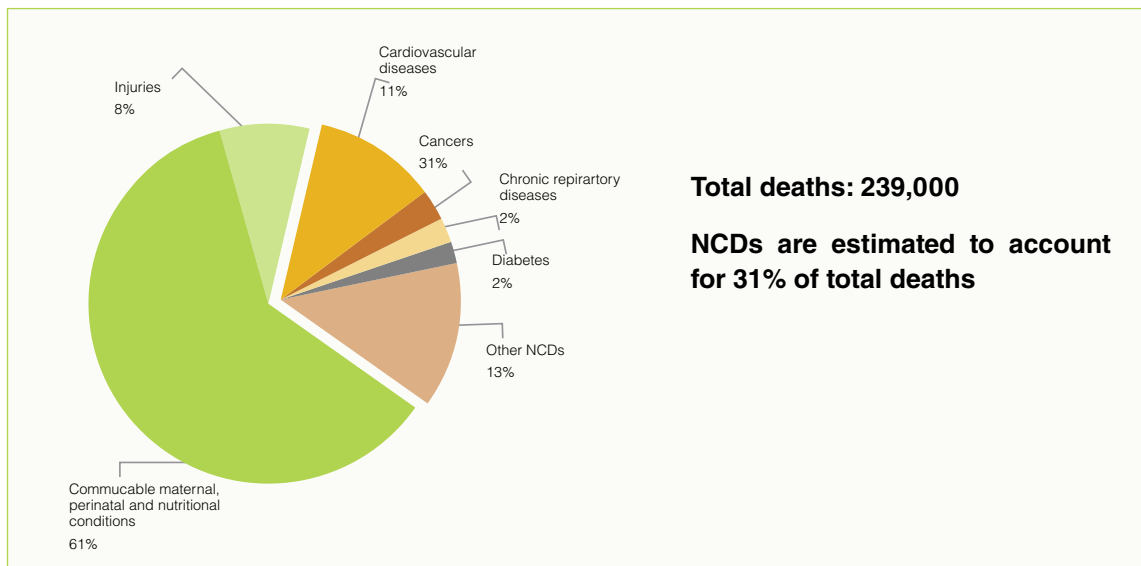
Cameroon, like other LMICs, is currently undergoing a socio-economic transition characterised by improving standards of living, rapid (mostly unplanned) urbanisation and westernisation of lifestyles, including increased tobacco use, unhealthy diet, insufficient physical activity and the harmful use of alcohol (4). These changes are accompanied by changes in the distribution and patterns of disease; with NCDs increasingly contributing a significant share of the public health burden of disease, alongside an unfinished agenda of infections. However, in Cameroon, like many other SSA countries, these observations are deduced from empirical evidence or projections. Very few population-based studies are carried out to objectively evaluate the exact burden of NCDs in terms of morbidity and mortality. The systematic data collected on hospital mortality by the Cameroon Ministry of Public Health cannot alone adequately reflect the total mortality due to NCDs in the general population. A study by the Ministry of Public Health on hospital mortality carried out in 1997 suggested that only 20% of all deaths in Cameroon occurred in a hospital. Therefore, the majority of deaths occurring at home or other places were not recorded in the causes of death registry, hence the challenge of estimating the respective contributions of different diseases to the total disease burden in Cameroon (2).

Mortality

In 2014, the WHO estimated that in Cameroon, NCDs – including cardiovascular diseases, diabetes, respiratory diseases and cancers) – represented 239 per 100,000 deaths, corresponding to 31%: 11% for cardiovascular disease, 2% for chronic respiratory diseases, 3% for cancer, 2% for diabetes, 8% for injuries and 13% for other causes (Figure 2) (5).

The probability of premature death (dying between ages 30 and 70) from any cardiovascular disease, cancer, diabetes, or chronic respiratory disease in Cameroon was 20.2% in 2010 and 19.9% in 2012 (5).

Figure 2: Proportional mortality in Cameroon (% of total deaths, all ages taken together) (5)





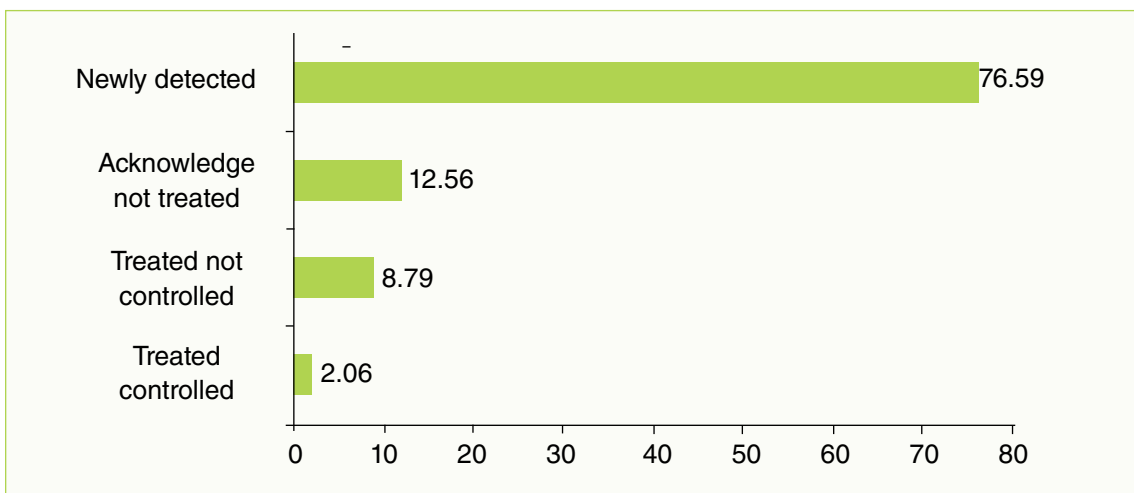
Morbidity

Like most LMICs, Cameroon is undergoing an epidemiological transition with increasing NCDs, the re-emergence of infectious diseases, HIV/AIDS infection, the threat of Severe Acute Respiratory Syndrome (SARS) and the avian influenza pandemic (6).

Cardiovascular diseases

In the 2004, 10,011 subjects were examined during the Cameroon Burden of Diabetes (CAMBoD) survey (7) in four sites using the WHO STEPwise approach. The results showed that the prevalence of hypertension was estimated at 24%. Among these, 76% were undiagnosed and only 2% were controlled by medical treatment. Of the patients with previously known hypertension, 46% were treated, and of this, only 19% were optimally controlled (Figure 3). According to WHO, the prevalence of hypertension in Cameroon (population aged 18+ years), in 2014 was 21.6% (5).

Figure 3: Percentages of people aware and managed for hypertension in Cameroon (7)



Diabetes mellitus

Data in Cameroonian adults based on three cross-sectional surveys during a 10-year period (1994-2004) revealed that an almost 10-fold increase in the prevalence of diabetes (Figure 4) (7). Based on the results of the STEPS Survey conducted during the Cameroon Burden of Diabetes (CAMBoD) project, the prevalence of diabetes was estimated at about 5.6% with more than 80% undiagnosed. Of the 67% known diabetes mellitus patients on treatment, less than 30% had optimal glycaemic controls (Figure 5) (7).

Figure 4: Prevalence of type 2 diabetes in Cameroon, 1994-2003 (7)

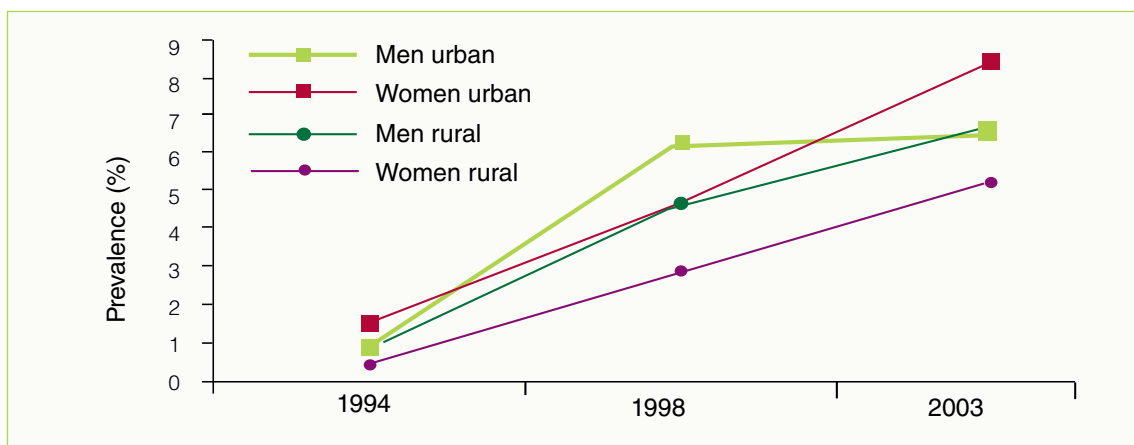
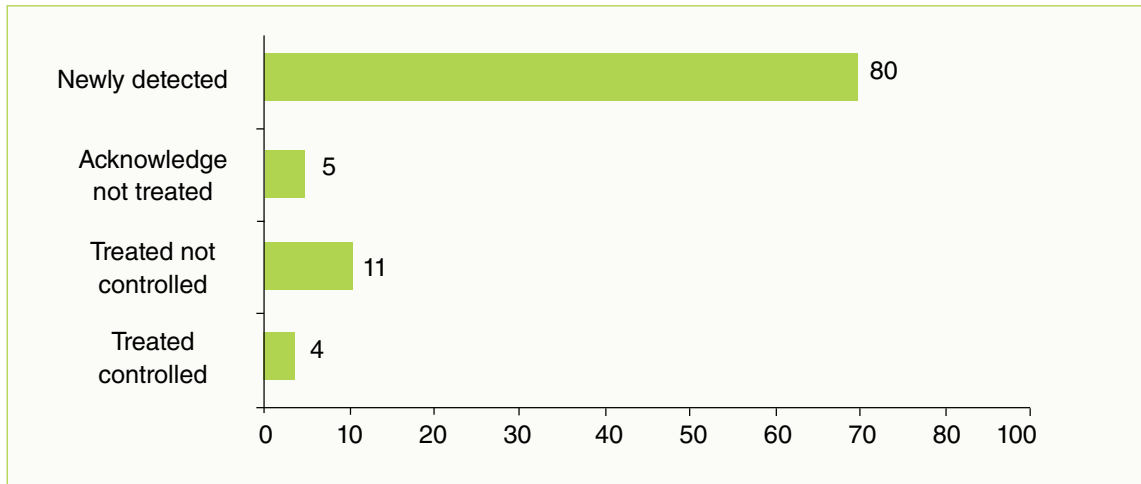




Figure 5: Percentages of people aware and managed for diabetes (7)



In 2015, the International Diabetes Federation (IDF) estimated the national prevalence of diabetes among Cameroonian adults aged 20-79 at 5.3%. The proportion of undiagnosed cases is also very high – about 60% (8).

Chronic respiratory diseases

National data on the prevalence of chronic respiratory diseases in Cameroon does not exist, but they occupy an important place in the country's epidemiological profile. They are one of the first causes of paediatric consultations after malaria. Epidemiological data warranting the measure of the frequency of these diseases in Cameroon is very limited, but the diseases are well known in the community (2). A community-based survey conducted from December 2013 to April 2014 of 2304 people showed the following results: prevalence rates were 2.7% for asthma, 6.9% for lifetime wheezing, 2.9% for current wheezing and 11.4% for self-reported lifetime allergic rhinitis; while 10.4% of participants reported current symptoms of allergic rhinitis, and 5.4% had allergic rhino-conjunctivitis (9).

Cancers

In Cameroon, there is a dearth of national data on cancer incidence, prevalence and trends. In 2008, The International Agency for Research on Cancer (IARC) estimated that population-based age-standardised incidence of cancers for both sexes, was 92.1 per 100,000 persons per year in Cameroon. For both sexes, the five most common cancers are breast, cervix, liver, non-Hodgkin's lymphoma and prostate cancer (10). According to 2002 estimates, 12,000 new cases of cancer are recorded each year in Cameroon; 25,000 people currently live with the disease. These figures could double by 2020 if nothing is done. More than 80% of people are diagnosed at an advanced stage of the disease and most die within 12 months of diagnosis. Cancer care is costly and generally beyond the reach of patients and their families (2).

NCD risk factors in Cameroon

Cameroon, like most LMICs, is undergoing elements of globalisation, such as urbanisation and change of dietary patterns. This leads to behaviours such as smoking, alcohol, physical inactivity and poor diet. Indeed, these behaviours have socio-cultural determinants. Some studies highlight the role of demographic changes as the main drivers of the epidemic of chronic diseases. The urbanisation and social mobility that accompanied economic development led to the increase in obesity, diabetes and hypertension with a higher prevalence in urban areas than in rural areas (11).



Tobacco use

In 2014, the Cameroon-Centre District conducted the Global Youth Tobacco Survey (GYTS), a school-based survey of students aged 13-15. The results showed that 20.7% had 'ever' smoked cigarettes (26.2% boys, 14.1% girls). About 16.1% of 'ever' smokers initiated smoking before age of 7; 26.8% ages 8-9 and 22.8% at age 10-11 years. Among these students, 5.7% 'currently' smoked cigarettes (8.3% boys, 2.5% girls) (12). In the same study, seven in 10 students saw anti-smoking media messages in the past 30 days; four in 10 students saw pro-cigarette advertisements on billboards in the preceding 30 days and 9% of students received free cigarettes offered by representatives of tobacco companies (12).

The Global Adult Tobacco Survey (GATS) was conducted in 2013 as a household survey in persons aged at least 15 and a total of 5,271 individuals completed the interviews. The results showed that 13.9% of men, 4.3% of women and 8.9% overall (1.1 million) 'currently' used tobacco products (13). Studies show that current smoking status is associated with the men, parental smoking, family smoking and friends smoking (14-16). People working in the informal sector had a higher prevalence of active smoking higher compared with other employment categories. Living with smokers is a risk factor of tobacco consumption. People living in the same household with smokers are more than 12 times more likely to be smokers than those who live in a smoke-free home (16).

Harmful use of alcohol

According to WHO, in 2010 the per capita alcohol consumption (in litres of pure alcohol), in population aged 15 and older, was 13.3% for men, 3.5% for women and an overall prevalence of 8.4% (17). In 2012, the overall adult per capita consumption was 8.6% (1). The prevalence of heavy episodic drinking (i.e. consumed at least 60 grams or more of pure alcohol on at least one occasion in the past 30 days) was 17.5% for men, 6.9% for women, and an overall of 12.1% in the total population (1).

Consumption of alcohol is deeply anchored in the customs of Cameroonians and dates back to the colonial era. Today, the situation is amplified. Indeed, consumption of alcohol in Cameroon is determined by several socio-cultural factors (18-21). Alcohol has a prestigious role in traditional events, such as dowry payment ceremonies, resolution of disputes, funerals, and weddings. These factors drive the production and consumption of traditional brews.

Apart from the traditional production of alcoholic beverages, urbanisation was accompanied by the consumption of Western drinks. For many years, there were three main alcoholic beverage industries based in the country. They fund multiple daily advertisements about the virtues, qualities and power of alcoholic beverages. In addition, price of alcohol is affordable, such as whiskey in small plastic sachets that costs 100 CFA francs (Coopération Financière en Afrique) (<\$20 USD). The socio-cultural environment therefore plays a big role in the alcohol consumption patterns in the country.

Insufficient physical activity

According to WHO, data from 2003 showed that the prevalence of insufficient physical activity in adults aged 18 years and older was 22.8% in men, 38.7% in women and an overall of 30.7% (1). Urbanisation is also accompanied by changes of a number of elements such as sedentary work, leisure and transportation. Studies in Cameroon show an urban-rural gap gradient in physical activity levels, with a significantly higher activity in rural areas, and a protective effect of physical activity on glucose intolerance (22,23).



Unhealthy diet

Cameroonians are increasingly exposed to unhealthy diets generally rich in carbohydrates, saturated fats and salt. A STEPwise survey realised in 2006 showed that the mean number of days fruits (2.5 days versus 2.7 days, $p < 0.03$) and vegetables (2.7 days versus 3.0 days, $p < 0.01$) were consumed in a typical day were higher in men compared with women. These numbers of days, which decreased with age, were higher in Bamenda and lowest in Yaoundé (24). National surveys showing the patterns on salt and fats intake are not available in Cameroon. However, the increase of NCDs and metabolic risk factors prevalence suggest the trends in sodium intake may have changed with time (11). Culturally, the usual diet in Cameroon is rich in starch. These phenomena are more pronounced in urban areas. All this probably contributes to increasing obesity (25–27), which is also influenced by the belief and perception that obesity is a sign of good health, good life and general well-being (28,29).

In general, Cameroon, like many other LMICs, has an apparent high burden of NCDs and their risk factors. Most population-based estimates on specific diseases are either not available or outdated. An accurate assessment of the current magnitude and trends is difficult to perform in the absence of multiple population-based data.

2.0



2.0 | Guiding frameworks

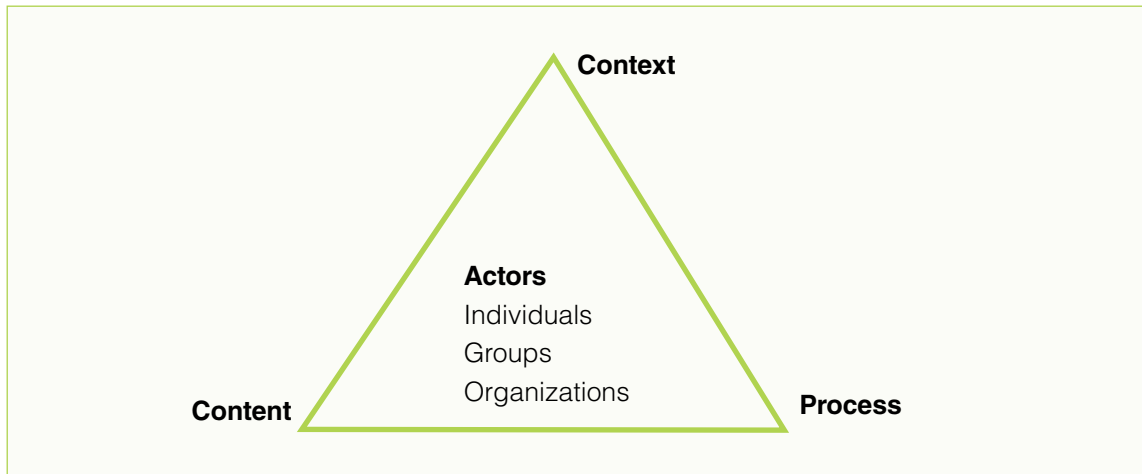


Guiding framework



In conducting policy analysis, data collection and analysis should be guided by existing policy analysis frameworks. In Africa, the Walt and Gilson (1994) framework was chosen for the analysis of NCD prevention policies (30). This framework focuses on the policy context, content, actors and processes through which the policy to be analysed was developed and implemented (Figure 6).

Figure 6: Guiding framework used in policy analysis by Walt and Gilson



Policy context includes situational factors (the specific conditions of a moment in history that impact on the policy change intended), structural factors (the relatively unchanged circumstances of the society and the polity, such as the structure of the economy and political system), cultural factors (the values and commitments of society and groups), and exogenous factors (the events and values outside of any one country or system). The factors in the context that influence a specific policy can be global or national.

Content relates to the specific nature and design of legislation or policies, the interaction between these policies and other institutional changes, and existence of implementation guidelines.

Policy actors are the people or organisations involved in health policy change, including implementers and beneficiaries. The analysis examines different actors' roles; how they use their power in taking forward, blocking or challenging policy formulation or implementation; and the influence of laws, norms and customs (institutions) on the behaviour of various stakeholders.

The policy process is concerned with the way in which laws/policies are identified, formulated and implemented, their timing, the strategies used, as well as the specific mechanisms or bodies established to take these policies forward.

The WHO framework for NCD prevention guides the analysis of NCD prevention policies at country level. WHO identified several best buys (31), which include population-based measures for reducing tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol and individual-based interventions ranging from counselling and drug therapy for cardiovascular disease to measures for preventing cervical cancer (Table 1) (31). We used the population-based best buys interventions to limit the scope of the NCD policies to be analysed in each country since they represent what should be priority interventions for NCD prevention. Analysis was also restricted to policies aimed at primary prevention that address the four main behavioural risk factors.



Table 1: WHO “best buys”

| Risk factor/disease | Policy interventions |
|--|--|
| Tobacco use | Tax increases Smoke-free indoor workplaces and public places Bans on tobacco advertising, promotion and sponsorship Health information and warnings |
| Harmful alcohol use | Tax increases Bans on alcohol advertising Restricted access to retailed alcohol |
| Unhealthy diet and physical inactivity | Reduced salt intake in food Replacement of trans fat with polyunsaturated fat Public awareness through mass media on diet and physical activity |
| Cardiovascular disease and diabetes | Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk ($\geq 30\%$) of a fatal and non-fatal cardiovascular event in the next 10 years Acetylsalicylic acid (aspirin) for acute myocardial infarction |
| Cancer | Prevention of liver cancer through hepatitis B immunisation Prevention of cervical cancer through screening (visual inspection with acetic acid [VIA] linked with timely treatment of pre-cancerous lesions) |

3.0  3.0 | Methods



Methods

For this project, we used a ‘case study’ approach, in which “how” and “why” questions are posed to understand historical or contemporary phenomena within real-life contexts the investigator has little or no control over (32). This particular design is suitable since the aim of the research was to provide an in-depth understanding of MSA in NCD prevention-related policy actions, why and how they were taken, and how they were implemented. A more detailed description of the design and other aspects of the methodology are described elsewhere (33). This was a multiple case study: each cluster of policies related to a specific risk factor formed a case. For instance, alcohol control policies formed one case and so did tobacco control policies.

Study area

This project was designed to deal with national policies, and their implementation is supposed to be effective in all 10 regions of the country. We selected five out of 10 regions – North, Northwest, Central, Littoral and South – to assess implementation based on the socio-economic and cultural difference between regions, as shown in Figure 7.

Data was collected using qualitative methods, including document reviews, in-depth interviews, and observations. All data was collected by trained researchers with experience in public health research.

3.1. Document review

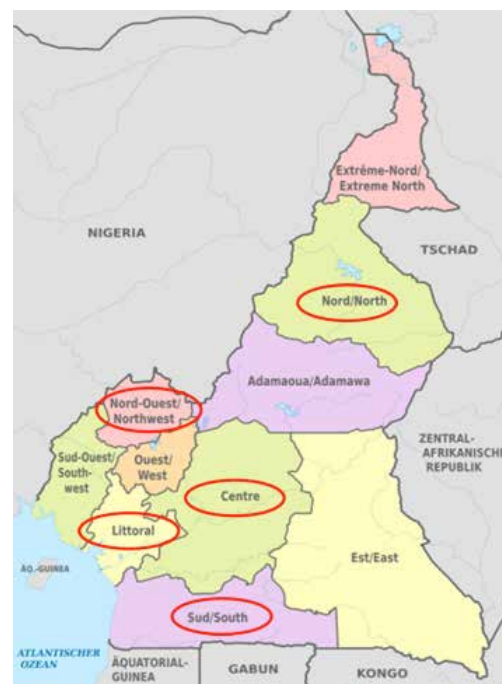
The document review describes the Cameroon policy context and content, identifies the existing policies and gaps, and understands the policy development processes and implementation status. We focused on the policy documents of NCD prevention (including acts and laws, strategic plans, guidelines and government directives), reviews and case studies of MSA in successful policy formulation and implementation at national level.

From mid-2014 to the end of 2015, we selected related sectors based on their expected role in policy formulation and implementation of NCDs of laws, presidential decisions, ministerial orders, circulars, recommendations and guidelines, action plans, both on websites and in physical space, government structures, research institutions, NGOs and civil society organisations. Institutions were purposively selected based on their expected role in NCD policy formulation and implementation. We specifically sought sectors that were not health-related (e.g., transportation, education) because of their often untapped potential for affecting health outcomes. After the initial review, we maintained documents with policy measures related to WHO best buys.

Data extraction

Data was extracted from retrieved documents with an Excel spreadsheet containing the following elements: authors, document title, date of publication, publisher/journal title, source, NCD policy element addressed, summary of document type and objective, and summary of key document analysis findings related to best buys.

Figure 7: Selected regions for the analysis of policy implementation





Analysis of documents

In the second part of the document review, we did an in-depth analysis of all the NCD national best buys policy documents based on the following elements (34): rationale; goals and objectives; programme measures; implementation and institutional arrangements; funding and other resources; indicators of success; and monitoring and evaluation plan. This was guided by the need to extract information mapped onto the main elements of the Walt and Gilson framework.

3.2. In-depth interviews

Interviews were conducted in order to understand the history and formulation of current policies and the extent to which the process was multi-sectoral from key informant perspectives, as well as their perspectives about the strengths and weaknesses of NCD policy formulation processes and barriers to implementation in Cameroon.

Sample

The following strategy was used to identify the key informant sample:

First, we listed the key sectors that were likely to be, or should have been, involved in development of various NCD policies. We then identified the specific policies critical to each identified sector. We created a list of potential contacts from the department or office in the sector responsible for the identified policy using information available in the public domain as well as contact of known key stakeholders. We obtained a list of other actors in the specific policy from the primary key contact and used a 'snowball' technique to progressively identify more actors. Furthermore, we identified other sectors likely to contribute to the policy in the process of interacting with the key contacts identified above. For each of these sectors, we identified a key contact person, and again using a snowball technique, we subsequently identified other actors in the specific policy. We repeated these steps for all the identified policies.

The interview guide

Due to the fact that all those involved in the formulation of a policy were not necessarily involved in its implementation, we decided to develop two interview guides depending on the level of the actors: one for policy makers, and the other for potential implementers. In the policymakers' interview guide, we focused on context, process and actors of formulation; in the guide of implementers, we focused on the process and actors of implementation (Appendix 9.1). We chose to conduct in-depth interviews with actors of policies formulated only in the past 10 years and implemented at the national level because of our focus on formulation and because of possible memory bias.

Type of data collected

We collected data on (1) the policy context, including the political and historical context, social and economic factors, the health system, and technological factors; (2) the policy content, including risk factors addressed in the policy, the rationale and objectives of the policy, the actors in the policy, other interventions mentioned, and mechanisms of actualising the policy; (3) policy formulation and implementation; (4) actors in the formulation and implementation of the policies, as well as facilitating and hindering factors in actor involvement; (4) funding for the policy's implementation; and (5) recommendations on to how facilitate multi-sectoral action on future policy formulation and implementation.



Training of field researchers

We trained five interviewers in this project: three in public health, one in social sciences and one in nursing. They all have adequate experience in the conduct of qualitative research studies with senior people.

We conducted competency-based training first with three principal interviewers. The content included: an overview of the research project and objectives; training objectives, process of training and expected outcomes; overview of NCD prevention policies with emphasis on WHO best buys; methods of data collection (record review, observation and interviews); data collection tools (rationale for each question, objective being answered by the question, extent of data required for each question, the appropriate probes); how to conduct the interviews; how to take accurate field notes; interviewer responsibilities, (importance of interviewer performance and quality assurance in data collection; and ethical principles to observe during data collection (informed consent, voluntary participation, privacy and confidentiality and safety of the respondents).

Data collection

Preparation for data collection. Preparatory activities for the data collection phase included: the development of a guideline/checklist for the field work and post-field activities; identification and selection of the study respondents; official notification of the gatekeepers and respondents; appointment schedules for the interviews or desk reviews; finalisation and printing of research tools; and procurement of fieldwork equipment (i.e. recorders).

Conducting the interviews. The interviews were conducted at times and venues mutually agreed upon by the research team and the respondents. These venues were free from distractions and other security risks, and conducted in a private place where the conversation was not easily overhead by others. All interviews were conducted in line with the ethical guideline provided using a digital recorder. The interviews lasted 60-90 minutes.

3.3. Observations

We carried out observations to obtain more information on the level of policy implementation. The observed policies were selected on the basis of what had a constant, visible effect. For example, during in-depth interviews, we observed whether the visible elements of the recommended actions were implemented in the five selected regions of Cameroon. In order to achieve this, we chose the non-participating direct observation and developed an observation guide (see appendix 9.2). In the different regions, and based on the observation guide for a selected policy, we selected an adequate number of sites to ensure they are representative of the larger population (secondary schools or main avenues and intersections). These observations helped us to triangulate the data collected during key informant interviews and document review.

3.4. Data quality assurance

A team led by a senior researcher in Cameroon collected data. At the start of the project, team members were trained on qualitative data collection techniques. During interviews, we asked each participant permission to record the interview by explaining the merits of the process (save time and reduce the risk of misquotes). Note-taking was done by the interviewer whenever recording was declined. After each interview, the research team listened to the recorded conversation and ensured verified accurate note-taking. Once the interviews were transcribed, another member re-listened to ensure transcription quality. Some key informants validated their transcripts.

Team meetings were held regularly to ensure smooth progress. Two meetings of the task force monitoring the project, involving several stakeholders, validated the process. Precautions described above ensured collection of good quality data.



Before and during interviews

Interviewer training. In general, the responsibilities of an interviewer include identifying key informants, making appointments, and conducting interviews. Before leaving the interview, the interviewer ensures they asked all questions on the guide and recorded the entire interview.

Supervision of the work done by research assistants:

- Checking interview records/transcripts to ensure the right questions were asked, all questions were asked, questions were properly framed, probing was used appropriately to get full information and new information provided by the respondent was followed up;
- Verifying key informants interviewed to be sure the correct respondent was interviewed;
- Discussing errors/discrepancies found in the collection of data with each interviewer;
- Checking the completed questionnaires and ensuring all key informants on the generated list were interviewed; and
- Recording aspects that cannot be captured by audio, such as interaction, body language, exclamations, and slang, among other issues.

After interviews

Control of the transcription process. At this level, we:

- Check transcripts to ensure they do not contain obvious mistakes made during transcription;
- Once transcribed, another member listens to the recording to ensure transcription quality;
- Ensure consistency by avoiding change in code meanings during the coding process;
- Research team meets daily to review all field notes for detailed documentation, analyse the information, clarify issues, identify issues requiring follow-up and corrections, discuss findings and observations to facilitate accurate process documentation while memories are fresh. Notes for each interview are appended to the interview transcript; and
- Organise task force meetings involving several stakeholders to validate the process.

3.5. Data management

Data collection and analysis was done concurrently. We prepared a **data analysis plan** and compiled all datasets, including: spreadsheets of policies, transcripts and field notes from interviews, and notes from observations.

Data cleaning involved reading through transcripts to identify incomplete sections, typographical and formatting errors, and clarify the use of idioms, metaphors and slang language. It also involved the insertion of notes where explanations were required before the data was uploaded to NVivo for coding and analysis. It included:

1. Comparison between planned and actual data sets available for analysis;
2. Verification that all the information in the different instruments was correctly recorded;
3. Ensuring that specific data sets were accurately labelled;
4. Clarifying new concepts and ideas with study participants and fieldworkers;
5. Linking data sets.

Once all the textual data was clearly and correctly labelled it was **uploaded into NVivo for coding** and analysis. NVivo is a data analysis program that aids in the storage, coding, and retrieval of qualitative data.

We developed a comprehensive codebook to guide coding based on the Walt and Gilson framework. Codes identified the content, context, and process of policies within the WHO best buys categories as well as the actors involved (individual, group, and organisation).

3.6. Data analysis

We analysed qualitative data using a content-analysis approach, guided by the key research questions about the extent and depth of MSA in policy formulation and implementation. The key content areas were pre-determined based on the policymaking framework described above and transcribed data was coded within that context.

Researchers conducted content analysis using NVivo software and the pre-determined coding frame. The software assisted researchers in labelling sections of text with content areas and key themes, which were further analysed during a secondary analysis by adding or discarding themes. We sorted the codes into categories depending on how they were related and linked. Each case was analysed separately.

More than 85% of the interviews in Cameroon were done in French. We analysed in French according to the different categories and sub-categories. While the transcripts were coded into NVivo and categorised, we compiled information in English for the results section of the report. We also translated some citations.

3.7. Data storage and transmission

All hard copy consent forms and respondent information are kept by the research team in an office at Health of Population in Transition (HoPiT) and will be stored for a period of five years. It is only accessible by the research team. Electronic data is stored on a password-secured hard drive. Copies of the data are backed up and saved on the existing server.

3.8. Ethical considerations

This research was approved by the National Ethics Committee of the Ministry of Public Health of Cameroon Data protection (annexe 9.3). The study adhered to the following general research ethics principles:

- *Privacy*: interviews were conducted in environments that allowed the respondent to freely express their views without fear of victimisation;
- *Confidentiality*: identities were protected and results presented showing the constituent they represent (i.e. policymaker – Health) rather than names or positions. Data collected through in-depth interviews was digitally recorded and later transcribed. The raw transcript was only accessed by the project staff. Samples of the raw and transcribed data was shown to the APHRC team for quality control purposes. All collected data was anonymised before presentation or sharing.
- *Voluntary participation*: Participation in any aspect of the study was voluntary throughout the interview process. Participants were free to withdraw their consent at any time during and after the interview. This was explicit in the consent form administered before every interview.
- *Benefit of research*: It was made known to the participants that there was no direct benefit. The expected benefit will be downstream once the evidence generated is used to improve the policy-making process and its outcomes.



- *Sharing of research findings:* The findings will be published in peer-reviewed journals and translated into formats accessible to non-academic audiences, such as research briefs, factsheets, media releases. Key stakeholders involved early in the research process will be the first to receive the findings from this study.
- *Measures to minimise risk:* The risks to participants was minimal due to the nature of the study and the safeguards taken during data collection. No participant was interviewed without informed consent. Prior to data collection, participants read a consent script written. We explained the aim of the research, the expected duration of the subject's participation, and the procedure. We also described how the research will be beneficial to the target group, explained that the research involved no risks and there was no cost of participation, and provided the name and the telephone contact of the project coordinator. Participants were given the opportunity to ask any questions. It was the responsibility of the interviewer to ensure that the participant fully understood what he/she was signing and agreed to take part in.

4.0



4.0 | Findings



Findings

4.1. Data sources

We identified **90 documents** (Table 2) related to NCD prevention in Cameroon and in the world. Among these, 17 were about tobacco prevention, eight on alcohol prevention and 12 on physical activity and one policy on unhealthy diet. In classifying these documents into the four WHO best buys interventions, we identified 12 policies on tobacco, six policies on alcohol and only one on physical activity. No policy about unhealthy diet was found. As a result, we conducted interviews to understand the policy context, content, process and actors for four tobacco control policies and one on alcohol control (Table 3). We did not conduct interviews related to policies for physical activity and unhealthy diet.

Table 2: Number and type of documents reviewed for the Cameroon NCD prevention policy analysis

| Document type | Total number |
|--|--------------|
| National NCD policy documents related to “best buys” | 19 |
| Published journal articles (relating to NCDs in the country) | 26 |
| Other articles related to NCDs | 15 |
| Reports from international organisations | 23 |
| Other grey literature | 7 |
| Total | 90 |

We conducted **in-depth interviews** with 43 policymakers and staff responsible for the formulation and implementation of policies related to harmful tobacco and alcohol use, including the context, process, content and actors with the NCD prevention policies. Interviews were conducted with decision-makers in Yaoundé, and implementers in five different regional capitals (Yaoundé, Garoua, Bamenda, Ebolowa and Douala). Selection was based on the previously described national ecosystems and cultures.

Table 3: Policies for which interviews were done with key informants and whose implementation was observed

| Risk Factor | Interviews done | Observations done |
|-------------|--|---|
| Tobacco use | Law No. 2006/018 of 29 December 2006 governing advertising in Cameroon | Law No. 2006/018 of 29 December 2006 governing advertising in Cameroon banning advertisements for cigarettes and other tobacco products |
| | Order No. 967 MINSANTE/ MINCOMMERCE of 25 June 2007 regarding health warnings on packages of tobacco products | Order No. 967 MINSANTE/ MINCOMMERCE of 25 June 2007 regarding health warnings on packages of tobacco products |
| | Law No. 2014/026 of 23 December 2014 on the finance law of the Republic of Cameroon for the 2015 financial year | Law No. 98/004 of 14 April 1998 on the orientation of education in Cameroon |
| | Circular Letter No. 19/ 07MINESEC/SG/ HR/ SDSSAPPS of 11 September 2007 on the establishment of anti-tobacco clubs in schools and making schools “non-smoking areas” | Circular Letter No. 19 / 07MINESEC /SG/HR/ SDSSAPPS of 11 September 2007 on the establishment of anti-tobacco clubs in schools and making schools “non-smoking areas” |



| | | |
|------------------------|---|--|
| Harmful use of alcohol | Law No. 2014/026 of 23 December 2014 on the finance law of the Republic of Cameroon for the 2015 financial year revising taxation of alcohol products | Law No. 98/004 of 14 April 1998 on the orientation of education in Cameroon prohibiting the sales, distribution and consumption of alcoholic beverages and banning of opening drinking spots, in or near schools |
|------------------------|---|--|

We interviewed policymakers and implementers. The majority of respondents interviewed were from the public sector, although many were enforcers from the education sector (Table 4). We approached civil society organisations known for their work in NCD prevention but they were neither involved in the formulation nor implementation of these best buys and therefore could not answer our questions. We also tried in vain to contact the NCD Officer at WHO National Office in Cameroon.

Table 4: Number and type of respondents for in-depth interviews by sector

| Number of respondents by government sector | N |
|--|----|
| Education | 23 |
| Health | 3 |
| Trade | 4 |
| Customs | 2 |
| Communication | 5 |
| Post and telecommunication | 1 |
| Economy | 1 |
| Sport | 1 |
| Water and energy | 1 |
| Finance | 2 |

Observations

In order to obtain more information on the level of implementation of some policies we also carried out observations to triangulate with information collected from the key informants and from document review. The policies observed were selected on the basis of those which had a constant visible effect. Then, between the NCD best buys policies, we decided to observe four tobacco-related policies and one alcohol-related policy, as shown in Table 3. As for the in-depth interviews, we observed some elements of these policies in each of the five selected regions in Cameroon.

4.2. NCD Policy landscape in Cameroon

The control of NCD risk factors in Cameroon, principally harmful tobacco and alcohol use, began in the 1960s with Law No. 64/LF/23 of 13 November 1964 on the protection of public health, although the literature shows that some measures on alcohol date back to 1930 (30). The formulation context of these measures varies from one risk factor to another. There are a good number of best buys policies on tobacco and alcohol control but fewer on physical inactivity and inadequate nutrition. The development of these policies was influenced by global and local contexts.



4.2.1. Global context

NCD prevention in Cameroon was not done synchronously, according to key informants. Policies were implemented by individual ministerial departments. However, some vestiges of global recommendations were present in certain policies (such as tobacco prevention) but not in others. The WHO actions played a significant role in introducing a number of WHO NCD prevention best buy interventions into Cameroon's policy agenda. The two main WHO actions that drove the policies' development were: the WHO Framework Convention on Tobacco Control (2004) and the Adoption of the Resolution of the UN General Assembly on the Prevention and Control of NCDs in 2010. Cameroon ratified the WHO Framework Convention on Tobacco Control in 2006, which motivated the formulation of the policy on health warnings on tobacco (46) and the creation of tobacco-free zones in some ministerial departments. A Ministry of Public Health staff member indicated that the policy requiring health warnings on cigarette packages (46) came about specifically because of the WHO framework. In addition, the Cameroonian policy on the taxation of cigarettes (35) also emerged from the framework:

"This was done in a context where Cameroon has ratified the Framework Convention on Tobacco Control and we have to respect the commitments that were made by ratifying this convention." (Ministry of Public Health, 10 years' experience)

"It is the dangerousness of tobacco, which prompted the government to raise excise duty. This is not necessarily a decisive argument, there's also the application of international conventions such as Convention on Tobacco framework of the WHO, which provides that States can use taxation to reduce their tobacco consumption. On taxation, the state is sovereign." (Ministry of Finances, 8 years' experience)

Cameroon adopted the WHO Resolution of the UN General Assembly on the Prevention and Control of NCDs in 2010. The resolution called for the WHO General Assembly in 2011 to conduct a high-level meeting on NCD prevention and control with heads of state and government. With WHO support, Cameroon elaborated a National Integrated and Multi-sector Strategic Plan for the Control of Chronic NCDs (NIMSPC-CNCD), (2) as explained in the following quotes:

"The Ministry of Public Health made us to understand that there is a UN high-level summit on NCDs in September 2011, and that there will be a signed agreement for participation. The head of state will be a co-signatory of that document. So we had to quickly establish standards, rules and procedures about NCDs prevention in Cameroon." (Ministry of Posts and Communication, 10 years' experience)

"WHO has played an important role, I also believe that WHO is also the United Nations. He remembers me that when writing this final document, it was said that the document would be represented at the UN session in September by the heads of states. Therefore the United Nations, through WHO, played a very important role in the development of this policy there." (Ministry of Sports and Physical Education, 7 years' experience)

A review of NIMSPC-CNCD showed that its development was guided by numerous global and regional policies and frameworks (2) as shown in Table 5.



Table 5: Global and regional policies and instruments used in developing the Cameroon NCD Strategic Plan

| Global policies and instruments | Africa region policies and instruments |
|---|---|
| Global Strategy for the Prevention and Control of NCDs (2000) | Non-Communicable Diseases: A Strategy for the African Region (2000) |
| WHO Framework Convention on Tobacco Control (2003) | Cardiovascular Diseases in the African Region: Assessment of the Current Situation and Prospects (2005) |
| Global Strategy on Diet, Physical Activity and Health (2004) | Diabetes Prevention and Control: A Strategy for the African Region (2007) |
| Neurology Atlas (2004) | Cancer Prevention and control: A Strategy for the WHO African Region (2008) |
| Neurological Disorders: Public Health Challenges (2006) | Implementation of the Regional Oral Health Strategy: Update and Way Forward (2008); |
| Resolution WHA60.23 on the Prevention and Control of NCDs | Reduction of the Harmful Use of Alcohol: A Strategy for the WHO African Region (2010) |
| Implementation of the Global NCD Strategy (2007) | Sickle Cell Anaemia: A Strategy for the WHO African Region (2010) |
| Oral Health: Action Plan for Promotion and Integrated Disease Prevention (2007) | Achieving Sustainable Health Development in the African Region: Strategic Directions for WHO 2010-2015 (2010) |
| Prevention and Control of Non-Communicable Diseases: Implementation of the Global Strategy (2008) | Strategic Plan for Non-Communicable Diseases Prevention and Control 2011-2015 WHO-AFRO (2011) |
| 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of NCDs (2008) | |
| Global Recommendations on Physical Activity for Health (2010) | |
| The Moscow Declaration (2011) | |

4.2.2. Local context

The structure of the Republic of Cameroon

The government of Cameroon is a multiparty presidential republic, which is similar to the French model. Under this model, power is distributed among the President, who is the head of state; the Prime Minister, who is the head of government; and the Cabinet ministers. The Republic is divided into 10 regions: Adamawa, Northwest, East, Far North, Littoral, South, Centre, Southwest, North, and West. All these administrative regions are supervised by a Governor, who co-ordinates Divisional officers, and subdivision officers (36).

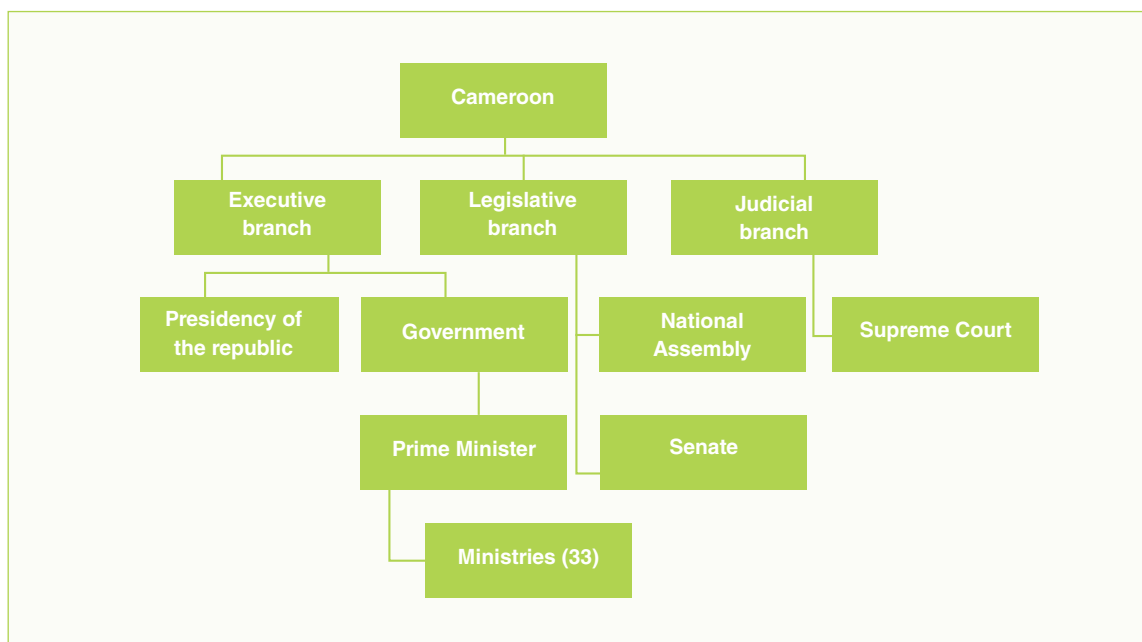
The Cameroon Constitution institutes three principal powers: executive, legislative, and judicial (Figure 9). The executive power in Cameroon lies with the President, who is elected by popular vote for a term of seven years and is eligible for re-election for a second term. The Government is headed by the Prime Minister, who is appointed by the President. Under the executive, the Cabinet consists of a council of ministers appointed by the President on the recommendations of the Prime Minister (37). There are currently 33 ministries; a full list is provided in Appendix 10.5. The Ministry of Public Health is the main actor in the NCD prevention framework.



The legislative branch is a bicameral Parliament, which consists of the Senate (100 seats; 70 members indirectly elected by regional councils and 30 appointed by the president; members serve five-year terms) and the National Assembly (180 seats; members directly elected in multi-seat constituencies by simple majority vote to serve five-year terms) (37).

The judicial system in Cameroon is based on the French civil law system and consists of the Supreme Court and High Court. Judges of the Supreme Court are appointed by the President while the High Court judges are appointed by the National Assembly. The High Court consists of nine judges and six substitutes. The judiciary in Cameroon is subordinate to the Ministry of Justice of the executive branch. The constitutional review of a law can be done by the Supreme Court only on the request of the President (37).


Figure 8: Structure of the government of Cameroon



NCD and other healthcare financing

Respondents reported that the Cameroonian healthcare system is grossly underfunded and NCDs are not prioritised by government and policy-makers – a factor recounted by key informants across the board as an overarching problem. The system, heavily funded privately through out-of-pocket payments and by donors, is neither fully functioning nor sustainable. According to the National Health Accounts 2009-10, the total health expenditure per capita was \$42 USD, and the government only contributed 29% of that. Government spending was 4.6% of the gross domestic product (GDP), less than a third of the 15% agreed upon at the Abuja Declaration¹ (2). Furthermore, within this system, the focus has long been on infectious diseases, such as malaria and HIV, and maternal and child health. The public sector provides the majority of healthcare in Cameroon. In this underfunded system, the communicable disease/maternal and child health burden takes priority, draining what little resources are available, therefore playing a major role in the failure to prioritise NCD prevention (2).

¹ In April 2001, the African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support.



Since 2001, the Cameroonian health agenda prioritises chronic NCDs. Some policies related to the management of chronic diseases were developed and adopted by the Ministry of Public Health. In 2002, a programme to control cancer was adopted. Diabetes and hypertension were recognised as emerging public health problems and incorporated into a national 10-year plan for health promotion. This led to the creation of two bodies within the Ministry of Public Health: the Department of Health Promotion and the Department of Disease Control, with a sub-directorate focusing on NCDs. This department developed both the NIMSPC-CNCD and national programmes to reduce NCD-linked morbidity and mortality between 2004 and 2010 (2).

Economic context of NCD risk factors

The tobacco industry in Cameroon

The national tobacco industry consists mainly of the production of raw tobacco leaves, the industrial production of cigarettes, and importation of tobacco products. Historical data concerning tobacco production and importation might be inaccurate because of the shortcomings of the country's statistical system. Furthermore, official import statistics do not reflect illicit trade (38). Cameroon is a tobacco-producing country (38). The industrialisation of tobacco farming developed steadily after World War II. Farming increased from 25 tonnes in 1945 to 950 tonnes in 1962. In 1963, a Franco-Cameroonian Society of Tobacco took over from a society called "Société d'Exploitation Industrielle des Tabacs et des Allumettes". On 30 January 1974, the Cameroon tobacco corporation, with the government as a majority interest holder, resumed all of the former operations of the Franco-Cameroonian Society of Tobacco. Under the supervision of the "Société Camerounaise des Tabacs" (Cameroon Tobacco Corporation or SCT), the production reached 2,400 tonnes in 1973-1974, including 1,740 tonnes of wrapper tobacco and 660 tonnes of cut tobacco, all auctioned on the Paris market. Eventually, 13 production centres were created to channel the tobacco produced by 10,000 producers in areas such as Batouri, Bertoua, Mindourou, Ngoura, Belita, Gribi, Bétaré-Oya, Bandagoué, Lolo, Bengué-Tiko, Boubara, Ngotto and Bounou. During this era, the population involved in tobacco farming, which employs growers and support personnel for six months of the year, was about 50,000 people. In addition, the SCT provided permanent employment for 800 people, including 35 executives. It also provided for 360 temporary workers hired during the conditioning period. SCT provides support for producers of wrapped tobacco. The British American Tobacco (BAT) and the Société Industrielle des Tabacs du Cameroun (SITABAC) respectively set up tobacco factories in Cameroon in 1950 and 1980, concentrating their businesses on cut tobacco production, conditioning, and marketing infrastructure. These companies' cigarettes are exported and sold in Cameroon.

In addition, the Cameroonian government, aware that tobacco farming generated substantial revenue for certain producers, approved a project supporting the revival of tobacco farming in eastern Cameroon, *Projet d'Appui à la Relance de la Tabaculture à l'Est Cameroon (PARTEC)*, for an amount of 2,086,745,299 franc CFA (\$3,573,683.16 USD), including 530,367,195 franc CFA (\$908,274,198 USD) as the Federation of Tobacco Producers and Other Food Crops of Cameroon contribution and 1,556,387,105 franc CFA (2 665 324,66 USD) in anticipated grant money from the Heavily Indebted Poor Country (HIPC) initiative.

More recent data suggests that 6,000 smallholder farmers are involved in tobacco. Various industry actors tried to make an inventory of farmers to prepare them for better production. After the SCT was liquidated in 1997-1998, the Batschenga station was taken over by an individual who now uses it for corn production. SCT executives were made redundant and tobacco producers were left to their own fate.

The net total of tobacco leaf production in Cameroon is higher than what the numbers above reflect. The Food and Agricultural Organization (FAO) of the United Nations estimated that unmanufactured tobacco leaf production was steady at about 4500 tonnes per year between 1999 and 2008.



In contrast, the production of manufactured tobacco products decreased recently, as illustrated in Table 1. From 1983 to 2004, BAT and SITABAC produced manufactured tobacco goods; SITABAC, citing counterfeiting and smuggling issues, closed its operations in 2004. In 2007, BAT closed its Cameroon manufacturing subsidiary as part of their African operational consolidation effort.

Table 6: Economic context of tobacco production and use in Cameroon

| Economic factor | Indicator | Unit | Measure |
|-----------------------------|---|-------------------|---------|
| Cigarette prices | Cigarette prices | per pack in USD | 2.02 |
| Affordability of cigarettes | Relative income price | 2010 | 25.73 |
| Manufacturing cigarettes | Production | in billion pieces | 1.22 |
| Illicit cigarettes | Illicit share of the total cigarette market | % | 15.2 |
| Tobacco taxes | Excise tax as % of cigarette price | % | 9.2 |
| Growing tobacco | Tobacco area harvested | hectares, 2000 | 3400 |
| | Tobacco area harvested | hectares, 2009 | 4173 |
| | Percent change in tobacco area harvested | 2000-2009 | 22.7 |
| | Tobacco production | tonnes, 2000 | 4700 |
| | Tobacco production | tonnes, 2009 | 7112 |
| | Percent change in tobacco production | 2000-2009 | 51.3 |

In 2013, the five most frequently purchased cigarette brands in Cameroon were: L&B Bleu (33.0%), Gold Seal Bleu (28.2%), Benson & Hedges (12.3%), L&B Menthol (10.9%) and Gold Seal Menthol (5.1%). About two-thirds (66.9%) of smokers made their most recent purchase at a shop; another 14.9% used a street vendor and 10.3% used a kiosk. Current smokers spent an average of 4,691 franc CFA (\$8.03 USD) per month on manufactured cigarettes, representing 8.9% of the monthly per capita GDP (2013). The mean cost of 100 packs (or 2000 sticks) of manufactured cigarettes as a percentage of 2013 GDP was 6.9% (26).

The alcohol industry in Cameroon

Unlike other consumer goods in Cameroon, most alcoholic drinks are produced by local breweries. Volume growth in 2014 was positive across virtually all categories of alcoholic drinks, encouraged by stable prices (40). While unit prices increased in 2013, the more stable situation in 2014 helped sustain volume sales as consumers remained loyal to their favourite brands. The alcohol market is very competitive led by local players (40). Cameroon produces alcoholic drinks by three main local breweries. In 2014, Les Brasseries du Cameroon maintained its leading position in terms of volume, followed closely by its major competitor, Guinness Cameroon (41). The year was marked renewed market growth and strong competition.

Historical or existing laws and policy instruments which influenced NCD policies at country level

The Cameroonian government responded to the increasing rates by incorporating NCDs into the Health Sector Strategy 2001-2015 and the National Health Development Plan (6,42). The Ministry of Public Health elaborated NCD-specific national programmes to reduce morbidity and mortality between 2004 and 2010. These programmes focused on control of hypertension/cardiovascular diseases, chronic respiratory diseases, chronic kidney disease, cancer, diabetes, among others. (4).

In 2011, the National Strategic Plan for the Prevention and Control of Chronic NCDs in Cameroon was developed for the period 2011-2015. Its main objective was to prevent or delay the onset of NCDs and their complications, improve treatment, resulting in the improved quality of life and life expectancy of Cameroonians (2).

Alcohol control has a longer history. Efforts began in colonial times with the 1928 decree prohibiting possession and circulation of traditional spirits. Several decrees succeeded one another in 1931, 1933, 1948 and 1958, all governing the sale and circulation of alcoholic beverages and soft drinks, and requiring licenses for trade in Cameroon under the French (43).

After independence, Decree No. 73/659 of 22 October 1973, on the regulation of licensed bars, was adopted and amended by Decree No. 74/644 of 16 July 1974, to be finally adopted as Decree No. 90/1483 of 9 November 1990, which laid down the conditions and operating procedures for drinking establishments (44). Emphasis was also laid on alcohol consumption in schools with Law No. 68/004 of 4 April 1998 on the orientation of education in Cameroon (45).

The control of tobacco use in Cameroon began in the 1960s with Law No. 64/LF/23 of 13 November 1964. Historically, tobacco control was ongoing within the framework of a small number of government measures. Tobacco control was solely regulated by Ministerial Decision No. 0222/D/MSP/SG/DMPHP of 8 November 1988, which prohibits tobacco use in institutions under the Ministry of Public Health. Moreover, tobacco use was restricted but not prohibited in government buildings and schools. The law No. 90/031 of 10 August 1990 governing commercial activity in Cameroon marked the starting point in controlling tobacco use among young people (38). Thereafter, correspondence from the Ministry of Communication dated 3 June 1996 was in favour of using the media to control smoking and alcoholism. By voluntary agreement, the tobacco advertising was banned in all media targeting young people and the number of advertisements on the radio, in the press and cinema, was limited.

A joint order of the Ministry of Industrial and Commercial Development and the Ministry of Public Health dated 8 June 1999 made it compulsory for all tobacco packages and products traded in Cameroon to contain the warning: "Message from the Ministry of Public Health: Tobacco consumption may be dangerous to your health".

A Ministry of Public Health sub-directorate in charge of prevention and community action was created by Article 70 of Presidential Decree No. 2002/209 of 19 August 2002 to include, among others, the control of alcohol abuse and smoking in the workplace. This sub-directorate is responsible for defining and implementing strategies and action plans for alcohol control and smoking; the development of legislation and regulations on alcohol and tobacco; creation of treatment centres and support for alcohol and tobacco addicts; and the definition and implementation of alcoholics' and smokers' rehabilitation strategies. Another Ministerial Decision, No. 11180/D/MSP/SG/DPS of 28 May 2004, undertook and implemented the expert group on smoking.

Tobacco control efforts intensified in 2004 by Decision No. 0180/D/MSP/SG/DPS of 28 May 2004. The Minister of Public Health created and set up a multi-sectoral panel on tobacco use. The subsequent Decision No. 0615 of 29 November 2004, as enacted by the same ministry, appointed the group members. On 27 July 2005, the National Assembly deliberated and adopted the law No. 2005/005 authorising the President of the Republic to ratify the FCTC; the ratification was accepted on 31 October 2005. Cameroon officially ratified the Framework Convention on 3 February 2006 and many uni-sectoral policies were formulated thereafter.

The Cameroon government is interested in promoting the health and well-being of the population through organisation of sport and physical activity. The concept of a national day for physical education was established in 2007, following a general assembly meeting of the United Nations, which proclaimed 2005 to be the international year of sport and physical education. The



control of physical inactivity intensified with Law No. 2011/018 of 15 July 2011 on the organisation and promotion of sport and physical activity, followed in 2012 by the creation and operation of fitness trails and Fédération Nationale du Sport Scolaire (FENASSCO) games, and finally the official inclusion of physical and sports education in secondary school curricula by order No. 002/MINSPE of 17 October 2013.

Social context and its influence on policy formulation

Findings indicate that most decisions for tobacco control in Cameroon were based on the knowledge of tobacco's adverse effects on humans as well as social considerations. Cameroon has a clear social and health context that emphasises reducing delinquency among youths, particularly in school settings. Tobacco use is perceived as delinquent behaviour. It is within this context that results from a research done produced a prompted response. Indeed a study conducted by the non-governmental organisation called Association for the fight against drug addiction and mental illness (Association de lutte contre la toxicomanie et les maladies mentales (LUTOMA)) showed that 44.42% of students in secondary schools smoked; this prompted instructions from the Prime Minister asking ministerial departments to develop policies for tobacco prevention, resulting in circular letter No. 19/07/MINESEC/SG/DRH/SDSSAPPS, which established smoke-free environments and anti-smoking clubs in secondary schools.

"The circular letter stipulated that a study was carried out and showed that in many secondary schools there is a great number of youths involved in tobacco use and alcohol consumption."
(Secondary school, Ministry of Secondary Education)

"I think the circular is clear some people wrote to the minister indicating that 44.42% of youths do smoke, so that was alarming enough to bring up the circular. It is clearly mentioned in the circular." (Ministry of Secondary Education)

According to some informants, the circular also served as a tool for strengthening existing measures in the internal regulation of schools, and as an awareness-raising tool for young people.

Furthermore, some implementation actors from regional delegations and schools did not have precise knowledge regarding the context of the policy's formulation, therefore thought this epidemiological context was the evidence that guided the circular's development.

4.2.3. Summary

This chapter discusses the political, economic, social and technological context of NCD risk factor prevention policies in Cameroon. It appears that the control of NCD risk factors, principally tobacco use and harmful use of alcohol, began in the 1960s, and even before in the colonial era in Cameroon. Despite the development of the NIMSPC-CNCD, which is the reference document for the prevention and control of NCDs, there was no plan that clearly included interventions to prevent risk of NCDs. However, there were many individual policies addressing WHO best buys interventions for the prevention of tobacco and alcohol use, and less on physical inactivity and inadequate nutrition. The formulation context of these policies varied from one risk factor to another. There were a good number of best buy policies on tobacco and alcohol control, but fewer on physical inactivity and inadequate nutrition. The development of these policies was influenced principally around the world by the WHO FCTC (2004) and the 2010 adoption of the Resolution of the UN General Assembly on the prevention and control of NCDs. Locally, health reform, economic and social contexts also influenced policy formulation. In 2001, the Cameroonian government prioritised chronic NCDs in its health agenda, which this led to the creation of two bodies in 2002 within the Ministry of Public Health: the Department of Health Promotion, which is in charge of prevention of smoking, alcoholism and unhealthy diet, and the Department of Disease Control with a sub-directorate focusing on NCDs. The department



developed national programs to reduce morbidity and mortality linked to NCDs. The economic context was marked by tobacco and alcohol industries. The national tobacco industry consists mainly of the production of raw tobacco leaves, the industrial production of cigarettes, and the importation of tobacco products. The alcohol industries consist of alcohol production by local breweries and importation with volume growth over time. This situation, correlated to the epidemiological transition, led to harmful effects on humans, with NCD risk factors increasing in prevalence. This situation motivated formulation of NCD prevention policies in general, and policies for tobacco use in particular.

In the next section, we present the content, process and actors of the different NCD preventions that address WHO best buys interventions. For a better flow and understanding of the findings, we present the analysis elements by risk factors.

4.3. Tobacco control policies in Cameroon

4.3.1. Policy content and history

As described previously, Cameroon has a long history of tobacco control policies. Below we summarise and later describe major initiatives taken and policies formulated for tobacco control, highlighting those related to best buys. Tobacco control initiatives in Cameroon are informed and influenced by a series of major initiatives by different ministries, as outlined below. These initiatives are divided into two groups: administrative procedures and tobacco control policies.

Administrative procedures

- 2004: Decision No. 0180/D/MSP/SG/DPS of 28 May 2004 for the creation and implementation of an expert committee on smoking.
- 2005: Law No. 2005/005 of the 24 July 2005, authorising the President of Cameroon, to ratify the WHO FCTC.
- 2005: Law No. 2005/440 Bis of 31 October 2005, ratifying the WHO FCTC.

Tobacco use prevention policies

The tobacco use prevention policies developed in Cameroon are presented in Table 7. They include policies to create tobacco-free spaces in public and various government institutions, bans on tobacco advertising, health warnings on tobacco packaging, and measures to raise tobacco taxes. Most of the measures are aimed at school environments. There are spurts of interest in tobacco control, possibly prompted by specific factors in global or local contexts. For instance, the first pair of measures creating tobacco-free spaces in schools were in 1998, followed by a series of measures in 2007, then one measure each in 2012, 2013, 2014 and 2015. There is also temporal clustering of measures, whereby different circulars are issued within a few months of each other by different institutions.

A review of the content of regulatory measures shows that they only contain the policy goals/objectives and measures adopted (changes or new behaviour). In a few instances, institutional arrangements for implementation are included. In most regulations, no details are given on success indicators, timelines, funding, and monitoring/evaluation plans.

Table 7: Tobacco Prevention and Control Policies in Cameroon

| Policy [Year] (reference) | Objective | Implementation actions | Institution |
|--|--|---|-------------------------------------|
| Creation of tobacco free spaces | | | |
| Decision No. 0222/P/MSP/SGF/DMSP of 08 November 1988 prohibiting smoking in all structures of the Ministry of Public Health [1988] (46) | To prohibit smoking in institutions and facilities under the Ministry of Public Health | Public places with smoking ban: the offices of central and external services of the Ministry of Public Health, Hospitals and public health facilities, public schools training health personnel | The Ministry of Health |
| Law No. 98/004 of 14 April 1998 on the orientation of education in Cameroon [1998] (45) | To guarantee the physical and moral integrity of students in the education system. | Ban on tobacco trade within or in the outskirts of schools. Prohibition of sales and consumption of tobacco and drugs. | Presidency of the Republic |
| Memo No. 1913 of 12 June 2007 of the Government Delegate of the Yaoundé City Council [2007] (47) | To prohibit smoking in the structures of the Yaoundé City Council. | No smoking in all structures of the Yaoundé City Council. | Yaoundé City Council |
| Circular No. 07/788/CF/L/ Finance Ministry / HR / SP of 15 June 2007 prohibiting smoking in all structures of the Ministry of Economy and Finances [2007] (48) | To prohibit smoking in all structures of the Ministry | No smoking in all structures of the Ministry | The ministry of Economy and Finance |
| Circular No. 012/B1/1464/MINEDUB/SG/HR/SDSS-APPS of 17 August 2007 establishing non-smoking and anti-tobacco clubs in schools [2007] (49) | To Ensure a healthy environment for students | The prohibition of tobacco use in schools and creation of anti-tobacco clubs | The Ministry of Basic Education |
| Circular No. 19/07/MINESEC / SG/HR/SDSS-APPS of 11 September 2007 on the establishment of anti-tobacco clubs in schools and making schools “non-smoking areas” [2007] (50) | To Ensure a healthy environment for students | Set a sign marked “college X / high school X or ENIET X is a smoke-free zone” at the main entrance of each facility, classrooms, offices and commercial corridors; Organize prevention activities with school staffs and students; Create within schools anti-smoking clubs | The Ministry of Secondary Education |
| Circular No. MINESUP / SG / DPDSU of 11 July 2012 on tobacco control in the central services of the Ministry of Higher Education and public universities [2007] (51) | To prohibit smoking in the central services of the ministry of higher education and public academic institutions | These institutions are declared “smoke-free” to eradicate smoking in these public places and thereby protecting non-smokers | The Ministry of Higher Education |
| Circular No. 003 /LC/ MINAS/ SG/DSN/ SDL-CES/SLCFS of 23 July 2014 prohibiting smoking in all structures of the Ministry of social affairs [2014] (52) | To prohibit smoking in all structures of the Ministry of social affairs | No smoking in all structures of the Ministry of Social Affairs | The Ministry of Social Affairs |



| | | | |
|--|--|--|--|
| Sub-Prefectoral decision No. 06/SPD/BLPA/2015 of 25 March 2015 prohibiting smoking in public places in Bamenda I Sub-Division [2015] (53) | To prohibit smoking in public places in Bamenda I Sub-Division | -Smoking is strictly prohibited in all public places in Bamenda I Sub Division. Any consumer or smoker is free to do so anywhere except where two or more non-smokers are gathered. Anybody caught in violation of the dispositions of this Decision shall be sanctioned in accordance with section 260, 261 and 28 of the Cameroon Penal code | Bamenda I Sub division |
| Ban of tobacco advertising | | | |
| Law No. 2006/018 of 29 December 2006 governing advertising in Cameroon [2015] (54) | - To ban tobacco advertising in Cameroon | Ban on advertisements for cigarettes and other tobacco products in the printmedia, through radio broadcasting, television broadcasting, poster advertisement and cinema or any other similar structure. Prohibition of any form of sponsorship or patronage; highlighting cigarettes and other tobacco products, as well as, cross-border advertising driven from Cameroonian territory | The Presidency of the Republic |
| Warning about the dangers of tobacco by marking Tobacco packages | | | |
| Order No. 967 Ministry of Public Health and Ministry of Commerce of 25 June 2007 regarding health warnings on packages of tobacco products [2007] (55) | To warn consumers on the serious risks they face when exposed and when they expose their entourage | Compulsory marking of packages, boxes, cases or other packaging materials. All packages, boxes, or other packaging materials of tobacco products provided in Cameroon on a paid basis and on a free basis shall bear information indicating the level of nicotine and tar, and the following "TOBACCO CAUSES SERIOUS HEALTH DAMAGE TO THE SMOKER AND THAT OF HIS SURROUNDING" " FOR SALE IN CEMAC "in French and English in unequivocal, visible and legible writing | The Ministry of Public Health and the Ministry of Commerce |
| Raise taxes on tobacco products | | | |
| Law No. 2014/026 of 23 December 2014 on the finance law of the Republic of Cameroon for the 2015 financial year [2014] (35) | To increase tobacco taxes | Article 142, paragraph 7: for the specific case of tobacco, the amount of excise duty resulting from the application of rates 25% referred to in paragraph 1 (b) above on it, cannot be less than 3500 CFA francs for 1000 cigarette rods | The Presidency of the Republic |



4.3.2. Policy process

The control of tobacco began in the 1960s, when smoking was recognised as a public health problem. Publication of data from local studies was a great contributor in the development of some tobacco control policies. The process of formulating these measures varies from one policy to another. The tobacco problem is stated in several strategic documents for the health sector. Evidence from local and international studies played a role in highlighting the public health impact of tobacco use, hence the inclusion of tobacco control in these documents.

In the 2000s, a WHO-supported international campaign against tobacco use resulted in the creation of the FCTC and motivated the administrative authorities of Cameroon to consider tobacco control measures. The Ministry of Public Health, through the Directorate of Health Promotion, created a multi-sectoral expert group of 15 people on tobacco by Decision No. 00615/D/MSP/DPS of 11 February 2004. The group's mission was to study tobacco use and its impact on public health as well as carry out consultative sessions. Members were selected based on their ministerial departments. In 2005, the Law No. 2005/005 of 24 July 2005, authorising the President of Cameroon to ratify the WHO FCTC was signed by parliament, and the FCTC was effectively ratified by the Law No. 2005/440 of 31 October 2005.

After signing the agreement, the Prime Minister, in order to mark Cameroon's accession to this framework agreement, convened a multi-sectoral meeting and asked each ministerial department to develop policies for the prevention and control of tobacco use.

The ministries of Basic Education, Secondary Education, Higher Education, and Finance developed internal policies for the **creation of non-smoking areas**. Key informants involved in the formulation of the circular letter No. 19/07/MINESEC/SG/HRD/SDSSAPPS establishing non-smoking areas and anti-tobacco clubs in secondary schools in Cameroon (50) said this was easily developed and successful.

"I observed that there was government commitment because we were convened by the Prime Minister to reflect on the measures to be considered by each ministerial department for the implementation of the FCTC" (Ministry of Secondary Education, 9 years' Experience)

The **marking of cigarette packaging** dates back to 1999 when joint order No. 006/MINDIC/MSP/CAB/DU of 08 June 1999 relating to health warnings on the packages of tobacco products was formulated. In this policy, it was recommended to write on all tobacco products "WARNING FROM THE MINISTRY OF PUBLIC HEALTH: TOBACCO MAY BE DANGEROUS TO YOUR HEALTH". In 2007, the joint order No. 967/Ministry of Public Health and Ministry of Commerce of 25 June 2007 the marking on tobacco product packaging was changed to "TOBACCO SERIOUSLY DAMAGES YOUR HEALTH AND THAT OF PERSONS CLOSE TO YOU".

This policy's formulation was part of tobacco expert group activities. Although the development of the national draft law on tobacco control in Cameroon was the ultimate goal, the expert group on tobacco first worked on the drafting of this joint decision between the health and trade sectors. The expert committee sought input from multiple sectors into the joint decision. A quick adoption of the joint decision acted as an impetus to the expert committee to do more and draft a more comprehensive law.

"We created the expert committee and showed its merits. We asked each ministerial department to nominate one participant. The participants were designated and we got together regularly. Firstly, we did the briefing in order to understand what tobacco is. Each department prepared a presentation in their field of expertise: trade representative spoke on the tobacco trade, the education representative spoke on tobacco and education. We did a three-day seminar covering all the topics with lots of discussions...." (Ministry of Public Health, 8 years' experience)



“What was nice is that the text was written quickly, and the authorities had understood the importance and signed without much hesitation and hindrance. This encouraged the expert committee to work harder.” (Ministry of Public Health, 10 years’ experience).

For many years, excise duties were applied at 25% on tobacco products and no less than 2100 CFA francs were taken for 1000 cigarettes. According to key informants, the increased minimum excise duty, from 2100 CFA francs to 3100 CFA francs for 1000 cigarettes, was motivated by many reasons, such as the Ministry of Public Health sensitising the Ministry of Finance on the harmful effects of tobacco products; the ratification of the FCTC, which stated that countries can use taxation to reduce tobacco consumption; and recognition that taxes on tobacco products can be used to increase the tax base in Cameroon.

The drafting of the **Finance Act 2015** (35) was facilitated through the establishment of a formal exchange platform, which led the development of this policy and allowed participation by different actors.

“At the time of the preparation of the formulation document, there was a formal discussion platform between the Ministry of Finance and certain professional groups (Groupement Inter-patronal du Cameroon, etc.) with the aim of involving the largest number of stakeholders in the decision making process. There were at least two consultation meetings during which the issue of increase of excise duty was raised. Even though the goal was not to cede its power of decision making to the private sector, this allowed the State to see whether it was worthwhile to proceed with the law.” (Ministry of Finance, 8 years’ experience)

4.3.3. Actors and multi-sectoral involvement

In this part, we will talk about the different actors involved in formulation and implementation of measures. We also analyse whether MSA was used during the whole process.

4.3.3.1. Actors in tobacco control policy formulation and implementation

We listed the major actors involved in the formulation, implementation and monitoring/evaluation of the different policies. We also characterised these actors according to their position and level of involvement. Actors’ interaction in policy process depended on whether the intervention had a multi-sectoral scope (Table 8). Actors were involved in different aspects of policies’ the development, ranging from leadership to low participation. In most cases, a government agency led the process. It is noteworthy that in spite of global regulations governing the role of the tobacco industry in policy formulation, industry was involved to a certain degree in the tax policy; for the other policies, industry was involved in the implementation stage. Most of key players in the policy formulation were actors from government departments and local agencies, suggesting a limited role for global actors like WHO. Some key sectors, such as Agriculture, Environment, Transport, were absent in the tobacco use prevention area.

4.3.3.2. Multi-sectoral involvement

MSA during formulation and implementation of tobacco prevention policies took two distinct formats: public-private and public-public collaborations. Public-private collaboration was seen during the development of the circular No. 19/07/MINESEC/SG/DRH/SDSSAPPS establishing smoke-free environments and anti-smoking clubs in secondary schools in Cameroon. LUTOMA a civil society organisation, produced the research that served as the catalyst for the policy on smoke-free environments in secondary schools. The tobacco industry was part of the formulation process during the development of the 2015 Finance Law.

In other instances, policies were formulated with only the participation of government actors. For example, industry stakeholders were not involved in the creation of smoke-free environments



nor requiring health warnings on tobacco packaging. Regarding the health warnings policy (46), no tobacco industry cooperation was unwanted during the formulation process.

In contrast to what can be observed during the formulation of tobacco control measures, few actors were involved in the implementation process: the tobacco industry primarily implemented the measures, and government took responsibility for enforcement and monitoring/evaluation. Overall, there was minimal stakeholder involvement in policy implementation. On one side, there are industries that have to follow the different regulations (taxation, health warnings), and on the other, public sectors in charge of implementation and/or follow-up and evaluation.

Table 8: Engagement of actors from multiple sectors in the formulation of tobacco control policies in Cameroon

| Policy | Categories of actors involved | Types of actors | Role in the policy process | | | Level/ extent of involvement | | | Actor positions | | |
|--|-------------------------------|---|----------------------------|----------------|----------------------|------------------------------|--------|-----|-----------------|-------|----------------|
| | | | Formulation | Implementation | Follow-up/evaluation | High/leadership role | Middle | Low | Supportive | Mixed | Non-supportive |
| Law No. 2006/018 of December 29, 2006 governing advertising in Cameroon which prohibit advertising of tobacco products | 7 | Parliament | x | | | x | x | | x | | |
| | | Presidency | x | | | | x | | x | | |
| | | Ministry of Communication | x | | x | x | | | x | | |
| | | Town Hall | | x | | | x | | x | | |
| | | Tobacco industry representatives | | x | | | x | | | x | |
| | | Advertising companies | | x | | | x | | x | | |
| | | Ministry of Justice | | x | | | x | | x | | |
| Law No. 2014/026 of 23 December 2014 on the finance law of the Republic of Cameroon for the 2015 financial year | 8 | Parliament | x | | | x | | | x | | |
| | | Presidency | x | | | | x | | x | | |
| | | Prime ministry | x | | | | x | | x | | |
| | | Ministry of Finance/General Direction of Taxation | x | x | x | x | | | x | | |
| | | Ministry of Finance/General Direction of Customs | | x | | | x | | x | | |
| | | Ministry of Commerce | x | x | | | x | | x | | |
| | | Ministry of Public Health | x | | | | | x | x | | |
| | | WHO | x | | | x | | | x | | |
| | | Groupement Inter-patronal du Cameroon | x | | | | | x | | x | |
| | | Tobacco companies | | x | | | x | | | x | |



| | | | | | | | | | | | | | | |
|---|---|----------------------------------|---|---|---|---|---|--|---|---|--|--|--|--|
| Order No. 967/ Ministry of Public Health and Ministry of Commerce of 25 June 2007 health warnings on tobacco products | 5 | Expert Group for Tobacco Control | x | | | | | | | | | | | |
| | | Ministry of Public Health | x | | x | x | | | x | | | | | |
| | | Ministry of Commerce | x | x | x | x | | | x | | | | | |
| | | General Direction of Customs | | x | | | | | x | | | | | |
| | | Tobacco industries | | x | | | x | | | x | | | | |
| Circular No. 19/07/ MINESEC/SG/HR/ SKSAPPS of 11 September 2007 on creating smoke-free zones and anti-smoking clubs | 2 | Ministry of Secondary Education | x | x | x | x | | | x | | | | | |
| | | LUTOMA | x | | | | x | | x | | | | | |

Facilitators and barriers in the use of MSA in formulation

Among the analysed policies, the involvement of several sectors was effective in all policies except for the creation of smoke-free environments, which is an internal document to the Ministry of secondary education.

The analysis of facilitators in the use of MSA in formulation was conducted only for policies on tobacco package health warnings and increased taxes on tobacco products. Respondents cited these factors as contributors to success: political will, personal motivation of the various actors in relation to awareness of the dangers of tobacco, and the existence of a formal exchange platform.

“The President of the Republic, when he signed the agreement and ratified the FCTC, it showed that there is a political will.” (Ministry of Public Health, 8 years’ experience)

“The government and the administration have set themselves the objective of improving the business climate which necessarily goes through the various exchanges and dialogues between the private and public sector.” (Directorate General of Taxation, Ministry of Finance, 8 years’ experience)

“One factor is the initial motivation. It must be said that this was the first time in Cameroon, the control of smoking took a formal character and people could sit down to talk about a serious problem.” (Ministry of Public Health, 10 years’ experience)

Conversely, they did not find any problem with the involvement of several sectors in the formulation process. The only problem noted is the one specific to individuals.

Facilitators and barriers in the use of MSA in implementation

The factors that contributed to the cooperation between the different sectors in the implementation of these measures, according to informants, are respect of hierarchical instructions and the adherence of stakeholders to the cause.

Many informants did not find barriers to the implications of several sectors/actors in implementing tobacco prevention measures. However, some informants noted that the main barriers were a lack of money and synergy between services. Indeed, these informants believe that including several sectors involves the mobilisation of more funds, which are not available. They also believe that the lack of synergy between sectors and services makes it difficult to mobilise the key players who can play an important role.



4.3.4. Implementation, monitoring and evaluation

There are many tobacco use prevention policies in Cameroon; for the most part, they are fully implemented, monitored, and evaluated within a single sector. In general, the implementation of these policies is partial, according to the policy implementers; the level of implementation differs from one policy to another and also from one region to another.

Below, we present findings on the level of implementation and the monitoring and evaluation mechanisms for each tobacco prevention policy analysed.

Law No. 2006/018 of 29 December 2006 governing advertising in Cameroon, which prohibits advertising of tobacco products

This law was passed in 2006 and its implementation followed soon after its promulgation that same year. Nevertheless, the full implementation of the regarding prohibition of tobacco advertising and sponsorship of tobacco companies in Cameroon is not well observed.

According to key informants, the implementation of the tobacco advertising is 100% effective in Cameroon. There are no advertising posters of cigarettes on the regulatory advertising area.

“Actually, we have the feeling that the advertisers and businessmen no longer advertise tobacco products.” (Regional Delegation, Ministry of Communication)

“The law banning tobacco product advertising is 100% respected. It is the role of the Ministry of Communication to control this. Maybe I should ask if you have recently seen such adverts on any local TV station.” (Regional Delegation, Ministry of Communication)

In spite of this optimism, some informants believe it is difficult to assess the impact of this policy without conducting concrete studies.

“I cannot say that there is a positive behaviour change because we do not have statistics ... So studies are to be conducted to evaluate what was done since 2006 when this law was adopted.” (Regional Delegation, Ministry of Communication)

Other key informants were not so optimistic. While the ban on advertising might be working, in their view, the overall impact on tobacco use was minimal. Some of these key informants were of the view that tobacco use, being a moral issue, was on the rise due to “declining moral standards in the general population”.

“Despite efforts by the government to control NCDs, one realises that these efforts are in vain since many young people still indulge in tobacco use and alcohol consumption.” (Regional Delegation, Ministry of Communication, 3 years’ experience)

However, findings showed that tobacco companies only partially complied with the law. Even if there were no advertising posters in regulatory advertising areas, we observed in the field that companies continue to violate this law by placing their advertising posters on non-regulatory zones, such as drinking spots and shops in all the five selected regions (Figure 9). This situation does not seem to be considered a violation by the authorities responsible for the policy’s implementation.

The most common form of backdoor advertising was through displays on daily use items, such as branded umbrella shades used in drinking spots and by roadside vendors. The second most common form was pinning posters in places that were not considered regulatory advertising areas.



Figure 9: Forms of advertising of tobacco products in five selected regions of Cameroon

Douala



Yaound'e



Garoua



Bamenda



Order No. 967/ Ministry of Public Health and Ministry of Commerce of 25 June 2007 on health warnings on tobacco products (55)

The implementation of the health warnings policy started one year after the co-joint signature of the decree by the Minister of Public Health and Minister of Trade. This one-year period was granted to allow tobacco manufacturers and importers to sell off current stock before the new packaging requirements came into effect.

"We invited the tobacco industry to the meetings ... the policy was discussed by the two presiding ministers (Health and Trade). We presented the conjoint decree to tobacco manufacturers and importers. They were then instructed to implement the policy within six months... They responded by saying six months was not sufficient to implement the policy because of the huge quantities of tobacco stock. We gave them another six months which they said was not still sufficient. We finally had to give them a final date after which control will be done to pick up any unmarked tobacco products." (Ministry of Public Health, 8 years' experience)

According to key informants, this policy is almost 100% effective in the field and unmarked products are usually contraband. The perceived level of implementation was higher than 95%, with respondents either stating the policy was 100% effective, or that between 2% and 5% of unmarked products were contraband.

“When a tobacco box is not marked [with the government-required warning], it is immediately destroyed. Today there are none. This is why I say it is a success; at least, you will not find a tobacco product that is not marked.” (Ministry of Public Health, 10 years’ experience)

“The policy is implemented. I believe that today you cannot see a pack of cigarettes which is not marked ... Even if there is, this can be about 2%-3 % coming from contraband.” (Ministry of Public Health, 8 years’ experience)

“We do carry out routine controls and all the contraband tobacco products are immediately withdrawn from the market and destroyed. All of this is done but might not be totally effective. I think there can be less than 5% of unmarked products.” (Regional Delegation, Ministry of Commerce)

“The counterfeit cigarettes without health warnings coming from Asian countries were brought fraudulently into the country. We dismantled a very large networks and we took cigarettes worth up to hundreds of millions of CFA francs and were destroyed in the outskirts of Douala.” (Regional Delegation, Ministry of Commerce, 4 years’ experience)

The findings confirmed informant interviews. Almost all tobacco products we found on the market had warning labels (Figure 10). We also found a few unmarked products in circulation that were probably contraband (Figure 11).

In spite of the absence of robust monitoring and evaluation data, the key informants believed policy implementation was successful and resulted in increased public knowledge that tobacco damages health. They believe the policy also resulted in the reduced number of smokers and fewer individuals taking up smoking.

“It must be said here that this policy has had an impact in Cameroon since 85% of tobacco users know that tobacco seriously damages health. The wording changed from ‘tobacco can seriously harm health’ to the wording ‘tobacco seriously damages health’. This was a good policy.” (Ministry of Public Health, 10 years’ experience)

“We often say a wise man is worth two and when we talk about health marking, this marking has helped many smokers to stop smoking and prevented many non-smokers to even start smoking. So it was a salutary policy for Cameroonians.” (Regional Delegation, Ministry of Commerce, 4 years’ experience)

Figure 10: Tobacco product packages with health warnings





Figure 11: Tobacco product packages with no health warnings



Circular MINESEC/SG/HR/SKSAPPS of 11 September 2007 on creating smoke-free zones and anti-smoking clubs in secondary schools

This circular letter took effect upon signature in September 2007 and was disseminated in all regions. Two key components are included in this policy: the creation of non-smoking areas and anti-tobacco clubs in secondary schools.

While the implementation of this policy is effective in most secondary schools according to the key informants at the central level of the Ministry of Secondary Education, observations on the ground do not bear this out.

“In this ministry, if you look in the hallways, you will not find a cigarette rod; you will not find staff members smoking because the text is respected. When we arrive at the level of the Regional Delegations and Schools, the policy is also implemented.” (Ministry of Secondary Education, 6 years’ experience)

“We are proud to say that nearly nine years after the policy was adopted, in schools, you will find this inscription: ‘no smoking area’. ... Generally, in school premises, everyone abstains from smoking.” (Ministry of Secondary Education, 7 years’ experience)

We conducted direct observations on the ground in 51 selected secondary schools to assess the degree of implementation of this circular. The findings showed clear gaps in the implementation of this policy in the regional capitals visited. The policy is inconsistently implemented in the secondary schools visited, and implementation also varied according to the region. The observations did not find any school with an anti-tobacco club, but did find that 84% of schools had another club in which tobacco control activities were integrated (Table 9).

“There is a health club that raises awareness about everything that can affect health in schools. Right next to the health club, as I have said, there are rules and regulations which are followed to the letter.” (Secondary school, Ministry of Secondary Education, 2 years’ experience)



“There is no anti-smoking club per se. There is the Red Cross and security club. There is also the club of friends of nature. They do intervene in the selling areas in the schools.” (Secondary school, Ministry of Secondary Education, 18 years’ experience)

Only 35% of schools visited had ‘smoking-free’ signs posted and the message’s presentation varied from one school to another (Figure 12). The percentage of schools with signs was very low in three regions (10%-13%), but in the north region, there were signs in more than 80% of schools. This policy is complementary to law No. 98/004 of 14 April 1998 on the orientation of education in Cameroon (prohibition of the sale and consumption of tobacco and drugs in school premises and their surroundings). The North region also had no schools where tobacco products were sold in their vicinity, while in Yaoundé, more than half of the schools visited had vendors in the vicinity.

According to some school officials, the policy of displaying ‘smoking-free area’ signs was not implemented because there are similar provisions included in the rules and regulations of their institutions, and therefore students and staff are informed they are in a non-smoking area. There are also sanctions for non-compliant students and staff.

“We don’t have the inscriptions... This is because the school rules and regulations are already pasted in the class rooms. You can get in and see for yourself.” (Secondary school, Ministry of Secondary Education)

Table 9: Implementation of the smoking-free area policy in secondary schools in five regions of Cameroon

| Region/Town | Number of schools visited | Number of schools with at least one ‘smoking-free space’ sign | Number of schools with an anti-tobacco club | Number of schools with a different club which integrate the control of smoking in its activities | Number of schools with cigarette vendors in their vicinity |
|--------------------|---------------------------|---|---|--|--|
| Centre/Yaoundé | 13 | 6 (46%) | 0 (0%) | 13 (100%) | 7 (54%) |
| South/Ebolowa | 9 | 1 (11%) | 0 (0%) | 1 (11%) | 3 (33%) |
| North-west/Bamenda | 8 | 1 (13%) | 0 (0%) | 8 (100%) | 0 (0%) |
| Littoral/Douala | 10 | 1 (10%) | 0 (0%) | 10 (100%) | 1 (10%) |
| North/Garoua | 11 | 9 (82%) | 0 (0%) | 11 (100%) | 0 (0%) |
| Total | 51 | 18 (35%) | 0 (0%) | 43 (84%) | 11 (22%) |

Figure 12: Implementation of the smoking-free area policy in some schools

Yaoundé



Garoua





Through this circular, according to key informants, there was a decline in rates of smoking in schools. Children no longer smoke in schools, and teachers who did stopped the practice. However, this view is not supported by robust scientific evidence. School authorities have no control over what students do outside of school. This circular is indeed implemented and respected in schools, despite the rising use of other drugs outside of school premises in some regions, such as the North region of Cameroon, where students are caught in places like abandoned houses, smoking not only cigarettes but also marijuana, cannabis and abusing drugs such as Tramol.

“For now, I think it is applied and it works. Children smoke less and even when they do, they do it in hiding. It is no longer within the institution’s environment. Those who are caught in the act, are penalized. Teachers are penalized, students are penalized. That’s the important thing.” (Ministry of Secondary Education, 9 years’ experience)

“I must say that there are many changes in the behaviour of our learners. Without pretending to say that smoking is completely eradicated in our schools, we must say that it is clearly in decline. Certainly there are still students who engage in this behaviour in secret, but it is very rare. I would say it is rare in our school to find a student who is smoking.” (Secondary school, Ministry of Secondary Education, 2 years’ experience)

“I will like to tell you that in my case it has brought about a lot of change. If you take a look at the frequency of sanctions against tobacco use in the school some 6-7 years back compared to today, then I must say that it has dropped tremendously.” (16, secondary school, Ministry of Secondary Education)

“In the north-west region, we don’t really have cases of indiscipline in our schools like cases of alcohol consumption, drug abuse and tobacco use. I will not say it is 100%, I will give the evaluation at 90%.” (Regional Delegation, Ministry of Secondary Education)

Law No. 2014/026 of 23 December 2014 on the finance law of the Republic of Cameroon for the 2015 financial year

The law on the taxation of tobacco products (35) is not new: in December 2012, the tobacco taxation Finance Act 2013 introduced tobacco products into the category of ‘luxury goods’. Excise duties were applied at 25% and no less than 2100 CFA francs per 1000 cigarettes. In 2014, the minimum excise duty was raised to no less than 3000 CFA francs per 1000 cigarettes by law No. 2014/026 of 23 December 2014 of the finance law of the Republic of Cameroon for the 2015 financial year. This is what is currently applied, and policy implementation seems to be going well.

“The implementation is actually effective; and yes business men meet their tax obligations by actually paying the additional excise duty.” (Ministry of Finance, 7 years’ experience)

In summary, it appears implementation of tobacco control policies is inconsistent across the country. On one hand, the level of implementation is high for policies on tobacco taxation and health warnings on tobacco packages, but on the other, the level of policy implementation on smoke-free zones in secondary schools is high in some region capitals, such as Garoua and Yaoundé, but very low in Douala, Ebolowa and Bamenda.



Funding for formulation and implementation

The financing mechanism for the formulation process of measures to curb smoking in Cameroon is not uniform. For example, the activities for the taxation of tobacco products are integrated into a wider process of drafting the law in the 2015 national finances. According to key informants, while this was a routine activity, funding for it was difficult (35).

“So the formulation was done in the intra-governmental expert group, with funding provided by the state of Cameroon.” (Ministry of Public Health, 8 years’ experience)

The circular on creating smoke-free environments in high schools did not require special funds for its formulation. The fact no special funds were set aside for it might be good because the actors were forced to concentrate on the main issue, which was developing the measure.

Document analysis of tobacco control policies shows the financial gaps of implementing most of the policies. This finding was reinforced by key informant interviews.

According to informants involved in both the formulation and implementation of the policies, the activities rising from the policies fall within the scope of their normal daily responsibilities, so it is difficult to find information about the budget allocated to these policies. The lack of specific funds earmarked for policy implementation was positively viewed by some key informants.

“No there isn’t. I think if it had needed money, it would fail because people were not going to see the importance... they would only see the money and sometimes when you’re engaged, you put in your own effort without relying on money and this is the best way to work-not to think about money. I did not put money first; if I did I think we would not get here.” (Ministry of Secondary Education, 9 years’ experience)

However, a funding mechanism exists for extracurricular activities in secondary schools who implemented the smoke-free school policy. This funding represents a fraction (200 CFA francs) of the school fees paid by each student. Some funding mechanisms are also implemented through the public investment budget for the NCD control and prevention strategic plan and also for the tobacco policy on health warnings.

“There is no external funding. In the fees, there are fractions that are assigned to each item. I think for the cooperative, it is perhaps 200 CFA francs per student.” (Secondary school, Ministry of Secondary Education)

“You know the school runs on a budget... there is a line for extracurricular activities and we consider clubs as one of these extracurricular activities. At the beginning of each school year, the needs of the club are provided for by the principal.” (Secondary school, Ministry of Secondary Education)

Despite the integration of activities in routine services, most implementers decried the insufficient funding for the effective implementation of policies they are responsible for.

“Inspectorates operate with credits (money for missions). And if I take the case of my inspection that must supervise the implementation of extracurricular activities in schools, the money for mission is 400,000 CFA francs for 10 persons per year.” (Regional Delegation, Ministry of Secondary Education, 2 years’ experience)

“The money we put in the budget for tobacco control was difficult to mobilise. Tobacco was not funded, but we worked with what we could. Eventually, we got funding from the public investment budget which we used only for two years.” (Ministry of Public Health, 8 years’ experience)

There is also external financial support for the government, especially from tobacco companies who perceive themselves as victims of contraband and who support regional services to curb illicit tobacco trade.

“Some structures which feel that they are victims of some unfair competition, accompany us in terms of equipment, in terms of technical support. They accompany us on the ground for cleaning up process.”(Regional Delegation, Ministry of Commerce, 5 years’ experience)

Monitoring and evaluation mechanisms put in place

Analysing tobacco control policies in Cameroon presents a fuzzy image of the mechanisms for monitoring and evaluation. However, interview findings from key informants showed that internal mechanisms, even if they are not well-coordinated, are in place to ensure the policies’ implementation. Such monitoring and evaluation activities consist of field trips to markets, schools, towns, and a ‘listening service’ in regional delegations of communication regarding the presence/absence of tobacco advertising in the media. This listening service is charged with monitoring audio and TV media programmes to ensure they conform to regulations in force.

“At the level of the delegation of communication, we have a listening service.” (Regional Delegation, Ministry of Communication, 3 years’ experience)

Interviews with key informants from different levels of the Ministry of Secondary Education showed that monitoring/evaluation mechanisms are established at all levels: central (secondary teaching ministries, Directorate for Health and Sport); intermediate (regional delegation of secondary education, guidance service and school life); and at the peripheral level (schools, governing board).

There are no formalised monitoring and evaluation frameworks with clear indicators, but some informants mentioned the number of students caught smoking as an indicator of the effectiveness of policies.

“We have not had cases of smoking in the school campus, which proves that our school is smoke-free. Our worry is that they should not engage in smoking out of the school premises.” (Secondary school, Ministry of Secondary Education)

Monitoring of policy implementation is taking place but it is ad hoc, not systematic. There are also no robust evaluation mechanisms to assess how successful the policy implementation was.

4.3.5. Facilitators and barriers to tobacco control policy formulation and implementation

A number of factors favoured or slowed the formulation and implementation processes of tobacco control policies in Cameroon.

Facilitators and barriers to policy formulation

The factors that facilitated the tobacco formulation process are common across most policies. The most-cited ones by respondents are: the political will to control the harmful effects of smoking in Cameroon and the commitment of first-line actors. In the cases of policies on marking tobacco products and taxation, establishing an exchange platform was a critical facilitating factor.

“At the time of the preparation of the formulation document, there was a formal discussion platform between the Ministry of Finance and certain professional groups (Groupement Inter-patronal du Cameroon, etc.). There were at least two consultation meetings during which the issue of increase of excise duty was raised with the aim of involving the largest number of stakeholders in the decision making process.” (Ministry of Finance, 8 years’ experience)

“What was nice is that the text was written quickly, and the authorities had understood the importance and signed without much hesitation and hindrance. This encouraged the expert committee to work harder.” (Ministry of Public Health, 10 years’ experience).



Furthermore, a specific factor in the taxation policy was the need to mobilise additional revenue to meet the increasing costs laid on the government to solve the public health problems caused by the trade of these products.

Most respondents did report any barriers in the tobacco control policy formulation process.

Facilitators and barriers to policy implementation

Perceived facilitators to successful implementation of the tobacco control policies can be categorised in two major groups: facilitators common across the different policies and facilitators specific to each policy.

The common facilitators of the implementation of tobacco control policies examined are:

1. Respect for hierarchy

Strong political will from the government to score a point in tobacco control resulted in clear policy pronouncements. The implementing actors received instructions from their superiors and they could only comply by implementing these policies. The respect for hierarchy was expressed as both obedience and discipline.

"It is simply obedience to the administration." (Customs service)

"The first factor is discipline" (Secondary school, Ministry of Secondary Education)

2. Commitment of key players for a common cause

Most actions are motivated by the necessity to protect populations and improve health. The officials responsible for implementation feel duty-bound to adhere to policies that protect their charges.

"I think the main factor is the danger faced by our students by engaging in tobacco consumption. We care about the health of our students and the health of youths in general." (Secondary school, Ministry of Secondary Education)

"Contributing factors is first of all the adhesion of key actors." (Regional delegation, Ministry of Communication)

"It is the engagement of managers and leaders in the region." (Regional delegation, Ministry of Commerce)

The second factor that facilitated implementation was the main actors' adherence to tobacco prevention, which is indispensable because it gives the actors additional motivation.

The facilitating factors specific to each policy are:

1. Creation of tobacco-free zones in schools

According to the respondents, the principal facilitating factors were awareness of the danger of tobacco and its prohibition in schools. Other factors mentioned, although less recurring were the control setting of the schools and the presence of staff to enforce school regulations. Indeed, key informants felt that the fact that schools were fenced off enabled better supervision of students. Also, the staff presence in team management, monitoring and enforcing school rules and regulations, ensured that tobacco control measures were enforced as part of the general school management procedures.



2. Warnings on tobacco product packages

Two important facilitating factors for the implementation of the policy about warnings on tobacco product packages were Cameroon's ratification of the FCTC and the protection of consumers as a duty.

The perceived barriers to successful implementation of tobacco control policies can also be classified into two: those common to all the policies examined and those specific to individual policies.

The most frequently mentioned barrier to policy implementation, which was common to all policies, was a lack of financial and human resources to carry out all the needed activities, including monitoring and evaluation.

The barriers specific to each policy are as follows:

1. Creation of tobacco-free zones

Some informants reported that young people tend to copy what they see on TV, in movies and on social media. As a result, tobacco control messages and interventions are counteracted in the media.

"There is also of course the influence of media, television and others. You see the unfortunate impact that the media has on our youth. Because especially in the media, it is common to see young people who smoke, youths who engage in alcohol consumption and drug abuse. This has a considerable impact on our learners." (Secondary school, Ministry of Secondary Education)

"We are in a society where young people do not respect the rule, as you know. They enjoy to behave like stars." (Secondary school, Ministry of Secondary Education)

Another barrier is the fact that some young people are already addicted and dependent on tobacco products and other drugs, which makes it difficult for them to break the habits despite whatever rules are in place.


"When a youth is already developing a substance addiction, it becomes practically difficult to abandon this habit. We often say habits die hard." (Secondary school, Ministry of Secondary Education)

Some key informants believe that parents play a big role in the education of their children. At this level, parental irresponsibility results in young people engaging in delinquent activities such as drug abuse and narcotic consumption. Lack of parental guidance also limits the effectiveness of measures instituted by schools, especially when students are off school premises.

"We also find among the difficulties the laxity of parents. Parents are the first educators and we often feel that parents do not fully play their role. Sometimes, it is really worrisome to see these things happening because parents have resigned from their role." (Secondary school, Ministry of Secondary Education)

2. Warnings on tobacco product packages

The principal barrier to effective implementation of the health warnings policy is illicit trade or contraband. Despite the various supervisory actions, it is nevertheless observed that contraband products remain widely available at the borders and environs. Some informants stated that the presence of unmarked cigarettes in the market was entirely due to contraband and were confident that all tobacco products entering Cameroon through legal channels comply with all the warning label requirements. Lack of resources for effective enforcement of importation laws is the underlying factor for contraband.



“...lack of means of transport, lack of staff ... You are two customs officers stationed at a place and smugglers are 15 and armed. They are armed and ready to kill.” (Customs service)

“The scourge that slows the full implementation of this text is contraband. Counterfeiting and contraband.” (Customs service)

4.3.6. Summary

Many policies have been developed for the control of smoking in Cameroon. Among these policies, 12 addressed WHO best buy interventions in terms of smoking prevention, namely: tax increases on tobacco products, the creation of non-smoking spaces, smoking in workplaces and public places, the ban on tobacco advertising, promotion and sponsorship, and health marking. The formulation of most of these policies was boosted at the international level by FCTC ratification and at the local level by the epidemiological data on tobacco use and the reorganisation of the Ministry of Public Health. Despite this context, the response was not comprehensive; even after the Prime Minister gave instruction on tobacco control measures, only a few ministries formulated mostly uni-sectoral policies for the prevention of tobacco use in their ministerial departments. These formulation processes differed from one policy to another. The policies on smoke-free areas were ministerial circulars; those for tobacco taxes and health warnings were more complex, involving at least two sectors and MSA through a formal exchange platform. The main actors were the ministries of Health, Education, Finance, Communication and Social Affairs. The formulation processes differed from one measure to another, but FCTC ratification was an accelerator common to the government awareness and therefore to the policies' formulation. The level of implementation varied considerably from one policy to another, sometimes from one region to another for the same policy. Political will, personal motivation and the existence of formal exchange platforms and buy-in were the main facilitators of formulation, implementation and use of MSA; while the lack of financial resources and synergy were the main barriers.

4.4. Alcohol-control policies in Cameroon

We also identified measures to prevent the harmful use of alcohol and will address the history of these measures, their contents, and the formulation and implementation processes, actors involved, and the facilitators and obstacles to the measures' development.

4.4.1. Policy content and history

Alcohol control – not unlike tobacco control – has a long history in Cameroon. The policy environment evolved over time with the emergence of evidence, global commitments, and economic factors, among others. Cameroon has several policies to control alcohol use. These policies are aligned to a certain degree to the NCD prevention best buys and are geared towards restricting access, increasing taxes, and restricting alcohol advertising, not banning it. A detailed description of the policies' integrated best buys is provided in Table 10. Policies seem to be made sporadically at an average of eight years' interval. Several updates were made in the policies on taxation, possibly to align the tax amounts to more current fiscal realities. These policies concerned the following ministries Education, Finance, Communication, Trade and Territorial administration.

Table 10: Harmful use of alcohol prevention and control policies in Cameroon

| Policy [Year] (reference) | Objective | Implementation actions | Institution |
|--|--|---|----------------------------|
| Restricted access to retailed alcohol | | | |
| Decree No. 90/1483 of 9 November 1990 for setting the conditions and operating procedures for drinking spots/bars [1990] (44) | To set the conditions and operating procedures for drinking spots/bars | Drinking spots to obtain a license issued by the competent authority after payment of the contributions relating thereto. Opening and closing hours of drinking spots to be as follows: Takeaway sales: 6:00 a.m. to 9:00 p.m.; Sales for consuming on site: 6:00 a.m. to midnight No drinking establishment/bar can be opened or moved to less than 200 meters away (as the crow flies) from a hospice, hospital, clinic, educational facility, or a place of worship. Penalties to be applied to any person operating a bar without authorisation, or operating an unlicensed bar or in a higher class than that granted him by the competent authority, shall be liable to fines and penalties contained in Articles 195 and following the General Tax Code | Presidency of the Republic |
| Law No. 68/004 of 4 April 1998 on the orientation of education in Cameroon [1998] (45) | To guarantee the physical and moral integrity of the pupils in the education system | Prohibition of sales, distribution and consumption of alcoholic beverages; ban on opening drinking spots, within or in the outskirts of schools | Parliament |
| Bans on alcohol advertising | | | |
| Law No.2006/018 of December 29, 2006 governing advertising in Cameroon [2006] (54) | To provide a framework for organising promotional activities; define the rules on the form and content of advertisements; to provide a general framework for the control and regulation of alcohol advertising | Advertisements for alcohol and alcoholic beverages are subject to restrictions on the conditions determined by regulation | Parliament |
| Tax increases on alcohol | | | |
| Law No. 2014/026 of 23 December 2014 on the finance law of the Republic of Cameroon for the 2015 financial year [2014] (35) | To increase taxes on alcohol and alcoholic beverages | To establish a minimum amount on alcohol drinks excise duties. In the specific case of alcoholic beverages, the excise duty amount resulting from the application of the 25% rate shall not be less than: <ul style="list-style-type: none"> ● 250 CFA francs per litre for beer; ● 150 CFA francs per alcohol level and per litre for wines, liquors and spirits with an alcohol content of between 0% to 24%; ● 200 CFA francs per alcohol level and per litre for wines, liquors and spirits with an alcohol content of between 25% to 50% ● 250 CFA francs per alcohol level and per litre for wines, liquors and spirits with an alcohol content above 50% | Parliament |



| | | | |
|--|--|---|---|
| <p>Joint Order No. 0000000 17 / MINFI / MINCOMMERCE OF 12 February 2015 setting out the implementation arrangements for excise duty of alcoholic drinks [2015] (56)</p> | <p>To determine the amounts of additional excise duty on alcoholic beverages under the reform of the specific excise duty contained in the Finance Act of the Republic of Cameroon 2015 in its devices on the general tax code</p> | <p>The amount of additional excise duty resulting from the application of the specific tax system is:</p> <ul style="list-style-type: none"> ● 75 CFA francs for beers of 65 cl and 37,5 CFA francs for beers of 33 cl ● 75 CFA francs for spirits of 50 cl ● 300 CFA francs for wines produced locally and lower range ● 2000 CFA francs for premium wines ● 500 CFA francs for the whisky of 75 cl produced locally ● 3000 CFA francs for premium whisky ● 100 CFA francs for whisky sold in sachets of 10 cl ● 2000 CFA francs for champagne 75 cl lower range ● 4000 CFA francs for premium champagnes | <p>Ministry of Finances, Ministry of Commerce</p> |
| <p>Ordinance No. 2015/002 of June 2, 2015 setting out the implementation arrangements for excise duty of alcoholic drinks [2015] (57)</p> | <p>To confirm the amounts of additional excise duty to apply to alcoholic beverages</p> | <p>This ordinance confirmed decisions taken in the joint order above</p> | <p>Presidency of the Republic</p> |

4.4.2. Policy development of the Finance Act 2015

Some of the policies presented in Table 10 were not fully examined as part of this study because of age: it would be difficult to find information on processes undertaken more than 20 years ago. The following description is therefore focused only on the law No. 2014/026 of 23 December 2014, which sought to increase taxes on alcoholic drinks in 2015.

4.4.2.1. Policy process

It is important to note that there is two types of excise duties: the specific and the Ad valorem taxes. The specific taxes involve a fixed monetary value per quantity of cigarettes. The Ad valorem taxes involve a percentage mark-up of the wholesale or import price (58). According to respondents, the 2015 finance law imposing tax increase on alcoholic beverages is not new. For several years, the tax code for the Central African Economic and Monetary Community (CEMAC) region classified alcoholic drinks as luxury products, so they are taxed at the 25% excise duty rate. The new law, imposes a perceptible minimum excise duty based on the percentage of alcohol and the quality of drinks, in addition to the Ad valorem tax.

“Concerning drinks, the Ad valorem system of excise duties already existed at 25%. In 2015, the law established a minimum perception of excise duties on drinks.” (Directorate General of Taxation, Ministry of Finance, 8 years’ experience)

The formulation of this policy followed two steps: problem definition and agenda-setting, and the actual policy formulation.

It is important to remember that the excise duty is a tax, and any tax aims to mobilise revenue to finance public offices. In addition to revenue mobilisation, the excise duties help to influence the demand and thus the consumption of tobacco products effectively.



“The excise duties have in addition to revenue mobilization, the aim to combat some scourges, especially to control the externalities associated with the consumption of certain products, in this case tobacco and alcohol.” (Directorate General of Taxation, Ministry of Finance, 7 years’ experience)

Key informants reported that the proposal to change the application system of excise duty on alcoholic beverages was on the table for a while, but the two main alcoholic beverage production industries, Guinness Cameroon and Les Brasseries du Cameroon, did not agree on which system to use. Guinness Cameroon funded missions to other countries to better understand these systems, and the challenges of changing the Ad valorem system to the specific tax system.

“Les Brasseries du Cameroon and Guinness did not agree on the right type of tax system to be adopted (Guinness was for the specific and Les Brasseries du Cameroon for Ad valorem). But in terms of the effects on public health, they all agreed. To manage this conflict, there have been study visits funded by Guinness in several African countries (Ghana and others) to see how this is done elsewhere. When the Finance Bill was enacted, Guinness was still in opposition, arguing that the fact that they also sell spirits will unfairly penalize them.” (Directorate General of Taxation, Ministry of Finance, 8 years’ experience)

In 2014, as part of measures to increase the tax base, the department in charge of legislation in the Directorate General of Taxes decided to change the tax system by moving from Ad valorem system to the specific tax system on alcoholic beverages.


Similar to what happened for tobacco control policies, key actors in the tax department were aware of the health impacts due to the harmful use of alcohol. Taking into account the high consumption of beer in Cameroon, which amounted to more than 620 million litres annually, action was needed. As in the case of the tobacco tax increase, a formal exchange platform exists at the Ministry of Finance and is consulted and/or informed during the development or reform of a policy. This platform was used during the development of the 2015 finance law (39) in 2014.

“At the time of the preparation of the formulation document, there was a formal discussion platform between the Ministry of Finance and certain professional groups. There were at least two consultation meetings during which the issue of increase of excise duty was raised with the aim of involving the largest number of stakeholders in the decision making process. Even though the goal was not for the government to cede its decision making power to the private sector, this allowed the State to see whether it was worthwhile to proceed with the law.” (Ministry of Finance, 8 years’ experience).

Once issued, this policy followed the usual path of finance law development. It was first prepared at the level of the directorate of Taxes at the Ministry of Finance, then conveyed and discussed at the level of the Prime Ministry, and later at the Presidency of the Republic. After the approval of the Presidency of the Republic, it was sent to the National Assembly to be legislated and finally promulgated by the President of the Republic.

“From the public point of view, this policy has followed the entire route of the finance laws (General Direction of Taxes, Prime Ministry, Presidency, National Assembly...).” (Ministry of Finance, 8 years’ experience)

At the end the formulation process, the 2015 Finance law was promulgated on 23 December 2014 with three main objectives: (a) to make the tax mechanism of excise duty more efficient, taking into account the alcohol content and volume of alcoholic beverages; (b) to reduce fraud generally observed in the Ad valorem taxation system (because with the latter, traders reduced the value of the product to reduce the tax [the dumping system]); and (c) to mobilise additional revenue to meet the increasing costs borne by the government to solve the public health problems caused by the consumption of alcohol products.



Furthermore, the funding of development of this policy was integrated into a wider process of drafting the 2015 finance law.

4.4.2.2. Actors and multi-sectoral involvement

4.4.2.2.1. Actors in alcohol control policy formulation and implementation

Similar actors were involved in revising the 2015 Finance Law (39) as those in the tobacco product taxation law. The only difference was in the type of industries associated with the platform, although all are represented by the Groupement Inter-patronal du Cameroun (GICAM). The actors involved in both the formulation and implementation of the 2015 Finance law are listed in Table 11. As stated for policies preventing tobacco use, different actors, mostly from the government, were involved in various aspects of the policy development, with different levels of participation and position. The Ministry of Finance led the process for this particular policy, followed by other government structures and legislation agencies. Industry was also involved in the policy formulation process, even if they don't support the end result. It is important to note that the formulation of the whole Finance Act, in its entirety, is a government project with high directives from the President of the Republic, who sets the direction; the Prime Minister ensures the follow-up and the various sectoral ministries bring their participation to the process.

4.4.2.2.2. Multi-sectoral involvement

MSA in the formulation and implementation process of increasing alcohol taxes was a public-private collaboration, as was the policy for increasing tobacco taxes. At the Ministry of Finance, where this particular policy was formulated, there was a formal exchange platform, of which these industrial associations are part. Within the Ministry of Finance is a formal platform Ministry of Finances/Industries committee, where different concerns of the private sector in order to find appropriate solutions discussed.

“At the time of the preparation of the formulation document, there was a formal discussion platform between the Ministry of Finance and certain professional groups (Groupement Inter-patronal du Cameroun, etc.). There were at least two consultation meetings during which the issue of increase of excise duty was raised with the aim of involving the largest number of stakeholders in the decision making process.” (Ministry of Finance, 8 years' experience)

There is also the Cameroon Business Forum Committee at the Prime Ministry, chaired by the Prime Minister himself. This committee provides clarification on the difficulties raised by the private sector. There is a follow-up committee for the implementation of tax recommendations that also involves the private sector (GICAM and Industries du Cameroun). These committees aim to improve the business climate, which involves different exchanges and dialogues between the private and public sectors.



Table 11: Engagement of actors from multiple sectors in the formulation and implementation of the Finance Act 2015

| Types of actors | Role in the policy process | | | Level/extent of involvement | | | Actor positions | | |
|--|----------------------------|----------------|-----------------------|-----------------------------|--------|-----|-----------------|-------|----------------|
| | Formulation | Implementation | Follow-up/ evaluation | High/leadership role | Middle | Low | Supportive | Mixed | Non-supportive |
| Parliament | x | | | x | | | x | | |
| Presidency | x | | | | x | | x | | |
| Prime Ministry | x | | | | x | | x | | |
| Ministry of Finance/General Direction of Taxation | x | x | x | x | | | x | | |
| Ministry of Commerce | x | x | x | | x | | x | | |
| Ministry of Public Health | x | | | | | x | x | | |
| WHO | x | | | x | | | x | | |
| GICAM (Groupement Inter-patronal du Cameroon) | x | | | | | x | | x | |
| IndustriCam (Industries du Cameroon) | x | | | | | x | | x | |

4.4.2.2.3. Facilitators and barriers in the use of MSA in formulation

Informants said the existence of a consultation platform and the will to improve the business climate were factors favouring the joint effort of different actors. No barrier to the use of MSA was mentioned for this policy.

4.4.2.3. Facilitators and barriers to alcohol control policy formulation and implementation

A number of factors favoured or slowed the formulation of the Finance Act 2015.

Facilitators and barriers to policy formulation

Participant interviews on the policy on the taxation of alcoholic drinks (39), reported several facilitators:

- The existence and legality of the specific mechanism chosen as indicated in the general code of CEMAC taxes: the fact that the specific taxation process was already an option enabled by the code of CEMAC tax allowed the passage of the excise duty collection system. Integrating the Ad valorem system into the specific tax system was easy.
- The political will to mobilise additional revenues for the resolution of public health problems caused by the trade of these products.



Barriers

The barrier identified in the formulation of this policy are human-related and was the lack of consensus.

“Yes there have been challenges. There has been lively debate, but this is the purpose of the exercise, hearing several opinions and reaching a consensus ... Les Brasseries du Cameroon and Guinness did not agree on the right type of taxation (Guinness was for the specific tax and Les Brasseries du Cameroon was for Ad valorem), while in terms of externalities and effects on public health, they are the same level.” (Directorate General of Taxation, Ministry of Finance, 8 years’ experience).

4.4.3. Implementation and monitoring/evaluation

There are many policies in Cameroon for the prevention of harmful alcohol use. We focused on the two policies that aligned the WHO best buys for alcohol prevention: restricting access to alcohol and the increasing taxes on alcohol products. Regarding the third policy, there is no legally binding regulation on alcohol advertising, (54) only a restriction. Also, there is no legally binding regulation on alcohol sponsorship/sales promotion; no legally required health warning labels on alcohol advertisements/containers; and no national monitoring system (59).

Law No. 2014/026 of 23 December 2014 on the finance law of the Republic of Cameroon for the 2015 financial year

Following the enactment of the Finance Act in December 2014, and despite the consultations that took place beforehand between industries/importers and the government, there was dissatisfaction among manufacturers, sellers and consumers of alcoholic beverages. An immediate increase in prices of alcoholic beverages was observed, even before the law was fully implemented. To regulate this, the Ministry of Commerce, through negotiations with the various associations, formulated the Inter-ministerial Order No. 00000017/MINFI/MINCOMMERCE of 12 February 2015 setting the guidelines for implementation of the excise duties on alcoholic drinks.

“When the law was enacted the discussions were more on the alcohol than on tobacco control. There were discussions with the Minister of Trade who served as the mediator between the Ministry of finance and all associations around the beverage industry. After these consultations, an agreement was reached. Also a decree of the President of the Republic signed and published this Friday confirmed decisions taken on this agreement. This law is yet to be implemented. There was a time when the price of these drinks increased but the State intervened to stop it.” (Directorate General of Taxation, Ministry of Finance, 8 years’ experience).

In June 2015, an order from the Presidency of the Republic validated the arrangements of the Inter-ministerial Order No. 00000017/MINFI/MINCOMMERCE of 12 February 2015, and key informants mentioned that these arrangements should therefore be passed in Parliament according to the legislation in the following months, and the implementation of this policy will be effective.

Law No. 68/004 of 4 April 1998 on the orientation of education

The law No. 68/004 of 4 April 1998 is based on the orientation of education in Cameroon prohibiting sales, distribution and consumption of alcoholic beverages and banning opening drinking spots in or near schools. This policy reinforces decree No. 90/1483 of 9 November 1990, laying down the conditions and operating procedures of licensed premises (44), in which it is stipulated that no drinking establishment/bar can be opened or moved to less than 200 meters away as the crow flies from a hospice, hospital, clinic, educational facility, or a place of worship. Many newspapers noted the failure of local authorities to comply with these regulations: the



distance between two pubs sometimes hangs on a wall; proximity to pubs with schools, places of worship, hospitals has become an obvious reality (59-64).

As we did for the policy making secondary schools 'non-smoking areas', we conducted direct observations in 51 selected secondary schools to assess the degree of the law No. 68/004 of 4 April 1998 on the orientation of education. The percentage of schools with drinking spots in general was 30% (Table 12). As we observed for the tobacco policy, the findings showed that the policy was inconsistently implemented in the secondary schools visited and implementation also varied according to the region. In Garoua and Bamenda, no drinking spots were found around visited schools, but we observed the presence of drinking spots around 84% of visited schools in Yaoundé and in 30% of visited schools in Douala (Figure 13).

Table 12: Implementation of the policy prohibiting sales, distribution and consumption of alcoholic beverages and banning opening of drinking spots, within or in the outskirts of school

| Region/Town | Number of schools visited | Number of schools with at least one drinking spot in or near schools |
|--------------------|---------------------------|--|
| Centre/Yaoundé | 13 | 11 (84.6 %) |
| South/Ebolowa | 9 | 1 (11.1 %) |
| North-west/Bamenda | 8 | 0 (0 %) |
| Littoral/Douala | 10 | 3 (30 %) |
| North/Garoua | 11 | 0 (0 %) |
| Total | 51 | 15 (29.4 %) |

Figure 13: Drinking spots found around some schools visited in Yaoundé and Douala

Yaoundé



Douala





4.4.4. Summary

We found three harmful use of alcohol prevention policies addressing best buys interventions for alcohol at a certain level: two policies addressing tax increase in alcoholic products and restricted access to retail alcohol; the third one addressed only the restriction of alcohol advertising and not the ban. These policies concerned essentially the Education, Finance, Communication, Trade and Territorial administration sectors. Concerning the process and actors of formulation of alcohol policies, we focused only on the policy increasing tax on alcohol products. The formulation of this policy boosted the awareness of key actors on the health effects due to alcohol abuse. In order to increase tax on alcohol products, they decided to move from the Ad valorem system to the specific tax system on alcoholic beverages. MSA was used through a formal exchange platform including government (Ministry of Finance) and industry organisations (GICAM and Industringam). This platform was a facilitator to MSA, even if the lack of consensus was a barrier. On the whole process of formulation and implementation, informants mentioned the political will and the existence of CEMAC regulations as facilitators, and similar to MSA, a lack of consensus as barrier. Due to this lack of adhesion after the enactment of the Finance Act, implementation was not effective at the time of this study, but new guidelines on the excise duties on alcoholic drinks were taken. Apart from the Finance Act, we also analysed implementation of the policy prohibiting sales, distribution and consumption of alcoholic beverages and banning opening drinking spots. Based on schools visited, the level of implementation of this policy was low (30%) and as we observed for the tobacco policy, the policy was also inconsistently implemented across regions. About the third best buy intervention, ban of alcohol products advertising, there is only a restriction on alcohol advertising in Cameroon; there are no regulations on sponsorship, sales promotion, health warning labels on alcohol advertisements/containers, nor is there a national monitoring system.

4.5. Other NCD prevention policies in Cameroon

As stated in the earlier sections of this report, the focus of the study was on policies in Cameroon for tobacco and alcohol control. A brief overview is given for policies aimed at promoting physical activity and healthy diets, without details on process, actors and the role of MSA in policy formulation and implementation, nor on actual implementation status. The findings are only derived from a review of policy documents.

4.5.1. Policies for the prevention of physical inactivity in Cameroon

4.5.1.1. Policy content and history

The government of Cameroon is interested in promoting the health and well-being of the population through organisation of sport and physical activity. A number of policies were developed starting in 1991. Policies were made to coincide with global events and policy agendas, but also in response to new evidence on the value of physical activity in promoting health and well-being. Most policies seem to be focused on promoting exercise – or leisure-related physical activity and are geared towards physical activity in defined settings or during organised events.

- 1991: Decree No. 91/255 of 30 May 1991 the organisation of the National Institute of Youth and Sports
- 1996: Law No. 96/09 of 5 August 1996 fixing the Charter of Physical and Sports Activities
- 1999: Accreditation of the Cameroonian Federation of Sport for All by the Ministry of Youth and Sports



- 2005: The creation of a sports service for all at the Ministry of sports and physical education by Decree 2005/098 of 6 April 2005 on the organisation of the department;
- 2007: Establishment of the concept of a national day for physical education following a United Nations General Assembly, which proclaimed 2005 to be an international year of sport and physical education
- 2011: Law No. 2011/018 of 15 July 2011 on the organisation and promotion of physical and sporting activities
- 2012: Order No. 14/CAB/PM of 14 September 2012 on the organisation and functioning of fitness trails and FENASSCO games
- 2012: Order No. 14/CAB/PM of 24 September 2012 on organisation and functioning of Parcours Vita
- 2012: Decree No. 2012/0881/PM of 27 March 2012 setting the terms of exercising certain competences transferred by the state to municipalities in sport and physical education
- 2013: Order No. 002/MINSPE of 17 October 2013 on the official programming of teaching physical education in continuous training
- 2013: Instruction No. 028 Ministry of Sport and Physical Education of 17 October 2013, aimed at making a child physically, mentally and morally healthy, well-educated, and fully enjoying his rights in respect of the social, cultural and spiritual values of his community and living in a healthy, fair and secure environment

A number of policies were taken in Cameroon for promoting physical activity. In referring to the WHO best buy recommendations on the promotion of physical activity through mass media, the only policy found is the **decree No. 2012/0881/PM of 27 March 2012 setting the terms of exercising certain competences transferred by the state to municipalities in sport and physical education**. This decree sets out the modalities according to which, as of 2012, the municipalities shall exercise the following powers transferred by the state in the field of sport and physical education:

- Support for sports associations;
- The promotion and animation of sports activities;
- The creation and management of sports facilities of municipal interest;
- Census and participation in the equipment of sports associations; and
- Participation in the organisation of competitions.

Under the promotion and animation of sports activities, media coverage of physical activities is recommended. Unfortunately, this provision was not yet implemented because the powers conferred by decentralisation were not yet transferred to the municipalities.

Furthermore, most of the physical activities and sports are covered sporadically without a real communication plan through mass media.

4.5.2. Policies for promotion of healthy diets in Cameroon

4.5.2.1. Policy content and history

The document review shows there are few policies in this area. Cameroon, like many SSA countries, has policies to resolve the undernutrition issue.



In 2006, the Government of Cameroon – aware that the problems of malnutrition and the quality of food staples are of great concern – developed a Food and Nutrition Policy (66) that defines main strategies for improved food and nutrition. This policy was implemented by the 2007-2011 National Programme for Food and Nutrition (67).

This document was developed through a participatory approach, involving sectors that manage Cameroon's nutritional problems (administrations, research institutes, development partners). It is divided into four parts: (1) the presentation of Cameroon; (2) the grounds for the development of this management tool and nutrition problems in Cameroon; (3) the nine priority areas of: promoting breastfeeding, malnutrition, micronutrient deficiencies; **prevention and management of nutrition-related NCDs**; nutritional support to economically disadvantaged social groups; supported nutrition for people living with HIV/AIDS; promotion of food safety regulators; food safety; and training and recruitment of nutrition professionals. Section 3 also contains the main activities to be conducted, selected strategies to achieve the objectives defined by indicators, and provides an assessment of the intervention costs required to improve the nutritional and health status of risk groups. The fourth section (4) defines the institutional framework that sets out the supervisory structures and coordination, the main tasks and the organisational structure of program. The implementation will be done at district, regional and central levels. A timetable of activities and an evaluation plan was developed to follow the overall implementation of the programme. Below we provide more details on the third section related to prevention and management of nutrition-related NCDs (67).

Main objective:

Reduce the incidence of NCDs related to nutrition in Cameroon.

Specific objectives:

1. Prevent NCDs related to nutrition;
2. Ensure nutritional support for people affected by NCDs in 60% of health facilities; and
3. Establish an NCD surveillance system related nutrition.

Strategies:

1. Screen for NCDs related to nutrition in training institutions, health facilities and communities;
2. Communication for behaviour change regarding NCD risk factors in the community and schools;
3. Advocate resource allocation for operational research on nutrition-related NCDs;
4. Continuing education of different stakeholders in NCD management; and
5. Surveillance of nutrition-related NCDs.

There is no clear strategy addressing best buy interventions. The outlined programme is also ambitious, as shown by the key specific objectives. The source of all the funding necessary for execution of the policy is not indicated in the programme document.

Other than government, some non-state actors have made efforts to formulate and implement strategies for the promotion of healthy diets in the country. For instance:

1. On 7-8 January 2010, the Cameroon Academy of Sciences (CAS) invited stakeholders involved in nutrition issues in Yaoundé to analyse the situation and suggest measures to prevent and mitigate the effects of nutrition on health in the country. The participants provided insight into how to improve policies, adjust research goals, and provide funding for infrastructure and programmes to fully tackle malnutrition (68).
2. The Cameroon Heart Foundation conducted public mass media awareness campaigns about unhealthy diets during national heart week, which falls in September. During this week, there is an intense media campaign on national television, radio and in newspapers, in partnership with the Society Eneo Cameroon (Energy of Cameroon), the national electricity company. In addition, a free screening initiative is held in various public hospitals. Other activities included training symposia on preventive cardiology for doctors and nurses, conferences and educational talks for the public.
3. In 2012, in Central and West Africa, an agro-foods company lowered salt content in all its food products by 2.69%. In 2013, the same company committed to reducing salt in all its brands to support the WHO's goal of a maximum daily allowance of sodium of 5g by 2025 (69). In 2016, this company, the Ministry of Public Health, and the Urban Municipality of Yaoundé, displayed posters to raise public awareness as part of a campaign to reduce salt intake by (Figure 15).

Figure 14: Poster on public awareness on the reduction of salt intake in Yaoundé



4.5.3. Summary

This chapter discussed the prevention of physical inactivity and unhealthy diet in Cameroon in relation to best buy interventions in this area: reduced salt intake in food, replacement of trans fat with polyunsaturated fat, and public awareness through mass media on diet and physical activity. It emerges from this analysis that there were no clear policies in relation to the best buys. Nevertheless, sensitisation of the population is carried out punctually during events related to these risk factors or the diseases they cause. For example, in Yaoundé, the capital of Cameroon, posters were produced to raise awareness about the reduction of salt intake. It is important to point out that the government is interested in promoting the health and well-being of the population through the organisation of sport and physical activity, and several policies were formulated for this purpose: creation of sport and physical activity institutions as well as spaces for community physical activity practices; introduction of physical education in secondary schools and organisation of games in primary and secondary schools and universities; and finally, transferring sport and physical activity from the state to municipalities, where media coverage is also recommended.

5.0



5.0 | Discussions



Discussions



This study looked at the formulation and implementation of NCD prevention policies in Cameroon, specifically those related to the WHO best buys. Guided by the Walt and Gilson framework, we examined the national and global context in which NCD policies were made; the actors involved; the process; and the extent of MSA during the formulation and implementation processes of these policies. The previous chapters presented the findings that emerged from this study; in this part, we will discuss the findings in three parts:

- i) The gaps in the development of NCD prevention policies in Cameroon;
- ii) The gaps in the use of MSA in formulation and implementation on the existing policies related to the WHO best buys;
- iii) The perceived facilitators and barriers of the development of these policies and on the use of MSA.

5.1. Gaps in NCD policy formulation and implementation

Recognising that NCDs and their risk factors pose a serious and urgent threat to health, economic and social development, and environmental sustainability, the Cameroon government took action for their prevention and control. Initially, policies developed were for NCDs or specific risk factors. In 2011, in order to comply with WHO recommendations on the prevention and control of NCDs (6,70), and ahead of the 2011 United Nations High Summit on NCDs, an integrated strategic document for prevention and control was developed.

The formulation and implementation of NCD prevention policies in Cameroon, like in other LMICs (71), has had gaps, as described below.

Non-compliance with policy writing standards

Most of the assessed policies had gaps in the way they were written. While most policy documents contained goals/objectives and measures adopted (changes or new behaviour), most did not include institutional arrangements of implementation. In most cases, no details were given on success indicators, timelines, funding, or monitoring/evaluation plans. In some instances, the quality of the final documents was found wanting. For instance, NIMSPC-CNCDs observations made by CAS on 2012 (4), identified shortcomings such as vague goals with no possible outcomes indicated. In addition, the goals were deemed unattainable and not possible to evaluate in future. The editorial quality was also found to be low.

Additionally, despite the timeframe for the strategic plan was for the period 2011-2015, it was never published nor disseminated.

Fragmented NCD prevention and control policies

Despite the existence of NIMSPC-CNCD, most other policies are characteristically suggestive of an opportunistic approach to NCD prevention. In fact, NIMSPC-CNCDs 2011-2015 proposes actions for many NCDs, such as diabetes, hypertension; ischemic heart diseases, cerebral vascular diseases and strokes; chronic kidney diseases; cancers; asthma and other chronic respiratory diseases; oral diseases; visual and hearing impairment; epilepsy and other neurological diseases; mental diseases; sickle cell anaemia and other genetic diseases (orphan diseases); rheumatic diseases; violence and injuries related to road accidents. The NIMSPC-CNCDs also proposes actions to tackle unhealthy diet and physical inactivity as main risk factors where to act. However, as earlier indicated, this policy was neither published nor disseminated. The long list of NCDs and the inclusion of injuries in the NIMSPC-CNCDs is inconsistent with the WHO global strategy for the prevention and the control of NCDs 2008-2013, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable



Diseases, which recommends that countries focus on the 4x4 approach (four diseases and four risk factors). To be more effective, the WHO Global Action Plan for NCD prevention recommends that priority should be on the four major NCDs – cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. Policies for prevention and control of this four NCDs need to address the unhealthy behaviours of people including tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol (6,70,72–75). Furthermore, the global NCD action plan is premised on the implementation of best buy interventions (6,73,76) and integration of prevention and control measures into policies across all government sectors (6). The NIMSPC-CNCDs is not comprehensive in its inclusion and coverage of these interventions or in the inclusion of other sectors in policy formulation or implementation. Other than the NIMSPC-CNCDs, Cameroon has a long history of developing policies for the prevention of some risk factors, particularly tobacco use and alcohol. Despite suggestions made at the international level for NCD prevention and cost-effective interventions for LMIC, Cameroon is slow to develop a clear strategy document for NCD control. Nevertheless, despite the fragmentation, some best buys are taken into account in a few policies. In fact, these policies are mostly single-sector; the tobacco case is the most illustrative of this situation in Cameroon.

Although there are numerous tobacco control policies, the absence of a comprehensive tobacco control bill in Cameroon is thought to be a key factor in the inadequate application of tobacco control in the country. A comprehensive tobacco control bill was prepared, and according to state procedure, is now in the Presidency of the Republic as the penultimate step before its submission to Parliament. Unfortunately, this bill has been in the same position for the past few years. Despite extensive brainstorming, no concrete solutions were proposed that could be used to move the tobacco bill out of the Presidency of the Republic (77).

The integration of NCD prevention and control policies is an important key for efficient actions. From 2000-2010, WHO surveyed 158 countries and its findings show there is a moderate increase in integrated policies (52%-67%) as well as specific policies, such as cardiovascular disease (34%-65%) or tobacco (39%-85%) (78). A study reviewing the different steps taken during the past 20 years for NCD prevention and control in Seychelles showed that different pieces of policy related to NCDs were developed over the years and there is a need for a comprehensive and multi-sectoral policy framework for NCD prevention (79). Therefore, comprehensive responses in all sectors for the prevention and control of NCDs must be strengthened and resources allocated to implementation with a focus on the rising risks and burden of such diseases.

Gaps in NCD policy implementation

In Cameroon, tobacco use is the only modifiable risk factor that has set policy actions aligned with the WHO best buys interventions for tobacco prevention, and to a lesser extent, for harmful use of alcohol. Even if most of the WHO best buy interventions for tobacco control are adopted, Cameroon's FCTC ratification did not result in a uniform position for the State of Cameroon. For instance, with regards to protection against exposure to passive smoking, while some public administrations (Ministry of Finance, Ministry of Public Health, all the education ministries) took measures to control smoking in their institutions, this was not the case in most other sectors. Policy responses tend to be piecemeal rather than comprehensive and integrated.

Another key factor in the poor implementation of tobacco control policies is political dissonance of the government of Cameroon. The FCTC, recognising that its recommendations will be detrimental to farmers who depend on tobacco crops for their livelihood, encouraged parties to help tobacco farmers make the transition from tobacco to other crops. In Cameroon, in spite of the ratification of the FCTC, there is discord between most of the existing judicial policies and their application by the different stakeholders. This situation is made even more complex by the fact that the government, which is supposed to be the main player in tobacco control, might instead be part of the tobacco industry. It was reported by Cameroonian Coalition Against

Tobacco (C3T) that the highest producer of tobacco in the country is the Cameroon Development Corporation, which is a government Parastatal. Furthermore, the government of Cameroon grants huge subsidies to its tobacco farmers. It was reported that these government aids actually are passed through Parliament (77). This situation may slow the Cameroonian government in preventing and controlling tobacco use.

In Cameroon, although infectious diseases (HIV/AIDS, malaria, tuberculosis) dominate the allocation of scarce public health resources, there is growing evidence that chronic diseases are beginning to receive government attention (42). Indeed, in the operational set-up of the Health Sector Strategy Paper 2001-2015, programming priority interventions/activities for the period 2009-2013, there was no budget allocation for NCD prevention and control. However, for the same period, 118,529 million CFA francs were budgeted for the control of HIV/AIDS and 157,457 million CFA francs for malaria (80). This catastrophic situation was improved in the 2016-2027 Health Sector Strategy Paper, in which about 600,000 million CFA francs were budgeted for the prevention of NCDs against 400,000 million CFA francs for the prevention of communicable diseases. In addition, 650,000 million CFA francs were budgeted for the treatment of cases of NCDs and communicable diseases (81). Nevertheless, not all conditions are fulfilled for optimal management of these resources given the fact that there is no national multi-sectoral committee on NCDs.

NCD under-prioritisation is a challenge in many countries. There is limited specific data on domestic NCD funding, but it is known that in spite of commitments to “increase and prioritise budgetary allocations for addressing NCDs” and “establish, by 2013, multi-sectoral national policies and plans for the prevention and control of NCDs”, only 50% of countries had such a policy with an associated budget to allow its implementation by 2013. Also, WHO advised countries to move away from subaccounts for a limited number of diseases, advising instead to provide a comprehensive overview of the distribution of expenditure across disease categories in line with the 2011 System of Health Accounts, in the hopes that information on diabetes, cardiovascular diseases, cancers and other NCD expenditures will be more readily available (82). A global survey conducted by WHO in 2009-2010 shows that while 65% of countries wrote policies targeting one or more NCDs or their risk factors, only 31% have operational programmes with dedicated funding (78). This situation was also observed in Cameroon, where the annual work plan showed that there is more emphasis on screening for and control of hypertension and diabetes. Implementation of the existing measures are also poorly coordinated. The absence of strong monitoring and evaluation plans means that the monitoring is not properly done. NCD prevention policy implementation is also hampered by severe shortages in human resources, financial resources occasioned by competing health priorities (71).

5.2. Gaps in MSA for formulation and implementation of NCD prevention policies

The WHO 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable diseases (6), as well as the UN Political Declaration on NCDs in 2011 (76), acknowledge the importance of MSA and the “Health in All Policies” approach for the prevention and control of NCDs. The “Health in All Policies” approach should be accompanied by clear, well-described implementation mechanisms (82-85). The recent WHO 2013-2020 plan also aims to strengthen national capacity, leadership, governance, MSA and partnerships to accelerate country response for NCD prevention and control. The purpose of this plan was first to lead and catalyse an inter-sectoral and multilevel response, with a particular focus on LMICs and vulnerable populations. Secondly, national policies and plans for the prevention and control of NCDs need to be established and strengthened. In the recent 2013-2020 plan, the second goal is to strengthen national capacity, leadership, governance, multi-sectoral action and partnerships to accelerate the country’s response to the prevention and control of NCDs (74). In the 2011



UN Policy Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs (280), heads of state and government and representatives of States and Governments recognised the primary role and responsibility of governments in responding to the challenge of NCDs and the essential need for the efforts and engagement of all sectors of society to generate effective responses for the prevention and control of NCDs. Taking into account the above, it emerges from our study that the human factor, the actor, appears in a duality: it is simultaneously at the centre of the prevention of NCD risk factors yet involved in decisions that have a deleterious effect on these preventive policies; the actor is the central component to understand public policy. During the formulation and implementation processes, the main actors were representatives of the public administration and MSA use was limited. In the area of tobacco prevention, for example, the the Prime Minister convened a meeting and instructed each ministerial department to develop policies for smoking prevention and control in their respective departments. The rest of the process was characterised by slowness, passivity, and even contradictions in government action. Although some ministries (health, education, finance, social affairs) followed the Prime Minister's instruction, others did not, and without any negative consequences. Finally, between "inertia" (87) and conflicting interests linked to the profits generated by tobacco production (88), the government's commitment is not complete. In fact, the FCTC, recognising that its recommendations will be detrimental to the farmers who depend on tobacco for their livelihood, encouraged governments to help tobacco farmers make the transition from tobacco to other crops (89). Despite this, the government – which was supposed to be the main player in tobacco control – granted huge subsidies to tobacco farmers (77). Unfortunately, as far as public action for tobacco control is concerned, the balance of power between the government conflict of interest and the other actors engaged in tobacco control is heavily weighted in the government's favour and the status quo. This situation showed a real political dissonance and a lack of cohesion and synergy in sectors. Nevertheless, the desire to use MSA for the prevention and control of NCDs was addressed in the NIMSPC-CNCDs, although it was vague and no mechanism was established for its operationalisation.

In summary, there is no national platform for the prevention and control of NCDs and the existing platforms are often dedicated to the resolution of a single risk factor or policy (i.e. tobacco taxation). This situation was also observed in other countries. In 2010, a WHO survey found that 86% of countries reported having some form of partnership or collaboration for implementing key activities relating to NCDs. The establishment of multi-sectoral committees is essential for the better prevention and control of NCDs, and in 2012, an analysis of 144 WHO country cooperation strategies showed that 136 member states requested support for the design and/or implementation of national multi-sectoral efforts to address NCDs (78).

5.3. Facilitators and barriers to NCD policy development

Facilitators

In Cameroon, several factors facilitated the NCD policy development process.

- International advocacy. First of all, there are legal dispositions like the ratification of international conventions and also presidential participation at the UN summit on NCDs in 2011. The Political Declaration issued at this meeting focused the attention of world leaders and the global health community on NCD prevention and control (90). In Mongolia, the 2011 UN High Level Meeting on NCDs was a unique opportunity for the Mongolian government to prioritise a new developmental agenda, exercise leadership, and call for action to address NCDs (91). In some European countries (Italy, Montenegro, Tajikistan), key European documents on NCD prevention and control, alongside international collaboration and WHO support, served as official drivers for NCD strategy development (92).



- Burden of NCDs and their risk factors. Another facilitator of NCD policy development is the epidemiological context with evidence-based data on NCD and prevalence of their risk factors. This is a frequent catalyst in the formulation and development of NCD prevention and control policies. In Ghana in 2012, policies and interventions that have scientific and/or historical evidence were prioritised (93). This was also the case in South-East Asia. In general, there is a strong evidence base that underpins the NCD policy agenda of most developed and developing countries in LMICs (71).
- Political will. Two important directorates were created in 2004 in the Ministry of Public Health: the Directorate of Health Promotion and Directorate of Disease Control (with the subdirectorates of Non-communicable Disease). We also have some policies adopted in some ministries (e.g., Health, Education and Finance) to move forward in the control of NCDs. In Azerbaijan, the inclusion of NCDs in the national development plan was identified as a potential reason for there being sufficient political will to move NCD policy development forward (92). In Mongolia, the participation of their president at this global meeting demonstrated high-level political commitment for NCDs, which led to the government undertaking numerous policy measures, particularly on alcohol and tobacco prevention and control (91).

Barriers

The most significant barriers to the NCD policy development process include:

- Lack of awareness and expertise. Although the NCD issue is recognised and actions are taken toward their prevention and control in Cameroon, lack of awareness and expertise of some key players remain barriers to the formulation and implementation of recommended interventions. This barrier was also observed in other developing countries. A 2007 study to assess the status of national capacity for prevention and control of NCDs in the member states of the WHO South-East Asia Region concluded that member states need to enhance capacity to address critical gaps in their national policies and programmes (94). In 2012, an article describing efforts from the Pan American Health Organization, which supported progress in country-driven planning and implementing of actions to address, found that major challenges include building human resource capacity (95). In Malawi in 2014, 78% of seniors officers interviewed during a study related to NCD implementation affirmed that there are inadequate human resources and 65% reported inadequate technical capacity (96). This challenge was also observed in Europe. In a 2015 European study, they stated that the lack of expertise is a challenge and mentioned a need to build the capacity of national stakeholders to work jointly with different international organisations and national institutions (92).
- Conflict of interest. Although we can appreciate the political will of the Government of Cameroon by taking certain key decisions – establishment of an NCD department in the Ministry of Public Health and the ratification of certain international treaties such as the FCTC – inconsistencies are observed, such as blocking the anti-tobacco law, funding of tobacco farming, and implementation of alcohol and diet policies. This lack of consensus results in conflicts with other political priorities, such as production and export of tobacco and alcohol, and was also observed in Barbados (97). This is why the Political Declaration on NCDs particularly recognises the fundamental conflict of interest between the tobacco industry and public health (78).
- Competing priorities (Communicable diseases vs NCDs). In Cameroon, communicable diseases – malaria, AIDS and tuberculosis – cause thousands of deaths annually. For several years, most health resources were directed towards the control of these diseases. SSA is undergoing an epidemiological health transition as increased globalisation and accompanying urbanisation are causing a double burden of communicable and NCDs. Rates of communicable diseases such as HIV/AIDS, tuberculosis and malaria in Africa are the



highest in the world. The impact of NCDs is also increasing (98). In Cameroon, like in many other LMICs (99), the health system is often oriented towards tackling communicable disease and the approach to NCDs is unstructured, lacks systematic follow-up and monitoring of NCDs and their risk factors, and provides little information about their morbidity and mortality, which is a crucial element for effective health planning (4). This situation is best illustrated by the budget allocation for NCDs prevention and control as we explained on the part talking about gaps in NCD policy implementation.

- Poor resource allocation for NCDs. The competing priorities between communicable and NCDs addressed above led to poor NCD resource allocation in Cameroon. This situation is quite common in LMICs. In 2013, a study evaluating the extent to which NCD-related policies introduced in Mongolia align with the WHO 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of NCDs suggests gaps in addressing some NCDs and their risk factors, but note lack of funding as a barrier (91). This was also the result of a study done in Malawi in 2016 (96). In 2014, during the High Level Meeting on the comprehensive review and assessment of the progress achieved in the prevention and control of NCDs, it was noted that in the developing world, the statistics on NCD burden are quite alarming. The president of the World Health Assembly pointed out that 80% of global deaths from NCDs occurred in developing countries, making them the most vulnerable and least resilient to NCDs. The problem is not the lack of political will, but rather the lack of technical and financial resources (100).



6.0

6.0 | Limitations



Limitations



This study had some limitations. Firstly, it was conducted during a limited time period. The results should be considered a 'snapshot' that only concerns a single point where stakeholder views on tobacco use prevention policies and their implementation were captured. This therefore calls for correlated research of other health policies in general and NCDs in particular. Despite these inherent limitations, this case study method is essential in health policy research and investigates a contemporary phenomenon in its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (101). Secondly, no centralisation of policy documents existed, making it difficult to access some documents, such as meeting notes, and to interview some people. Nevertheless we gained an understanding of the underlying contextual factors, content, processes, actors of the formulation and implementation of NCD prevention policies in Cameroon and the use of MSA in the process.



7.0 | Conclusion



Conclusion



This case study analysed the context, content, processes and actors of formulation and implementation of NCD risk factors prevention policies in Cameroon in order to establish the extent to which MSA is applied both in formulation and implementation. After reviewing the existing data of the burden of NCD, their risk factors and their prevention policies, we conducted in-depth interviews with keys informants and direct observations.

At the end of this study, the objectives were achieved. Findings show that some policies for NCD risk factor prevention exist in Cameroon, and some address the WHO best buys, particularly for tobacco use and harmful use of alcohol prevention. Most of the policies, especially for tobacco use, are laws, ministerial orders, and circulars. The formulation of these policies in Cameroon was driven locally by NCD social and health context s and their risk factors, and globally by the WHO efforts. The formulation process differed from one policy to another and the level of implementation varied considerably. The majority of these policies are uni-sector-oriented and the use of MSA in the formulation and implementation process was limited. Indeed, even though the MSA was used during the formulation of certain policies such as the NIMSPC-CNCD, it remained very limited during implementation. This situation is favoured by a fragmentation observed in NCD prevention and control policies and also in the functioning of the different sectors or institutions. This suggests that opportunistic approach to NCD prevention. Meanwhile, political will was identified as the major facilitator of MSA use and poor resource allocation and lack of synergy as principal barriers.

These findings challenges us on the shortcomings and opportunities that can be seized to move forward NCD prevention and control in Cameroon, particularly on the use of MSA in policy formulation and implementation. For this purpose, the following recommendations are proposed



8.0

8.0 | Recommendations



Recommendations



In order to improve NCD prevention and control and the use of MSA in the formulation and implementation processes, the following recommendations are proposed to relevant stakeholders:

- **Advocacy for action on NCDs.** It is important to build and disseminate evidence-based information on the burden of NCDs in Cameroon and the strategies that can be used to solve the issue. The implementation of WHO best buys is an opportunity.
- **Politics, governance and holistic approach.** A major challenge for good policy and governance is that the translation of evidence in-to policy is not done adequately. Also, clear roles are often lacking for all key actors and institutions involved in the control and prevention of NCDs. Furthermore, since risk factors are common to the main NCDs, it is essential to address this problem as well as solutions in an integrated way and not with piecemeal process.
- **Partnerships and use of MSA.** It will be essential to establish a national multi-sectoral committee for the prevention and control of NCDs. This committee will help to put together all stakeholders that should be involved on NCD prevention and control. The role of each stakeholder must be clear as well as the functioning structures and mechanisms.
- **Resources.** Funding for capacity-building is not easily available and is rarely seen in budgets and appropriations. The government should increase domestic budgetary allocations for NCD prevention and control and explore viable financing options through voluntary innovative financing mechanisms, including taxation. For example, WHO recommended a taxation of tobacco products at 75% and Cameroon, it is only at 44.75%.
- **Broad training for health promotion.** Although curative health workers receive training in health promotion, it would be beneficial to provide training to a wider spectrum of workers associated with health care, including staff in health promotion, health policy, and health administration.

9.0



9.0 | Reference list



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10.0



10.0 | Appendices



Appendices



10.1. Final interview guides

Interview guide for policymakers

I Context of formulation of NCDs prevention policies in Cameroon

1. **What is your opinion on the development of policies against X (alcoholism/ tobacco use/ physical inactivity/inadequate nutrition) in this country?**
2. **What issues led to the development of the policy X?**

a. In the Cameroonian context

(Probe for: epidemiological data, political changes, health sector reforms, organisational changes, fiscal policies, economic situation, and contradictory programmes)

(Probe for: evolution of the issue with time)

b. At the Global level

(Probe for: epidemiological data, global movements, declarations, meetings, Global financial situation, conflicting development agendas and technological factors)

3. **What is your view on the introduction of this measure in Cameroon**

II- Content of NCDs prevention policies in Cameroon

4. **What is the aim of this policy?**
5. **Is there any change of this content with time?**

III- Actors in NCDs prevention policies formulation in Cameroon

6. **What was your role in the formulation of this policy? (3a)**
7. **Please describe your experience as you participated in the formulation of this policy (What in your opinion went well? What could have been done differently?)**
8. **Which other sectors were involved in the formulation of this policy? (4a)**

(If one actor, please go to 8.c, 9 and after 12)

- a. What was the role of the sectors that were involved? (Probe for the sectors mentioned)?
- b. Who led the process in formulating this policy?
- c. Who else should have been involved in your view and why?
 - i. Why do you think they were not involved?
 - ii. What in your view would have been the impact on the policy if they had been involved?

For Tobacco and alcohol policies

9. **Please comment on how (alcohol or tobacco) industry influenced the alcohol/tobacco policy development process (negatively or positively).**

- a. How did you overcome any challenges that industry interference may have generated?

IV- Process of formulation NCDs prevention policies formulation in Cameroon

10. What strategies were used to bring the different stakeholders/sectors to work together in formulating this policy? (4d)

(Probe for: formal or informal invitation, type forum: consultations, meetings, workshops, etc.)

- 11. What factors enabled different sectors to work together in formulating this policy?**
- 12. What were the challenges encountered in bringing the different sectors together in formulating this policy? (4e)**

V- Implementation of NCDs prevention policies formulation in Cameroon

13. During the formulation, is the strategy of the policy disseminated to various implementing agencies was discussed?

14. Is there any plan for the implementation of the policy?

15. What do you think about the implementation of this policy? (5)

16. Is your institution involved in the implementation of this policy?

- a. If so, what is its function?

(Probe: training/capacity-building, advocacy, providing services, IEC, logistics, planning, finance, monitoring/evaluation)

- i. How were you involved in the implementation of this policy?
- b. If no, are you aware about actors involved in the implementation of this policy?

If the informant doesn't know about implementation actors and processes, please end the interview

17. Which other sectors/ stakeholders were involved in the implementation?

(Probe for government sectors and other stakeholders)

- a. What was the role of the sectors that were involved? (Probe for the sectors mentioned)?
- b. Who else should have been involved in your view and why?

(If uni-sectoral policy, please go to question 18)

- c. In your understanding, what is the lead institution for implementing the policy?
- d. How can you qualify the leadership of this institution in implementing the policy?
- e. What are the difficulties encountered in the implementation of this measure?

(Probe for difficulty raising several sectors in the implementation)



- f. What factors enabled different sectors to work together in implementing this policy?
- g. What were the challenges encountered in implementing this policy (Probe for challenges in bringing several sectors together to support implementation)

18. What are, on your view, strategies (coordination mechanism) that can facilitate the implementation of this measure?

19. What is the institution responsible for monitoring/evaluation of the implementation of this policy?

20. Is there a mechanism in place to ensure funding for the implementation of this policy?

- a. If yes, what kind of funding is available?

(Probe: For amount of funding; Sources of funding; Are there arrangements such as joint budgeting and delegated financing aimed at addressing promoting physical activity issues?)

- b. Is this funding sufficient? Why?

(Probe for sponsors and their interests)

- c. If no, how do you do to finance activities related to the implementation of this measure?

21. What are future plans (planning, strategy) for the implementation of this measure?

22. What were the benefits of involving many actors in the policy development processes?

- a. What losses were incurred from involving many actors?

23. What would you recommend to facilitate the working of different sectors in formulating / implementing the policies X for the future?

(Probe for: mechanisms and structures through which the MSA can be improved)

24. Which other policies for the prevention of NCDs are you aware of in Cameroon?



Interview guide for implementers

I. Context, content and process of formulation of NCDs prevention policies in Cameroon

1. **What issues led to the development of the policy X in Cameroon?**
2. **Is you or your institution involved in the formulation of this policy?**
 - **Explain please** (*probe for the role of his institution*)
3. **How the strategy of the policy was disseminated to various implementing agencies?**
(*Probe: how and when were you informed of the existence of this policy?*)

II. Actors in NCDs prevention policies implementation in Cameroon

4. **Which sectors/ stakeholders are involved in the implementation of this policy at your structure?**

(*Probe for the actors: ministries, private sectors, civil societies For the role of each sector: advocacy, providing services, IEC, logistics, planning, finance, monitoring/evaluation*)

5. **How did you get involved in the implementation of this policy?**
6. **In your opinion, what is the leading institution in charge of implementation?**
 - a. How would you describe his leadership in implementing the measure?
7. **In your opinion, what other sectors could be involved and why?**
 - i. Why do you think they were not involved?
 - ii. What in your view would have been the impact on the policy if they had been involved?
8. **What factors enabled different sectors to work together in the implementation of this policy?**

III. Implementation of NCDs prevention policies formulation in Cameroon

9. **Is there any plan for the implementation of the policy?**

(*if not, go to question 12*)

10. **If yes, does your organisation has participated in the development of this implementation plan?**
11. **Is that implementation plan useful?**
 - Explain please

(*If yes at the question 9, go to question 13*)

12. **If there is no plan of the measure, which document guides you through the implementation of this policy?**
13. **What do you think about the implementation of this policy?**
14. **The implementation of this policy does it require changes in your organisation?**

- 
- a. If so, changes in what order?

(Probe: structural reform, adequacy of human and material resources, difficulties and challenge)

15. Have you or your institution received training / capacity building on issues related to the implementation of this policy?

16. Is there a mechanism in place to ensure the financing of the implementation of this policy?

- a. If so, which mechanism?

Exploring the sources of funding: government, private sector, donor, other)

- b. This funding is it sufficient for the execution of different roles in your organisation?
- c. If not, how are you doing to the implementation of this policy?

17. Do you have any problems/barriers to access funds for your activities?

- a. Explain please
- b. Depending on how this problem can be solved?

18. Is there a mechanism in place to coordinate the implementation of this policy?

- a. If so, which mechanism?

19. In your opinion, what are the factors that enable the implementation of this policy?

20. What are the factors slowing the implementation of this measure?

(Probe for difficulty raising several areas in the implementation of this measure, influences groups (support or opposition)

21. What solutions do you propose for the effective implementation of the policy?

22. What is the institution responsible for monitoring / evaluation of the implementation of this policy?

23. What method is used for monitoring / evaluation of the implementation of this policy?

(Probe for specific approaches such as regular meetings, periodic activity reports, site visits, and service statistics)

24. What are the indicators used to monitor the implementation of this policy?

25. Do you receive or give feedback on the overall extent of the implementation of this policy?

- a. If so, what kind of feedback?
- b. From whom/to whom?

26. Do you begin to see positive changes as a result of the implementation of this policy?

- a. If so, which changes?
- b. If not, why do you think there are not so far?



27. Referring to the objectives and aims of the measure cited above, do you think it provides a solution to the existing problem in Cameroon?

Can you explain your point of view?

28. (For regions only) Is it in your structure / place / community, local regulations that operate with similar objectives to those of this policy?

10.2. Final observation guide

- Policy 1 : Law No. 98/004 of 14 April 1998 on the orientation of education in Cameroon

Proscription of sale and consumption of tobacco, drugs and establishment of drinking establishments at the periphery of schools

| Schools | Date and time | Findings A = Applied NA = Not Applied | Comments |
|---------|---------------|---|----------|
| | | | |
| | | | |
| | | | |

- Policy 2: Circular Letter No. 19/07/MINESEC/SG/HR/SDSSAPPS of 11 September 2007 on the establishment of anti-tobacco clubs in schools and making schools “non-smoking areas.”

| Schools | Date and time | Findings A = Applied NA = Not Applied | Comments |
|---------|---------------|---|----------|
| | | | |
| | | | |
| | | | |

- Policy 3 : Order No. 967 MINSANTE/MINCOMMERCE of 25 June 2007 regarding health warnings on packages of tobacco products

| City and point of sale | Date and time | Brands of tobacco products | Findings A = Applied NA = Not Applied | Comments |
|------------------------|---------------|----------------------------|---|----------|
| | | | | |
| | | | | |
| | | | | |

- Policy 4 : Law No. 2006/018 of 29 December 2006 governing advertising in Cameroon
Advertising on tobacco products

| City and point of advertising | Date and time | Brands of tobacco products | Findings A = Applied NA = Not Applied | Comments |
|-------------------------------|---------------|----------------------------|---|----------|
| | | | | |
| | | | | |
| | | | | |

10.3. Ethics review certificate

COMITE NATIONAL D'ETHIQUE DE LA RECHERCHE POUR LA SANTE HUMAINE

Arrêté N° 0977/A/MINSANTE/SESP/SG/DROS/ du 18 avril 2012 portant création, organisation et fonctionnement des comités d'éthique de la recherche pour la santé humaine au sein des structures relevant du Ministère en charge de la santé publique

N° 2014/04/438/L/CNERSH/SP

Yaoundé, le 14 avril 2014

Cnethique_minsante@yahoo.fr

CLAIRANCE ETHIQUE

Le Comité National d'Éthique de la Recherche pour la Santé Humaine (CNERSH), en sa session du 27 février 2014, a examiné le dossier de demande de clairance éthique pour le projet de recherche intitulé «**Analysis of Non Communicable Diseases Prevention Policies in Cameroon (ANPPA)**» soumis par le **Professeur MBANYA Jean Claude**, Investigateur principal, Université de Yaoundé1.

Le projet est d'un grand intérêt scientifique et social. Cette étude permettra de mieux comprendre les facteurs tels que les acteurs, les institutions, le contexte et le contenu des politiques affectant le processus d'élaboration des politiques des Maladies Non Transmissibles au Cameroun. La procédure de l'étude est bien documentée et claire. Les risques de participation à l'étude sont minimes. La notice d'information et le formulaire de consentement éclairé, en français et en anglais, sont bien élaborés et simples à comprendre. Les mesures prises pour garantir la confidentialité des données collectées sont présentes dans le document. Les CVs des investigateurs les décrivent comme des personnes compétentes, capables de mener à bien cette étude. Pour toutes ces raisons, le Comité National d'Éthique approuve pour une durée d'un an, la mise en œuvre de la présente version du protocole.

Les investigateurs principaux sont responsables du respect scrupuleux du protocole approuvé et ne devraient y apporter aucun amendement aussi mineur soit-il, sans avis favorable du CNERSH. Les investigateurs sont appelés à collaborer pour toute descente du CNERSH pour le suivi de la mise en œuvre du protocole approuvé. Le rapport final du projet devra être soumis au CNERSH et aux autorités sanitaires du Cameroun.

La présente clairance peut être retirée en cas de non respect de la réglementation en vigueur et des recommandations sus-mentionnées.

En foi de quoi, la présente clairance éthique est délivrée pour servir et valoir ce que de droit.

Ampliations

- MINSANTE

N.B : cette clairance éthique ne vous dispense pas de l'autorisation administrative de recherche (AAR), exigée pour mener cette étude sur le territoire camerounais. Cette dernière vous sera délivrée par le Ministère de la Santé Publique.



LE PRESIDENT

Pr Eugène KAPTUE

10.4. List of key informants for each policy analysed

| National integrated strategic plan for the prevention and control of chronic noncommunicable diseases in Cameroon | | |
|---|--------------------|--|
| | Key informants | Institutions |
| 1. | Mr Ngoa Claude | Ministry of Public Health |
| 2. | Mrs Ngo Soa | Ministry of economy, Planning and Regional Development |
| 3. | Mme Owona Leonie | Ministry of posts and telecommunications |
| 4. | Dr Manyim Florence | Ministry of Sports and Physical Education |
| 5. | Dr Alobwede Jane | Ministry of Energy and Water resources |

| Circular Letter N° 19 /07MINESEC/SG/HR/SDSSAPPS of 11 September 2007 on the establishment of anti-tobacco clubs in schools and making schools “non-smoking areas | | |
|--|--------------------------|--|
| | Key informants | Institutions |
| 6. | Mrs Kouamou | Ministry of Secondary Education |
| 7. | Mr Nlanga | Ministry of Secondary Education |
| 8. | Mme Mekongo | Inspection of Orientation and School Life in the North |
| 9. | Mr Hassana | Principal at Lycée Classique et Moderne de Garoua |
| 10. | Mr Njock | Principal at the Ste Thérèse college of Garoua |
| 11. | Mme Aminatou | Principal GBS Garoua |
| 12. | Mr Sali | Principal Government Technical High School Garoua |
| 13. | Mr Younoussa | Principal of the Government High School of Kolleré |
| 14. | Mrs Nguekeng | Principal Protestant college of the North |
| 15. | Mr Ojong | Inspection of Orientation and School Life in the North West |
| 16. | Mrs Ngoran | Orientation Counselor Government Bilingual High School Down town Bamenda |
| 17. | Mr Mungu John | Principal of the Government High School of Atiela Nkwen Bamenda |
| 18. | Mme Mindja | Regional Delegation of Secondary Education Centre |
| 19. | Mr Nsegbe | Principal Montesquieu College |
| 20. | Mr Atangana Alain | Responsible of the Health School at the Retraite College |
| 21. | Mr Ebanga Jean Claude | Nkolbisson Government Technical High School |
| 22. | Mr Okala Vincent | Principal of the Nkol-Eton Government High School |
| 23. | Mr Atangana Charly André | Inspection of Orientation and School Life in the South |
| 24. | Mr Mekoulou M'Awomo | Principal of the United College of Elat |
| 25. | M. ETOUNDI Albert | Principal Ebolowa Government High School |
| 26. | M. Owono Bertin | Principal Ebolowa Government Bilingual High School |
| 27. | M. Ngadji Martin | Censor Ebolowa Government Technical High School |
| 28. | M. MBAH Jean Marie Alain | Principal Akak Essatolo Government Technical High School |

Order No. 967 MINSANTE/MINCOMMERCE of 25 June 2007 regarding health warnings on packages of tobacco products

| | Key informants | Institutions |
|------------|-----------------------|---|
| 29. | M. Awono Pascal | Permanent Secretary of the national committee against tobacco and drugs |
| 30. | M. Sibetcheu | EX Director of Health Promotion department |
| 31. | M. Dahirou | DR commerce Nord |
| 32. | M. Ngwesse | Chef Brigade mobile douane Garoua |
| 33. | M. Ayuk | DR commerce Nord Ouest |
| 34. | M. Epka | Chef Brigade mobile Bamenda |
| 35. | M. Meka'a Lucas | DR Commerce Littoral |
| 36. | M. Bekete Magloire | DR Commerce du Sud |

Law No. 2006/018 of 29 December 2006 governing advertising in Cameroon

| | Key informants | Institutions |
|------------|----------------------------|---|
| 37. | M. Essiakou | Regional Delegation of the Communication of the North |
| 38. | M. Begne Louis Marie | Regional Delegation of the Communication of the West |
| 39. | Mme Nkoulou Yollande | Regional Delegation of the Communication of the Centre/ Chef Service des media privés et de la publicité |
| 40. | M. Nkake Ngowla | Regional Delegation of the Communication of the Littoral |
| 41. | M. Effa Essiane Guy Paulin | Regional Delegation of the Communication of the South/ Chef Service des media privés et de la publicité |

Law N° 2014/026 of 23 December 2014 on the finance law of the Republic of Cameroon for the 2015 financial year

| | Key informants | Institutions |
|------------|-----------------------|---|
| 42. | M. Nomo Maximilien | Ministry of Finance /Directorate of Taxes |
| 43. | M. Ebune Bertrand | Ministry of Finance /Directorate of Taxes |



10.5. Ministries in Cameroon

1. Prime Ministry
2. Ministry of Culture
3. Ministry of Commerce
4. Ministry of Communication
5. Ministry of Defence
6. Ministry Under the Presidency of the Republic
7. Ministry of Urban Development and Housing
8. Ministry of Economy and Finance
9. Ministry of Basic Education
10. Ministry of Livestock Fisheries and Animal Industries
11. Ministry of Employment and Vocational Training
12. Ministry of Energy and Water Resources
13. Ministry Of Secondary Education
14. Ministry of Secondary and Superior Education
15. Ministry of Environment and Nature Protection in Cameroon
16. Ministry of Public Service and Administrative Reforms
17. Ministry of Forestry and Wildlife
18. Ministry of Industry, Mines and Technological Development
19. Ministry of Youth Affairs
20. Ministry of Planning, Programming and Regional Development
21. Ministry of Small and Medium-sized Enterprises, Social Economy and Handicrafts
22. Ministry of Posts and Telecommunications
23. Ministry of Women's Empowerment and the Family
24. Ministry of Scientific Research and Innovation
25. Ministry of External Relations
26. Ministry of Public Health
27. Ministry of Sports and Physical Education
28. Ministry of Tourism
29. Ministry of Transport
30. Ministry of Labour and Social Security
31. Ministry of Public Works
32. Ministry of Justice
33. Ministry of Territorial Administration and Decentralization



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