The World Breastfeeding Trends Initiative (WBT*i*)

Name of the Country: CAMEROON

Year: 2012

Ministry Public Health FECABPA

Report Presented by:

Mrs. Joyce Chanetsa, Regional Coordinator, IBFAN Africa
James Achanyi-Fontem, Coordinator, IBFAN Cameroon Link Group
Dr. Ekoum Joseph, Head of Plannification, Regional Delegation for Public Health, Littoral
Dr. Balo Jean Richard, District Medical Officer, Bonassama
Mrs. Koe Marie Hortense, Nutrition Focal Point, Regional Delegation for Public Health, Littoral
MIBE Samuel, Head of Maternal and Child Health Protection Bureau, RDPH/Littoral
Mrs. Socki Jeanne, Head of Health Bureau, Bonassama District

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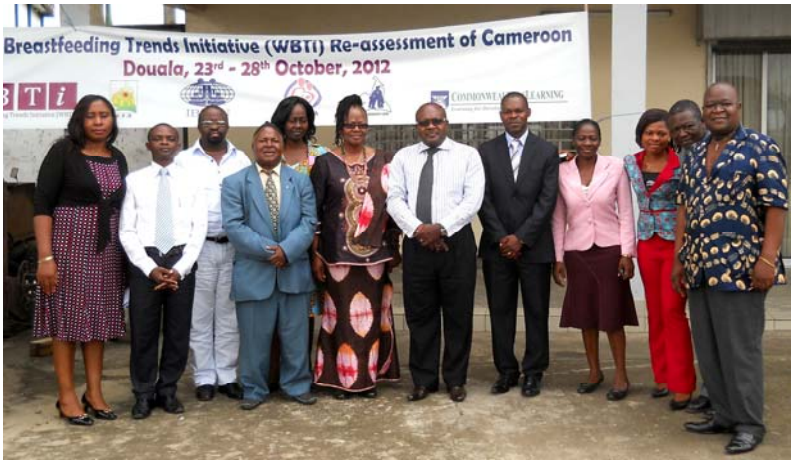
Content

Acronyms

AIDS Acquired Immunodeficiency Syndrome
BFHI Baby Friendly Hospital Initiative
BFCI Baby Friendly Community Initiative
COL Community of Learning
FECABPA Federation of Cameroon Breastfeeding Promotion Associations
GIMS Global Initiative for Mother Support
GIFS Global Initiative for Father Support
GSIYCF Global Strategy for Infant & Young Child Feeding
HIV Human Immunodeficiency Virus
HTC HIV Testing and Counseling
IBFAN International Baby Food Action Network
IEC Information, Education & Communication
ILO international Labour Organisation
IYCF Infant & Young Child Feeding
DHS Demographic Health Survey
M&E Monitoring and Evaluation
MPH Ministry of Public
MPC Maternity Protection Convention
MTCT Mother To Child Transmission of HIV
NGO Non Governmental Organisation
PMTCT Prevention of Mother to Child Transmission of HIV
TAM **T**racking, **A**ssessing and **M**onitoring
UNICEF United Nations Children's Fund
WBTi World Breastfeeding Trends Initiative
WHO World Health Organisation
WABA World Alliance for Breastfeeding Action

WBTi Re-assessment Workshop in Cameroon
24-28 October 2012



WBTi Cameroon Core Persons

Executive Summary

IBFAN Africa conducted a three-day workshop from 24-28 October 2012, to orient the government of Cameroon on how to conduct periodic monitoring and evaluation of infant and young child feeding practices, policies and programmes using a simple to use World Breastfeeding Trends Initiative tool (the WBTi). The workshop was held at Hotel du Rail Bonaberi-Douala for 16 participants who came from the government, Civil Society Organisations (CSO), Infant Feeding advocacy CBOs. Being gender sensitive, training and reassessment included men, women and youth groups. The workshop was facilitated by the Regional Coordinator of IBFAN Africa, Mrs. Joyce Chanetsa, and the Coordinator of IBFAN Cameroon Link Group, James Achanyi-Fontem, who triples as the National President of the Federation of Cameroon Breastfeeding Promotion Associations (FECABPA) and Coordinator of WABA Men's Initiative.

The objectives of the workshop were to:

1. Sensitize participants on the Global strategy on Infant and Young Child Feeding and how it is linked to the WBTi tool;
2. Impart knowledge and skills on the application of the WBTi tool for monitoring and evaluation as well as for advocacy and action to improve IYCF;
3. Discuss unique national situations as regards the tool;
4. Identify sources of representative local data and methods of its gathering;
5. Develop an action plan from the national reassessment.

The workshop achieved its objectives and beyond as it was able to conduct a preliminary rough score of the country (95,5/150 or 63.6% of achievement) on implementation of the Global strategy; it came up with a concrete plan to complete the country assessment and already begun utilizing the draft assessment results to advocate for further action using with exchange of views working sessions at the ministry of public health with the Technical adviser No. 2, Dr. Baye Martina Lukong, at UNICEF Cameroon office with the Deputy Representative, Dr. Zakari Adam, the head of health section, Dr. Bechir Aounen, head of young child programme, Dr. Jeanne Ejigui, and the Radio TV channels and Cameroon Link internet blog. The Regional Coordinator of IBFAN Africa, Joyce Chanetsa and President of Cameroon Link, James Achanyi-Fontem, appeared on national TV immediately after the workshop and made a call for further action on some identified indicators.

Among the achievements observed on implementation of Global Strategy nationally are:

1. Excellent initiation of breastfeeding within one hour of birth (95.6%).
2. Cameroon has a national Code on the Marketing of Breastmilk Substitutes, even though it is not enforced and it has no sanctions.
3. Many health facilities in Cameroon practice kangaroo care to provide care to low birth weight or pre-term infants.
4. Exclusive breastfeeding for 6 months is increasing even though slowly.

5. Community based support by mother support groups is fairly good except there is lack of optimal and correct information for mothers and community workers.
6. The World breastfeeding Week is celebrated nationally annually.

Among identified major gaps are:

1. Too early introduction of other foods and water (26.2%) and too late introduction of complementary foods for 20% of infants.
2. Lack of a National Coordinator for infant and young child feeding in the Ministry of Health and a national coordinating committee supported by the Ministry of Health and fully responsible for IYCF.
3. The National Code of Marketing is not translated into English so that all can understand and lacks sanctions.
4. Information, education and communication efforts are only reaching 63.6% of the population.
5. High bottle feeding practices for infant 0-6 months (75%)
6. No efforts are made to implement BFHI in health facilities.
7. No awareness of infant feeding in emergencies.
8. On Maternity protection, not all provisions of the ILO 183 Convention are addressed and there is no protection of agricultural workers and those in the informal sector.

Observed Opportunities

- Cameroon has over 75 community radio stations that are not fully utilized by the government for infant and young child feeding education.
- Cameroon boasts of having a good national Federation of Cameroon Breastfeeding Promotion Associations, FECABPA; it hosts the Men's Initiative of the World Alliance for Breastfeeding Action, WABA; and is strongly affiliated to IBFAN and the Baby Milk action that are two advocacy houses for infant and young child feeding.
- Good relationships between UNICEF, IBFAN Africa, Cameroon Link and the Government. The government and UNICEF were fully supportive of the WBTi reassessment and contributed in the gathering of preliminary data for the process.
- A very strong Cameroon Link, coordinating the federation of nutrition networking associations (FECABPA), is affiliated to many other national and international groups involved in infant and young feeding promotion.

Among the key recommendations made to the government and local partners are:

1. Appoint a national Coordinator for infant and young child feeding who is in a senior position and a national committee answerable to the Ministry of Health and the Federation.
2. The government is advised to have a budget for implementing infant and young child feeding programme.
3. The government was invited to translate the national Code into English so that all can benefit during the revision of the Code so that it includes sanctions.
4. The government, UNICEF and WHO to initiate urgent efforts to train health workers on Community Baby Friendly Initiative (CBFI) outreach action and implement the BFHI in health facilities and communities.
5. The government needs to integrate guidelines on infant feeding in emergencies within the nutrition policy.
6. The Government with the support of WHO and UNICEF to improve monitoring and evaluation of IYCF indicators within existing systems.

Major request made to IBFAN

1. IBFAN to consider including Cameroon in all future training and assist with IYCF documentation in order to achieve full participation of the Infant and Young Child Feeding (IYCF) stake holders of Cameroon.

DETAILED PROCESS

WBTi is a web based tool that is adapted from the WABA's GLOPAR 1993 tool and the WHO's tool "Infant and Young Child Feeding: A tool for assessing national practices, policies, and programs" (2003/4). It is an action oriented tool that encourages involvement of all stakeholders from assessment, analysis to action planning and implementation.

The periodic use of the WBTi tool for monitoring of progress of the infant and young child activities is expected to identify best lessons of achievement and existing gaps and thereby generate action to improve on policies and programmes for maternal and child health. This in turn is expected to lead to improved infant feeding practices and maternal health and therefore speed up the achievement of MDG 4 and 5.

The WBTi objectives are to:

- Provide critical information to governments, needed to bridge gaps in infant and young child feeding policy and practice

- Provide evidence to IBFAN groups to advocate for greater effort and investment to promote early and exclusive breastfeeding in the respective countries and regions
- Contribute to attaining MDG-4 and 5 and reducing under-five child mortality and improve women's health
- Document best practices and share them with other countries in regional forums.

Preparation of WBTi Training

Cameroon Link made preparations for the workshop including development of information packs for all participants and collecting preliminary data on most of the 15 indicators, which enabled mock data processing-filling of forms, analysis and rating and scoring; as well as generating excellent discussions based on real life situations during the workshop.

Cameroon Link is the national Focal Point for the International Baby Food Action Network (IBFAN) in Cameroon. It is through Cameroon Link that the Ministry of Health of Cameroon now collaborates with IBFAN Africa closely. Cameroon Link has been instrumental in the formation of the national Federation of Cameroon Breastfeeding Promotion Associations, FECABPA, and the Men's Initiative of the World Alliance for Breastfeeding Action, WABA.

After the workshop the national team finalized the national re-assessment, conducted partial analysis and submit their national report to IBFAN AFRICA Regional Coordinator who had to share the content with stakeholders during advocacy meetings in Yaoundé and with IBFAN Asia to finalize the report cards for Cameroon country advocacy work and further action. From the re-assessment report, the national group will design their advocacy strategy for improving country action for IYCF.

THE WORKSHOP PROCESS

SESSION ONE

1. **Expectations:** After self-introduction of the participants and their respective roles played in the promotion of health sector activities, IBFAN Cameroon Link Group coordinator, James Achanyi-Fontem, led a sharing discussion on the expectations of the workshop by participants:

- ✓ Participants expected everything to be said about what WBTi is.
- ✓ Come out with key rating indicators and explanation of their values.
- ✓ Discuss Cameroon's contribution in the promotion of WBTi.
- ✓ Insist on the Implementation of recommendations.
- ✓ Involve the media in the sharing of Cameroon WBTi report content.
- ✓ Follow up the implementation of recommendations process.

2. In the welcome address, the national coordinator of IBFAN Cameoon Goup, James Achanyi-Fontem said, Cameroon is honored to have another opportunity for an orientation and reassessment training workshop on the World Breastfeeding Trends Initiative (WBTi).
   He thanked Mrs. Joyce Chanetsa, the Regional Coordinator of IBFAN Africa who included Cameroon on the list of countries to benefit from the training and reassessment on the World Breastfeeding Trends Initiative (WBTi). He recalled that Cameroon undertook the first assessment in November 2009.
   He thanked the government though the ministry of public health for allowing the event to happen and fo the patronage. He acknowledged that since the first assessment, many changes have taken place though the influence and guidance of the Minister of Public Health. The secondary data was reached for preparation of this re-assessment using WHO/ UNICEF data and information system for analyzing the 15 key indicators of Cameroon's trends so far documented.
   The data used during the WBTi training and reassessment in Cameroon are based on information collected from the Demographic Health Survey (DHS) in Cameroon, statistics from the Ministry of Public Health, Ministry of Planning, Programming and Territorial Development, WHO, UNICEF and ILO sources in Yaoundé, capital of Cameroon.
   The department for health promotion in the ministry of public health contributed through researched data as the policy and decision making channel within the frame work of its

collaboration with Cameroon Link, FECABPA and IBFAN Cameroon Group that reports regularly on all its activities.

He concluded by saying, since the government is working on putting in place a national nutrition programme, he used the opportunity of this training and re-assessment to advise the Cameroon government through His Excellency, the Minister of Public Health, on the key areas of budgeting for achieving successful breastfeeding in a country.

He explained that in other countries of the world, a national budget for breastfeeding promotion activities is often broken down to cover the key budget lines of activities:

- budget for training in IYCF counselling,
- budget for Code implementation and protection of breastfeeding
- budget for promoting maternity benefits,
- budget for policy development of breastfeeding/IYCF promotion,
- budget for developing and promotion of legislation on the Code,
- budget for promotion of the setting up of good crèche systems,
- and a budget for annual operating costs of the nutrition programme.

If the government improves on its policy by taking decisions to make the necessary resources available, there is no doubt that breastfeeding rates will increase from the current 20% to 65% by the year 2015, he concluded.

It was highlighted UNICEF is working with communities and the government to increase access to sanitation from 33 per cent to over 60 per cent by 2015. During the training, participants had the opportunity to listen to Mrs. Tamfu Hanson Ghandhi, a Cameroonian UN volunteer on emergencies, who had the opportunity to serve in Rwanda. He addressed the preparedness of Cameroon in handling emergency situations in flood regions and where there has been an influx of refugees in the north and east regions of Cameroon.

It was observed that the influx of refugees create silent emergency in some parts of Cameroon apart from the natural disasters, which are more and more regular.

The participants agreed that additional challenges facing refugee children in Cameroon include the lack of birth registration as well as an increase in child sexual exploitation, early marriages and early pregnancies.

James Achanyi-Fontem made a call, saying that unless the Cameroonian Government and host communities receive the support they need to develop long-term solutions, the silent emergency will continue to grow.

The Regional Coodinator, Mrs. Chanetsa emphasized on the fact that over 2.000.000 child deaths is recorded each year due to poor infant feeding practices, and the strategy ensues that mothers feed their babies properly. She explained how the Innocenti Declaration came about with its objective in 2003 and was revised in 2005. The Innocenti Declaration was actually to show young mothers how to breastfeed rightly.

It was within the frame wok the declaration that Cameroon came out in December 2005 with an act of the national code for regulating the marketing of breastmilk substitutes throughout the territory. It was observed that the breastfeeding mothers are not protected after delivering their babies, most especially working mothers. The addition targets aim to remedy some of the IYCF lapses in a way to promote timely, adequate, safe and appropriate complementary feeding with continued breastfeeding by providing guidance on IYCF**.**

The head of the health plannification service at the regional delegation for public health in the littoral, Mr. Ekoum Joseph (MPH), officially opened the workshop with an acknowledgement to IBFAN for their support and efforts towards improvement of Infant and Young Child Feeding, IYCF. He thanked Mrs. Joyce Chanetsa, current regional coordinator of IBFAN Africa for including Cameroon on the list of countries that have benefited from the training for the second time in the Africa region. He also presented exclusive breastfeeding trends from 2009 to 2012, indicating significant drop for the exclusively breastfed children.

SESSION TWO

Mrs. Joyce Chanetsa, IBFAN Africa Regional Coordinator briefed trainers on the Global Strategy on IYCF (GSIYCF) as the basis for the protection, promotion and support of all IYCF activities. She highlighted the goal of the Global Strategy as:

- To improve the feeding of infants and young children by,

- protecting, promoting and supporting optimal feeding practices
- empowering mothers/families/care-givers to make, and carry out, fully informed decisions about feeding, free from adverse commercial influences and misinformation; and
- ensuring supportive conditions for exclusive and continued breastfeeding as well as timely, adequate, safe and appropriate complementary feeding for every child
- Increase the commitment of governments, civil society and international organisations to protecting, promoting and supporting optimal infant and young child feeding.
- provision of accurate, objective and consistent information about optimal child feeding practices
- skilled support to initiate/sustain the optimal feeding practices, preventing/overcoming difficulties
- protection from misinformation and inappropriate commercial influences
- creating enabling environment for mothers/families to adequately feed and care for their infants and young children

The Regional Coordinator emphasized on the Innocenti Targets and the additional targets of the Global Strategy as basis for the WBTi implementation

Innocenti Declaration Targets.

All governments are expected to:

1. appoint a national breastfeeding coordinator
2. ensure that every facility providing maternity services fully practices the Ten Steps to Successful Breastfeeding
3. take action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant resolutions of the World Health Assembly
4. enact imaginative legislation protecting the breastfeeding rights of working women and establish means for its enforcement

Additional operational targets

All governments are expected to:

5. develop a comprehensive policy on infant and young child feeding:

- ensure that all key players protect, promote and support exclusive breastfeeding for the first 6 months of life
- promote timely, adequate, safe and appropriately done complementary feeding
- develop guidelines on appropriate feeding of infants and young children in exceptionally difficult circumstances, including HIV/AIDS
- adopt national legislation and other suitable measures for implementing the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA Resolutions.

GSIYCF

- describes interventions for promotion, protection & support of IYCF
- concentrates on the role of critical partners (Government, Int. org, civil society)
- builds on existing approaches
- comprehensive (all-inclusiveness)
- calls for investment into IYCF

The challenge

How do to use the strategy to ensure that appropriate IYCF is a reality in my country to achieve the United Nations Millennium Summit – MDG 4 and 5 (2000)
Each country has been urged to develop, implement, monitor and evaluate a plan of action on IYCF. Many have plans but how well are they implementing and reporting on the achievement of the operational goals.
This emphasis was made again in the Innocenti Declaration on IYCF (2005) that countries should put resources into IYCF as over 60% of under fives mortality is attributable to inadequate infant and young child feeding.

She stated that:
The achievement of the OPERATIONAL GOALS needs to be monitored
Action needs to be stimulated at all levels for implementation of the Global Strategy from the national assessments.
IBFAN Asia has innovatively summarized the WHO monitoring tool into a more manageable tool-the WBTi
The WBTi addresses all the 9 goals; is participatory, action oriented and is simple to use;
It is the best in **T**racking, **A**ssessing and **M**onitoring (TAM) the implementation of Global Strategy for IYCF

SESSION THREE

Introduction to WBTI and the trainers' reading of the resource modules

A brief presentation of the WBTi was made followed by the participants reading the resource modules and answering questions that followed; which were mostly well understood.
This was followed by discussion of Cameroon's experience in relation to other African countries. The regional coordinator briefed participants on the rationale for selection of countries and the work that followed at each country level during the first assessment. To date 40 countries including Cameroon have their reports posted on the WBTi website, while other reports are still being reviewed by the IBFAN Regional office and IBFAN Asia.

Conduction of national re-assessments
This was a brief power point presentation on the steps that each country follows in conducting assessments. This was followed by a brief discussion.

SESSION 4, 5
In these sessions, the participants worked in 3 groups for understanding the questionnaires and identifying the sources of data for each of the indicators.
This was followed by group presentations: Major sources of secondary data for Cameroon were the DHS, MICS, Ministry of Public Health, UNFPA, WHO and UNICEF. Others were HIV/AIDS National Committee, Ministry of Labour and ILO; and health facilities referenced reports. Documentation was received from UNICEF Cameroon office for information and data updates.
This was followed by another group work to read each indicator in detail: reading the question and the sub-set, suggesting possible sources of data and method of collecting the data. This was then followed by group presentations of findings and challenges.

Groups were constituted as follows:
Group 1: Indicators -1, 2, 3, 11, 12
Group 2: Indicators - 4, 5, 6, 13, 14
Group 3: Indicators - 7, 8, 9, 10, 15

SESSION 6, 7, 8
This Sessions consisted of reviewing the Cameroon report of 2009 on how the form was filled and comparing it to the current year; filling the blank template using available national data, analyzing the data and rating and scoring; and discussing how to identify gaps, identify achievements, making recommendations for action on bridging the gaps.
This was then followed by presentation of groups' finding and discussion.
At the end of this session all the indicators were scored and the country score, determined (relatively true score because of the available information).

There was then a brief discussion on how the collected information and the score could be utilized for advocacy and since there were several media specialists in the groups, many useful suggestions came up including: involvement of community radio media houses, civil society organisations for outreach, newsletters, meetings with policy makers, training of health workers and community resource people and sharing of IEC materials. Here are the results of the findings and re-assessment of breastfeeding trends in Cameroon.

Indicator 1: *National Policy, Programme and Coordination*

Key Question: Is there a national infant and young child feeding/breastfeeding policy that protects, promotes and supports optimal infant and young child feeding and the policy is supported by a government programme? Is there a mechanism to coordinate like National Infant and Young Child Feeding Committee and Coordinator?

Criteria of Indicator 1	Scoring	Results ✓ *Check any one*
1.1) A national Infant and Young Child Feeding/Breastfeeding policy has been officially adopted/approved by the government	2	✓
1.2) The policy promotes exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	2	✓
1.3) A National Plan of Action has been developed with the policy	2	✓
1.4) The plan is adequately funded	1	
1.5) There is a National Breastfeeding Committee	1	
1.6) The National Breastfeeding (Infant and Young Child Feeding) Committee meets and reviews on a regular basis	1	
1.7) The National Breastfeeding (Infant and Young Child Feeding) Committee links with all other sectors like health, nutrition, information etc., effectively	0.5	
1.8) Breastfeeding Committee is headed by a coordinator with clear terms of reference	0.5	
Total Score	**6/ 10**	**Yellow**

Information and Sources Used: Ministry of Public Health, IBFAN Cameroon, Nutrition NGOs etc.

Gaps: Inadequate funding. There is no national Infant and Young Child Feeding (IYCF) policy, hence there is non-existence of a National Breastfeeding Committee and no National Coordinator appointed at the level of the Ministry of Public Health.

Recommendations: The government (Ministry of Public Health) should equally consider breastfeeding as an urgent public health issue like Cancer, Malaria, Sickle Cell Disorder and HIV/AIDS, create a National Infant and Young Child Feeding Committee and allocate adequate funds. Appoint a National Coordinator with clear terms of reference.

Indicator 2: *Baby Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding)*

Key Question:

2A) What percentage of hospitals and maternity facilities that provide maternity services have been designated "Baby Friendly" based on the global or national criteria? NA

2B) What is the skilled training inputs and sustainability of BFHI? NA

2C) What is the quality of BFHI program implementation? NA

2A) Quantitative

*2.1) What percentage of hospitals and maternity facilities that provide maternity services have been designated "Baby friendly" based on the global or national criteria? **0 %***

2B) Qualitative

2.2) What is the skilled training inputs and sustainability of BFHI? NA

BFHI designated hospitals that have been certified after a minimum recommended training of 18 hours for its entire staff working in maternity services ***0%***

Qualitative

2C) What is the quality of BFHI program implementation? NA

Criteria	Score	Results ✓ *Check that apply*
2.3) BFHI programme relies on training of health workers	.5	
2.4) A standard monitoring system is in place	.5	
2.5) An assessment system relies on interviews of mothers	.5	
2.6) Reassessment systems have been incorporated in national plans	.5	
2.7) There is a time-bound program to increase the number of BFHI institutions in the country	.5	
Total Score		
Total Score 2A, 2B and 2C	**0/10**	**Red**

Information and Sources Used: Ministry of Public Health, IBFAN Cameroon Report

Gaps: 1. Complete absence of trained health workers and facilities for BFHI activities.
2. There is frequent redeployment and high attrition rate of trained workers.
3. Monitoring of BFHI is infrequent at the national and regional levels.

Recommendations: Implementation of the BFHI Programme has to be put in place with the training of BFHI health workers in the ten steps of successful breastfeeding throughout all ten regions of Cameroon including rural areas. Set up a monitoring and evaluation system to ensure follow-up of this activity. Nutrition Civil Society Organisation (CSO) should be involved and work together with staff of the Ministry of Public Health for the expansion of Baby Friendly Community

Initiative (BFCI) to succeed and create youth support groups, father support groups and mother support groups.

Indicator 3: *Implementation of the International Code*

Key Question: Are the *International Code of Marketing of Breastmilk Substitutes* and subsequent WHA resolution given effect and implemented? Has any new action been taken to give effect to the provisions of the Code?

Criteria	**Scoring**	**Results** ✓ ***Check those apply.If more than one* is applicable, record the highest score.**
3.1) No action taken	0	
3.2) The best approach is being studied	1	
3.3) National breastfeeding policy incorporating the Code in full or in part but not legally binding and therefore unenforceable	2	
3.4) National measures (to take into account measures other than law), awaiting final approval	3	
3.5) Administrative directive/circular implementing the Code in full or in part in health facilities with administrative sanctions	4	
3.6) Some articles of the Code as a voluntary measure	5	
3.7) Code as a voluntary measure	6	
3.8) Some articles of the Code as law	7	
3.9) All articles of the Code as law	8	✓
3.10) All articles of the Code as law, monitored and enforced	10	
Total Score:	**8/10**	Blue

Information and Sources Used: Ministry of Public Health, ICDC, IBFAN, WABA, BMA.
Gaps: National Code (2005) does not carry any sanctions for company violations.

Recommendations: The government (Ministry of Public Health) should ensure punitive measures are included into the national code on the marketing of breast milk substitutes. Nutrition Health Civil Society Organisations (CSO) should monitor code implementation and advocate for its application in all health facilities. Health workers should be trained on the code. Some articles of the code related to corruption should be printed in poster format and pasted in all health facilities for better sensitization and information of users and staff. CSO should educate members of parliament on the code and advocate for implementation.

Indicator 4: *Maternity Protection*

Key Question: Is there legislation and are there other measures (policies, regulations, practices) that meet or go beyond the International Labour Organization (ILO) standards for protecting and supporting breastfeeding for mothers, including those working mothers in the informal sector?

Criteria	Score	Results Check ✓ that apply
4.1) Women covered by the national legislation are allowed the following weeks of paid maternity leave		
a. Any leave less than 14 weeks	0.5	
14 to 17weeks	1	✓
18 to 25 weeks	1.5	
26 weeks or more	2	
4.2) Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily.		
a. Unpaid break	0.5	
b. Paid break	1	✓
4.3) Legislation obliges private sector employers of women in the country to give at least 14 weeks paid maternity leave and paid nursing breaks.	1	✓
4.4) There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector.	1	✓
4.5) Women in informal/unorganized and agriculture sector are:		
a. accorded some protective measures	0.5	
b. accorded the same protection as women working in the formal sector	1	
4.6) Information about maternity protection laws, regulations, or policies is made available to workers	0.5	✓
There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.'	0.5	✓

4.7) Paternity leave is granted in public sector for at least 3 days.	0.5	✓
4.8) Paternity leave is granted in the private sector for at least 3 days.	0.5	✓
4.9) There is legislation providing health protection for pregnant and breastfeeding workers and the legislation provides that they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	0.5	
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	0.5	✓
4.11) ILO MPC No 183 has been ratified, or the country has a national law equal to or stronger than C183.	0.5	
4.12) The ILO MPC No 183 has been enacted, or the country has enacted provisions equal to or stronger than C183.	0.5	✓
Total Score:	**7/10**	

Information and Sources Used: The International Labour Organisation, Ministry of Labour and Social Security and Cameroon National Assembly

Gaps: Legislation does not cover all sectors, especially women in the agriculture and informal sector.

Recommendations: The government should strive to fully implement the ILO recommendations on maternity protection, and accelerate measures being put in place to protect women in the informal sector.

Indicator 5: *Health and Nutrition Care System*

Key Question: Do care providers in these systems undergo *skills training*, and do their pre-service education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and whether health workers responsibilities to Code are in place?

Criteria	**Results** ✓ *Check that apply*		
	Adequate	Inadequate	No Reference
5.1) A review of health provider schools and pre-service education programmes in the country[1] indicates that infant and young child feeding curricula or session plans are adequate/inadequate	2	1	0
	✓		
5.2) Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care.	2	1	0
	✓		
5.3) There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers.[2]	2	1	0
	✓		
5.4) Health workers are trained with responsibility towards Code implementation as a key input.	1	0.5	0
		✓	
5.5) Infant feeding-related content and skills are integrated, as appropriate, into training programmes focusing on relevant topics (diarrhoeal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, etc.)	1	0.5	0
	✓		
5.6) These in-service training programmes are being provided throughout the country.[3]	1	0.5	0
	✓		
5.7) Child health policies provide for mothers and babies to stay together when one of them is sick	1	0.5	0
	✓		
Total Score:	9.5/**10**		

1 Types of schools and education programmes that should have curricula related to infant and young child feeding may vary from country to country. Which departments within various schools are responsible for teaching various topics may also vary. The assessment team should decide which schools and departments are most essential to include in the review, with guidance from educational experts on infant and young child feeding, as necessary.

2 The types of health providers that should receive training may vary from country to country, but should include providers that care for mothers and children in fields such as medicine, nursing, midwifery, nutrition and public health.

3 Training programmes can be considered to be provided "throughout the country" if there is at least one training programme in each region or province or similar jurisdiction.

Information and Sources Used: Ministry of Public Health, Department in charge of Mother and Child Health protection, WHO, UNICEF, FECABPA, Cameroon Link.

Gaps: Lack of information on pre-service curricula in the country and insufficient training of health personnel.

Recommendations: The Government should augment IYCF courses in health training institutions. There should be baby friendly hospital initiative, mother friendly hospital initiative and community baby friendly initiative. More national and international standard code training should be organised.

Indicator 6: *Mother Support and Community Outreach*

Key Question: Are there mother support and community outreach systems in place to protect, promote and support optimal infant and young child feeding?

Criteria	**Results** ✓ *Check that apply*		
	Yes	To some degree	No
6.1) All pregnant women have access to community-based support systems and services on infant and young child feeding.	2	1	0
		✓	
6.2) All women have access to support for infant and young child feeding after birth.	2	1	0
		✓	
6.3) Infant and young child feeding support services have national coverage.	2	1	0
		✓	
6.4) Community-based support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development strategy (inter-sectoral and intra-sectoral.	2	1	0
	✓		
6.5) Community-based volunteers and health workers possess correct information and are trained in counselling and listening skills for infant and young child feeding.	2	1	0
		✓	
Total Score:	**6/10**		

Information and Sources Used: Ministry of Public Health, FECABPA, IYCF Promotion Organisations.
Gaps: Insufficient information and training for community based volunteers and health workers.

Recommendations: There is great need for the Ministry of Public health and its partners to improve on training and recycling of health staff. There is a frame agreement document for collaboration between public health and community health volunteer. This document should be used for facilitation of the circulation of health information.

Key question: Are comprehensive Information, Education and Communication (IEC) strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being implemented?

Criteria	**Results** ✓ *Check that apply*		
	Yes	To some degree	No
7.1) There is a comprehensive national IEC strategy for improving infant and young child feeding.	2	1	0
	✓		
7.2) IEC programmes (e.g. World Breastfeeding Week) that include infant and young child feeding are being actively implemented at local levels	2	1	0
	✓		
7.3) Individual counselling and group education services related to infant and young child feeding are available within the health/nutrition care system or through community outreach.	2	1	0
		✓	
7.4) The content of IEC messages is technically correct, sound, based on national or international guidelines.	2	1	0
	✓		
7.5) A national IEC campaign or programme[4] using electronic and print media and activities has channelled messages on infant and young child feeding to targeted audiences in the last 12 months.	2	1	0
	✓		
Total Score:	**9/10**		

Indicator 7: *Information Support*

Information and Sources Used: Ministry of Public Health, UNICEF, WHO, IBFAN,

Gaps: Inadequate circulation and use of information on existing national programme of IYCF strategy.

Recommendations: The government (Ministry of Public Health) should consider putting in place a coherent communication strategy for circulation of information on Infant and Young Child Feeding.at health district level.

[4] An IEC campaign or programme is considered "national" if its messages can be received by the target audience in all major geographic or political units in the country (e.g., regions or districts).

Indicator 8: *Infant Feeding and HIV*

Key Question: Are policies and programmes in place to ensure that HIV - positive mothers are informed about the risks and benefits of different infant feeding options and supported in carrying out their infant feeding decisions?

Criteria	**Results** ✓ *Check that apply*		
	Yes	To some degree	No
8.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding and HIV	2	1	0
	✓		
8.2) The infant feeding and HIV policy gives effect to the International Code/ National Legislation	1	0.5	0
	✓		
8.3) Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	1	0.5	0
	✓		
8.4) Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	1	0.5	0
	✓		
13.5) Infant feeding counselling in line with current international recommendations and locally appropriate is provided to HIV positive mothers.	1	0.5	0
	✓		
13.6) Mothers are supported in making their infant feeding decisions with further counselling and follow-up to make implementation of these decisions as safe as possible.	1	0.5	0
	✓		
13.7) Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	1	0.5	0
	✓		0
13.8) On-going monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.	1	0.5	0
	✓		
13.9) The Baby-friendly Hospital Initiative incorporates provision of guidance to hospital administrators and staff in settings with high HIV prevalence on how to assess the needs and provide support for HIV positive mothers.	1	0.5	0
			0
Total Score:	**9/10**		

Information and Sources Used: Ministry of Public Health, National AIDS Control Committee, WHO, UNICEF, HIV Counselling Centres

Gaps: Insufficient Community Health Relay Trained Workers on HIV Home Care. All health centres need to institute follow up of HIV – positive pregnant mothers.

Recommendations: More community health relay staff should be recruited and trained. There is a need for more IEC campaigns and peer education activities amongst youth groups. Women should be empowered and men educated to support women in the context of HIV.

Indicator 9: *Infant Feeding during Emergencies*

Key Question: Are appropriate policies and programmes in place to ensure that mothers, infants and children will be provided adequate protection and support for appropriate feeding during emergencies?

Criteria	**Results** ✓ *Check that apply*		
	Yes	To some degree	No
9.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies	2	1	0
	✓		
9.2) Person(s) tasked with responsibility for national coordination with the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations have been appointed	2	1	0
	✓		0
9.3) An emergency preparedness plan to undertake activities to ensure exclusive breastfeeding and appropriate complementary feeding and to minimize the risk of artificial feeding has been developed	2	1	0
		✓	
9.4) Resources identified for implementation of the plan during emergencies	2	1	0
		✓	
9.5) Appropriate teaching material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.	2	1	0
Total Score:	**6/10**		

Information and Sources Used: Ministry of Public Health, Minstry of Territorial Administration and Decentralisation. UNICEF, Red Cross

Gaps: No data and references to activities of breastfeeding in emergencies. Emergency situation safety action has been sporadic.

Recommendations: Breastfeeding, infants and young child feeding during emergencies should be included on the public health agenda, within a preparedness action plan.

Indicator 10: *Monitoring and Evaluation*

Key Question: Are monitoring and evaluation data routinely collected and used to improve infant and young child feeding practices?

Criteria	**Results** ✓ *Check that apply*		
	Yes	To some degree	No
10.1) Monitoring and evaluation components are built into major infant and young child feeding programme activities.	2	1	0
		✓	
10.2) Monitoring or Management Information System (MIS) data are considered by programme managers in the integrated management process.	2	1	0
		✓	
10.3) Baseline and follow-up data are collected to measure outcomes for major infant and young child feeding programme activities.	2	1	0
		✓	
10.4) Evaluation results related to major infant and young child feeding programme activities are reported to key decision-makers	2	1	0
		✓	
10.5) Monitoring of key infant and young child feeding practices is built into a broader nutritional surveillance and/or health monitoring system or periodic national health surveys.	2	1	0
	✓		
Total Score:	**6/10**		

Information and Sources Used: **Ministry of Public Health, WHO, UNICEF. UNFPA**

Gaps: Monitoring and evaluation system does not captures complete infant and young child feeding data, National nutrition surveillance system within the organigramme of the Ministry of Public Health should be decentralized at district and health area levels.

Recommendations: Reinforce national nutrition surveillance system within the organigramme of the Ministry of Public Health for proper data collection, management and follow up of Infant and Young Child Feeding activities nationwide.

Indicator 11: Early Initiation of Breastfeeding

*Key question: Percentage of babies breastfed within one hour of birth …**95.6%***

Source of data: Demographic Health Survey for Cameroon-2010, Ministry of Public Health, Ministry of Planning, Programming and Territorial Development, WHO, UNICEF, Cameroon Link Report – 2010.

Summary Comments Cameroon's Health Policy promotes breastfeeding initiation within the first 30 minutes after delivery.

Indicator 12: Exclusive breastfeeding for the first six months

Key question: *Percentage of babies 0<6 months of age exclusively breastfed in the last 24 hours? **20. %***

Source of data: Multiple Indicator Cluster Survey (MICS 2010), Demographic Health Survey for Cameroon - 2010, Ministry of Public Health, WHO, UNICEF, Cameroon Link Report – 2010.

Summary Comments: Health workers in public and private facilities need recycling on mother and child care updated strategies to improve on the breastfeeding rate, which is alarming at 20% in 2012 from 37% in 2009. Community health workers should be trained and involved in the counselling of mothers as follow up strategy when the mothers leave the health facility for the community. Working women should be informed and educated on breastmilk extraction, preservation techniques and use of baby feeding cups to make breastmilk available at all times to their babies. ILO maternity protection convention should be enacted and government should take steps towards its ratification.

Indicator 13: Median duration of breastfeeding

Key question: Babies are breastfed for a median duration of how many months? ……. months

Guideline:

Indicator 3	**WHO's** *Key to rating*	**Existing Situation %**	**SCORE**	**COLOUR**	**GRADE**
Median Duration of Breastfeeding					
	0-17 Months	17.5 months	3	Red	D
	18-20 ''				
	21-22 ''				
	23-24 ''				

Source of data: Multiple Indicator Cluster Survey (MICS 2011), Demographic Health Survey for Cameroon - 2011, Ministry of Public Health, WHO, UNICEF, Cameroon Link Report – 2012.

Summary Comments: This figure has not changed at 17.5 months since the assessment in 2009. Information, social mobilization, advocacy and sensitization campaigns need to be intensified with the involvement of community health workers, nurses, midwives, CSO, CBO and media. Capacity building workshops for health personnel and social workers recommended to ensure standardization of messages.

Indicator 14: Bottle feeding

Key question: What percentage of breastfed babies less than 6 months old receives other foods or drinks from bottles? .....%?

Guideline:

Indicator 4	**WHO's** Key to rating	**Existing Situation %**	**SCORE**	**COLOUR**	**GRADE**
Bottle Feeding (<6 months)					
	30-100%	75	3	Red	D
	5-29%				
	3-4%				
	0-2%				

Source of data: Ministry of Public Health, WHO, UNICEF

Summary Comments: Ministry of Public Health should take the lead and support health civil society organisation to enforce code monitoring and publish the company violations. Sensitization at the maternity level should be increased. Community health workers should be involved in monitoring and counselling of mothers and advise mothers on the use of locally available foods. Health personnel and social workers should be recycled on breastfeeding, infant and young child feeding issues.

Indicator 15: Complementary feeding

Key question: Percentage of breastfed babies receiving complementary foods at 6-9 months of age?

Guideline:

Indicator 5	**WHO's Key** to rating %	**Existing Situation %**	**SCORE**	**COLOUR**	**GRADE**
Complementary Feeding (6-9 months)					
	0-59%				
	60-79%	79.2	6	Yellow	C
	80-94%				
	95-100%				

Source of data: Demographic Health Survey 2010, Ministry of Public Health, WHO, UNICEF,

Summary Comments: Continued breastfeeding after introduction of complimentary foods should

be promoted and supported, however as the rate of breastfeeding has fallen, it is very likely that we may be facing a problem of early supplementation.

COMPARISON WITH 2009 ASSESSMENT

Table: Indicators 1-15: Trends in Infant feeding practices

Indicator	Status in the last assessment in 2009	Current status 2012	Score	Colour	Grade
1. National Policy, Programme and Coordination	6/10	6/10	6		**Yellow**
2. Baby Friendly Hospital Initiative	0/10	0/10	0		**Red**
3. Implementation of the National Code	8/10	8/10	8		**Blue**
4. Maternity Protection	6.5/10	7/10	7		**Blue**
5. Health And Nutrition Care	5.0/10	9.5/10	9.5		**Green**
6. Community Outreach	7/10	7/10	6		**Blue**
7. Information Support	9/10	9/10	9		**Green**
8. Infant Feeding and HIV	6/10	8/10	9		**Blue**
9. Infant Feeding During Emergencies	0/10	6/10	6		**Yellow**
10. Monitoring and Evaluation	4/10	6/10	6		**Blue**
	51,5 %		66.5/100		**Yellow**
11. Percentage of babies breastfed within one hour of birth	95.6%	95.6%	10		**Green**
12. Percentage of babies exclusively breastfed for first six months	37%	20%	6		**Yellow**
13. Median Duration of Breastfeeding	17.5 months	17.5%	3		**Red**
14. Bottle- Feeding	75%	75%	3		**Red**
15. Complementary Feeding	79.2%	79.2%	6		**Yellow**

Total out of 100%	51.5%		28/50		**Yellow**
Total out of 150	79.5/150		94.5/150		**Yellow**

Observation

Red stands for the worst performance

Yellow stands for worse performance

Blue stands for average performance

Green stands for Good performance

Overall Comments: Cameroon has moved from 79,5% to 94,5% but the global yellow colour coding has not changed. This means that the red and yellow colour rating should be seen as priority areas for government to react urgently.

Overall Recommendations: We encourage the government to enforce the legislation already put in place. The government decisions should ensure that business is done within the respect of laws put in place, as tools for the protection of the mothers and their babies.

We strongly recommend that the government should prioritize the following programme areas: Baby Friendly Hospital Initiative (BFHI), Infant feeding during emergencies, Ensure that the median duration of breastfeeding is practiced in the community and that bottle feeding should be strongly discouraged.

Government to develop an infant and young feeding policy and put in place the necessary structure for implementation.

The next priority areas are those coded in yellow.

CAMEROON

Report Card 2012

94.5/150

The State of Infant and Young Child Feeding (IYCF)

Policies and Programmes (Indicator 1-10)

Score Out of 10

1. National Policy, Programme and Coordination
Concerns national policy ,plan of action, funding and coordination issues.
6/10

2. Baby Friendly Hospital Initiative
Concerns percentage BFHI hospitals, training, standard monitoring, assessment and reassessment systems.
0/10

3. Implementation of the International Code
Concerns implementation of the Code as law, monitored and enforced.
8/10

4. Maternity Protection
Concerns paid maternity leave, paid breastfeeding breaks, national legislation encouraging work site accommodation for breastfeeding and/or childcare and ratification of ILO MPC No 183.
67/10

5. Health and Nutrition Care Systems
Concerns health provider schools and pre-service education programmes, standards and guidelines for mother-friendly childbirth procedures, in-service training programmes.
9.5/10

6. Mother Support and Community Outreach-
Concerns skilled counseling services on infant and young child feeding, and its access to all women. (During pregnancy and after birth)
6/10

7. Information Support
Concerns national IEC strategy for improving infant and young child feeding, actively implemented at local levels.
9/10

8. Infant Feeding and HIV
Concerns policy and programmes to address infant feeding and HIV issue and on-going monitoring of the effects of interventions on infant feeding practices and health outcomes for mothers and infants.
98/10

9. Infant Feeding during Emergencies
Concerns policy and programme on infant and young child feeding in emergencies and material on IYCF in emergencies integrated into pre-service and in-service training for emergency management.
6/10

10. Mechanisms of Monitoring and Evaluation System
Concerns monitoring, management and information system (MIS) as part of the planning and management process.
6/10

Practices (Indicator 11-15)

95.6%

Indicator 11:
Early Initiation of Breastfeeding
(Score: 10/10)

20%

Indicator 12:
Exclusive Breastfeeding for the first 6 months (Score: 6/10)

17.5 Months
Indicator 13: Median Duration of breastfeeding
(score : 3/10)

75%

Indicator 14:
Bottle-feeding
(Score: 3/10)

79.2%

Indicator 15:
Complementary Feeding
(Score: 6/10)

Total Score (Indicator 1-15): 94.5/150

Key to scoring, colour- rating, grading and ranking:
The level of achievement of infant feeding practices is taken in 'percentage' except median duration, which is an absolute number of months.

In the case of indicators 11 to 15 on practices, key to rating is used from the WHO's '"Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". Scoring and colour-rating are provided according to IBFAN Asia Guidelines for WBT . Each indicator is scored out of maximum of 10.

For indicators 1 to 10, there is a sub set of questions leading to key achievement, indicating how a country is doing in a particular area. Each question has possible score of 0-3 and the indicator has a maximum of 10.

IBFAN Asia Guidelines for WBT for rating and grading individual indicators 1 to 15 are as: 0 - 3 is rated Red, 4 - 6 is rated Yellow, 7 - 9 is rated Blue and more than 9 is rated Green.

Total score of all indicators 1 to 15 is calculated out of 150.

Key Gaps

Inadequate funding, Non-existence of a national programme of IYCF, no committee and there is no National Coordinator at the level of the Ministry of Public Health.
Complete absence of trained health workers and facilities for BFHI activities.
Monitoring of BFHI is non existent at the national and regional levels.
No data and references to activities of breastfeeding in emergencies. Emergency situation safety action has been sporadic.
Exclusive breastfeeding rate is alarming at 20% in 2012 from 37% in 2009.
Cameroon national code lacks an article on sanctions for violations.

Key Recommendations

The government needs to put in place a national infant and young feeding committee and appoint a national coordinator with a national budget for breastfeeding promotion activities

There is great need for the Ministry of Public health and its partners to improve on training and recycling of health staff on BHFI, Code Monitoring, Infant Feeding in emergencies and counselling..

Country Assessment 2012

IBFAN Africa conducted a three-day workshop from 24-28 October 2012, to orient the government of Cameroon on how to conduct periodic monitoring and evaluation of infant and young child feeding practices, policies and programmes using a simple to use World Breastfeeding Trends Initiative tool (the WBTi).
The workshop was held at Hotel du Rail Bonaberi-Douala for 16 participants who came from the government, Civil Society Organisations (CSO), Infant Feeding advocacy CBOs. Being gender sensitive, training and reassessment included men, women and youth groups. The workshop was facilitated by the Regional Coordinator of IBFAN Africa, Mrs. Joyce Chanetsa, and the Coordinator of IBFAN Cameroon Link Group, who triples as the National President of the Federation of Cameroon Breastfeeding Promotion Associations (FECABPA) and Coordinator of WABA Men's Initiative.

Partner Organisations

Ministry of Public Health
Ministry of Labour
WHO/UNICEF
IBFAN Africa
Commonwealth of Learning
FECABPA
National Media

Convention on the Right of the Child (CRC)

CRC Commitment

1. Ensure the full participation of civil society, including breastfeeding and young child feeding NGOs, in the elaboration and implementation of the national breastfeeding policy and programme;
2. Raise awareness and sensitize mothers about the importance of exclusive breastfeeding of infants up to the age of six months; inform and involve traditional leaders and provide trainings to health workers;
3. Widely disseminate the existing National Infant Feeding Code among the population, and ensure that it is translated in all appropriate languages.

Recommendations of the CRC Committee 2010

(a) Effectively implement the breastfeeding policy as well as the National Infant Feeding Code and allocate sufficient resources for their implementation and monitoring, particularly in rural areas;
(b) Include breastfeeding in the annual budget allocation of the Ministry of Public Health;
(c) Set up a consolidated breastfeeding data collection system disaggregated, by age, sex, ethnic group, region and other child-related indicators in line with the CRC Convention;
trainings to health workers.

Global Commitments on Infant and Young Child Feeding

Global Strategy for Infant and Young Child Feeding 2002: World Health Assembly (WHA) and UNICEF adopted the Global Strategy, which sets five additional targets: national policy on infant and young child feeding, community outreach, information support, infant feeding in difficult circumstances and monitoring and evaluation. http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/gs_iycf.pdf

Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding 1990: http://www.unicef.org/programme/breastfeeding/innocenti.htm

World Health Assembly Resolutions: call upon Member States to implement policies and programmes to improve infant nutrition. The recent resolution adopted on May 27,2006 calls on Member States to implement Global Strategy for Infant and Young Child Feeding and multilateral and bilateral donor arrangements and international financial institutions to direct financial resources for Member States to carry out these efforts. Resolutions 49.15, 58.32, 61.20 call upon member states to avoid conflicts of interests in programmes of child health.
http://www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_32-en.pdf
http://www.who.int/gb/ebwha/pdf_files/A61/A61_R20-en.pdf

WHO HIV and Infant Feeding Technical Consultation Consensus Statement, Geneva, October 25-27, 2006: http://www.who.int/hiv/mediacentre/Infantfeedingconsensusstatement.pf.pdf.

Millennium Development Goals: www.un.org/millenniumgoals/

Innocenti Declaration 2005 on Infant and Young Child Feeding: www.unicef.org/nutrition/index_breastfeeding.html

Maternity Protection Convention: http://www.ilo.org/

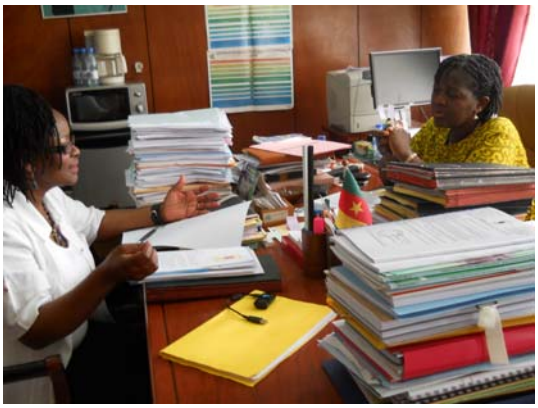
For detailed report please contact

Ministry of Public, Health FECABPA, Cameroon Link
WBTi Cameroon Coordination Office,
P.O. Box 1460 Douala, Littoral Region, Cameroon
Tel: +237 77758840 - +237 94340874
Email: camlink99@gmail.com
http://camlinknews.blogspot.com, http://uk.youtube.com/camlink99/
http://www.spreaker.com/user/camlink/teenage_prenancy

WBT*i* Coordinating Office

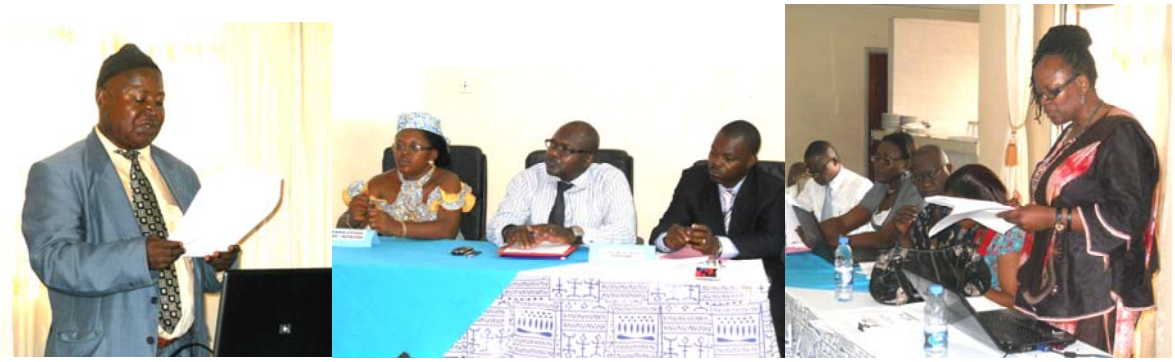
International Baby Food Action Network (IBFAN), Asia /
Breastfeeding Promotion Network of India (BPNI)
BP-33, Pitampura, Delhi 110 034, India
Tel: +91-11-27343608, 42683059 Fax: +91-11-27343606
Email: info@ibfanasia.org
Websites: www.ibfanasia.org , www.worldbreastfeedingtrends.org
www.worldbreastfeedingmovement.org , www.onemillioncampaign.org

TheWorld Breastfeeding Trends Initiative (WBT) is IBFAN Asia's flagship programme.WBT is being implemented as an integral part of two projects "Global Breastfeeding Initiative for Child Survival" (GBiCS), in partnership with the Norwegian Agency for Development Cooperation (Norad) and Global Proposal for Coordinated Action of IBFAN and WABA: Protecting, Promoting and Supporting Breastfeeding through Human Rights and Gender Equality" in partnership with Swedish International Development Agency (Sida).

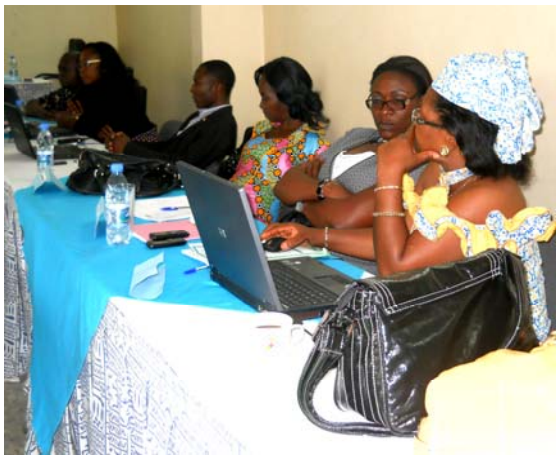


Joyce Chanetsa at MPH with Dr. Baye Martina

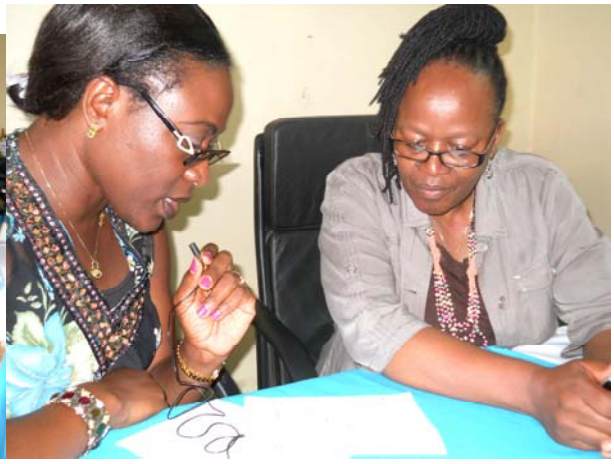
UNICEF Cameroon Officials review WBTI rating



Ministry of Public Health Officials listen to 2012 WBTi Cameroon reassessment statements

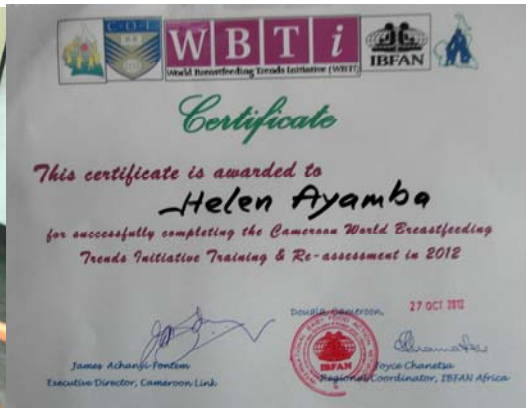



2012 WBTi Cameroon assessors during work in groups

IBFAN Africa RC, Mrs. Joyce Chanetsa, accords WBTi Press Conference in Douala, Cameroon

IBFAN Africa RC received at CAMLINK Douala



Sample WBTi 2012 Certificate of Participation

The World Breastfeeding Trends Initiative (WBT*i*)

Re-assessment of Cameroon 2012

The following persons participated in the Cameroon WBTi reassessment workshop facilitated by Mrs. Joyce Chanetsa, the Regional Coordinator of the International Baby Food Action network, IBFAN Africa.

- Joyce Chanetsa, Regional Coordinator, IBFAN Africa, ibfan.jchanetsa@realnet.co.sz
- Okala Georges, Sub Director, Food & Nutrition, MOH, okalageorges@yahoo.fr
- James Achanyi-Fontem, Coordinator, IBFAN Cameroon Group, camlink99@gmail.com
- Dr. Ekoum Joseph, Representative of Public Health Ministry, jekoum@yahoo.fr
- Dr. Balo jean Richard – Chief Medical Officer, Bonassama, balojeanrichard@yahoo.fr
- Mrs. Koé Marie Hortense, MOH Nutrition Focal Point, Littoral koebellu2005@yahoo.fr
- Tamfu Hanso Ghandi – UN Volunteer on Emergencies, tamhanson2000@yahoo.com
- Samuel Mibe, Head of Bureau, Maternal and Child Protection (MOH), samuelmibe@yahoo.fr
- Jeanine Souki – Head of Health Bureau (Bonassama District) kenkojeanine@yahoo.fr
- Dorothy Ndikum – Director, Health Watch Yaoundé, Dorothy_ndikum@yahoo.com
- Sally Ebenye – CRTV Health Programme, salebenye@yahoo.fr
- Suzanne Ayuk, Youth Representative, Cameroon Link, ayumsusan@yahoo.com
- Henry Kejang – Editor-in- Chief, Canal 2 Tv Douala, kejang_henry_atembeh@yahoo.com
- Andela Elizabeth, Nutrition Counsellor, AFFE Mbalmayo, adielte2012@hotmail..fr
- Helen Ayamba – Adm. Assistant, Cameroon Link, heleayamba@yahoo.com
- Ayuk Thomas Fotany, Comedian/ Entertainer, kingspilete@yahho.com
- Mike Achanyi, ICT Officer, Cameroon Link, mikepac715@gmail.com
- Njinguet Julienne – Femmes Elites Mambanda Tel. 99902521
- Dzeuta Dze Arsel, Coordinator, Ass. Des Jeunes New Style Bonendale
- Neh Mary Ngwa, IYCF Counsellor, COGESID Mambanda, cogesid@yahoo.com

2012 WBTI Cameroon Media Coverage

No	Name	Media Organ	Email
1	Christopher Jator	Cameroon Tribune	**chriznje@yahoo.com**
2	Madeleine Ngeunga	Sweet FM Radio	**n_maud86@yahoo.fr**
3	Theodore Tchopa	Le Jour	**tchopatheo@yahoo.fr** Tel:+237 77513859
4	Nde Walters	Sky One Radio	**ndewalters222@yahoo.com** Tel: +237 78000712
5	Boudowin Nyobe	La Meteo	**papyrecords@yahoo.fr** Tel: +237 79789452
6	Adeline Tchouakak	Le Messager	**Tadeline2000@yahoo.fr** Tel: +237 75689475
7	Nono Potue	DBS Tv	**nonoaotue@yahoo.fr**
8	Paolo Ngombe	Le Popoli	**paolongombe@yahoo.fr**
9 10	Frederic Moutome Christian Tamfu	LTM Tv	**maurin-moutome@yahoo.fr** Tel: +237 99541566
11	Benoit Ndongmo Luc Ngatcha	Camnews 24 Tv	**Ben_duta@yahoo.fr** Tel: +237 7533802
12	Martin Djeumo	Canal 2 Tv	Tel: +237 99321248
13	Mokube Robert	Equinox Tv	Tel: +237 77405749
14	Helen Ayamba	Camlink Radio	**helenayamba@yahoo.com** Tel: +237 71806969

WHO Cameroon

Global Health Observatory Data Repository

Statistics

Total population	**19,599,000**
Gross national income per capita (PPP international $)	**2,270**
Life expectancy at birth m/f (years)	**51/51**
Probability of dying under five (per 1 000 live births)	not available
Probability of dying between 15 and 60 years m/f (per 1 000 population)	**420/409**
Total expenditure on health per capita (Intl $, 2010):	**122**
Total expenditure on health as % of GDP (2010):	**5.1**

Figures are for 2009 unless indicated. Source: Global Health Observatory

Indicator	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990
Infant mortality rate (probability of dying between birth and age 1 per 1000 live births)	84					88					91					91					85
Adolescent fertility rate (per 1000 girls aged 15-19 years)									141												
Contraceptive prevalence (%)					29.2																
Unmet need for family planning (%)							20.2														
Under-five mortality rate (probability of dying by age 5 per 1000 live births)	136					142					148					147					137
Median availability of selected generic						58.3															

medicines (%) - Public																				
Median consumer price ratio of selected generic medicines - Public						2.2														
Antiretroviral therapy coverage among people with advanced HIV infection (%)																				
Children aged <5 years sleeping under insecticide-treated nets (%)					13.0															
Children aged <5 years with fever who received treatment with any antimalarial (%)					58															
Deaths due to malaria (per 100 000 population per year)			121 [91-158]																	
Deaths due to tuberculosis among HIV-negative people (per 100 000 population)	14.0 [9.00-21.0]	15.0 [9.30-22.0]	15.0 [9.60-23.0]	16.0 [9.20-26.0]	18.0 [10.0-27.0]	20.0 [13.0-30.0]	22.0 [15.0-32.0]	25.0 [17.0-35.0]	25.0 [18.0-34.0]	26.0 [19.0-35.0]	25.0 [18.0-32.0]	24.0 [18.0-31.0]	22.0 [17.0-29.0]	22.0 [17.0-28.0]	22.0 [16.0-28.0]	19.0 [14.0-25.0]	17.0 [11.0-24.0]	15.0 [8.40-23.0]	14.0 [6.90-24.0]	13.0 [6.00-25.0]	11.0 [4.70-23.0]
Deaths due to tuberculosis among HIV-positive people (per 100 000 population)																				
Prevalence of HIV among adults aged >=15 years (per 100 000 population)																				
Incidence of tuberculosis (per 100 000 population per year)	177 [145-212]	182 [149-218]	187 [152-225]	192 [156-231]	197 [160-237]	202 [164-243]	204 [166-246]	202 [165-244]	194 [158-234]	181 [148-219]	168 [137-202]	154 [125-186]	142 [116-171]	132 [107-159]	123 [100-148]	116 [95.0-140]	109 [84.0-137]	102 [74.0-134]	95.0 [65.0-131]	89.0 [58.0-127]	81.0 [50.0-117]
Tuberculosis detection rate under DOTS (%)																				
Prevalence of tuberculosis (per 100 000 population)	185 [86-299]	190 [88-308]	196 [91-317]	204 [92-341]	214 [99-356]	228 [108-379]	239 [115-394]	250 [121-410]	245 [118-400]	240 [115-395]	224 [107-368]	212 [101-350]	198 [94-326]	191 [89-316]	184 [85-305]	173 [81-284]	161 [75-274]	149 [66-263]	143 [58-267]	138 [52-271]	123 [43-253]
Tuberculosis treatment success under DOTS																				

(%)																					
Births attended by skilled health personnel (%)					59[0]																
Maternal mortality ratio (per 100 000 live births) - Interagency estimates	690 [430-1200]					720 [450-1300]					730 [450-1300]					720 [430-1300]					670 [400-1200]
Children aged <5 years stunted (%)																					
Population below minimum level of dietary energy consumption																					
Unmet need for family planning, among women aged 15-19 (%)							19.5														
Contraceptive prevalence, among women aged 15-19 (%)							23.6														
Case detection rate for all forms of tuberculosis	69 [58-85]	71 [59-87]	70 [58-86]	68 [57-84]	66 [55-82]	61 [50-75]	50 [42-62]	47 [39-58]	35 [29-43]	39 [32-48]	20 [17-25]	32 [27-40]	24 [20-29]	20 [17-25]	17 [14-21]	20 [17-25]	49 [39-64]	52 [40-72]	55 [40-81]	61 [43-94]	60 [41-96]
Antiretroviral therapy coverage among people with advanced HIV infection (%), WHO 2006 guidelines																					
Antiretroviral therapy coverage among people with advanced HIV infection (%), WHO 2010 guidelines	38 [34-43]																				
Maternal mortality ratio (per 100 000 live births) - Country reported estimates		669																			
Smear-positive tuberculosis treatment-success rate (%)		78	77	76	74	74	71		71	62	77	75	75	60	59	53	44				
Smear-positive tuberculosis case-detection rate (%)																					
Prevalence of HIV among adults aged 15 to 49		5.3 [4.9 -	5.3 [4.9 -	5.4 [4.9	5.4 [4.9 -	5.4 [4.9 -	5.4 [5.0 -	5.5 [5.0	5.5 [5.1 -	5.5 [5.1	5.5 [5.0 -	5.4 [5.0 -	5.3 [4.8	5.1 [4.6	4.8 [4.2	4.2 [3.6	3.4 [2.6	2.5 [1.6	1.6 [1.0	1 [0.6 - 2.5]	0.6 [0.3 - 2.4]

(%)		5.8]	5.8]	-5.9]	5.9]	5.9]	5.9]	-6.0]	6.0]	-6.0]	6.0]	5.9]	-5.9]	-5.7]	-5.3]	-4.8]	-4.0]	-3.1]	-2.7]		
Children aged <5 years underweight (%)																					
Births attended by skilled health personnel, among women aged 15-19 (%)							61.6														
Number of community health workers																					
Distribution of causes of death among children aged <5 years (%) - Pneumonia	15	15	17	17	17	17	17	17	17	16	16										
Distribution of causes of death among children aged <5 years (%) - Injuries	3	3	3	3	3	3	3	3	3	3	3										
Distribution of causes of death among children aged <5 years (%) - Diarrhoea	13	13	13	13	13	13	13	14	14	13	13										
Distribution of causes of death among children aged <5 years (%) - Measles	0	0	0	0	1	1	0	0	0	7	6										
Distribution of causes of death among children aged <5 years (%) - Causes arising in the perinatal period																					
Distribution of causes of death among children aged <5 years (%) - HIV/AIDS	5	5	6	6	6	6	6	7	7	6	6										
Distribution of causes of death among children aged <5 years (%) - Other diseases	18	17	17	17	17	16	16	16	15	14	14										
Distribution of years of life lost by broader causes (%) - Communicable			75																		
Distribution of years of life lost by broader causes (%) - Noncommunicable			17																		
Distribution of years of life lost by broader causes (%) - Injuries			7																		
Population using solid fuels (%)																					

Age-standardized mortality rate by cause (per 100 000 population) - Communicable			861																		
Distribution of causes of death among children aged <5 years (%) - Prematurity	11	11	11	11	11	10	10	10	10	10	10										
Distribution of causes of death among children aged <5 years (%) - Neonatal sepsis	5	5	5	4	4	4	4	4	4	4	4										
Distribution of causes of death among children aged <5 years (%) - Congenital anomalies	5	5	5	5	5	5	5	5	5	4	4										
Number of pharmaceutical personnel							700														
Distribution of causes of death among children aged <5 years (%) - Malaria	16	17	16	16	16	17	17	17	17	16	16										
Age-standardized mortality rate by cause (per 100 000 population) - Noncommunicable			879																		
Total expenditure on health as a percentage of gross domestic product	5.1[1]	4.9[2]	5.1[3]	4.7[4]	4.7[5]	4.7[6]	4.7[7]	5.0[8]	4.9[9]	4.7[10]	4.5[11]	4.4[12]	4.4[13]	4.6[14]	5.2[15]	3.9[16]					
Dentistry personnel density (per 10 000 population)							0.1														
Private expenditure on health as a percentage of total expenditure on health	70.4[17]	74.1[18]	79.6[19]	77.6 [20]	77.0[21]	76.4[22]	76.1[23]	73.2 [24]	73.4[25]	76.0 [26]	79.2[27]	81.2[28]	82.2 [29]	78.9 [30]	82.7 [31]	76.7 [32]					
Nursing and midwifery personnel density (per 10 000 population)							16														
General government expenditure on health as a percentage of total expenditure on health	29.6[33]	25.9[34]	20.4[35]	22.4 [36]	23.0[37]	23.6[38]	23.9[39]	26.8 [40]	26.6[41]	24.0 [42]	20.8[43]	18.8[44]	17.8 [45]	21.1 [46]	17.3 [47]	23.3 [48]					
Community health workers density (per 10 000 population)																					
Deaths due to malaria (per 100 000 population)																					
Antenatal care coverage - at least four visits							60														

(%)																					
Per capita total expenditure on health at average exchange rate (US$)	61	60[49]	64	53	47	45	43	40	32	28	27[50]	29	29	29	34	25					
Number of other health service providers																					
Population using improved sanitation facilities (%)			47			47					47					48					47
Other health service providers density (per 10 000 population)																					
Age-standardized mortality rate by cause (per 100 000 population) - Cancer																					
Age-standardized mortality rate by cause (per 100 000 population) - Cardiovascular																					
Age-standardized mortality rate by cause (per 100 000 population) - Injuries			111																		
Number of environment and public health workers							28														
Density of pharmaceutical personnel (per 10 000 population)							0.4														
Age-standardized mortality rate by cause (ages 30-70, per 100 000 population) - Cancer			122																		
Age-standardized mortality rate by cause (ages 30-70, per 100 000 population) - Cardiovasular disease and diabetes			473																		
Age-standardized mortality rate by cause (ages 30-70, per 100 000 population) - Chronic respiratory conditions			115																		
Crude birth rate (per 1000 population)	36																				
Crude death rate (per 1000 population)		14																			

Cellular subscribers (per 100 population)	44																					
Most recent census (year)						2005																
Number of cause-of-death registration years available																						
Number of national population surveys - child anthropometry																						
Number of national population surveys - child mortality																						
Number of national population surveys - maternal mortality																						
Number of national population surveys - HIV prevalence																						
Number of national population surveys - adult health																						
Civil registration coverage of cause-of-death (%)																						
Ill-defined causes in cause-of-death registration (%)																						
International Statistical Classification of Diseases and Related Health Problems (ICD)																						
Age-standardized mortality rate by cause (ages 30-70, per 100 000 population) - All causes			1846																			
Postnatal care visit within two days of childbirth (%)																						
Density of environment and public health workers (per 10 000 population)							<0.01															
Number of reported cases of tuberculosis																						
Distribution of causes of death among children	8	8	8	8	8	8	8	8	8	7	7											

aged <5 years (%) - Birth asphyxia																					
BCG immunization coverage among 1-year-olds (%)	96	92	99	94	98	90	83	82	79	79	78	78	80	75	69	62	59	58	62	69	76
Polio (Pol3) immunization coverage among 1-year-olds (%)	83	79	82	81	78	79	72	72	66	62	57	58	53	47	43	46	42	34	37	46	54
Stillbirth rate (per 1000 total births)		26																			
Radiotherapy units (per 1 000 000 population)	0.2																				
Antenatal care coverage - at least one visit, among women aged 15-19 (%)							83.2														
Number of under-five deaths (thousands)	93					91					82					79					66
Number of infant deaths (thousands)	58					57					50					49					42
Number of neonatal deaths (thousands)	24					23					21					19					17
Children aged <5 years with ARI symptoms who took antibiotic treatment (%)																					
Life expectancy at age 60 (years)		15									15										15
Malaria - number of reported deaths	4536	4943	7673																		
Estimated number of malaria cases (000's)																					
Estimated number of malaria deaths																					
Number of under-five deaths from malaria	15000	15000	15000	15000	15000	15000	16000	15000	15000	14000	14000										
Cholera - number of reported cases	10759																				
Healthy life expectancy (HALE) at birth (years)				45																	
Neonatal mortality rate (per 1000 live births)	34					34					35					35					34
Adult mortality rate (probability of dying between 15 and 60 years per 1000 population)		413									397										321

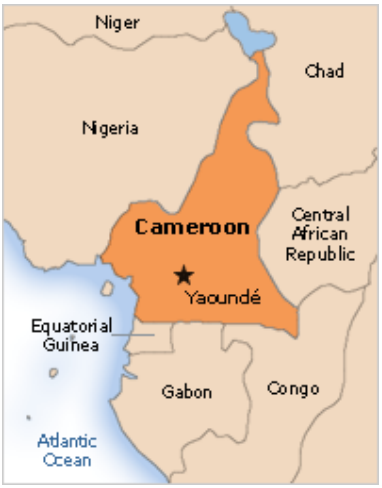
Low-birth-weight newborns (%)					11																
Infants exclusively breastfed for the first six months of life (%)					21																
Children aged <5 years overweight (%)																					
Alcohol consumption among adults aged ≥15 years (litres of pure alcohol per person per year)						4.7															
Literacy rate among adults aged >= 15 years (%)			75.9	70.7							68.4										
Population (in thousands) total	19599	19175	18759	18350	17948	17554	17165	16783	16408	16040	15678										
Population median age (years)	19					19					18					18					17
Population proportion under 15 (%)	41																				
Population living on <$1 (PPP int. $) a day (%)				9.56						10.77				24.88							
Life expectancy at birth (years)		51									51										55
Measles - number of reported cases	240	251																			
Diphtheria - number of reported cases																					
Japanese encephalitis - number of reported cases																					
Pertussis - number of reported cases																					
Leprosy - number of reported cases	532	453	406	549	714	537															
Total tetanus - number of reported cases	83	72																			
Meningitis - number of reported cases	835	1001		107	35			539	899	1822	1432	2272	2887	572	178		578	5372	27752	2625	2684
Malaria - number of reported cases		0																			
Poliomyelitis - number of reported cases																					

Yellow fever - number of reported cases	16	8																				
H5N1 influenza - number of reported cases																						
Plague - number of reported cases																						
Mumps - number of reported cases																						
Number of reported cases of tuberculosis (DOTS)			14232																			
Congenital Rubella Syndrome - number of reported cases																						
Neonatal tetanus - number of reported cases	29	39																				
Rubella - number of reported cases	48	33																				
Civil registration coverage of births (%)					70																	
Population proportion over 60 (%)	5																					
Births by caesarean section (%)							2.0															
Median consumer price ratio of selected generic medicines - Private						13.6																
Hepatitis B (HepB3) immunization coverage among 1-year-olds (%)	84	80	84	82	81	79																
External resources for health as a percentage of total expenditure on health	13.2[51]	10.9[52]	8.2[53]	6.6[54]	5.8[55]	5.7[56]	6.6[57]	6.7[58]	5.9[59]	4.9[60]	4.2[61]	2.3[62]	3.2[63]	2.9[64]	2.7[65]	4.6[66]						
Population using improved drinking-water sources (%)			74			71					64					57						50
Number of dentistry personnel							147															
Children aged 6-59 months who received vitamin A supplementation (%)					57.7																	
Physicians density (per 10 000 population)							1.9															
Distribution of years of life lost by broader																						

causes (%)																					
Number of nursing and midwifery personnel							26042														
Neonates protected at birth against neonatal tetanus (PAB) (%)	91	91	86	83	81	76	73	71	65	52	54	55	47	40	21	20	18	18	26	19	19
Hib (Hib3) immunization coverage among 1-year-olds (%)	84	80																			
Social security expenditure on health as a percentage of general government expenditure on health	2.6[67]	5.2[68]	4.2[69]	3.5[70]	3.2[71]	3.1[72]	3.3[73]	2.9[74]	3.0[75]	3.5[76]	3.9[77]	4.7[78]	4.8[79]	3.6[80]	4.0[81]	3.8[82]					
Number of physicians							3124														
Deaths due to HIV/AIDS (per 100 000 population)		188 [151-233]																			
General government expenditure on health as a percentage of total government expenditure	8.5[83]	7.3[84]	5.6[85]	6.8[86]	7.4[87]	7.7[88]	7.1[89]	8.2[90]	7.9[91]	6.8[92]	6.1[93]	5.0[94]	4.9[95]	6.6[96]	5.9[97]	6.1[98]					
Antenatal care coverage - at least one visit (%)					82																
Gross national income per capita (PPP int. $)	2270	2240	2190	2150	2040	1930	1870	1770	1660	1640	1540	1510	1450	1380	1320	1260	1230	1270	1320	1360	
Civil registration coverage of causes of deaths (%)																					
Total fertility rate (per woman)	4.5																				
Population living in urban areas (%)	58																				
Annual population growth rate (%)	2.2																				
Antiretroviral therapy coverage among HIV-infected pregnant women for PMTCT (%)																					
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	84	80	84	82	81	80	73	73	66	64	62	59	56	48	46	46	38	37	37	42	48
Median availability of selected generic						52.5															

medicines (%) - Private																					
Hospital beds (per 10 000 population)	13				15[99]																
Private prepaid plans as a percentage of private expenditure on health	0[100]	0[101]	0[102]	0[103]	0[104]	0[105]	0[106]	0[107]	0[108]	0[109]	0[110]	0[111]	0[112]	0[113]	0[114]	0[115]					
Per capita government expenditure on health at average exchange rate (US$)	18	16[116]	13	12	11	11	10	11	9	7	6[117]	5	5	6	6	6					
Per capita total expenditure on health (PPP int. $)	122	117[118]	112	101	97	94	91	92	86	81	74[119]	70	67	68	72	52					
Children aged <5 years with ARI symptoms taken to a health facility (%)					34.8																
Children aged <5 years with diarrhoea receiving ORT (%)					19.2																
Per capita government expenditure on health (PPP int. $)	36	30[120]	23	23	22	22	22	25	23	19	15[121]	13	12	14	13	12					
Measles (MCV) immunization coverage among 1-year-olds (%)	79	74	80	74	73	68	64	61	53	51	49	46	47	43	39	46	38	32	37	48	56
Out-of-pocket expenditure as a percentage of private expenditure on health			94.5																		

UNICEF Cameroon Child Survival Data



■Cameroon is ranked 18th amongst the 20 countries in the world with the highest mortality for children under the age of five, which stands at 148 per 1,000

■Only 13 per cent of children under five sleep under insecticide-treated nets, and malaria accounts for more than 40 per cent of all deaths in this age group

■Maternal mortality is alarmingly high at 670 per 100,000 births

■Limited access to, and utilization of, prevention-of-mother-to-child-transmission (PMTCT) services results in HIV infection to children

■Nationally 30.7 per ent of the population lack access to safe drinking water, and some 66.9 per cent lack adequate sanitation, resulting in regular outbreaks of cholera

■Limited access to quality primary education in four regions (Extreme North, Adamawa, East and North) is characterized by low enrolment rates and significant gender disparities

■Thirty per cent of births are not registered in Cameroon, effectively denying an identity and education to these children.

Activities and results for children

■More than 80 per cent of children under five are vaccinated each year, with UNICEF support

■Nearly 80 per cent of health facilities nationwide provide PMTCT services in partnership with UNICEF

■Essential nutrition services are provided in priority health districts where child malnutrition is elevated

■In 2009, UNICEF worked with the government to secure €120 million from Global Fund to Fight AIDS, Tuberculosis and Malaria, with the aim of increasing bed net coverage from 13 per cent to over 80 per cent by 2015

■UNICEF is working with communities and the government to increase access to sanitation from 33 per cent to over 60 per cent by 2015

■Educational quality is being improved through an integrated approach that includes teacher training, parental education and community involvement in school management. Cameroon, a lower middle-income country, has launched an ambitious, long-term development plan for economic growth and employment. UNICEF works to ensure that the rights of children are included in a substantial way in the national plan. While Cameroon is a signatory to all the major child protection conventions, their application is uneven and draft national legislation that would strengthen the legal protection framework has not yet been adopted. UNICEF partners with other actors to accelerate progress in this area.

Conditions for Cameroon's children have deteriorated in recent years. Infant and under-five mortality rates in 2005 were actually higher than their 1990 levels. Issues facing children in Cameroon include Maternal mortality which is alarmingly high.

under-5 mortality rank: 18
under-5 mortality rate 2007: 148
neonatal mortality rate 2004: 30
total population (thousands) 2007: 18.549

Basic Indicators

Under-5 mortality rank : 15
Under-5 mortality rate, 1990: 137
Under-5 mortality rate, 2010: 136
Infant mortality rate (under 1), 1990: 85
Infant mortality rate (under 1), 2010: 84
Neonatal mortality rate, 2010: 34
Total population (thousands), 2010: 19599
Annual no. of births (thousands), 2010: 710
Annual no. of under-5 deaths (thousands), 2010: 93
GNI per capita (US$), 2010: 1160
Life expectancy at birth (years), 2010: 51
Total adult literacy rate (%), 2005-2010*: 71
Primary school net enrolment ratio (%), 2007-2009*: 92
% share of household income 2000-2010*, lowest 40%: 15
% share of household income 2000-2010*, highest 20%: 51

Source: The UNICEF State of the World's Children

Influx of refugees creates silent emergency in eastern Cameroon

In the run-up to the 20th anniversary of the Convention on the Rights of the Child – a landmark international agreement on the basic human rights of all children – UNICEF is featuring a series of stories about progress made and challenges that remain. Here is one of those stories.

By Eva Gilliam

DHAHONG, Cameroon, 6 July 2009 – On the surface, the refugee situation in eastern Cameroon looks like a success, but it is also one of immense chaos. Since 2002, over 60,000 refugees from the neighbouring Central African Republic (CAR) have been integrated into host communities here.

Fragile communities

The refugees – primarily from the Mbororo ethnic group, which spans the region – are nomadic pastoralists and have a long history of shepherding their cattle across the Cameroon-CAR border.

Their familiarity with the terrain and the local villages has made for relatively easy integration, as most of the refugees began living alongside Cameroonians from the start. The generous hosts have shared all the necessary resources, including land, food, water and schools for refugee children.

School attendance nearly doubled in eastern Cameroon in 2008, filling already crowded classrooms with children from refugee families – but most refugee children still are not in school.

"There has been an overwhelming hospitality by the Cameroonian Government towards these refugees," said UNICEF Representative in Cameroon Ora Musu Clemens. "The borders remain open, and the CAR people are welcome to come and take refuge here. But these communities are very fragile already."

Resources strained

Five years since the influx began, the integration of refugees and host communities still holds. However, resources are becoming increasingly strained.

"It has reached an urgent level, but no one knows," said Ms. Clemens. "There has been very little attention to the situation, and that is why we are calling this a 'silent emergency.'"

Traditionally dependent on raising cattle for survival, the Mbororo now find themselves settled in agricultural communities. Many have lost most or all of their herds. They struggle to nourish their families on monthly food distributions from the UN refugee agency.

Child malnutrition increasing

Absatu, a mother and CAR refugee, has been staying at the therapeutic nutrition centre in Djahong, approximately 100 km from the CAR border. Her oldest son is five years old but looks much younger. Absatu brought him to the centre because he became so malnourished, he could no longer walk.

"My husband is gone ... most of the month trying to sell the few cows we have left," she said. "When he comes back, he will have enough money for maybe a week or two. Then he leaves again, and I have to fend for the family. There just isn't any food."

Absatu is not alone. The Mbororo are at a loss for income with which to buy food and other daily necessities. And because the population has grown while the amount of agricultural production has largely stayed the same, the region has seen severe child malnutrition among both refugee children (at nearly 20 per cent) and, increasingly, children from host communities.

“We’re seeing more Cameroonians now,” said Dr. Dzudjo Pierre, who runs a nutritional screening and treatment programme in Garoua Boulai. “When we began, the programme was directed towards Central African refugees, but as we went on, we understood that Cameroonians, too, had the same problem.”

Traditionally dependent on raising cattle for survival, nomadic Mbororo refugees from CAR now find themselves settled in agricultural communities in Cameroon.

Limited school facilities

The move away from traditional patterns has also meant adjusting to village life for refugee families – including schooling for the Mbororo children. School attendance nearly doubled in eastern Cameroon in 2008, filling already crowded classrooms with children from refugee families – but about two-thirds of the 28,000 refugee children still are not in school.

“They were about 150 [students] before,” explained the Director of the Manju Primary School in East Cameroon, Gilbert Nouab. “Now there are more than 300.” Mr. Nouab said many more children who would like to attend school, but there is no infrastructure to support them: “We simply don’t have the buildings.”

The International Federation of the Red Cross is offering to help pay the school fees of children whose families are unable to do so, but if all the children were to come school, there would be no place for them. The UN High Commissioner for Refugees and UNICEF have contributed to infrastructure where possible, yet resources remain insufficient.

International support needed

Additional challenges facing refugee children in Cameroon include a lack of birth registration as well as an increase in child sexual exploitation, early marriage and pregnancy.

Meanwhile, the urgent humanitarian needs in this economically deprived region have gone largely unnoticed by the international community. UNICEF and its partners – including UNHCR, the International Medical Corps and the Red Cross – are doing the most they can with the few resources available to them.

But unless the Cameroonian Government and host communities receive the support they need to develop long-term solutions, this silent emergency will continue to grow.

Infant Feeding In Emergency
By Tamfu Hanson Ghandhi, UN Emergency Volunteer

Cameroon has sporadic emergencies, and according to officials at the ministry of Public Health, department of Health Promotion no specific focus is laid on IYCF, rather all the children are considered globally." Our concern is generally to reduce mortality during emergencies and I think we have been succeeding in this.", retorted Mr. George Okala Sub-director in charge of Food and Nutrition at MINSANTE, when asked why there is no priority for IYCF. But this is very disadvantageous to this group of people with specific needs.

A number of issues pertinent to infant feeding practices in emergencies arose during this programme:

The practice of wet nursing was unacceptable because of the high prevalence of HIV. Mothers, potential wet-nurses, carers and staff would not accept this practice.

There was little choice about which artificial milk products to use. Guigoz and Nestle were the only available brand products and were available for purchase in local shops. Dried Skim Milk, which was not considered an alternative option because of the availability of formula milk, became available later on. There was a lack of non-generic formula feed products through all supply networks e.g. donors, UNICEF. Another artificial milk for malnourished children - Nutriset, was available but not suitable for infant feeding due to impact/influence on the feeding practices of carers. A cup and spoon was used as the method of feeding with infants fed on demand.

There was a general lack of guidelines available for infant feeding practices at field level.

Since no relatives were available, accurate chronological age was difficult to assess. This problem was exacerbated by poor nutritional status and made it difficult to calculate the appropriate feeding regimen.

One carer for each infant was an essential element of the programme. Important aspects such as patience, emotional support and stimulation could then be put into practice.

Carers were reluctant to give infants additional weaning foods before six months. The concept of provision for individual needs for this age group was not accepted.

Medical care was as important as the provision of suitable nutrition in the Concern centre. This was particularly relevant to the older infants who suffered infections etc.

A higher success rate in terms of mortality was generally achieved with the youngest infants (1 to 6 months) in comparison to older infants (7 to 12 months).

It was not apparent why this was the case but it was felt that this may have been due to rapid referral and the fact that the infants were quickly started on suitable formula.

A higher mortality rate was reported for older infants. A possible reason for this was that older infants survived longer under the harsh conditions when hiding in the forests, where inappropriate foods (poisonous bark, diluted milks) were eaten, possibly causing infections and clinical complications. The young infants who endured these situations may not have survived at all. In fact the young babies admitted to the care centres may have spent less time separated from their mothers, giving them a better chance of survival.

If and when relatives were found, the problem of inappropriate foods available at household level remained. Formula feeds were either unavailable or unaffordable in rural areas.

According UNICEF update for Cameroon 459,200 children between 6-23 months are facing nutrition crises in Cameroon's northern regions alone- a situation that has been complicated by ongoing floods affecting the region.

The authorities complain that due to similarities in cultures during the influx of CAR and Chadian refugees, identification is rather difficult as the people easily integrate within Cameroonian societies. These and other reasons including the difficulties in convincing donors on emergency situations are advanced by Cameroonian authorities.

In addition to leaving up to international norms, Cameroon should of necessity include the IYCF-E in its National Emergency Plan.

According to a UNICEF humanitarian action update published on March 27, 2009. Cameroon is facing a silent emergency of malnutrition, lack of basic health services and a lack of access to basic education. Many partners cannot sustain their emergency response capacities due to the lack of funding support.

In 2009, 283,000 people including 63,000 refugees from Central African Republic needed humanitarian assistance particularly in the North and the East of the country which have traditionally been neglected.

There is a need to reinforce existing community-based interventions in almost all sectors.